THE DISCIPLINE COMMITTEE OF THE COLLEGE OF OPTOMETRISTS OF ONTARIO

Panel: Dr. Linda Chan, Chair
Dr. Mark Eltis
Dr. Vivian Habib
Mr. Hsien Ping (Albert) Liang
Mr. Brian Rivait

B E T W E E N:

The College of Optometrists of Ontario	)	Ms. Bonni Ellis Counsel for the College of Optometrists of Ontario
- and -	)	
Dr. Andrew M. Mah	)	Mr. Matthew Wilton Counsel for Dr. Andrew M. Mah
	)	Ms. Julie Maciura Independent Legal Counsel
	)	**Heard on September 5, 2018**

DECISION AND REASONS

This matter came before a Panel of the Discipline Committee of the College of Optometrists of Ontario (the “College”) on September 5, 2018, at the College of Optometrists of Ontario, 65 St. Clair Ave E, Suite 900, Toronto, Ontario.

The purpose of the hearing was to consider allegations of professional misconduct referred by the Inquiries, Complaints and Reports Committee against Dr. Andrew M. Mah (the “Member”).

The five members of the Discipline Panel referred to above were in attendance, as well as Dr. Andrew M. Mah and his counsel, Mr. Matthew Wilton; Ms. Bonni Ellis, counsel for the College, accompanied by Dr. Paula Garshowitz, Registrar; and Ms. Julie Maciura, independent legal counsel to the Discipline Panel.

The hearing was called to order at 9:45 a.m. September 5, 2018. The Chair introduced the Panel and the other people present in the room.

Publication Ban

On the consent of Dr. Mah, College counsel requested, and the Panel granted, a ban on the publication, broadcasting or disclosure of the names of any patients and/or any information that would disclose the identity of any patients, referred to during the hearing or in documents filed at the hearing.

The Panel's reasons for granting the motion are that personal health information or other matters may be disclosed at the hearing, which are of such a nature that the harm created by disclosure would outweigh the desirability of adhering to the principle that hearings be open to the public. The signed Order granting the publication ban was filed as Exhibit 1.

Allegations and Evidence

College counsel took the Panel through the Notice of Hearing, which was filed as Exhibit 2.

The Notice of Hearing made the following allegations against Dr. Mah:

1. You have committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.16 of Ontario Regulation 859/93 (now revoked) and/or paragraph 1.13 of Ontario Regulation 119/94, in that, between approximately January, 2014 and July, 2015 you recommended and/or provided unnecessary diagnostic or treatment services in relation to patients 1-25, including, but not limited to:

    a) ongoing monitoring and/or office visits;

    b) automated visual field testing (AVF);

    c) fundus photography;

    d) Heidelberg retinal tomography (HRT);

    e) pachymetry;

    f) digital retinal imaging (DRI);

    g) optical coherence tomography (OCT);

    h) Ultrasound Corneal Pachymetry (UCP);

    i) Anterior Ocular Imaging (AOI); and/or

j) prescriptions for spectacles.

2. You have committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.17 of Ontario Regulation 859/93 (now revoked) and/or paragraph 1.14 of Ontario Regulation 119/94, in that, between approximately January 2014 and July 2015, you failed to maintain the standards of practice of the profession in relation to your care and management of patients 1-25 and, in particular,

   a) portions of your healthcare records for these patients were illegible;

   b) you diagnosed patients with glaucoma or as "glaucoma suspect", in circumstances where that diagnosis was not supported by the clinical findings;

   c) you recommended that patients return for office visits in circumstances and at frequencies that were not clinically indicated;

   d) you prescribed eyeglasses for patients in circumstances where such prescriptions were not supported by the clinical findings, and/or unnecessary, and/or inappropriate;

   e) you referred patients for consultations with an ophthalmologist in circumstances where such a referral was not clinically indicated;

   f) you failed to conduct the appropriate tests and/or use the appropriate equipment to investigate patients with suspected glaucoma; and/or

   g) you failed to conduct the appropriate tests and/or use the appropriate equipment to investigate patients with suspected diplopia.

3. You have committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.27 of Ontario Regulation 859/93 (now revoked) and/or paragraph 1.24 of Ontario Regulation 119/94, in that, between approximately January 2014 and July 2015 you failed to maintain records in accordance with Part IV in relation to patients 1-25, including, but not limited to deficiencies with respect to your documentation of:

   a) the patient's health and oculo-visual history;

   b) the clinical procedures used;

   c) the clinical findings obtained; and/or

d) the diagnosis.

4. You have committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.32 of Ontario Regulation 859/93 (now revoked) and/or paragraph 1.28 of Ontario Regulation 119/94, in that, between approximately January 2014 and July 2015 you submitted or allowed to be submitted an account(s) for professional services in relation to patients 1-25 that you knew or ought to have known was false or misleading and, in particular, you:

   a) submitted accounts to OHIP under billing codes V402, V406, V408, V409, V410 in circumstances where you knew or ought to have known that the criteria for submitting accounts under those billing codes were not met; and/or

   b) submitted accounts to patients for visits, tests and/or procedures that you knew or ought to have known were not clinically indicated.

5. You have committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.53 of Ontario Regulation 859/93 (now revoked) and/or paragraph 1.39 of Ontario Regulation 119/94 in that, between approximately January 2014 and July 2015, you engaged in conduct or performed an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical regarding your care and management of patients 1-25, you:

   a) recommended that patients attend at your office for visits, tests, procedures and/or ongoing monitoring in circumstances where such visits, tests, procedures and/or ongoing monitoring was not clinically indicated;

   b) billed OHIP and/or patients for office visits, tests, and procedures that were not clinically indicated;

   c) made diagnoses, referrals, and prescriptions that were not clinically indicated;

   d) failed to maintain legible patient records; and/or

   e) failed to maintain adequate patient records.

Agreed Statement of Facts

College counsel advised the Panel that agreement had been reached on the facts and filed an Agreed Statement of Facts that was signed by Dr. Mah and the Registrar of the College and was marked as Exhibit 3.

The Agreed Statement of Facts provided as follows:

THE MEMBER

1. Dr. Andrew Mah, ("the Member") has been registered with the College of Optometrists of Ontario ("the College") in the general class since September 1996, after obtaining his Optometry degree from the University of Waterloo, School of Optometry and Vision Science earlier that year.

2. The Member has his own practice, "Dr. Andrew Mah & Associates", which is located in Oshawa ("the Clinic"), where the events at issue in this proceeding took place.

3. Dr. Jason Dorfman, MD, FRCS(C), DABO ("Dr. Dorfman"), is the Director of Ophthalmology at the Clinic.

4. At the time the events in this matter took place, the Member was a member in good standing at the College and was subject to the jurisdiction of the College.

THE MEMBER'S PRIOR DISCIPLINE HISTORY

5. The Member has a prior discipline history with the College. A hearing was held on January 24, 2014 to address allegations of professional misconduct against the Member, which had been referred to the Discipline Committee by the Inquiries, Complaints, and Reports Committee. The matter proceeded by way of an Agreed Statement of Facts (ASF) and a Joint Submission on Penalty (JSP), meaning that it was an uncontested hearing.

6. The ASF included the Member's admissions that he routinely provided and charged for services that were not clinically indicated and were unnecessary, including visual field examinations (VFE) [also referred to as automated visual field testing (AVF)], pachymetry testing, anterior ocular imaging (AOI), digital retinal imaging (DRI), and Heidelberg retinal tomography (HRT). With respect to some of the unnecessary VFE, the Member had charged both the patient and the Ontario Health Insurance Plan (OHIP). With respect to the other tests the Member had charged the patients. Further, the Member had used the OHIP diagnostic code for glaucoma to justify billing and providing services that were not clinically necessary, as listed above. The Member also admitted that he had failed to maintain adequate records.

7. The panel of the Discipline Committee ("the Panel") appointed to preside over the Member's hearing issued its written Decision and Reasons immediately after the hearing on January 24, 2014 ("Appendix "A"). The Panel made findings that the Member had engaged in professional misconduct with respect to:

   a. providing unnecessary treatment or diagnostic services;

   b. charging fees that were excessive or unreasonable in relation to the services performed;

   c. charging or receiving more than the amount payable under OHIP; and

   d. engaging in conduct that members of the profession would view to be disgraceful, dishonourable, unprofessional or unethical.

8. In the context of the "penalty" portion of the hearing, the parties presented the Panel with an Undertaking (a contract) between the Member and the College, in which he agreed to certain things, including:

   a. a practice assessment and practice re-assessment, both of which would occur on a random date within twelve (12) to twenty-four (24) months, to review his clinical judgment and records as well as his billing practices in relation to twenty-five (25) patient files; and

   b. to pay, within six (6) months, restitution totaling $4,706 in relation to thirty-one (31) patients, whom he had charged inappropriate fees between January 1 and July 22, 2011.

9. The Undertaking was a significant factor in the Panel's decision to accept the terms of the JSP, which included the following components:

   a. an oral reprimand;

   b. a three (3) month suspension, the entirety of which would be remitted (not served) if the Member paid the restitution to the patients identified in his Undertaking within six (6) months; and

   c. costs payable to the College in the amount of $11,000.

10. During the hearing, the Member apologized for his behaviour, which he recognized had affected the public trust, and said that he was committed to ensure that the conduct would not recur.

11. The current matter stems from the information obtained during the practice assessment component of the Member's Undertaking.

THE ASSESSMENT PROCESS

A. OHIP Information

12. Prior to assessing the Member's practice, the College wrote to the Ministry of Health and Long Term Care (MOHLTC) on May 7, 2015, to request details about claims for OHIP insured services that the Member had submitted between March 1, 2014 and February 28, 2015. Specifically, the College requested the following information with respect to claims submitted within these dates:

- the date the claim was submitted to OHIP;
- the date the service was rendered;
- the amount claimed;
- the diagnostic billing code used; and
- the amount OHIP paid the Member.

13. OHIP provided a report to the College dated May 11, 2015 with the requested information.

B. Patient Health Records

14. The terms of the Member's Undertaking stipulated that his practice would involve a review of twenty-five (25) patient health records. On July 8, 2015, a College representative attended the Member's office to obtain full records in relation to at least twenty-five (25) patients for whom the Member had provided an examination and billed OHIP after the January 24, 2014 date of his Undertaking. Based on the report it received from OHIP, the College provided the representative with three lists setting out the names and other identifying details for patients who met these criteria. These patients were grouped into the following categories:

    a. patients over the age of sixty-five (65) with 406 and 402 OHIP billing codes;

    b. patients between the ages of twenty (20) and sixty-four (64) with 409/408 OHIP billing codes; and

    c. patients under the age of twenty (20).

15. The College representative obtained fifteen (15) patient files from list (A) and at least five (5) files from each of lists (B) and (C), so that twenty-five (25) patient health records in total could be reviewed.

C. The Practice Assessment Questionnaire

16. As part of its assessment, the College also sent the Member a *Practice Assessment Questionnaire* ("the Questionnaire") on July 31, 2015. The Member was asked to provide his answers to the Questionnaire and was advised that these would be used as part of the

assessment and records review process. The Member returned his completed Questionnaire together with a blank patient record (including an initial examination form and subsequent examination form), a welcome sheet, and a table of acronyms/abbreviations commonly used in his clinical records, which had also been requested by the College.

17. One of the questions on the Questionnaire asked whether the Member's practice was limited to a particular patient population. In his response, the Member stated "no", but provided the following clarification:

> *However we work closely with several general ophthalmologists and consequently our patient population includes a high percentage of patients with glaucoma, diabetes, age-related macular degeneration as well as other more advanced ocular disease conditions.*

D. The Records/Billing Review

18. The College forwarded the twenty-five (25) patient health records and the Member's answers to the Questionnaire to Dr. William Ulakovic ("the Assessor"), with instructions to undertake both a complete record assessment (CRA) and a billing assessment of each patient health record in accordance with the following criteria:

    a. whether records were maintained in accordance with Part IV – Records of O. Reg. 119/94;

    b. whether the services provided, and the corresponding fees charged to patients and/or OHIP, were clinically justified and medically necessary, both generally speaking and with regard to the OHIP *Schedule of Benefits for Optometry Services* ("the OHIP Schedule"), with particular attention to the use of the diagnostic codes for glaucoma, visual field testing, pachymetry testing, anterior ocular imaging, digital retinal imaging and Heidelberg retinal tomography;

    c. whether there were instances where both the patient and OHIP were charged for the same service; and

    d. whether the Member had maintained the standards of practice in accordance with the *Optometric Practice Reference* (OPR).

E. The Assessor's Reports and the Member's Responses

19. The Assessor's CRA report, dated October 13, 2015 (Appendix "B"), provided both general comments regarding the Member's billing practices, treatments and records as well as specific observations in relation to each of the twenty-five (25) patient health records he reviewed. The Assessor identified several serious omissions and specific concerns in relation to nine (9) of the files. The Member was provided with an opportunity to comment

on the Assessor's CRA report. However, the Assessor made several comments regarding the illegibility of the Member's notations in the patient health records.

20. As a result, the College wrote to the Member to request transcriptions of his notations in eleven (11) of the patient health records, which the Member provided. These, in turn, were sent to the Assessor together with a copy of the Member's response to the Assessor's initial report. Following his review of both documents, the Assessor provided the College with an updated assessment report dated November 28, 2016 (Appendix "C"). At times the Assessor reversed his initial criticism of the Member's care and/or billings on the basis of the information the Member provided in his transcriptions.

21. It was subsequently noted that the Member's transcriptions of his clinical records supplement considerably what is noted in those documents.

THE STANDARDS/ONTARIO REGULATION 119/94, PART IV - RECORDS

22. Part IV – Records of O. Reg. 119/94 ("Part IV"), which was in place at the relevant time, sets out the requirements for patient health records, which includes the following:

10 (2) The patient health record must include the following:

- The patient's health and oculo-visual history.
- The clinical procedures used.
- The clinical findings obtained.
- The diagnosis, when possible.

23. Further, Section 5.1 of the College's *Optometric Practice Reference* (OPR), which provides additional clarifications regarding the standards of practice for the patient health record, includes the following expectations:

- be legible and complete;
- include proposals for care and advice offered; and
- include a description of the care rendered and recommendations for ongoing care.

24. Together, these documents inform the standards of practice expected of Ontario Optometrists with respect to patient health records.

THE OHIP BILLING CODES/CRITERIA

25. The following chart summarizes, in lay terms, the OHIP billing codes and the circumstances in which it is acceptable to use them. These codes and their criteria are published in the *OHIP Schedule of Benefits for Optometry Services*, which is readily

available on the website for the MOHLTC. Members are expected to be aware of the billing and diagnostic codes and the criteria for using them

Billing Code	**Type of Assessment**	**Age Criteria**	**Description**
V402	Minor	Children 65+	Reassessment after (404 or 406) major examination within past 12 months.
V404	Major	Children	Annual eye exam (once per 366 days up to age 19).
V406	Major	65+	Annual eye exam (once per 366 days up to age 19).
V408	Minor	20-64	Reassessment after major (409) examination within past 12 months.
V409	Major	20-64	Patient must have one or more of the following: diabetes mellitus (DM), glaucoma (diagnostic code 365), cataract (diagnostic code 366), retinal disease, amblyopia, visual field defect (VFD), corneal disease, strabismus (diagnostic code 378), recurrent uveitis, or optic pathway disease. OR have a referral from a physician or registered nurse in the extended class (RNEC) A patient must have been diagnosed with glaucoma to justify the use of diagnostic code 365: a diagnosis of "glaucoma suspect" is not sufficient.
V410	Automated Visual Field Testing (AVF)		When necessary/appropriate to assess the extent and sensitivity of visual fields. Cannot bill OHIP for a 410 unless the patient has already received an OHIP insured service (i.e., a 409 for adults, a 404 for children, or a 406 for seniors). Can conduct AVF testing for "glaucoma suspect" in accordance with the standards but cannot bill OHIP for the test, as "glaucoma suspect" is not an insured service under 409.

THE ASSESSOR'S CONCLUSIONS

26. The Assessor's criticisms of the Member relate to inappropriate and unnecessary testing, services, diagnosis, referrals and billing. The Assessor was also critical of the Member's patient health records.

A. Provided Unnecessary Diagnostic and/or Treatment Services [Allegations 1(a) to (i), and 5(a)]

27. The Assessor noted several instances where the Member provided ongoing monitoring and testing that was not warranted by the patient's history, symptoms, clinical picture and/or diagnosis. For example, the Assessor commented that the Member monitored patients and performed tests in circumstances where ongoing monitoring and/or testing was not clinically indicated and/or where the monitoring and testing was duplicative.

28. With respect to the latter concern, the Assessor noted that the Member often continued to monitor and perform testing on patients he suspected for normal tension glaucoma despite having referred them to Dr. Dorfman for the same concern.

29. More generally, the Assessor identified numerous examples of diagnostic and/or treatment services that the Member provided, which were unnecessary, including automated visual field testing (AVF), fundus photography, Heidelberg retinal tomography (HRT), digital retinal imaging (DRI), optical coherence tomography (OCT), corneal pachymetry, and/or anterior ocular imaging (AOI).

30. As an example of how this was occurring, the Assessor observed that:

> *Patients will present with a chief complaint, such as blurred vision in one eye, which [the Member] does not investigate with further questioning that would assist him in formulating his plan of investigation. In several cases he immediately chooses to do additional testing, even when the visual acuity is 20/20, e.g. visual fields, digital retinal and anterior segment imaging for complaints that are not resolved on his initial examination. Many of these patient complaints were seen to be associated with either dry eye disease or inconsequential vague symptoms. Performing chief-complaint specific testing, such as slit-lamp examination of the tear layer, break-up times, eyelids, etc., for patients that complaint of intermittent blurred vision rather than moving onto threshold fields and digital imaging would be more appropriate.*

31. By way of further example, the Assessor commented on the Member's approach to patients who the Member identified as "normal tension glaucoma suspect" based on normal IOP with 0.3 cupping, C/D asymmetry, or unreliable threshold visual field results. Specifically, the Assessor criticized the Member's lack of clinical judgment for preforming repeated AVF, DRI, and HRT on such patients when all other clinical findings were normal,

particularly in relation to those under the age of ten (10) and over the age of eighty-five (85).

B. Provided Prescriptions for Spectacles that Were Unwarranted [Allegations 1(j), 2(d), and 5(c)]

32. The Assessor noted that the Member had issued prescriptions for spectacles to several patients under the age of twenty (20) in circumstances where the prescription was not supported by the history, symptoms, examination, clinical findings, and/or diagnosis. For example, where the findings were negligible and the prescriptions would provide no clinical benefit to the patient (e.g., Rx of plano/ -0.25 x 180 OU).

C. Submitted Accounts that Were Misleading by Billing for Services that Were Unnecessary and/or Inappropriately Using OHIP Codes [Allegations 4(a), 4(b), and 5(b)]

33. The Assessor also expressed concern with respect to the Member's billing. For example, in his initial CRA report, the Assessor noted that:

> *[T]he OHIP billing profile and non-insured billings for additional testing procedures for his patients are not only excessive, often based on third-party insurance benefits, but not clinically supported or necessary.*

34. The Assessor made a similar but more specific criticism in his November 2016 report:

> *It is apparent from looking at his daily OHIP reconciliation that almost every patient he sees is tandem billed an additional V402, V408 or V410 with no apparent clinical justification to support these extra billings or procedures.*
>
> *Patients are often asked to return for additional office visits with additional insured and non-insured billings added for procedures that are not clinically supported from his records. Many clinical records show that he performs annual pachymetry readings and charges the patient each time. This is an example of how he performs unnecessary procedures that are clinically irrelevant and not supported by the literature in the area of glaucoma management.*

35. Throughout his reports, the Assessor identified specific instances where the Member was not justified billing OHIP using codes V402, V406, V408, V409, and V410. For example, there are many cases where the Member used diagnostic code 365, which is for patients who have been diagnosed with glaucoma, to support his billing under V410 and V409, even though the patient was merely "glaucoma suspect" and/or where the Assessor opined that the clinical picture did not justify even that suspicion. The billing code for glaucoma cannot be used to justify testing and services, such as those related to V410 and V409, for patients who have merely been identified as "glaucoma suspect" and do not have a

diagnosis of glaucoma. Further, if the billing under V410 or V409 was unjustified for that reason, any subsequent re-assessment related to those billing codes (e.g., V408) would also be inappropriate.

36. It is the College's position that the Member was aware that diagnostic code 365, for glaucoma, cannot be used to justify 409 and/or 410 billing in cases of suspected glaucoma, as this very issue was the subject of his previous discipline hearing.

37. Further, the Assessor identified specific instances where the Member had billed patients directly for testing or monitoring for other conditions which, based on the clinical picture, did not warrant ongoing care or the additional tests.

D. Made Diagnoses of Glaucoma and "Glaucoma Suspect" that were Not Supported by the Clinical Findings [Allegations 2(b) and 5(c)]

38. Throughout both of his reports, the Assessor was critical of the Member's over-diagnosis of "normal tension glaucoma suspect", noting that "[h]e appears to assume that any patient with normal intraocular pressures with larger than 0.3 cupping, C/D asymmetry, or unreliable threshold visual field results" automatically warrant this diagnosis.

39. With respect to the Member's diagnoses of glaucoma and "glaucoma suspect", the Assessor opined that "[t]he vast majority of his clinical records do not support his diagnosis".

40. The Assessor was particularly critical of the Member's glaucoma-related diagnoses with his younger patients:

> *His judgment in diagnosing glaucoma, glaucoma suspects and normal tension glaucoma [NTG] is questionable and not supported by the clinical findings. This is even apparent in files for those patients under 20 years old. Many of these patients had a tentative diagnosis of NTG or suspects and underwent excessive additional testing including both insured and non-insured procedures.*

E. Referred Patients for Consultations with an Ophthalmologist that Were Unwarranted [Allegations 2(e) and 5(c)]

41. The Assessor identified several patients who the Member had identified as "glaucoma suspect" and referred to Dr. Dorfman for consultation on that basis. The Assessor disagreed with the basis upon which the Member made these diagnoses and, as such, opined that the referrals were unwarranted. The Assessor was also critical of the Member continuing to monitor and perform tests on these same patients in relation to their suspected glaucoma given that this was the basis of his referral to Dr. Dorfman.

42. In his second report, the Assessor made the following observation:

His referrals to Dr. Dorfman for further assessment and guidance more often appears to result in a duplication of services and OHIP billings with patients being sent back and forth between practitioners.

F. Failed to Conduct the Appropriate Tests and/or Use the Appropriate Equipment [Allegations 2(f) and 2(g)]

43. The Assessor was critical of the Member's choice to use a non-contact tonometer (NCT) to obtain intra-ocular-pressure (IOP) readings in those patients the Member had identified as "glaucoma suspect". Although the Assessor was often critical of the accuracy of this diagnosis, he stated that the standard of practice called for a Goldmann applanation tonometer to be used to obtain IOP readings in patients with glaucoma or suspected glaucoma rather than NCT.

44. Similarly, the Assessor criticized the Member for using AVF testing to assess a patient presenting with diplopia (double vision) when the standard of practice requires a binocular vision assessment (BVA).

G. Failed to Maintain Health Records as Required [Allegations 2(a), 3(a) to (d), 5(d) and 5(e)]

45. The Assessor identified several areas where the Member's patient health records fell short of expectations, including in relation to legibility and deficiencies in documentation.

46. With respect to legibility, the Assessor noted in his original report that:

[h]is hand writing is for the most part illegible when it comes to making an assessment and management plan. I cannot comment on whether an appropriate course of action/disposition or future treatment plan has been discussed with the patient or if it clinically warranted because I cannot read his writing.

47. Specifically, the Assessor identified sixteen (16) of the patient health records as illegible.

48. With respect to documentation deficiencies, the Assessor noted that the Member "is lacking in detail and investigation in the history taking aspect of his records".

49. On a similar vein, the Assessor noted that "[t]he format of his examination form is very difficult to follow and, as mentioned, there is very little space available to obtain a proper history or indicate a plan for his patients".

50. On his initial CRA Report, the Assessor noted multiple omissions in relation to eight (8) of the patent health records. Five (5) of those patient health records also contained serious omissions. The omissions and serious omissions included deficiencies with respect to the Member's charting of the clinical procedures he used, the findings he obtained, and his diagnoses.

ADMISSIONS

51. The Member admits to the truth of the facts set out in paragraphs 1 – 50 above (the "Agreed Facts").

52. The Member acknowledges that the OPR, Part IV of Ontario Regulation 119/94, and the opinions of the Assessor, who was appropriately qualified to provide those opinions, reflect the standards of practice that were in place at the relevant times.

53. The Member admits that the conduct attributed to him in the Agreed Facts constitutes professional misconduct for the purposes of subsection 51(1) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, and as defined in Ontario Regulation 859/93 and/or Ontario Regulation 119/94, which were in effect at the relevant times.

54. Specifically, the Member admits that he committed an act or acts of professional misconduct as described in paragraph 1 of the Notice of Hearing when, between January, 2014 and July, 2015 he recommended and/or provided unnecessary diagnostic or treatment services in relation to patients [redacted], and/or [redacted], including, but not limited to:

    a. ongoing monitoring and/or office visits;

    b. visual field testing (AVF);

    c. fundus photography;

    d. Heidelberg retinal tomography (HRT);

    e. pachymetry;

    f. digital retinal imaging (DRI);

    g. optical coherence tomography (OCT):

    h. Corneal Pachymetry;

    i. Anterior Ocular Imaging (AOI); and/or

    j. prescriptions for spectacles.

55. The Member further admits that he committed an act or acts of professional misconduct as described in paragraph 2 of the Notice of Hearing when, between January 2014 and July 2015, he failed to maintain the standards of practice of the profession in relation to his care and management of patients [redacted], and/or [redacted] and, in particular,

a. portions of his health records for these patients were illegible;

b. he diagnosed patients with glaucoma or as "glaucoma suspect", in circumstances where that diagnosis was not supported by the clinical findings;

c. he recommended that patients return for office visits in circumstances and at frequencies that were not clinically indicated;

d. he prescribed eyeglasses for patients in circumstances where such prescriptions were not supported by the clinical findings, and/or unnecessary, and/or inappropriate;

e. he referred patients for consultations with an ophthalmologist in circumstances where such a referral was not clinically indicated;

f. he failed to conduct the appropriate tests and/or use the appropriate equipment to investigate patients with suspected glaucoma; and/or

g. he failed to conduct the appropriate tests and/or use the appropriate equipment to investigate patients with suspected diplopia

56. The Member further admits that he committed an act or acts of professional misconduct as described in paragraph 3 of the Notice of Hearing when, between January 2014 and July 2015 he failed to maintain records in accordance with Part IV in relation to patients [redacted], and/or [redacted], including, but not limited to deficiencies with respect to his documentation of:

a. the patient's health and oculo-visual history;

b. the clinical procedures used;

c. the clinical findings obtained; and/or

d. the diagnosis.

57. The Member further admits that he committed an act or acts of professional misconduct as described in paragraph 4 of the Notice of Hearing when, between January 2014 and July 2015 he submitted or allowed to be submitted an account(s) for professional services in relation to patients [redacted]

[redacted], and/or [redacted] that he knew was false or misleading and, in particular, he:

a. submitted accounts to OHIP under billing codes V402, V406, V408, V409, V410 in circumstances where he knew that the criteria for submitting accounts under those billing codes were not met; and/or

b. submitted accounts to patients for visits, tests and/or procedures that he knew were not clinically indicated.

58. The Member committed an act or acts of professional misconduct as described in paragraph 5 of the Notice of Hearing when, between January 2014 and July 2015, he engaged in conduct or performed an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical regarding his care and management of patients [redacted] Ms. [redacted], Mr. [redacted] and/or [redacted], he:

a. recommended that patients attend at his office for visits, tests, procedures and/or ongoing monitoring in circumstances where such visits, tests, procedures and/or ongoing monitoring was not clinically indicated;

b. billed OHIP and/or patients for office visits, tests, and procedures that were not clinically indicated;

c. made diagnoses, referrals, and prescriptions that were not clinically indicated;

d. failed to maintain legible patient records; and/or

e. failed to maintain adequate patient records.

59. With respect to (a) to (c), above, the Member admits that his conduct would reasonably be regarded by members as disgraceful, dishonourable, unprofessional and unethical. With respect to (d) and (e), above, the Member further admits that his conduct would reasonably be regarded by members as dishonourable and unprofessional.

60. By this document, the Member confirms that he:

a. understands fully the nature of the allegations against him;

b. understands that by signing this document he is consenting to the evidence contained therein being presented to the Panel;

c. understands that by admitting to the allegations, he is waiving his right to require the College to prove the allegations against him in a contested hearing;

d. understands that any agreement between him and the College with respect to the Order that the parties will jointly propose to the Panel does not bind the Panel; and

e. understands that the Panel's Order as well as its decision and a summary of its reasons, including reference to his name, will be published in the College's annual report and on its website, may also appear in other publications of the College, and will be published on CanLii;

f. understands and acknowledges that he is executing this ASF voluntarily, unequivocally, free of duress, free of inducement or bribe, and that he has obtained legal advice regarding the settlement of the subject matter of this proceeding, including in relation to his ASF, from Matthew Wilton of Matthew Wilton & Associates.

Plea

Dr. Mah pleaded guilty and accepted the facts and allegations included in the Agreed Statement of Facts.

Submissions of the Parties on Finding

College counsel submitted that the College must prove the allegations on a balance of probabilities and in her submission, it has done so here through the Agreed Statement of Facts and attachments to it. The evidence in the Agreed Statement of Facts establishes that it is more likely than not that Dr. Mah engaged in the conduct attributed to him and that the conduct amounts to the type of misconduct to which he has made admissions.

College counsel reviewed the differences between conduct that could be seen as unprofessional, versus disgraceful, dishonourable and unethical, noting that some element of moral turpitude was generally involved in the latter descriptions. In this case, the College and the Member agreed that some of the conduct is "unprofessional" and some is disgraceful, dishonourable and unethical, as specifically noted in paragraph 59 of the Agreed Statement of Facts.

Finding on Misconduct

After considering the Agreed Statement of Facts and the submissions of College counsel and counsel for Dr. Mah, as well as the admissions of Dr. Mah, the Panel found that the facts are sufficient for the College to discharge its onus and prove the allegations in paragraphs 1 through 5 of the Notice of Hearing and specifically, the Panel makes the findings of misconduct against Dr. Mah set out in paragraphs 53 through 59 of the Agreed Statement of Facts.

Reasons for Finding of Misconduct

Dr. Mah agreed that the conduct set out in the Agreed Statement of Facts, in which he admitted engaging, constitutes professional misconduct. After considering the Agreed Statement of Facts and the submissions of counsel, the Panel found that the College proved the allegations on a balance of probabilities.

It was obvious to the Panel that the conduct described in the Agreed Statement of Facts did constitute professional misconduct.

Dr. Mah committed professional misconduct when he engaged in the following with respect to 25 patients:

1. Recommending that patients attend at his office for visits, tests, procedures and/or ongoing monitoring in circumstances were such visits, tests, procedures and/or ongoing monitoring was not clinically indicated;
2. Inappropriately billing OHIP and/or patients for office visits, tests, and procedures that were not clinically indicated;
3. Making diagnoses, referrals, and prescriptions that were not clinically indicated; and
4. Failing to maintain legible and adequate patient records.

The Panel indicated that it was prepared to proceed to the sanction phase of the hearing.

Joint Submission on Order and Costs

College counsel advised the Panel that the parties had reached agreement as to an appropriate Order in this matter and provided to the Panel a Joint Submission on Order and Costs that was signed by Dr. Mah and a College representative and was filed as Exhibit 4.

The Joint Submission proposed the following Order:

1. Requiring the Member to appear before the Panel to be reprimanded at the conclusion of the hearing on September 5, 2018.

2. Directing the Registrar to suspend the Member's certificate of registration for an uninterrupted period of approximately three and one half (3.5) months, starting on October 17, 2018 and finishing at 11:59 pm on Sunday, January 27, 2019.

3. Directing the Registrar to impose the following terms, conditions and limitations on the Member's certificate of registration:

a) the Member shall successfully complete, at his own expense, with an unconditional pass, and within two (2) years of the date that this Order becomes final, both the ProBe Program on professional/problem-based ethics offered in Ontario and the ProBe Plus follow-up module;

b) the Member shall cooperate with, participate in, and pay for, eight (8) full day, one-on-one sessions ("the Sessions") with a practice coach/monitor, who has been pre-approved by the Registrar ("the Practice Coach/Monitor"). The requirements for the Sessions are as follows:

   i. each Session shall be at least six (6) hours in duration;

   ii. the Sessions shall focus on the following subjects and/or areas of practice:

      a. maintaining healthcare records that are legible, accurate, complete and that meet the standards of practice of the profession and the requirements set out in Ontario Regulation 119/94, including in relation to recording:

         - the patient's health and oculo-visual history;
         - the clinical procedures used;
         - the clinical findings obtained; and/or
         - the diagnosis;

      b. appropriate billing for optometric tests and procedures, including in relation to the criteria for submitting accounts to OHIP under billing codes V402, V406, V408, V409 and V410; and/or;

      c. the appropriate investigations for patients suspected of having glaucoma and/or diplopia, including:

         i. the appropriate tests to conduct;

         ii. the appropriate equipment to conduct such tests; and/or

iii. the clinical findings necessary to support such a diagnosis;

d. when, from a clinical and timing perspective, it is appropriate to:

i. refer patients for consultations with an ophthalmologist;

ii. recommend that patients return for office visits and/or ongoing monitoring;

iii. recommend, provide, and/or bill diagnostic or treatment services with respect to:

- visual field testing (AVF);
- fundus photography;
- Heidelberg retinal tomography (HRT);
- digital retinal imaging (DRI);
- optical coherence tomography (OCT):
- corneal pachymetry;
- anterior optical imaging (AOI); and/or
- prescriptions for spectacles (together, "the Subjects").

iii. the first three (3) to four (4) Sessions, shall take before the end of the Member's suspension ("the Learning Sessions"), and shall focus on improving the Member's knowledge, skill, judgment, and understanding in relation to the Subjects;

iv. any remaining Sessions that the Member has not completed by the end of his suspension ("the Implementation Review Sessions") shall be scheduled once every four (4) to six (6) weeks thereafter, but in any event, all of the Sessions shall be completed with one (1) year of the date of the Panel's Order, and all of the Implementation Review Sessions shall include:

a. a review of the Member's patient health records and practice by the Practice Coach/Monitor to assess whether the Member has improved his knowledge, skill, judgment, and understanding in relation to the

Subjects and whether the Member has successfully incorporated those improvements into his practice;

b. a discussion between the Practice Coach/Monitor and the Member regarding the Practice Coach/Monitor's assessment;

c. a learning plan to address any deficiencies identified by the Practice Coach/Monitor.

v. At least seven (7) days before the first Session, the Member shall provide the Practice Coach/Monitor with a copy of:

1. the Notice of Hearing;

2. the Agreed Statement of Facts;

3. this Joint Submission on Order and Costs, and

4. a copy of the Panel's Order and the Panel's Decision and Reasons, if available;

vi. the Member shall review, be familiar with, and be prepared to discuss with the Practice Coach/Monitor, at any of the Sessions:

1. Ontario Regulation 119/94, Part IV – Records;

2. the following sections of the College's *Optometric Practice Reference*:

a. Section 4.5 – Referrals;

b. Section 5.1 – the Patient Record;

c. Section 6.3 – Refractive Assessment and Prescribing; and

d. Section 7.2 – Glaucoma; and

3. any other materials that the Practice Coach/Monitor asked the Member to review prior to the next Session.

vii. at the end of each Session, the Member shall request the Practice Coach/Monitor to forward, within thirty (30) days, a written report to the Registrar, which shall be copied to the Member, confirming:

1. the date of the Session and, in relation to the first Session, whether the Member had provided the Practice Coach/Monitor with the documents specified in paragraph 3(b)(v), above;

2. whether the Member had reviewed and was prepared to discuss the materials listed in paragraph 3(b)(vi), above;

3. the Practice Coach/Monitor's assessment of whether the Member has improved his knowledge, skill, judgment, and understanding in relation to the Subjects and, with respect to the Implementation Review Sessions, whether the Member has successfully incorporated those improvements into his practice.

c. within twelve (12) to eighteen (18) months of the Member completing the Sessions, the Member shall undergo and cooperate in one (1) unannounced inspection of his practice, at his expense, to a maximum of $3,500 ("the Practice Inspection"). The requirements for the Practice Inspection are as follows:

i. The Practice Inspection shall be conducted by an individual chosen by the College's ("the Inspector") and shall include the Inspector's review of twenty-five (25) patient health records and any other documentation and/or information the Inspector considers appropriate;

ii. The purpose of the Practice Inspection shall be to assess:

A. the Member's compliance with the term set out in paragraph 3(d); and

B. whether the Member is maintaining the standards of practice and/or may be engaging in professional misconduct in relation to the Subjects.

iii. the Member shall request the Practice Inspector to forward, with thirty (30 days after completing the Practice Inspection, a written report to the Registrar setting out his/her assessment.

d. the Member shall ensure that his clinical records are legible for the purpose of the Sessions referred to in paragraph 3(b) and the Practice Inspection referred to in paragraph 3(c);

4. Directing the Member to partially reimburse the College for its costs in relation to this proceeding in the amount of $25,000 to be paid by post-dated cheques provided to the College by September 5, 2018, according to the following schedule:

   a) one cheque dated September 5, 2018 in the amount of 5,000;

   b) one cheque dated December 5, 2018 in the amount of $5,000;

   c) one cheque dated March 5, 2019 in the amount of $5,000;

   d) one cheque dated June 5, 2019 in the amount of $5,000; and

   e) one cheque dated September 4, 2019 in the amount of $5,000.

College counsel presented a table of partial costs incurred for the hearing up to and including September 5, 2018, with the total of partial costs being $45,710, and this table was filed as Exhibit 5. College counsel also filed as Exhibit 6, information regarding the “ProBe: Ethics & Boundaries Program – Canada”.

College counsel submitted that in accepting the Joint Submission on Order and Costs, the panel should consider the principles of specific and general deterrence, public protection, rehabilitation, as well as aggravating and mitigating factors related to the particular misconduct.

College counsel submitted that the suspension, mentoring and inspection conditions in the Joint Submission satisfy the objectives of specific and specific deterrence and are aimed at ensuring the member will not engage in the same misconduct in the future.

College counsel submitted that the Panel ought to consider the remedial measures that not only need to be taken to deter future conduct but also to assist in the retraining the member; the coaching sessions and the ProBe course and ProBe Plus are aimed at providing that rehabilitation.

College counsel submitted that aggravating factors in this case were the extent of the concerns noted by the assessor, as well as the fact that so many unnecessary tests were ordered.

Defence counsel submitted that the proposed penalty was sufficient and appropriate in the circumstances. In his submission, the certainty that comes with a Joint Submission is of paramount importance to Dr. Mah and so he urged the Panel to accept the Joint Submission, echoing College counsel's submission about the high test for rejecting one (as set out in *R. v. Anthony-Cook*). Unless the Joint Submission is so unreasonable, either so lenient or so harsh in the circumstances, that the Panel's acceptance of it would bring the administration of justice into disrepute, or otherwise be contrary to the public interest, the Panel must accept it.

Defence counsel also reminded the Panel that the remediation proposed in this case was extensive and would involve considerable time and expense to Dr. Mah. It is extremely difficult for a practitioner to be away from his or her practice for an extended period of time and the suspension in this case will impact the goodwill associated with his practice.

In addition to the long period of time away from his practice (during which he will not be earning money), Defence counsel also stressed the other financial implications of the proposed Order, including the cost of the remediation sessions, the cost of the ProBe course, and the actual costs award of $25,000.

In the submissions of Defence counsel talk, Dr. Mah has shown remorse, he has pleaded guilty and shown insight. He cooperated fully in the College process. In the submissions of Defence counsel the proposed Order is fair and he urged the Panel to accept it.

Decision on Order and Costs

After deliberating and considering the information filed and the submissions of counsel, the Panel accepted the Joint Submission on Order and Costs as proposed by the parties.

Reasons for Order

The Panel determined that the proposed Order was fair and reasonable, being neither too lenient nor too onerous in the circumstances and made the Order on penalty and costs as jointly submitted by counsel for the parties and filed as Exhibit 4.

In determining the appropriate Order in this particular case, the Panel reminded itself that the primary purpose of the proceedings is protection of the public. The public must have confidence in the profession's ability to regulate itself effectively and in a manner that protects the public. Additionally, the Panel also must consider the particular circumstances of Dr. Mah.

When considering the interests of the profession the Panel recognizes that it has a duty to enforce and maintain the high standards of practice that the public expects of College members and that members expect of themselves. In each case, a Panel of the Discipline Committee must consider the extent to which a message to the profession is required to make it clear that the conduct in issue will not be tolerated.

In reaching its decision, the Panel considered the submissions of college counsel as well as Dr. Ma's counsel. The Panel also considered the case law submitted by the parties (which included *CPSO v Shin,* 20156 ONCPSD 19 (CanLII); *OCP v Etemad-Rad*, 2018 ONCPDC 29 (CanLII) and *OCP v. Siha*, 2015 (ONCPDC 22 (CanLII)). The Panel found that while none of the cases was identical to the case before it, the cases did demonstrate a range of appropriate orders and it gave comfort to the Panel that this particular Joint Submission on Order and costs fell within that range.

In the Panel's opinion, public interest is maintained by this Order by way of the suspension of the Dr. Mah's certificate, the restrictions on his practice (the practice monitoring and the unannounced inspection), and the requirement to complete the ProBe course and ProBe Plus.

Specific deterrence is achieved by way of a suspension of the Member's certificate and the imposed terms, conditions and limitations once he returns to practice. These terms will serve to deter the Member from engaging in similar conduct in the future.

General deterrence is achieved by way of the suspension and the terms, conditions and limitations on the Member's certificate. These terms, which are comprehensive and will ultimately span over two years, will send a clear message to the membership that such behaviour will not be tolerated.

The Order also addresses remediation of the Member by way of the requirement that he successfully complete the ProBe course, and the ProBe Plus module. The Panel believes that successful completion of this course and the one-on-one ProBe Plus mentoring afterwards will improve the Member's decision-making in the future and ultimately improve his practice going forward.

The Panel did consider that the member cooperated with the investigation and that he pled guilty, thereby saving considerable time and expense to the College. Those are mitigating factors. However, an aggravating factor is the fact that the Member has been before a discipline panel of the College before.

After balancing all of the relevant factors in this case, the Panel felt that the proposed Order as to penalty and costs was an appropriate one in all the circumstances.

Upon reviewing the orders included in past cases, the Panel concluded that the proposed Order was within the range of what had been ordered in cases dealing with similar (although not identical) conduct, taking into account both the aggravating and mitigating factors.

The Panel also felt that it was appropriate to order Dr. Mah to pay $25,000 towards the costs of the investigation, prosecution and hearing in this matter. Without such a costs order, it would be Dr. Mah's peers who would have to fund the entire cost of the investigation and prosecution of this matter.

At the conclusion of the hearing and after confirming that Dr. Mah had waived his right to appeal the reprimand (filed as Exhibit 7), Dr. Mark Eltis, on behalf of the Panel, delivered the reprimand to Dr. Mah, a copy of which is attached to this decision.

Dated this 13 day of September, 2018, at Toronto, Ontario.

(Signed)

Dr. Linda Chan, Chair

TEXT OF ORAL REPRIMAND

Delivered on September 5, 2018

College of Optometrists of Ontario and Dr. Andrew M. Mah

Dr. Mah, would you please stand?

Dr. Mah, the fact that you have received this reprimand will be part of the public portion of the Register, and as such will form part of your record with the College.

We are disappointed that you are before a Discipline panel of the College a second time.

The Panel has made findings of serious professional misconduct against you. The assessor consistently found problems with the patient charts that were reviewed. This appears to have been a pattern of your practice rather than an isolated occurrence or an oversight.

You have disregarded regulations and requirements that have been put in place to protect the public, in patient care as well as in billing. These rules and requirements are there to ensure best practices in Optometry and are aimed at protecting the public when they receive those services. When these rules and regulations are disregarded, we fail to ensure public safety.

The public is not protected when unnecessary tests and inappropriate billing takes place. You abused the trust that your patients placed in you. Patients trust you with their health and they trust you to act appropriately with regard to testing and assessments. This conduct reflects poorly on you and the profession at large.

It is a privilege to be able to bill OHIP directly and when that privilege is abused, it reflects poorly on, and brings disrepute to, the entire profession both in the eyes of the public and in the eyes of the government which funds many of the services optometrists may provide.

Additionally, you failed to maintain your records in an appropriate and legible manner.

The purpose of this reprimand is to express our disappointment on behalf of the members of the College and the general public in regard to your actions.

This panel's expectation is that you will participate in the remediation and successfully complete it.

We trust that you will not appear before a Discipline panel again. If you do find yourself in that position again, the penalty will be even more onerous.

We expect that you will take this experience seriously and modify your behaviour accordingly.

You may sit down.