

**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. Mark Peter Angelini (CPSO #76402)
(the Respondent)**

INTRODUCTION

The College received information raising concerns about the Respondent's billing practices. Subsequently, the Committee approved the Registrar's appointment of investigators to conduct a broad review of the Respondent's practice.

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of November 13, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to his inappropriate billings. The Committee also accepted an undertaking from the Respondent, including self-study, a period of clinical supervision, professional education, and a reassessment.

COMMITTEE'S ANALYSIS

As part of this investigation, the Registrar appointed an independent Assessor to review a number of the Respondent's patient charts, interview the Respondent, and submit a written report to the Committee.

The Assessor concluded that the Respondent's clinical skills met the standard of care. However, he noted concerns with the Respondent's billing. Specifically, he noted a pattern of inappropriate and excessive billing. He pointed out that each case reviewed had multiple instances of inappropriate billing code submissions, and several patients had procedure codes applied when no procedure was done at any visit. The Assessor stated that the Respondent displayed an attitude that billing excessively was perhaps acceptable and that it was the responsibility of the Ministry of Health and Long Term Care to police excessive billing practises.

In responding to the Assessor's report, the Respondent acknowledged that there were deficiencies in his billing practices, which he stated he regrets. He stated that in his interview with the Assessor he did not mean to imply that he bills indiscriminately on surgical billings or to offer justification for inappropriate billing, and that he did not intend to leave the impression that he believes the onus is on the Ontario Health Insurance Plan (OHIP). The Respondent's counsel provided details of the Respondent's interactions with OHIP over the years, in which concerns were raised about the Respondent's billings, as well as copies of cancelled cheques showing repayments to OHIP.

The Committee noted that the information before it raised long-standing concerns about the Respondent's billing practices. It showed that OHIP had raised several issues with the Respondent about his billing over the years and that he had been required to pay back large amounts of money. At a minimum, the Committee was of the opinion that the Respondent's behaviour in terms of his billing was irresponsible. In the circumstances, the Committee concluded that it was appropriate to caution the Respondent and accept his undertaking to improve his practice, as set out above.