SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee
(the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Clement Ka-Chun Yeung (CPSO # 32020)
(the Respondent)

INTRODUCTION

The Complainant was a patient in the Respondent's family practice, and saw him several times between July 2014 and September 2014. The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's conduct.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent:

- **billed OHIP for six appointments in 2014 when the Complainant only attended three or four appointments; and**
- **billed OHIP in July 2014 under codes which the Complainant describes as "untrue".**

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of May 8, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to his medical record-keeping (not only in terms of the quality of the records but also his difficulty in locating the record) and his OHIP billings. In addition, the Committee brought its concerns about the Respondent's OHIP billings to the attention of the General Manager of OHIP. The Committee took no action on the concern that the Respondent billed for visits that did not take place.

COMMITTEE'S ANALYSIS

Billed OHIP under inappropriate codes

- The Complainant stated that while the Respondent billed OHIP for a general assessment in mid-July 2014, he only saw the Respondent to have a cyst from an ingrown hair assessed. The Committee noted that the medical record contained a template for a general assessment, although some expected components were missing. It also noted that the Respondent billed for three major assessments of the Complainant within a one month period, which in the Committee's opinion seemed excessive.

- The Complainant also pointed out that for the visit in mid-July, the Respondent billed OHIP under code Z101A (Skin-Inc. Abscess-Subcut –One – LOC.Anaes) and Z200A (Bones-Applic.- Unnas Paste), but all he did was provide the Complainant a prescription. The Respondent maintained that he performed an incision and drainage of what appeared to have been an infected skin abscess and swabbed the incision site and sent it for analysis, and noted the record contained culture results and a consent form the Complainant signed stating he consented to "undergo the assessment, investigation, treatments or minor procedure ordered by or to be performed by [the Respondent]." The Committee found the Respondent's notes problematic, in that the reliance on templates is confusing and there is a lack of detailed information as to what occurred on each visit. The poor quality of the records made it challenging to ascertain with certainty what the Respondent did during the visit in issue.

- The Committee noted that in terms of billing code Z200A, the Respondent acknowledged that the code was billed incorrectly, due to an administrative error, and stated that he attempted to rectify the issue in December 2016 by contacting OHIP.

- In light of the various issues regarding the Respondent's billings noted in this case (as well as similar concerns that have been raised in two concurrent matters before the Committee), the Committee was of the view that a caution, as set out above, was appropriate.

Medical record-keeping

- The Respondent initially advised that he was unable to locate the Complainant's paper medical record and indicated that he believed the Complainant had the chart (which the Complainant denied). The Respondent later indicated that he located the paper file, which had somehow been misfiled in the office, and he apologized for assuming the Complainant had it in his possession. The Committee was concerned about the Respondent's initial inability to locate the paper record, given his obligation to store records in a safe and secure manner, and to ensure that they are readily producible when legitimate use is required.

- The Committee also had concerns regarding the quality of the Respondent's records, as they consisted of templates with little in the way of detailed information which made it difficult to obtain a good understanding of the care provided. The Respondent acknowledged that there were issues with his charting, including his use of templates. He noted that in a recent assessment by a College assessor he received recommendations to improve his record-keeping, that he would be commencing

supervision to address the deficiencies in his records, and that he has taken a medical record-keeping course.

- The Committee recognized that the Complainant had engaged in remediation and was currently undergoing a reassessment of his record-keeping in another College proceeding, and indicated that it trusted the interventions would lead to improvement in that aspect of the Respondent's practice going forward. As such, they were satisfied that a caution was sufficient to address the concerns in this case regarding the Respondent's record-keeping, and that it was not necessary to impose further remediation at this time.

Other outcomes

- Given the concerns regarding the Complainant's billings, the Committee directed that the information be brought to the attention of the General Manager of OHIP.

- Regarding the Complainant's concern that the Respondent billed for visits that did not take place, the Committee was satisfied that the contemporaneous documentation indicated that the Respondent did see the Complainant on the six dates billed to OHIP.