SUPREME COURT OF NOVA SCOTIA
Citation: *Taylor v. Nova Scotia (Health and Wellness)*, 2017 NSSC 131

Date: 20170630
Docket: *Hfx No.* 458203
Registry: Halifax

Between:

Mark Taylor, Jonathan Trites, Matthew Rigby, Rob Hart, David Morris, Manohar Bance, Emad Massoud, Harry Henteleff, Gerald MacKean, Min Lee, Patrick Casey, Chad Coles, William Oxner, Carman Giacomantonio, Marius Hoogerboord, Katerina Neumann, Lucy Helyer

Applicants

v.

Her Majesty the Queen in Right of the Province of Nova Scotia, as represented by the Minister of Health and Wellness, Medavie Blue Cross, Administrator of Medical Services Insurance, The Attorney General of Nova Scotia

Respondents

LIBRARY HEADING

Judge: The Honourable Justice Ann E. Smith

Heard: May 16, 2017 in Halifax, Nova Scotia

Subject: Interpretation of contractual provisions in Agreement between the Minister of Health and Wellness (DHW) and Doctors Nova Scotia (DNS)

Summary: The Applicant physicians sought judicial review of decisions of the Minister of Health and Wellness made through Medical Service Insurance (MSI). The decisions had refused their requests for access to "facilitated resolution" of their pre-payment assessments pursuant to the 2016 Master Agreement between DHW and DNS. The Applicants claimed that MSI was wrong in its interpretation of the transition and appeal processes found in Schedule E of the Master

Agreement.

Issues: The sole issue was whether MSI correctly interpreted Schedule E of the Master Agreement when it denied the Applicants' requests for facilitated resolution of their pre-payment assessments.

Result: The Application is dismissed. The Applicants are not a party to the 2016 Master Agreement. Articles 52, 53 and 54 of Schedule E contain ambiguities. Taking into account the commercial context of the Master Agreement and reading it as a whole, the Court interpreted the relevant provisions in a manner which best reflected the intent of the parties at the time of their agreement. The interpretation advanced by the Applicants did not result in a sensible commercial result for a number of reasons.

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Heard:	May 16, 2017, in Halifax, Nova Scotia
Counsel:	Brian P. Casey, Q.C., for the Applicants Peter McVey, Q.C., for the Respondents

By the Court:

INTRODUCTION

[1] The Applicant physicians seek judicial review of decisions of the Minister of Health and Wellness (DHW), made through Medical Services Insurance (MSI). These decisions refused their requests for "Facilitated Resolution" of their pre-payment assessments pursuant to the 2016 Master Agreement between Doctors Nova Scotia (DNS) and DHW. The Applicants say that MSI, which administers the Master Agreement, was wrong in its interpretation of the transition and appeal processes found in Schedule E of that Agreement.

Standard of Review

[2] Murphy J. in *Lymburner v. Nova Scotia*, 2016 NSSC 23 concluded that the standard of review for interpreting the appeal provisions in a previous Master Agreement was correctness. The parties agree that although this case involves an interpretation of a Schedule to the Master Agreement, and not the appeal provisions which were at issue in *Lymburner*, nonetheless the standard of review is correctness. I agree. The Court must determine the correct meaning of the provisions of Schedule E at issue.

ISSUE: The sole issue is whether MSI correctly interpreted Schedule E of the Master Agreement when it denied the Applicants' requests for Facilitated Resolution of their pre-payment assessments.

Background and Legislative Framework

[3] Nova Scotia's public health insurance plan is known as Medical Services Insurance or MSI. MSI is created under the *Health Services and Insurance Act*, RSNS 1989, c. 197, as amended *(HSIA*).

[4] Under MSI, most physicians provide medical services to patients and bill the Province under MSI on a fee-for-service basis.

[5] Pursuant to section 3 of the *HSIA*, Nova Scotia residents are insured for medical services in accordance with the "terms and conditions in respect of

payment of the cost of insured professional services to the extent of the tariffs." The tariffs govern all billing matters, including the quantum of payment to physicians. The *HSIA* provides the statutory authority.

[6] Section 3 of the *HSIA* also establishes that it is the Minister of Health and Wellness who establishes the tariff of fees for insured services. In practice, the Minister collaborates with the physicians' bargaining agent, DNS, to negotiate, oversee and update the tariff of fees. The Minister retains the legislative function and power to "interpret tariffs and determine their application to the assessment of claims" (s. 13(1)(d)).

[7] The Minister of Health and Wellness is empowered to negotiate on behalf of the Province all compensation for insured physician services (*HSIA* s. 13(1)(a)). Pursuant to the *Doctors Nova Scotia Act*, SNS 1995-96, c. 12, s. 7 DNS is empowered to enter into agreements with the Province on behalf of all physicians respecting the tariff for insured services. Once such an agreement is entered into, (known as the "Physician Services Master Agreement", or "Master Agreement"), it is binding on each of the Minister, DNS and all medical practitioners (*HSIA*, s. 13A).

[8] On September 9, 2016 the DHW entered into a new Master Agreement with DNS. Article 5 of this Agreement, under the heading, "Governance" provides for the creation of a Master Agreement Management Group ("MAMG") to oversee the implementation and operation of the Agreement, and a Fee Committee ("FC") to amend current fees and create new fees" (Article 4(d)).

[9] Pursuant to article Schedule D of the Agreement, DNS and DHW have equal representation on these governance bodies. The MAMG and FC are to engage in ongoing collaboration respecting the entire scheme of physician billings (Schedule D).

[10] Physicians providing insured services are entitled to receive payment from MSI for their services. The *HSIA* provides that physicians are entitled "only [to] the fee or compensation provided for in the tariff of fees" (s. 29(1) and s. 13)). Physicians who submit claims to MSI must do so in accordance with the procedures established through the MSI program (*HSIA*, s. 27(1)).

[11] In *Lymburner v. Nova Scotia (Health and Wellness)*, 2016 NSSC 23 Murphy J. stated that the "statutory purpose" of the *HSIA* "includes providing a system for doctors' billings to be audited, and for those audits to be reviewed by

way of compliance review" (para. 31). Accordingly, such audit reviews are part of the statutory regime.

[12] The tariff, once adopted by the Governor in Council, has the status of a regulation under the *Regulations Act* (*Cameron v. Nova Scotia (Minister of Health*), [1999] NSJ No 33 (SC), para. 52; upheld on appeal, 1999 NSCA 14, para. 71; *HSIA*, s. 13(c)).

[13] The interpretation and application of such a regulation by a government actor, such as MSI, may be the subject of judicial review.

[14] Section 8 of the *HSIA* provides that the Minister may enter into an agreement with an organization such as Medavie Blue Cross to administer the MSI Plan. The administrator acts on the instructions of the Minister of Health and Wellness.

[15] The 2016 Agreement provides that DHW recognizes DNS as the sole bargaining agent for physicians in Nova Scotia (article 3 (c)). Section 7(1) of the *Doctors Nova Scotia Act*, provides that DNS "may enter into agreements with Her Majesty in right of the Province that bind its members and for that purpose is constituted the sole bargaining agent for any and all duly qualified members." Such agreements may address, among other matters, "the tariff of fees, other systems of payment and the management of the delivery of medical services" (s. 7(1)(a)).

[16] The subject matter of this dispute is addressed in the 2016 Master Agreement signed by the Minister of Health and Wellness and DNS.

[17] The 2016 Agreement introduced, for the first time, an appeal process for "pre-payment assessments." This appeal process is set out in Schedule E to the Agreement. Schedule E provides, as of the Implementation Date (October 9, 2016), a procedure for physicians to challenge both "pre-payment assessments" and "post audit" assessments.

[18] In the preamble to Schedule E, DNS and DHW agreed that, "it is the physician's responsibility to ensure claims are appropriate and consistent with the MSI Physician's Manual, clarifications articulated in the Physicians' Bulletins and that they meet the minimum standards for billing purposes."

[19] The 2016 Agreement provides for physician remuneration in different ways, the most common being by assigning an annual dollar amount per "unit value" and for collaborative negotiation of the number of units assigned to each insured service or procedure undertaken by physicians.

[20] While physicians may bill MSI on a "fee for service basis", the sixteen (16) Applicant physicians all participate in an "Alternate Funding Plan" as defined under the 2008 Master Agreement. The Record before the Court establishes that they bill as a single group, "Surgery AFP", Group #1401." They receive block funding as a Group. They decide themselves how to divide up this block funding. Each of the Applicants has a specialization in surgery.

[21] In order to receive payment by MSI for medical services rendered, physicians, using electronic software, file a claim to MSI for payment. The claim includes the date a service is performed, the patient name and "service encounter number" (a code describing the service), the diagnosis and the claimed units. The insured medical services, including the description of the services, the codes and their value in units are defined in the MSI Physicians' Manual.

[22] The 2016 Agreement, as did previous agreements, creates a procedure for physicians to challenge billing determinations made by the MSI Program. Schedule E of the Agreement describes that procedure, and is binding on all physicians (Article 56).

[23] DNS has agreed, on behalf of all physicians, that the Minister of Health and Wellness has the right to conduct audits of physicians, for any claims with respect to insured medical services, including claims under Alternative Funding contracts, within the terms outlined in Schedule E (Article 8 of the Agreement).

[24] The previous Master Agreement provided only for post-payment audit appeals pursuant to Schedule Z. Schedule E to the 2016 Agreement provides, for the first time, procedures for both pre-payment assessments and post-payment audits. Physicians are only permitted to challenge pre-payment assessments and post-payment audits by the Schedule E procedures (Article 57 of the Agreement).

[25] Schedule E is the "Claims Monitoring and Resolution Mechanism" to the 2016 Agreement. The preamble to Schedule E establishes that the Schedule was the result of a collaborative process among the Minister of Health and Wellness, DNS and Medavie Blue Cross. The process established in Schedule E is like an

appeal, with the physician being deemed to accept MSI's determination absent initiating a contest of a decision.

[26] Schedule E contains Transition Provisions. It is the interpretation of these provisions which is at the heart of this dispute.

[27] DNS is not a party to this dispute. Rather, there are 16 physicians with individual disputes with MSI. The fact that one of the two parties to the Agreement is not before the Court creates some difficulty. The Minister can advise of her interpretation of the provisions, but DNS cannot.

[28] In order to put this dispute in context, I will review the process for physician appeals of post-payment audits as set forth in Schedule Z to the previous Master Agreement.

2008 – 2013 Physician Services Master Agreement – Schedule Z

[29] In October, 2008 DNS entered into a "Physician Services Master Agreement" with the Minister of Health (now DHW). The term of this Agreement was from April 1, 2008 to March 31, 2013.

[30] Article 4 of the Agreement sets out the responsibilities of the parties. It places the contract in a commercial context, with DHW responsible for managing and funding Insured Medical Services to ensure that insured medical services are provided by physicians in accordance with the Agreement. DNS recognizes in this Article that Health oversees and directs funding for the health care system within the limits of a budget.

[31] Article 10(b) provides for the right of DHW to conduct audits of physicians with respect to payments for insured medical services and that the parties agreed to negotiate in good faith, on fair and appropriate criteria, for the conduct of these audits and on appropriate appeal processes by March 31, 2009.

[32] The parties did negotiate an appeals process for audits in November, 2010. The process is set out in a document called, "Audit and Appeal Mechanism." That document became "Schedule Z" to the Agreement. Schedule Z sets out in detail a process and time-lines for physicians to appeal audit results. Schedule Z does not provide for appeals of pre-payment assessments.

[33] The fact that Schedule Z does not provide for appeals of pre-payment assessments does not mean that pre-payments were not being carried out.

[34] The Record discloses that in 2009 the Minister of Health was of the opinion that post-payment audits were not properly responding to physician billing practices. This was problematic for the Minister. The basis for the Minister's concern arose from analysis of claims conducted during fiscal year 2008-2009 which found that forty per cent (40%) of major surgery claims appeared to be billed incorrectly in favour of surgeons. The Minister directed MSI to manually review, by pre-payment assessment, all claims with a "service occurrence greater than one" and all "stacked" claims.

[35] A "service occurrence greater than one" arises when a surgeon submits a claim and it identifies the same physician, the same patient, the same day and a particular surgical code occurring more than once.

[36] A "stacking error" arises when a surgeon breaks a procedure down into components which are each billed separately, rather than billing the over-arching procedure, or if the surgeon bills both the over-arching procedure and the components.

[37] The Minister considers "service occurrences of over one" and "stacked" claims to be billing errors (over-billing) within the MSI system negotiated with DNS.

[38] In response, a new criteria for pre-payment assessment was added to the MSI system effective April 1, 2010, with a further phase in of the plan on July 1, 2010.

[39] Each of the Applicants is a specialist who practices the kind of "major surgery" with billing practices which MSI determined warranted pre-assessment claims review for stacking and service occurrence of greater than one.

[40] As noted previously, physician claims are normally dealt with on an "honour" system basis, with the claims being paid as submitted, with the possibility of an audit at a later date. What the Minister was directing MSI to do was to electronically hive off claims meeting the above criteria, prior to payment. These claims would be manually reviewed and a decision would be made whether to pay all, part, or none of the claim. There was no appeal from MSI's final decision.

[41] While the Applicants' counsel says in his brief that "sometimes" MSI conducts a pre-payment assessment, and that it is a "matter of chance whether a particular account is reviewed before or after payment", the Record discloses that there is nothing random or accidental about the process for pre-payment assessments. Rather, in 2010 a particular process was put in place to focus attention on particular billing practices that MSI found problematic and wanted fixed.

The 2016 Physician Services Master Agreement – Schedule E

[42] In September, 2016 DNS and DHW negotiated a new Master Agreement. For the first time, a process was established for physicians to challenge pre-payment assessments.

[43] The 2016 Agreement was signed September 9, 2016 with an implementation date of October 9, 2016. Schedule E to the Agreement provides a process for appealing pre-payment assessment as well as post-payment audits. The Schedule contains "Transition Provisions" for certain claims started pursuant to the Schedule Z process, but to be completed pursuant to the Schedule E process.

[44] The Preamble to Schedule E provides, in part, as follows:

> In May, 2013, the DHW and DNS jointly commissioned Mr. John Carter, FCA to review the claims monitoring and resolution mechanisms that were in place in Nova Scotia at that time. The resulting report, *The Physician Audit and Appeal in Nova Scotia*, recommended a number of improvements based on best practices across the country to ensure appropriate accountability, while at the same time reducing claims payment wait time in some areas.
>
> An implementation team was struck to execute the report's recommendations, and was comprised of representatives from DNS, the DHW and Medavie Blue Cross (the claims administrator for Medical Services Insurance of MSI), as well as Mr. Carter. This collaborative process has resulted in a new appeal process (Schedule E) that will guide future audit and prepayment assessment appeals.
>
> (emphasis added)

[45] I note that only a very small percentage of claims submitted in 2016 were subject to pre-payment assessment. The "MSI Medicare Final Audit Plan of 2016/2017" indicates that of the 7.8 million claims processed in 2016, only an average of 0.8% were reviewed manually by pre-payment assessment. Obviously,

only a very small percentage of claims are subject to pre-payment assessment, with the vast majority of claims being paid on the "honour system" with the possibility of post-payment audit.

The Transition Provisions of Schedule E – The Heart of the Dispute

[46] Schedule E has Transitions Provisions, the correct interpretation of which is at the heart of this dispute. The Applicants say that the Transition Provisions allow them to appeal pre-payment assessments retroactively. In other words, they say that the Transition Provisions open up the door for them to appeal historic pre-payment assessments under the new appeal provisions of Schedule E. They say so because the transition provisions refer, in effect, to pre-payment assessments being "in the hopper" as of the date of Implementation.

[47] The Minister acknowledges that the language of the Transition Provision refers to pre-payment assessments as being in the hopper as of the Implementation Date, but says that since that could not have been the case (there being no possibility of appealing these pursuant to Schedule Z), the Court should interpret the Transition Provisions in a way which gives effect to the true intent of the parties, which it says was that Schedule E would be for new, not historic, pre-payment assessment appeals.

[48] The Transition Provisions are as follows:

> 52. With the exception of any Arbitrations that are already scheduled as of the Implementation Date of the revised Schedule E, any portion of the claims monitoring process as defined herein that remains outstanding at the Implementation Date shall be governed by the revised Schedule E.
>
> 53. With the exception of any Arbitrations that are already scheduled as of the Implementation Date, each physician for whom any portion of the claims monitoring process is ongoing will be notified fifteen (15) days in advance of the Implementation Date.
>
> 54. Within twenty (20) days of the Implementation Date, each physician must communicate a request to proceed to the next step in the claims monitoring process, otherwise any outstanding Audit or Pre-payment assessment will be confirmed.
>
> a) For greater certainty:
>
> i. a physician who has received and disagrees with an Audit Result shall submit to MSI a Notice of Audit Review to initiate Audit Review as outlined herein;

> ii a physician who has received and disagrees with a Notice of Determination shall submit a Notice of Dispute in writing to MSI, and Facilitated Resolution shall proceed as outlined herein;
>
> iii a physician who has submitted a Notice of Dispute but has not yet had Arbitration scheduled shall proceed with Facilitated Resolution as outlined herein.
>
> 55. Any dispute that ceases to follow the processes set out in this Schedule E, or the initiation of any insolvency steps by the Physician, will result in the commencement of collection procedures as outlined herein.
>
> 56. DNS and DHW agree that, pursuant to s. 7 of the *Doctors Nova Scotia Act*, this Schedule E is an agreement which DNS may enter into that binds its members.
>
> 57. Physicians are only permitted to challenge pre-payment assessment of claims and/or post-payment audit of claims through the processes outlined in this Schedule.
>
> 58. The results of any arbitration, facilitated resolution or decision pursuant to clauses 6, 10, 12, 19, 20, and 25(a) are final and conclusive, and are not open to question or review by a court or other body on any grounds, including by way of judicial review.
>
> (emphasis added)

[49] The term "monitoring" is defined in Schedule E as including both pre-payment assessments of claims and post-payment audit of claims.

[50] In September and October, 2016, each of the physician Applicants wrote to MSI stating that he or she objected to its decisions concerning submitted claims. Most of the 16 physicians attached detailed lists of historic pre-payment assessments which MSI had determined in its favour.

[51] Each physician received a letter in response from an MSI Appeals Coordinator stating:

> Thank you for your letter dated_____. Only those pre-payment assessment results which take place <u>after</u> Schedule E was implemented fall under the Schedule E process.
>
> (emphasis added)

[52] Each physician replied to this letter:

> Re: <u>Notice of Dispute</u>

> Further to my previous correspondence, I wish to confirm that I am in disagreement with MSI's determination concerning my claims and I am providing you with my notice of dispute in accordance with Schedule E of the Physician Services Master Agreement (the "Agreement").
>
> The Agreement at Schedule E, section 52 says:
>
> *With the exception of any Arbitrations that are already scheduled as of the Implementation Date of the revised Schedule E, any portion of the claims monitoring process as defined herein that remains outstanding at the Implementation Date shall be governed by the revised Schedule E.*
>
> *(Emphasis added.)*
>
> Section 29 of Schedule E reads:
>
> > *If the physician disagrees with the Notice of Determination, the physician may, by notice in writing, within twenty (20) days from the date he/she receives the Notice of Determination, submit an objection in writing to MSI (the "**Notice of Dispute**").*
>
> I rely on the correspondence I have previously sent in support of this Notice of Dispute.
>
> As I am objecting to MSI's determination, this matter should be handled in accordance with the Facilitated Resolution process set forth in Schedule E.
>
> I look forward to resolving this matter.
>
> (emphasis added)

[53] It is noted that although the physicians refer to their "notice of dispute" and the "notice of determination", those terms are the terms employed in Articles 24-30 with respect to post-payment audit reviews. Articles 4-12 deal with pre-payment assessments.

[54] I accept the following excerpts from the Minister's brief at paragraphs 55-56 and 59-64 to be an accurate review of the Schedule E regime:

> The procedure under the Agreement for challenging a pre-payment assessment is detailed. It starts with electronic notification from MSI to the physician, advising the physician that the claim was rejected or "adjusted" as a result of a "Pre-Payment Assessment; this is called the "MSI Result." [Article 4]
>
> The physician is now deemed to have received the MSI Result within five days of its sending. [Article 5] If a physician disputes a MSI Result, the physician must, within ten (10) business days of receipt or deemed receipt of the MSI Result, contact MSI in writing to initiate a request for Pre-Payment Assessment Review. [Article 8]

> If the physician fails to act within the ten business day window following receipt of an MSI Result (or deemed receipt), the physician is further deemed to agree with the MSI Result and "forfeits further rights to Facilitated Resolution or Arbitration." [Article 9]

[55] The opening words of Articles 52 and 53 refer to "Arbitrations that are already scheduled as of the Implementation Date." None of the Applicant physicians had a dispute concerning any pre-payment assessment already scheduled for arbitration as of the Implementation Date, as pre-payment assessments were not subject to arbitration under the former Schedule Z.

[56] There could not be pre-payment assessments already scheduled for arbitration; yet, the reference to the "claims monitoring process" in the plain language of Articles 52 and 53 suggests that such cases could have been already scheduled.

[57] Article 54 also refers to outstanding "Audit(s)" and "Pre-assessment" payments. The Article states that any "outstanding audit or pre-payment assessment will be confirmed" unless "within twenty (20) days of the Implementation Date, the physician communicates a request to proceed to the next step in the claims monitoring process." However, prior to the new Agreement, there were no "next steps" in the "claims monitoring process" to take in relation to pre-payment assessments. The former Schedule Z only provided for "next steps" for post-payment audits.

[58] Given the ambiguities I have noted in the language of the Transition Provisions, I turn to a review of the law governing contract interpretation.

LAW AND ANALYSIS

General Law of Contract Interpretation

[59] The Supreme Court of Canada in *Eli Lilly 8 Co*, [1998] 2 S.C.R. 129 urged the Court to search for a contractual interpretation which appears to advance the true intent of the parties at the time of their agreement (para. 52):

> …[T]he normal rules of construction lead a court to search for an interpretation which, from the whole of the contract, would appear to promote or advance the true intent of the parties at the time of entry into the contract.

[60] The more recent decision of the Supreme Court of Canada in *Sattva Capital Corp. v. Creston Moly Corp.*, 2014 SCC 53 reiterates that a decision maker must read the contract as a whole, consider the surrounding circumstances known to the parties at the time of the agreement, using a practical and common sense approach:

> **47** Regarding the first development, the interpretation of contracts has evolved towards a practical, common-sense approach not dominated by technical rules of construction. The overriding concern is to determine "the intent of the parties and the scope of their understanding" (*Jesuit Fathers of Upper Canada v. Guardian Insurance Co. of Canada*, 2006 SCC 21, [2006] 1 S.C.R. 744, at para. 27 *per* LeBel J.; see also *Tercon Contractors Ltd. v. British Columbia (Transportation and Highways)*, 2010 SCC 4, [2010] 1 S.C.R. 69, at paras. 64-65 *per* Cromwell J.). To do so, a decision-maker must read the contract as a whole, giving the words used their ordinary and grammatical meaning, consistent with the surrounding circumstances known to the parties at the time of formation of the contract. Consideration of the surrounding circumstances recognizes that ascertaining contractual intention can be difficult when looking at words on their own, because words alone do not have an immutable or absolute meaning:
>
> > No contracts are made in a vacuum: there is always a setting in which they have to be placed… . In a commercial contract it is certainly right that the court should know the commercial purpose of the contract and this in turn presupposes knowledge of the genesis of the transaction, the background, the context, the market in which the parties are operating.
> >
> > (*Reardon Smith Line*, at p. 574, *per* Lord Wilberforce)
>
> **48** The meaning of words is often derived from a number of contextual factors, including the purpose of the agreement and the nature of the relationship created by the agreement (see *Moore Realty Inc. v. Manitoba Motor League*, 2003 MBCA 71, 173 Man. R. (2d) 300, at para. 15, *per* Hamilton J.A.; see also Hall, at p. 22; and McCamus, at pp. 749-50). As stated by Lord Hoffmann in *Investors Compensation Scheme Ltd. v. West Bromwich Building Society*, [1998] 1 All E.R. 98 (H.L.):
>
> > The meaning which a document (or any other utterance) would convey to a reasonable man is not the same thing as the meaning of its words. The meaning of words is a matter of dictionaries and grammars; the meaning of the document is what the parties using those words against the relevant background would reasonably have been understood to mean. [p. 115]

[61] In *Eli Lilly* the Supreme Court of Canada referred to its earlier decision in *Consolidated – Bathurst Export Ltd. v. Mutual Boiler and Machinery Insurance Co.*, [1980] 2 S.C.R. 888 at p. 901:

> … [L]iteral meaning should not be applied where to do so would bring about an unrealistic result or a result which would not be contemplated in the commercial atmosphere in which the insurance was contracted. Where words may bear two constructions, the more reasonable one, that which produces a fair result, must certainly be taken as the interpretation which would promote the intention of the parties. Similarly, an interpretation which would promote the intention of the parties. Similarly, an interpretation which defeats the intentions of the parties and their objective in entering into the commercial transaction in the first place should be discarded in favour of an interpretation … which promotes a sensible commercial result.
>
> (emphasis added)

[62] I interpret the principles expressed in these cases as requiring the Court to read the contract as a whole, give the words their ordinary meaning, consider the surrounding circumstances known to both parties at the time they entered into the contract in order to inform the Court's understanding of the mutual and objective intentions of the parties, consider the purpose of the agreement and the nature of the relationship between the parties.

[63] I will apply these principles in determining whether the parties intended pre-payment assessments prior to October 9, 2016 to be covered by Schedule E.

Interpretation of the Transition Provisions of Schedule E

[64] DHW and DNS have not expressed their intentions clearly in Articles 52, 53 and 54.

[65] It bears repeating that the 16 Applicant physicians are not a party to a contract with DHW. Rather, their bargaining agent, DNS, is a party to the 2016 Master Agreement and Schedule E of that Agreement. DNS is not a party to this proceeding and accordingly the Court does not have the benefit of hearing its views on the matters at issue. The interpretation advanced by the Applicants is theirs alone. There is no evidence that this interpretation is supported by DNS.

[66] The key provisions of Schedule E are set out above. Reading these provisions alone provides the Court with little assistance in deciding whether historic pre-payment assessments are caught by the Transition Provisions since Articles 52, 53 and 54 are inherently ambiguous.

[67] Looking at the 2008 Master Agreement as a whole, the only thing that DNS and DHW expressly said would remain in effect after the expiration of the

Agreement in 2013 were the tariffs and the provisions relating to dispute resolution between DNS and DHW.

[68] Looking at the 2016 Master Agreement, only the rate increases (for physician payment) are retroactive to April 1, 2015. All other provisions of the agreement are effective on execution (September 9, 2016).

[69] What this means is that DNS and DHW expressed some intent in the terms of agreement clauses of the 2008 and 2016 Agreements about certain things which would continue under the 2008 Agreement, and certain things which would be retroactive under the 2016 Agreement. DNS and DHW expressed no direct intent that Schedule E would have the retroactive effect proposed by the Applicants.

[70] The Applicants say that since Schedule E identified a 24-month time period for audits, it is clear that Schedule E is intended to have retroactive effect. The Minister argues that a two-year time period is the standard time frame for every external billing audit, as set out in the MSI Procedures Manual, with the two-year period being in place for many years.

[71] Audits are inherently retroactive and it is clear that retroactive audits have been in place for a long period of time. The fact that Schedule E refers to a 24-month time period does not bolster the Applicants' argument that the Transition Provisions have retroactive effect.

[72] The language of Articles 52, 53 and 54 clearly refers to pre-payment assessments being "ongoing" and "outstanding" on October 9, 2016. The Applicants say that the Court should not conclude that the parties inserted this language without intending for it to have meaning.

[73] The Applicants say that the ordinary meaning of the language used in Schedule E, reading Articles 52, 53 and 54 together, is that a portion of the claims monitoring process relating to pre-payment assessments may remain outstanding as of October 9, 2016 (the Implementation Date). That, say the Applicants, triggers an obligation on MSI to give notice of any pre-payment assessments which have not concluded by full payment or arbitration.

[74] The Applicants say that the effect of Articles 53 and 54 together gives a physician 35 days for initiating an appeal – a longer period than exists under paragraphs 8 and 24 for "new" claims' appeals. This, they say, is consistent with the fact that the Transition Provisions might catch a large number of pre-payment

assessments. The Applicants say that Articles 57 and 58 act like a curtain, imposing a limitation period on the appeal of all pre-payment assessments not disputed within 20 days of the Implementation Date.

[75] However, for the Court to adopt the Applicants' interpretation, the Court must ignore the plain language of Article 53 which says that physicians with ongoing claims "will be notified fifteen (15) days in advance of the Implementation Date." None of the Applicants were so notified. The Applicant physicians agree that they did not receive notice, but say that this should not mean that MSI can ignore their appeals; otherwise, MSI could simply refuse to give notice to a physician and rely upon its inaction to determine the physician's rights.

[76] Rather than being notified, the Applicants have "self-notified" themselves as having pre-payment assessment disputes, a process which is not provided for in the Transition Provisions.

[77] I note that a Physician's Bulletin dated September 14, 2016 states:

> MSI will be sending a notification to each physician for whom any portion of the claims monitoring process is ongoing.

[78] The Minister argued, and the Applicants did not contend otherwise, that Physician Bulletins are a type of delegated instrument with legal significance. It is also noted that the preamble to Schedule E states, in part:

> All parties agree that it is the physician's responsibility to ensure claims are appropriate and consistent with the MSI Physician's Manual and **clarifications articulated in the Physicians' Bulletins** and that they meet the required minimum standards for billing purposes."
>
> (emphasis added)

[79] In essence, what the Applicant physicians did was reverse the process described in Article 53 and the September 14, 2016 Physician's Bulletin by themselves giving notice to MSI 30 days in advance of the Implementation Date advising of their belief that they had outstanding pre-payment claims in advance of the Implementation Date.

[80] I find that Article 53 makes it clear that DNS and DHW intended and agreed that the process of assessments was to be initiated by MSI, and not, as proposed by the Applicants, by individual physicians. It was MSI which would be the party which would identify those physicians that had a live claims monitoring dispute,

and they would do so in advance of October 9, 2016. Three of the Applicant physicians were so notified by MSI because they had outstanding post-payment audits.

[81] While Article 54 does say that any "outstanding Audit or pre-payment assessment will be confirmed" if not challenged by a request to proceed "to the next step in the claims monitoring process", prior to the 2016 Agreement, there were no "next steps" in the claims monitoring process. Looking only at the text in Articles 52-54, the Applicants' argument has some logic, but I must consider not just the pure text, but also the other factors noted above, including the commercial effect of the Applicants' interpretation.

[82] In that regard, Article 9 provides that once a pre-payment assessment review is initiated, "this will be considered by both the DHW Medical Consultant within fifteen (15) days of receipt of the Request for Pre-Payment Assessment Review." If the Applicants' interpretation is correct, the two Medical Consultants would have had to convene within 15 days of September 9th and resolve all of the 16 Applicants' "disputes" going back two years. The Minister argued, and I agree, that the parties could not have intended to so overburden the system they mutually agreed to by bringing into the mix these dated, and already determined assessments. This retroactive interpretation creates a construction that could overwhelm the system the parties agreed to for resolving billing disputes.

[83] The Applicants' interpretation of Article 54 ignores the fact that the "For Greater Certainty" clause only refers to post-audit reviews. Article 54(a)(i) refers to an "Audit Result", which is post-audit. Article 54(a)(ii) refers to a "Notice of Determination", also post-audit and Article 54(a)(iii) refers to a "Notice of Dispute", similarly, post-audit. I find that the "For Greater Certainty" clause better captures the mutual intention of DHW and DNS than does the reference to pre-payment assessments in the lead-in sentence of Article 54.

[84] Also, Article 54 does not refer to existing "MSI Results" – which is the determination in Article 4 that is made for all pre-payment assessments. Nothing is said about advancing pre-payment disputes by means of any document for pre-payment assessments, only post-payment audits. The "For Greater Certainty" clause provides no advice on how to advance such claims.

[85] If the logic of the Applicants is followed and the Transition Provisions apply to these pre-payment assessments, then Article 5 of Schedule E also applies. Article 5 states that all such outcomes must be challenged within ten days of the

physician being advised of the pre-payment assessment or the physician is deemed to have accepted the result.

[86] As noted previously, many of the pre-assessment claims of the Applicants' go back months and even years. To accept the Applicants' interpretation would be to ignore the fact that the "deemed acceptance" deadline for most of the pre-payment assessments has long passed.

[87] I agree with the Minister, that if the Applicants' retroactive interpretation is correct with respect to pre-payment assessments, then it logically follows that post-payment audits could also be retrospective. That would mean that two very different procedures for post-payment audits would both apply during the supposed retroactive time frame. The "terrain" covered by Schedule Z would also be retroactively covered by Schedule E. That could not have been the mutual intention of the DNS and DHW.

[88] I find that the Applicants' reading of the Transition Provisions does not reflect the actual intention of the parties. The parties could not have intended that:

(a) Physicians may self-select whether they have outstanding billing disputes, in circumstances where Article 53 and the Physician's Bulletin make it clear that MSI identifies those physicians. In this regard, I do not accept that MSI chose not to "notify" these physicians to thwart their appeal efforts. Rather, I accept that MSI considered the Applicants' self-identification of "outstanding" claims to be an attempt to have historic pre-payment assessments appealed in circumstances where they had already been determined.

(b) The "For Greater Certainty" clause (Article 54) applies to pre-assessment payments, yet omits directions for advancing such disputes.

(c) The "ten day" requirement to challenge pre-payment assessments and time is of the essence implicit principle would be (implicitly) waived.

(d) All of Schedule E may be applied retroactively, despite the prior existence of Schedule Z, covering the same ground for post-payment audits.

(e) The Preamble to Schedule E which refers to Schedule E as "guid[ing] future audit and prepayment assessment appeals" is to be ignored.

[89] I am conscious that a Court is to give meaning to a document without doing violence to the language used. However, I am convinced that in this case, taking into account the commercial context of the relationship between DNS and DHW, I must interpret the Transition Provisions in a manner which supports the intentions of the parties and their objectives in entering into the Agreement, including Schedule E. I must favour an interpretation which promotes a sensible commercial result. I find that that result is that the parties intended that only post-payment audits would be caught by the Transition Provisions. In doing so, I am mindful that I must ignore the plain language of the Articles which clearly refers to pre-payment assessments. However, I feel a departure of the plain meaning of the words is justified in the circumstances.

[90] If the parties to the Agreement thought that pre-payment assessments would be caught by the Transition Provisions, surely they would have provided the kind of language found in the "For Greater Certainty" clause concerning post-audit appeals. Nowhere in the Transition Provisions is there a process set forth as to how a physician could challenge an historic pre-payment assessment. The Applicants acknowledge as much and that is evident by the fact that they "self-identified" as having an outstanding MSI dispute when their bargaining representative, DNS, had agreed with MSI, that it would be MSI which would notify physicians who had ongoing disputes. Indeed several of the physician Applicants were notified by MSI that they had outstanding audit disputes that would now be dealt with pursuant to Schedule E, and the process for dealing with those disputes. They were not so notified concerning pre-assessment audits.

[91] The parties could not have wanted both Schedule Z and Schedule E applying to post-payment audits, which would be the absurdity which would result if the Applicants' interpretation is accepted.

CONCLUSION

[92] I conclude that the interpretation of the Transition Provisions by the MSI Program is correct. The Applicants may not appeal their historic pre-assessment claims pursuant to Schedule E.

[93] The Applicants' application for judicial review is dismissed with costs. If the parties cannot agree on costs, I will receive submissions within 30 calendar days of the date of this decision.

Smith, J.