Public

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

December 3, 2012

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Joseph Grossman, M.D.
[redacted]

Re: License No. 138493

Dear Dr. Grossman:

Enclosed is a copy of the New York State Board for Professional Medical Conduct (BPMC) Order No. 12-264. This order and any penalty provided therein goes into effect December 10, 2012.

Please direct any questions to: Board for Professional Medical Conduct, 90 Church Street, 4th Floor, New York, NY 10007-2919, telephone # 212-417-4445.

Sincerely,

[redacted]

Katherine A. Hawkins, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Gerald W. Dibble, Esq.
Dibble & Miller, P.C.
55 Canterbury Road
Rochester, NY 14607

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

BPMC No. 12-264

IN THE MATTER OF JOSEPH GROSSMAN, M.D.	CONSENT ORDER

Upon the application of (Respondent) Joseph Grossman, M.D. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and

it is further

ORDERED, that this Consent Order shall be effective upon issuance by the Board, either

by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR

upon facsimile transmission to Respondent or Respondent's attorney,

whichever is first.

SO ORDERED.

DATE: 11/30/2012

[redacted]

ARTHUR S. HENGERER, M.D.
Chair
State Board for Professional Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
JOSEPH GROSSMAN, M.D.

CONSENT AGREEMENT AND ORDER

Joseph Grossman, M.D., represents that all of the following statements are true:

That on or about July 2, 1979, I was licensed to practice as a physician in the State of New York, and issued License No. 138493 by the New York State Education Department.

My current address is [redacted] and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct (Board) has charged me with one or more specifications of professional misconduct, as set forth in a Statement of Charges, marked as Exhibit "A", attached to and part of this Consent Agreement.

I admit guilt to the first specification, in full satisfaction of the charges against me, and agree to the following penalty:

- Pursuant to New York Public Health Law § 230-a(2), my license to practice medicine in New York State shall be suspended for thirty-six months, with thirty-six months stayed.
- Pursuant to New York Public Health Law § 230-a(3), my license to practice medicine in New York State shall be limited to preclude the ability to prescribe Schedule 2 and Schedule 3 narcotic controlled substances, and to permit me to practice only pediatrics and pediatric neurology.
- Pursuant to New York Public Health Law § 230-a(9), I shall be placed on probation for thirty-six months, subject to the terms set forth in attached Exhibit "B."

I further agree that the Consent Order shall impose the following conditions:

That Respondent shall remain in continuous compliance with all requirements of N.Y. Educ Law § 6502 including but not limited to the requirements that a licensee shall register and continue to be registered with the New York State Education Department (except during periods of actual suspension) and that a licensee shall pay all registration fees. Respondent shall not exercise the option provided in N.Y. Educ. Law § 6502(4) to avoid registration and payment of fees. This condition shall take effect 120 days after the Consent Order's effective date and will continue so long as Respondent remains a licensee in New York State; and

That Respondent shall remain in continuous compliance with all requirements of N.Y. Pub. Health Law § 2995-a(4) and 10 NYCRR 1000.5, including but not limited to the requirements that a licensee shall: report to the department all information required by the Department to develop a public physician profile for the licensee; continue to notify the department of any change in profile information within 30 days of any change (or in the case of optional information, within 365 days of such change); and, in addition to such periodic reports and notification of any changes, update his or her profile information within six months prior to the expiration date of the licensee's registration period. Licensee shall submit changes to his or her physician profile information either electronically using the department's secure web site or on forms prescribed by the department, and licensee shall attest to the truthfulness, completeness and correctness of any changes licensee submits to the department. This condition shall take effect 30 days after the Order's effective date and shall continue so long as Respondent remains a licensee in New York State. Respondent's failure to comply with this condition, if proven and found at a hearing pursuant to N.Y. Pub. Health Law § 230, shall constitute professional misconduct as defined in N.Y. Educ. Law § 6530(21) and N.Y. Educ. Law § 6530(29). Potential penalties for failure to comply with this condition may include all penalties for professional misconduct set forth in N.Y. Pub. Health Law §230-a, including but not limited to: revocation or suspension of license, Censure and Reprimand,

probation, public service and/or fines of up to $10,000 per specification of misconduct found; and

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Consent Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Consent Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State.

I stipulate that my failure to comply with any conditions of this Consent Order shall constitute misconduct as defined by N.Y. Educ. Law § 6530(29).

I agree that, if I am charged with professional misconduct in future, this Consent Agreement and Order **shall** be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict

confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to N.Y. Pub. Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Consent Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first. The Consent Order, this agreement, and all attached Exhibits shall be public documents, with only patient identities, if any, redacted. As public documents, they may be posted on the Department's website. OPMC shall report this action to the National Practitioner Data Bank and the Federation of State Medical Boards, and any other entities that the Director of OPMC shall deem appropriate.

I stipulate that the proposed sanction and Consent Order are authorized by N.Y. Pub. Health Law §§ 230 and 230-a, and that the Board and OPMC have the requisite powers to carry out all included terms. I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and I ask that the Board adopt this Consent Agreement.

I understand and agree that the attorney for the Department, the Director of OPMC and the Chair of the Board each retain complete discretion either to enter into the proposed agreement and Consent Order, based upon my application, or to decline to do so. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

DATE 11.20.12

[redacted]

JOSEPH GROSSMAN, M.D.
Respondent

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 11/20/12

[redacted]

GERALD W. DIBBLE, ESQ.
Attorney for Respondent

DATE: 11/26/12

[redacted]

VALERIE B. DONOVAN
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 11/29/12

[redacted]

KEITH W. SERVIS
Director
Office of Professional Medical Conduct

Exhibit "A"

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

JOSEPH GROSSMAN, M.D.

STATEMENT

OF

CHARGES

Joseph Grossman, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 2, 1979, by the issuance of license number 138493 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From in or around August 2009 through around November 2010, Respondent provided medical care to Patient A (patients are identified by name in Appendix A), a male who presented to Respondent's medical office at 1304 Portland Avenue, Rochester, New York with complaints of pain. Respondent wrote fifty two prescriptions for controlled substances, consisting of a combination of hydrocodone or oxycodone with APAP for Patient A. Respondent's care of Patient A deviated from accepted standards of medical care as follows:

1. Respondent failed to obtain a complete medical history and conduct a thorough examination of Patient A during the initial evaluation.

2. Respondent failed to obtain interval histories and conduct physical examinations of Patient A during subsequent visits.

3. Respondent failed to accurately document the controlled substances he prescribed to Patient A.

4. Respondent failed to maintain a medical record that accurately reflected his evaluation and treatment of Patient A.

B. From in or around 2006 through around September 2008, Respondent provided medical care to Patient B, a female who presented to Respondent's medical office with complaints of depression and anxiety. Respondent's care of Patient B deviated from accepted standards of medical care as follows:

1. Respondent inappropriately prescribed Xanax to Patient B three times prior to her initial visit with Respondent.

2. Respondent failed to obtain a complete medical history and conduct a thorough physical examination of Patient B during her initial visit.

3. Respondent failed to obtain interval histories and conduct physical examinations of Patient B during subsequent visits.

4. Respondent failed to maintain a medical record that accurately reflected his evaluation and treatment of Patient B.

C. From in or around December 2010 through around July 2011, Respondent provided medical care to Patient C, a female who presented to Respondent's medical office with a history of diabetes, GERD, asthma, hyperlipidemia, hypertension, atrial fibrillation, coagulopathy secondary to Coumadin, and congestive heart failure. Respondent prescribed 1440 narcotic tablets to Patient C, as well as other medications. Respondent's care of Patient C deviated from accepted standards of medical care as follows:

1. Respondent inappropriately prescribed multiple doses of narcotics to Patient C without documentation of an office visit.

2. Respondent failed to obtain a complete medical history and conduct a thorough physical examination of Patient C during her initial visit.

3. Respondent failed to obtain interval histories and conduct physical examinations of Patient C during subsequent visits.

4. Respondent failed to obtain a HGA1C to monitor Patient C's diabetes.

5. Failed to refer Patient C for dilated retinal exam.

6. Failed to adequately address Patient C's abnormal Calcium reading.

7. Failed to repeat Patient C's basic metabolic panel to assess Potassium level after treatment with Potassium replacement, and/or delayed treatment of Patient C's low Potassium level.

8. Respondent failed to maintain a medical record that accurately reflected his evaluation and treatment of Patient C.

D. From in or around June 2010 through around June 2011, Respondent provided medical care to Patient D, a female, at Respondent's medical office. Respondent's care of Patient D deviated from accepted standards of medical care as follows:

1. Respondent wrote forty-eight prescriptions for narcotics and/or other controlled substances for Patient D without adequately identifying the medical condition(s) which required these substances.

2. Respondent failed to appropriately recognize and address Patient D's drug seeking behavior when notified by Medicaid of controlled substance prescriptions prescribed to Patient D by other providers.

3. Respondent failed to adequately obtain interval histories and physical exam findings during Patient D's follow up visits.

4. Respondent failed to maintain a medical record that accurately reflected his evaluation and treatment of Patient D.

E. From in or around February 2010 through around July 2011, Respondent provided medical care to Patient E at Respondent's

medical office. Respondent's care of Patient E deviated from accepted standards of medical care as follows:

1. Respondent failed to obtain a complete history and perform a complete physical examination of Patient E on his initial visit.

2. Respondent failed to adequately obtain interval histories and physical exam findings during Patient E's follow up visits.

3. Respondent failed to maintain accurate records regarding the thirteen prescriptions for narcotics, including Fentanyl patches, he wrote for Patient E.

4. Respondent failed to maintain a medical record that accurately reflected his evaluation and treatment of Patient E.

F. From in or around July 2008 through around February 2010, Respondent provided medical care to Patient F, a male who presented to Respondent's medical office with a history of low back pain. Respondent wrote seventy prescriptions for opiates, benzodiazepines and an anti-depressant for Patient F. Respondent's care of Patient F deviated from accepted standards of medical care as follows:

1. Respondent failed to obtain an adequate history and/or perform an adequate physical examination of Patient F.

2. Respondent failed to document the nature of Patient F's need for an anti-depressant.

3. Respondent failed to obtain history regarding Patient F's Hypogonadism and the need for Testosterone Replacement Therapy.

4. Respondent failed to document four patient visits.

5. Respondent failed to maintain a medical record that accurately reflected his evaluation and treatment of Patient F.

G. From in or around February 2009 through around July 2011, Respondent provided medical care to Patient G, a female, at Respondent's medical. Respondent's care of Patient G deviated from accepted standards of medical care as follows:

1. Respondent prescribed over 15,000 doses of Hydrocodone/APAP and multiple doses of Demerol for Patient G without adequate indication for these prescriptions.

2. Respondent failed to obtain a complete history and perform an adequate physical examination of Patient G on her initial visit.

3. Respondent failed to obtain interval histories and physical exam findings during Patient G's follow up visits.

4. Respondent inappropriately, and without adequate medical justification, prescribed narcotics to Patient G who suffered from Multiple Sclerosis.

5. Respondent failed to perform health maintenance measures on Patient G.

6. Respondent failed to conduct a complete gynecological examination while prescribing birth control pills for Patient G.

7. Respondent inappropriately prescribed narcotic medications to Patient G on February 17, 2009, with no established doctor patient encounter conducted.

8. Respondent failed to appropriately obtain a history of Patient G's complaint of depression, and/or he increased her medication dose without a history entry in the medical record.

9. Respondent failed to document the medical necessity for prescribing Demerol in addition to Hydrocodone for Patient G.

10. Respondent failed to maintain a medical record that accurately reflected his evaluation and treatment of Patient G.

H. From in or around August 2010 through around August 2011, Respondent provided medical care to Patient H, a female, at Respondent's medical office. Respondent's care of Patient H deviated from accepted standards of medical care as follows:

1. Respondent failed to obtain a complete a medical history and conduct a complete physical examination at Patient H's initial visit.

2. Respondent failed to order fasting labs to monitor Patient H's cholesterol.

3. Respondent failed to order a complete metabolic profile for Patient H to note liver function results, blood sugar results, and/or renal function results.

4. Respondent failed to order an EKG in response to Patient H's hypertension.

5. Respondent failed to document the medical necessity for the narcotics he prescribed for Patient H and/or failed to keep accurate medical records regarding these prescriptions.

6. Respondent failed to repeat a vitamin D level for Patient H.

7. Respondent failed to recommend routine health maintenance screening, including mammography and colon cancer screening for Patient H.

8. Respondent failed to obtain interval histories and perform physical exams of Patient H during follow-up visits.

9. Respondent failed to adequately monitor Patient H's blood pressure on October 20, 2010, December 16, 2010 and April 12, 2011 and/or failed to record the treatment he provided in response to Patient H's abnormal blood pressure on August 3, 2011.

10. Respondent failed to document the medical necessity for prescribing the anti-depressant medication Cymbalta for Patient H.

11. Respondent failed to maintain a medical record that accurately reflected his evaluation and treatment of Patient H.

I. From in or around February 2009 through around July 2011, Respondent provided medical care to Patient I, a male, at Respondent's medical office. Respondent's care of Patient I deviated from accepted standards of medical care as follows:

1. Respondent failed to obtain a complete medical history and conduct a complete physical examination of Patient I at his initial visit.

2. Respondent failed to maintain adequate records regarding Patient I's medications.

3. Respondent failed to maintain accurate records regarding narcotic prescriptions he provided to Patient I, including approximately 6,000 doses of hydrocodone/APAP.

4. Respondent inappropriately prescribed medications for Patient I without an established doctor-patient relationship.

5. Respondent failed to obtain interval histories and perform physical exams during follow-up visits with Patient I.

6. Respondent failed to maintain a medical record that accurately reflected his evaluation and treatment of Patient I.

J. From in or around November 2010 through around July 2011, Respondent provided medical care to Patient J, a male, at Respondent's medical office. Respondent's care of Patient J deviated from accepted standards of medical care as follows:

1. Respondent failed to obtain a complete a medical history and conduct a complete physical examination of Patient J at his initial visit.

2. Respondent failed to maintain adequate records regarding prescriptions he wrote for Patient I, including 1240 narcotic pills.

3. Respondent failed to inquire/recommend colon cancer screening for Patient J.

4. Respondent failed to obtain interval histories and perform physical exams of Patient J during follow-up visits.

5. Respondent failed to maintain a medical record that accurately reflected his evaluation and treatment of Patient J.

K. From in or around August 2010 through around June 2011, Respondent provided medical care to Patient K, a female, at Respondent's medical office. Respondent's care of Patient K deviated from accepted standards of medical care as follows:

1. Respondent failed to obtain a complete medical history and perform an adequate physical examination of Patient K.

2. Respondent inappropriately prescribed approximately 300 narcotic pills to Patient K prior to the first office visit recorded in the medical record.

3. Respondent failed to document the medical conditions for which he prescribed approximately 3600 narcotic pills for Patient K.

4. Respondent failed to maintain a medical record that accurately reflected his evaluation and treatment of Patient K.

L. From in or around February 2009 through around June 2011, Respondent provided medical care to Patient L, a female, at Respondent's medical office. Respondent's care of Patient L deviated from accepted standards of medical care as follows:

1. Respondent failed to maintain accurate records regarding prescriptions he wrote for Patient L.

2. Respondent failed to document and/or perform health maintenance measures including gynecological care and mammograms for Patient L.

3. Respondent failed to document the basis for his diagnosis that Patient L suffered from attention deficit disorder.

4. Respondent inappropriately prescribed medications to Patient L without establishing a doctor patient relationship.

5. Respondent failed to maintain a medical record that accurately reflected his evaluation and treatment of Patient L.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

1. Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, D and D. 1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, G and G.8, G and G.9, G and G.10, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, H and H.7, H and H.8, H and H.9, H and H.10, H and H.11, I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, K and K.1, K and K.2, K and K.3, K and K.4, K and K.5, L and L.1, L and L.2, L and L.3, L and L.4 and/or L and L.5.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

2. Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, D and D. 1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, G and G.8, G and G.9, G and G.10, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, H and H.7, H and H.8, H and H.9, H and H.10, H and H.11, I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, K and K.1, K and K.2, K and K.3, K and K.4, K and K.5, L and L.1, L and L.2, L and L.3, L and L.4 and/or L and L.5.

THIRD THROUGH FOURTEENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

3. Paragraphs A and A.1, A and A.2, and A and A.3.

4. Paragraphs B and B.1, B and B.2, and B and B.3.

5. Paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, and C and C.7.

6. Paragraphs D and D. 1, D and D.2, and D and D.3.

7. Paragraphs E and E.1, E and E.2, and E and E.3.

8. Paragraphs F and F.1, F and F.2, F and F.3, and F and F.4

9. Paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, G and G.8, and G and G.9.

10. Paragraphs H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, H and H.7, H and H.8, H and H.9, and H and H.10.

11. Paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5.

12. Paragraphs J and J.1, J and J.2, J and J.3, and J and J.4.

13. Paragraphs K and K.1, K and K.2, K and K.3, and K and K.4.

14. Paragraphs L and L.1, L and L.2, L and L.3, and L and L.4.

FIFTEENTH THROUGH TWENTY-SIXTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

15. Paragraphs A and A.1, A and A.2, and A and A.3.

16. Paragraphs B and B.1, B and B.2, and B and B.3.

17. Paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, and C and C.7.

18. Paragraphs D and D. 1, D and D.2, and D and D.3.

19. Paragraphs E and E.1, E and E.2, and E and E.3.

20. Paragraphs F and F.1, F and F.2, F and F.3, and F and F.4

21. Paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, G and G.8, and G and G.9.

22. Paragraphs H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, H and H.7, H and H.8, H and H.9, and H and H.10.

23. Paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5.

24. Paragraphs J and J.1, J and J.2, J and J.3, and J and J.4.

25. Paragraphs K and K.1, K and K.2, K and K.3, and K and K.4.

26. Paragraphs L and L.1, L and L.2, L and L.3, and L and L.4.

TWENTY SEVENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

27. Paragraphs A and A.3, A and A.4, B and B.4, B and B.5, C and C.1, C and C.8, D and D.4, E and E.3, E and E.4, F and F.2, F and F.3, F and F.4, F and F.5, G and G.1, G and G.9, G and G.10, H and H.5, H and H.9, H and H.10, H and H.11, I and I .2, I and I.3, I and I.6, J and J.2, J and J.5, K and K.5, L and L.1, L and L.2, L and L.3, and L and L.4.

DATE: November 26, 2012
Albany, New York

[redacted]

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical Conduct

EXHIBIT "B"

Terms of Probation

1) Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by N.Y. Educ. Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to N.Y. Pub. Health Law § 230(19).

2) Respondent shall maintain active registration of Respondent's license (except during periods of actual suspension) with the New York State Education Department Division of Professional Licensing Services, and shall pay all registration fees.

3) Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204-2719, with the following information, in writing, and ensure that this information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, arrests, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility. Respondent shall notify OPMC, in writing, within 30 days of any additions to or changes in the required information.

4) Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

5) Respondent's failure to pay any monetary penalty by the prescribed date shall subject Respondent to all provisions of law relating to debt collection by New York State, including but not limited to: the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law § 171(27); State Finance Law § 18; CPLR § 5001; Executive Law § 32].

6) The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30 day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume and

Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in Exhibit "A" or as are necessary to protect the public health.

7) The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

8) Respondent shall adhere to federal and state guidelines and professional standards of care with respect to infection control practices. Respondent shall ensure education, training and oversight of all office personnel involved in medical care, with respect to these practices.

9) Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

10) Respondent shall enroll in and successfully complete a continuing education program in the area of medical record keeping, and prescribing practices. This continuing education program is subject to the Director of OPMC's prior written approval and shall be successfully completed within the first 90 days of the probation period.

11) Within thirty days of the Consent Order's effective date, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Any medical practice in violation of this term shall constitute the unauthorized practice of medicine.

    a) Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no fewer than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

b) Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

c) Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

d) Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

12) Respondent shall comply with this Consent Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or a violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.