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HEALTH

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

Sue Kelly
Executive Deputy Commissioner

September 13, 2011

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dianne Abeloff, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

Matthew Miller, M.D.
160-28 21 Avenue
Whitestone, New York 11357

Paul Levinson, Esq.
Amalia Goldvaser, Esq.
McLaughlin & Stern, LLP
260 Madison Avenue
New York, New York 10016

RE: In the Matter of Matthew Miller, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 11- 217) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

~~Sincerely~~,

REDACTED

James F. Horan, Acting Director
Bureau of Adjudication

JFH:nm
Enclosure

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

COPY

IN THE MATTER	:	DETERMINATION
OF	:	AND
MATTHEW MILLER, M.D.	:	ORDER

BPMC No. 11-217

A Notice of Hearing and Statement of Charges, both dated November 30, 2010, were served upon **MATTHEW MILLER, M.D.**, Respondent. An Amended Statement of Charges was issued on January 10, 2011. **THEA GRAVES PELLMAN**, Chairperson, **ZORAIDA NAVARRO, M.D.**, and **MICHAEL J. REICHGOTT, M.D., Ph.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **WILLIAM J. LYNCH, ESQ., ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer.

The Department of Health ("the Department") appeared by THOMAS CONWAY, General Counsel, by **DIANNE ABELOFF, ESQ.**, of Counsel. The Respondent appeared by McLAUGHLIN & STERN, LLP, **PAUL H. LEVINSON, ESQ.**, and **AMALIA GOLDVASER, ESQ.**, of Counsel. Evidence was received and witnesses sworn and heard, and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Pre-Hearing Conference:	January 10, 2011
Hearing Dates:	February 18, 2011 March 8 and 15, 2011 April 28, 2011
Witnesses for Petitioner:	Joseph H. Feinberg, M.D., M.S. Patient A Patient B
Witnesses for Respondent:	Matthew Miller, M.D. Patient T.P. Patient D.U. Patient E.K. Patient V.S.
Receipt of Submissions:	June 23, 2011
Deliberation Held:	July 18, 2011

STATEMENT OF CASE

The State Board for Professional Misconduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq of the Public Health Law of the State of New York [hereinafter "P.H.L."]).

This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to §230 of the P.H.L. Matthew Miller, M.D. ("Respondent") is charged with ten specifications of professional misconduct, as defined in §6530 of the Education Law of

the State of New York ("Education Law"). The charges relate to Respondent's medical care of two patients. The charges include allegations of negligence on more than one occasion, incompetence on more than one occasion, fraudulent practice, harassing a patient, moral unfitness and failure to maintain records. A copy of the Notice of Hearing and Amended Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding. Having heard testimony and considered documentary evidence presented by the Petitioner and Respondent, the Hearing Committee hereby makes the following findings of fact:

1. Matthew Miller, M.D., the Respondent, was authorized to practice medicine in New York State on October 30, 1981, by the issuance of license number 148343 (Ex. 1).

2. In June 2004, Respondent signed a consent agreement in which he agreed not to contest allegations that on or about September 7, 2001, he blocked a nurse's path and did not accede to her requests to move away from her; that he inappropriately touched her buttock and vaginal area while she was bending to tend to another patient; that he made sexual comments and/or advances toward her on numerous occasions, and that he inappropriately invited her to socialize with him away from the hospital (Ex. 6).

3. Respondent further agreed the Consent Order would be admitted into evidence in a proceeding if he was charged with professional misconduct in the future (Ex. 6).

4. The Terms of Probation in the 2004 Consent Order included a requirement for Respondent to receive therapy and to complete a continuing education program in the area of Sexual Harassment (Ex. 6).

5. Respondent became aware of a position available for a physician at New Millennium Comprehensive Medical Health, P.C. ("New Millennium") through a newspaper advertisement in 2006. A chiropractor who was acting as the general manager hired Respondent (T. 508-509).

6. Respondent took over ownership of New Millennium in December 2007, and he closed the practice in June 2008 (T. 485).

7. In 2007, Patient A was considering breast reduction surgery

and went to see a plastic surgeon. The plastic surgeon told Patient A that the next step in the process was to see Respondent at New Millennium (T. 15-16, 41-45; Ex. C).

8. Patient A had suffered lower back pain for a number of years, and alleviating that pain was her major reason for considering the surgery (T. 34-35).

9. Patient A understood that her health care provider would not pay for breast reduction surgery as an elective procedure and that many of the plastic surgeon's patients had received insurance coverage for the surgery following treatment at New Millennium (T. 44-45).

10. On September 28, 2007, Patient A went to New Millennium. She was first seen by a chiropractor who took x-rays and explained the process employed by New Millennium to obtain insurance coverage for breast reduction surgery (T. 17-18).

11. Patient A was then seen by Respondent. When asked the reason for her visit, Patient A told Respondent that she wanted her "boobs to be smaller" (T. 23-24).

12. Respondent lifted his hands and making a squeezing motion said, "Well, maybe we should just squeeze them" (T. 24).

13. When Respondent examined Patient A, she told him that she was in no current pain and did not feel any pain when he applied pressure to a number of points on her back and shoulders (T. 25- 27).

14. Respondent nonetheless administered six trigger point injections, "one in the right and the left trapezius muscle and two in the right and two in the left quadratus lumborum muscle at the L4-L5 level" (T. 25-27; Ex. 2).

15. Trigger point injections are invasive injections that are inserted through the skin in a tender area that is identified by the patient on physical examination. These injections cannot be given based upon past pain or prophylactically to prevent future pain (T. 263-264).

16. Respondent knew that Patient A did not have any medical indication for the administration of trigger point injection. Administering trigger point injections without a medical indication is a deviation from the accepted standard of medical care. Respondent administered the injections to mislead Patient A's insurance carrier (T. 22-27, 265).

17. Respondent documents that Patient A's sensation is generally intact and that she is generally neurologically intact, but he failed to adequately describe his neurological examination in Patient A's medical record (Ex. 2, T. 257-262).

18. Patient B was injured in a motor vehicle accident on November 21, 2007. She was referred to New Millennium by her worker's compensation attorney (T. 116-118; Ex. 3).

19. On December 5, 2007, Patient B went to New Millennium. She

initially met with a chiropractor and was then seen and examined by Respondent (Ex. 3: T. 119).

20. Electromyography ("EMG") testing is performed to evaluate a patient's peripheral nerves and muscles to determine whether there is a neurological injury or disorder or a muscle disorder. One part of the testing is the nerve conduction study which is performed by stimulating the nerves and measuring the response. The second part of the exam is performed by using a needle that is inserted into the patient's muscle and obtaining electrical signals from the muscle tissue (T. 316-317).

21. Patient B's chief complaints included cervical spine pain, numbness and tingling in her left arm and hand, and lower back pain (Ex. 3, p. 49).

22. The subjective complaint of numbness or tingling in the fingers can be a symptom of radiculopathy or carpal tunnel syndrome (T. 319-320).

23. Radiating pain, numbness and tingling are symptoms which could indicate the need for an EMG to rule out radiculopathy, but Patient B's complaint of neck pain in December 2007 did not substantiate the need for an EMG (Ex. 3; T. 317-319, 373-374).

24. Respondent's physical examination of Patient B was inadequate to substantiate the need for an EMG to address her complaint of pain. Respondent did not make any physical finding

regarding Patient B's motor strength, and his neurological findings of her upper extremities did not substantiate the need for an EMG.

25.Respondent nonetheless referred Patient B for EMGs of the upper extremities (Ex. 3, p.49).

26. Respondent knew that there was no medical justification for referring Patient B for an EMG because his physical examination showed that Patient B had normal strength, reflexes and sensation and did not have symptoms of radiculopathy. Respondent intended to mislead Patient B's insurance carrier (Ex. 3; T. 321-322).

27. Respondent administered trigger point injections to patient B without medical indication. Respondent failed to document Patient B's response to previous injections. Respondent knew there no medical indication for these injections and intended to mislead Patient B's insurance carrier (Ex. 3; T. 325, 337-339, 349-350, 358, 371, 570-572).

28. Respondent documented that Patient B was generally intact neurologically with normal cerebral and cerebellar function, but the record fails to adequately reflect his evaluation (Ex. 3; T. 322, 373-374, 515).

29. During Patient B's second appointment, Respondent asked her whether she was interested in going out with him to a supper club, where they had "dining and drinks." Patient B told Respondent she was not interested (T. 120, 122-123).

30. At a subsequent visit, Respondent asked Patient B to stand. When she did, Respondent placed his hand around her waist and waltzed her around in a circle (T. 124-125).

31. Respondent sat on a rolling ball chair when he examined his patients at New Millennium (Ex. F; T. 435-437).

32. On one of Patient B's visits, Respondent rolled himself on the balance ball chair from his desk toward Patient B until his face was within six inches of her face and he was seated right in front of her with his legs spread open (T. 128-129).

CONCLUSIONS OF LAW

Respondent is charged with ten specifications alleging professional misconduct within the meaning of Education Law §6530. The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony.

The Department presented testimony by Joseph H. Feinberg, M.D., M.S. Dr. Feinberg graduated from Albany Medical College in 1983. He then performed surgeries at Mount Sinai Hospital for two years. He went on to do a research fellowship in orthopedic pathology at the Hospital for Special Surgery from 1985 to 1986, and then a residency in Physical Medicine and Rehabilitation at the Rusk Institute of Rehabilitation Medicine. His current medical practice

is at the Hospital for Special Surgery where he sees a variety of the conditions typically seen by an outpatient physiatrist. Dr. Feinberg has no stake in the outcome of this case, and he testified in a direct and forthright manner. The Hearing Committee found that Dr. Feinberg's testimony was credible.

The Department also offered the testimony of Patients A and B. The Hearing Committee found that these witnesses were both forthright and candid. Neither witness showed any inclination to fabricate or exaggerate the conduct and treatment which they described.

Patient A was very clear in her testimony. She had chronic back pain. Her insurance company would pay for the surgery if it was medically necessary, and her preference would be to have her insurance cover the surgery. Her purpose in going to New Millennium, however, was not to fabricate medical necessity if the medical professionals determined that one did not exist.

The Hearing Committee considered and rejected Respondent's contention that Patient B's testimony was called into question because she brought her complaint against him after she learned in a newspaper about another case against him. Although some confusion of Patient B's testimony regarding the date of certain contacts was noted, she showed no attempt to deceive, and her testimony regarding Respondent's conduct and comments was credible.

Respondent testified on his own behalf. Much of his testimony was evasive. For example, when the Committee questioned Respondent regarding his relationship with the other practitioners at New Millennium as the owner and the role of the chiropractor employed there, Respondent avoided answering these inquiries directly, stating that as far as he knew the chiropractor had his own records which were unavailable to him even though he was physically in the same site as Respondent (T. 504). Respondent also stated that he could not tell the Committee whether the chiropractor was an independent practitioner or an employee of New Millennium. In view of the fact that Respondent took over ownership of New Millennium in December 2007, his assertion that he lacked actual knowledge and his failure to answer these questions directly was an indication of his evading a truthful response.

The Hearing Committee also felt that Respondent testified falsely. When a Hearing Committee member asked Respondent whether he consistently ordered x-ray of the cervical and lumbar spine at the same time that he ordered cervical and lumbar MRIs as he had done with patient A, Respondent answered the form which he had completed for Patient A was merely a plan which would evolve over weeks depending upon the patient's progress. When pressed further by the Committee member that the form's title "Patient Referral" created the inference that Respondent's clerical staff would arrange for all of

the ordered services including the x-ray, the MRI, the EMG, the Physical Therapy and the Trigger Point Injections, Respondent was unable to reconcile his attempt to portray his several simultaneous orders as merely possible stages of treatment with the plain language written on the form which he had signed. Respondent then incredibly testified that it was "sort of a plan of what [he] expects to do" when he uses the word "referral" (T. 509-513).

Respondent's demeanor was generally attentive appearing to understand the seriousness of the charges against him, yet the Hearing Committee noted that Respondent revealed a more flippant attitude towards the proceedings on occasion. For example, when a Hearing Committee member questioned him about documentation of having examined a patient for cerebellar and cerebrum function, Respondent answered, "...I could have put it in the note, I didn't, mea culpa" (T. 515). When another Committee member was attempting to ascertain whether Respondent had acknowledged in his testimony that the insufficiency of his documentation in the patient's medical record had deprived him of sufficient information to answer questions regarding his patient care, Respondent first answered that he was not sure. Rather than directly answering the question, Respondent then stated, "If that's what I said, then you'd be correct, sir" (T. 572).

The Hearing Committee also found Respondent's suggestion that he had no option other than using a balance ball chair in the

medical office at New Millennium was a poor attempt to deflect responsibility for his own willful conduct. Respondent described the balance ball chair as a large beach ball with wheels underneath and a back, and he asserted that he sat on the balance ball chair "with great trepidation" (Ex. F; T. 436). As a defense to having rapidly moved himself within inches of Patient B on the balance ball chair with his legs astride her legs, Respondent claimed that the chair was in the office because another physician liked to use it. This claim does not explain why Respondent typically used that chair to approach patients rather than obtain a regular chair which he could control appropriately. The Hearing Committee concluded that Respondent chose himself to use the balance ball chair and acted intentionally toward Patient B.

Respondent also offered the testimony of four patients. Patient T.P. testified that Respondent has provided excellent care as the primary care physician for both her and her son for approximately 25 years. Patient D.U. stated, "He's just the most wonderful doctor I've ever had in my life." Patient E.K. described Respondent as one of the few physicians who makes him feel comfortable in a doctor's office setting. Patient V.S. credits Respondent with saving his life by recommending a cardiac specialist. Although these four witnesses were all credible; the Hearing Committee felt that their testimony had little bearing on the issue of Respondent's care and conduct

toward Patients A and B.

Two of the factual allegations in the Statement of Charges claim that Respondent ordered an MRI and prescribed Motrin and Flexeril for Patient A without medical indication. Although Dr. Feinberg offered testimony indicating that the MRI and prescriptions were not medically indicated, he admitted that he was not aware previously that Patient A had experienced chronic neck and back pain. Although Dr. Feinberg's testimony provided some credible evidence to sustain these allegations, the Hearing Committee determined that the Department did not meet its burden of establishing that these two allegations by a preponderance of the evidence in light of the chronic pain which Patient A had experienced. The Hearing Committee, however, determined that the Department did establish all the remaining paragraphs and the ten specifications of misconduct contained in the Statement of Charges by a preponderance of the evidence.

Patient A told Respondent that she was in no current pain and that she did not feel any pain when he applied pressure to a number of points on her back and shoulders. Knowing that Patient A was in no current pain, Respondent nevertheless administered trigger point injections. Since Respondent had no medical justification for administering these injections, the Hearing Committee infers that Respondent intended to administer the injections to mislead the

patient's insurance carrier. Respondent's administration of trigger point injections which were without medical indication also indicates that Respondent lacks the knowledge necessary to practice the medical profession and that his medical treatment of Patient A deviated from acceptable medical standards.

As indicated in the discussion regarding credibility, the Hearing Committee determined that Respondent prescribed EMG testing and administered trigger point injections for Patient B which were not medically indicated. As with Patient A, the Committee infers that Respondent intended to prescribe these treatments to mislead the patient's insurance carrier. Similarly, Respondent's prescription of EMG testing and administration of trigger point injections without medical justification also indicates that Respondent lacks the knowledge necessary to practice the medical profession and that his medical treatment of Patient B deviated from acceptable medical standards.

Respondent's sexually suggestive comments, gestures and conduct toward both Patient A and Patient B establish that he willfully harassed, abused and intimidated these patients. In light of the opportunity which he was given to rehabilitate himself after the two prior disciplinary actions brought against him, Respondent's conduct toward these women is even more egregious. Further, the Hearing Committee concluded that Respondent's conduct violated the

public trust that was bestowed upon him by virtue of his medical license. Both Respondent's fraudulent practice of medicine and his inappropriate sexually suggestive conduct toward his patients violate the moral standards of the medical community.

Factual Allegations

In accordance with these Conclusions of Law and based upon the Findings of Fact set forth above, the Hearing Committee makes the following determinations regarding the factual allegations contained in the Statement of Charges:

Paragraph A - A.1	Not Sustained
Paragraph A - A.2	Not Sustained
Paragraph A - A.3	Sustained (3-0)
Paragraph A - A.4	Sustained (3-0)
Paragraph A - A.5	Sustained (3-0)
Paragraph B - B.1	Sustained (3-0)
Paragraph B - B.2	Sustained (3-0)
Paragraph B - B.3	Sustained (3-0)
Paragraph B - B.4	Sustained (3-0)

Specifications

The First Specification charged Respondent with practicing with negligence on more than one occasion within the meaning of New York Education Law §6530(3). The Department established paragraphs A, A(3), A(5), B, B(1), B(2) and B(4) contained in the Statement of Charges by a preponderance of the evidence. As discussed in detail

above, the Hearing Committee determined that the Respondent was negligent in his care of Patient A and Patient B. As a result, the First Specification is **Sustained.**

The Second Specification charged Respondent with practicing with incompetence on more than one occasion within the meaning of New York Education Law §6530(5). The Department established paragraphs A, A(3), A(5), B, B(1), B(2) and B(4) contained in the Statement of Charges by a preponderance of the evidence. As discussed in detail above, the Hearing Committee determined that the Respondent was incompetent in his care of Patient A and Patient B. As a result, the Second Specification is **Sustained.**

The Third and Fourth Specifications charged Respondent with fraudulent practice within the meaning of New York Education Law §6530(2). The Department established paragraphs A, A(3), B, B(1), and B(2) contained in the Statement of Charges by a preponderance of the evidence. As discussed in detail above, the Hearing Committee determined that the Respondent was fraudulent in his care of Patient A and Patient B. As a result, the Third and Fourth Specifications are **Sustained.**

The Fifth and Sixth Specifications charged Respondent with harassing a patient within the meaning of New York Education Law §6530(31). The Department established paragraphs A, A(4), B, and B(3) contained in the Statement of Charges by a preponderance of the

evidence. As discussed in detail above, the Hearing Committee determined that the Respondent harassed Patient A and Patient B. As a result, the Fifth and Sixth Specifications are **Sustained.**

The Seventh and Eighth Specifications charged Respondent with failing to maintain a record for Patient A which accurately reflects the care and treatment of the patient within the meaning of New York Education Law §6530(32). The Department established paragraphs A, A(5), B, and B(4) contained in the Statement of Charges by a preponderance of the evidence. As discussed above, the Hearing Committee determined that Respondent's record fails to accurately reflect the evaluation of Patient A and Patient B. As a result, the Seventh and Eighth Specifications are **Sustained.**

The Ninth and Tenth Specifications charged Respondent with moral unfitness within the meaning of New York Education Law §6530(20). The Department established paragraphs A, A(4), B, and B(3) contained in the Statement of Charges by a preponderance of the evidence. As discussed in detail above, the Hearing Committee determined that the Respondent evidenced moral unfitness in his care of Patient A and Patient B. As a result, the Ninth and Tenth Specifications are **Sustained.**

DETERMINATION AS TO PENALTY

After the Hearing Committee sustained the above specifications, the members commenced consideration of the appropriate penalty. At that time, they received a copy of a Determination and Order of the Administrative Review Board ("ARB") dated September 1998 (Penalty Ex. 1). In that determination, the ARB sustained a prior charge that Respondent had practiced with moral unfitness by participating in a sexual relationship with a patient while he was treating her. The ARB noted that Respondent ignored the danger of allowing a social relationship to color his decision making process for his own sexual gratification. At the time, the ARB concluded that Respondent's actions were an ethical lapse because no evidence presented the Respondent to be a predator. In that action, the ARB voted to suspend the Respondent's license, stay the suspension and place the Respondent on probation.

As stated above in the findings of fact, Respondent was then charged with violating this probation in 2001 and agreed not to contest allegations that he blocked a nurse's path and did not accede to her requests to move away from her; that he inappropriately touched her buttock and vaginal area while she was bending to tend to another patient; that he made sexual comments and/or advances toward her on numerous occasions, and that he inappropriately invited her to socialize with him away from the hospital. The new terms of probation

in a 2004 Consent Order included a requirement for Respondent to receive therapy and to complete a continuing education program in the area of Sexual Harassment.

During his testimony at the current proceeding, Respondent demonstrated that the severity of the prior penalties had had little impact on his understanding of the significance of his conduct. When asked whether the required continuing education program in the area of sexual harassment addressed ethical boundary violations, Respondent answered, "I don't remember exactly, but it was basically a course of medical ethics, as best I remember." When further asked whether he recalled discussing boundaries in the doctor/patient relationship, Respondent stated, "I don't recall, but I believe they discussed them." Respondent's inability to recall the content of the course that he was required to take during his prior suspension suggests that further efforts to correct his inappropriate conduct would be futile.

Petitioner recommended that Respondent's license be revoked. The Hearing Committee concurs with this recommendation because Respondent has failed to utilize the prior opportunities provided to rehabilitate himself. As such, the Hearing Committee sees no lesser penalty which would safeguard the public.

The Hearing Committee also imposes a penalty of $10,000 per specification for a total penalty of $100,000. Respondent's practice

of medicine was fraudulent, and his conduct toward his patient was abusive, harassing and intimidating. In light of the previous disciplinary actions brought against him and the significant efforts made to ensure that Respondent was aware of his ethical obligations as a physician, the Hearing Committee determined that this civil penalty is fully warranted.

This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT**:

1. The Ten Specifications of professional misconduct, as set forth in the Statement of Charges are **SUSTAINED**;
2. A civil penalty of $100,000.00 is assessed.
3. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes but is 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 section 171(27); State Finance Law section 18; CPLR section 5001; Executive Law section 32.

4. Unless otherwise specified herein, the fine is payable within thirty (30) days of the effective date of this Order. Payments must be submitted to:

   Bureau of Accounts Management
   New York State Department of Health
   Empire State Plaza
   Corning Tower, Room 1245
   Albany, New York 12237

5. Respondent's license to practice medicine as a physician in New York State is hereby **REVOKED**;

6. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: New York, New York
Sept. 12, 2011

REDACTED

THEA GRAVES PELLMAN (CHAIR)

ZORAIDA NAVARRO, M.D.
MICHAEL J. REICHGOTT, M.D., Ph.D.

TO: Dianne Abeloff, Esq.
Associate Counsel
New York State Department of Health
90 Church Street -4th Floor
New York, New York 10007

Matthew Miller, M.D.
160-28 21 Avenue
Whitestone, New York 11357

Paul Levinson, Esq.
Amalia Goldvaser, Esq.
McLaughlin & Stern, LLP
260 Madison Avenue
New York, New York 10016

APPENDIX I

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

IN THE MATTER

OF

MATTHEW MLLER, M.D.

NOTICE

OF

HEARING

TO: MATTHEW MILLER, M.D.
160-68 21 Avenue
Whitestone, N.Y. 11357

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on January 18, 2011, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th floor, N.Y., N.Y., and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel who shall be an attorney admitted to practice in New York state. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

YOU ARE HEREBY ADVISED THAT THE ATTACHED CHARGES WILL BE MADE PUBLIC FIVE BUSINESS DAYS AFTER THEY ARE SERVED.

Department attorney: Initial here

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. JAMES HORAN, ACTING DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of

the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
November 30, 2010

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Dianne Abeloff
Associate Counsel
Bureau of Professional Medical Conduct
212-417-4431

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

IN THE MATTER

OF

MATTHEW MILLER, M.D.

AMENDED STATEMENT OF CHARGES

MATTHEW MILLER, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 30, 1981, by the issuance of license number 148343 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about September 28, 2007, ~~through~~ Respondent treated Patient A (the identity of the patients is contained in the attached appendix) in his office. His care and treatment deviated from accepted medical standards, in that Respondent:

1. Ordered an MRI of the cervical and lumbar spine ~~and electrodiagnostic testing~~ without medical indication;

   a. This treatment was knowingly and intentionally ordered by Respondent as a medically necessary service, when in fact, Respondent knew that there was no medical justification for these services. Respondent intended to mislead.

2. Prescribed motrin, flexeril and a ~~supplement~~ without medical indication;

EXHIBIT
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a. These prescriptions were knowingly and intentionally issued by Respondent as a medically necessary service, when in fact, Respondent knew that there was no medical justification for these services. Respondent intended to mislead.

3. Administered trigger point injections without medical indication;

a. This treatment was knowingly and intentionally performed and/or billed by Respondent as a medically necessary service, when in fact, Respondent knew that there was no medical justification for these services. Respondent intended to mislead.

4. Made inappropriate sexual comments to Patient A.

5. Failed to maintain a record that accurately reflects the patient's condition and the care and treatment rendered by Respondent to Patient A.

B. From on or about December 5, 2007 through June 6, 2008, Respondent treated Patient B for complaints of pain in her neck, low back which radiated down into her upper limbs. His care and treatment deviated from accepted medical standards, in that Respondent:

1. Prescribed EMG testing which was not medically indicated;

a. This treatment was knowingly and intentionally ordered by Respondent as a medically necessary service, when in fact, Respondent knew that there was no medical justification for these services. Respondent intended to mislead.

2. Administered an excessive number of trigger point injections given the patient's condition;

   a. This treatment was knowingly and intentionally performed and/or billed by Respondent as a medically necessary service, when in fact, Respondent knew that there was no medical justification for these excessive services. Respondent intended to mislead.

3. Made inappropriate sexual comments to Patient B and inappropriately touched her for other than a good faith medical purpose;

4. Failed to maintain a record that accurately reflects the patient's condition and the treatment rendered by Respondent to Patient B.

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 two or more of the

following:

1. Paragraph A , A (1), A(2), A (3), A (5) ; and/or Paragraph B, B (1), B (2), B(4).

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 two or more of the following:

2. Paragraph A , A (1), A(2), A (3), A (5) ; and/or Paragraph B, B (1), B (2), B(4).

THIRD THROUGH FOURTH SPECIFICATION
FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. Paragraph A, A(1)(a), A(2)(a), A(3)(a)
4. Paragraph B, B(1)(a), B(2)(a)

FIFTH THROUGH SIXTH SPECIFICATION
HARASSING A PATIENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(31) by wilifully harassing, abusing, or intimidating a patient either physically or verbally alleged in the facts of:

5. Paragraph A and A (4);
6. Paragraph B and B (3)

SEVENTH THROUGH EIGHTH 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 care and treatment of the patient, as alleged in the facts of:

7. Paragraph A and A(5);
8. Paragraph B and B (4).

NINTH THROUGH TENTH SPECIFICATION
MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

9. Paragraph A and A (4);
10. Paragraph B and B (3)

DATE: January 10, 2011
New York, New York

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct