Public

STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

July 15, 2009

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Maria-Lucia Anghel, M.D.
2410 Hempstead Turnpike
East Meadow, NY, 11554

Maria-Lucia Anghel, M.D.
Redacted Address

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Bureau of Professional Medical Conduct
145 Huguenot Street
New Rochelle, NY 10801

RE: In the Matter of Maria-Lucia Anghel, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 09-132) 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 Signature

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

OF

MARIA-LUCIA ANGHEL, M.D.

DETERMINATION
AND
ORDER

BPMC 09 - 132

Sheldon H. Putterman, M.D. (Chair), Fred S. Levinson, M.D., and James J. Ducey, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law (**P.H.L.**).

Marc P. Zylberberg, Esq., Administrative Law Judge, ("**ALJ**") served as the Administrative Officer ("**AO**"). The Department of Health ("**Department**") appeared by Claudia Morales Bloch, Esq., Associate Counsel. Maria-Lucia Anghel, M.D. ("**Respondent**") appeared personally and was represented by Raskin, Moscou, Faltischek, P.C., Alexander G. Bateman, Jr., Esq., of Counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Notice of Hearing:	April 16, 2008
Date of Amended Statement of Charges:	May 13, 2008
Date of Second Amended Statement of Charges:	September 26, 2008

Date of Answer to Charges:	June 10, 2008	
Pre-Hearing Conference Held:	June 11, 2008	[P.H.T-1-157][1]
Hearings Held: - (First Hearing day):	June 23, 2008	[T-1-218]
	July 24, 2008	[T-219-510]
	July 29, 2008	[T-511-664]
	August 7, 2008	[T-665-909]
	September 4, 2008	[T-909-1166]
	September 18, 2008	[T-1167-1451]
	September 23, 2008	[T-1452-1657]
	September 24, 2008	[T-1657-1780]
	October 7, 2008	[T-1781-2072]
	November 25, 2008	[T-2073-2433]
	December 3, 2008	[T-2434-2765]
	December 4, 2008	[T-2766-3123]
	December 9, 2008	[T-3124-3465]
	January 13, 2009	[T-3466-3825]
	February 9, 2009	[T-3826-4143]
	February 10, 2009	[T-4144-4352]
	February 24 , 2009	[T-4353-4666]
	March 3, 2009	[T-4667-4794]
	March 5, 2009	[T-4795-5122]
Intra-Hearing Conferences Held:	June 23, 2008	[I.H.T-1-11]
	July 24, 2008	[I.H.T-12-58]
	July 29, 2008	[I.H.T-59-77]
	August 7, 2008	[I.H.T-78-98]
	September 4, 2008	[I.H.T-99-123]
	September 23, 2008	[I.H.T-124-192]
	September 24, 2008	[I.H.T-193-219]
	October 7, 2008	[I.H.T-220-249]
	November 25, 2008	[I.H.T-250-313]
	December 3, 2008	[I.H.T-314-362]
	December 4, 2008	[I.H.T-363-395]
	December 9, 2008	[I.H.T-396-418]

[1] Numbers in brackets refer to Hearing transcript pages [T-], Intra-Hearing transcript pages [I.H.T-] or to Pre-Hearing transcript pages [P.H.T-]. The Hearing Committee was not present at, and did not review, the Intra-Hearings or the Pre-Hearings but, when necessary, was advised of the relevant legal decisions or rulings made by the AO.

Intra-Hearing Conferences Held:	January 13, 2009	[I.H.T-419-440]
	February 9, 2009	[I.H.T-442-478]
	February 24, 2009	[I.H.T-479-511]
	March 3, 2009	[I.H.T-512-522]
	March 5, 2009	[I.H.T-523-567]
Location of Hearings:	Offices of New York State Department of Health 90 Church St., 4th Floor New York, NY 10007	
Witnesses called by the Department:	Patient A[2] Patient B[3] Thomas L. Heckert Eileen Heaphy Stephan Petranker, M.D. Michael James Stephano	
Witnesses called by the Respondent:	Daniel Anghel, M.D. Maria-Lucia Anghel, M.D. Dawn Huggins Charles Argoff, M.D. Jacqueline Thelian, CPC	
Department's Proposed Findings of Fact, Proposed Conclusions of Law and Proposed Sanction:	May 5, 2009	
Respondent's Summation, Proposed Findings of Fact, and Conclusions of Law:	May 5, 2009	
Deliberations Held: (last day of Hearing)	May 13, 2009	

[2] The testimony of Patient A was withdrawn by the Department. Factual Allegations A-3, A-4, A-8 and A-9 were also withdrawn by the Department. The AO removed Department's Exhibit # 5-B, and the transcripts of Patient A's testimony, or references thereto [T-515-516].

[3] The record and this Determination and Order refer to the patients by letter to protect patient privacy. All Patients are identified in the Appendix annexed to the Second Amended Statement of Charges (Department's Exhibit #1-A).

STATEMENT OF CASE

The State Board for Professional Medical Conduct 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). This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct (**Petitioner** or **Department**) pursuant to §230 of the P.H.L. Maria-Lucia Anghel, M.D. (**Respondent**) is charged with twenty-five (25) specifications of professional misconduct as set forth in §6530 of the Education Law of the State of New York (**Education Law**).

Respondent is charged with professional misconduct by reason of: (1) practicing the profession of medicine fraudulently[4]; (2) practicing the profession of medicine with negligence on more than one occasion[5]; (3) practicing the profession of medicine with incompetence on more than one occasion[6]; (4) practicing the profession of medicine with gross negligence[7]; (5) willful or grossly negligent failure to comply with substantial provisions of federal regulations governing the practice of medicine[8]; (6) ordering excessive tests, or treatment not warranted by the condition of the patient[9]; and (7) failing to maintain a record for each patient (seven patients) which accurately reflects the care and treatment of that patient[10].

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[4] Education Law §6530(2) - (First through Eighth Specifications in the Second Amended Statement of Charges [Department's Exhibit # 1-A]).

[5] Education Law §6530(3) - (Ninth Specification in the Second Amended Statement of Charges [Department's Exhibit # 1-A]).

[6] Education Law §6530(5) - (Tenth Specification in the Second Amended Statement of Charges [Department's Exhibit # 1-A]).

[7] Education Law §6530(4) - (Eleventh Specification in the Second Amended Statement of Charges [Department's Exhibit # 1-A]).

[8] Education Law §6530(16) - (Twelfth Specification in the Second Amended Statement of Charges [Department's Exhibit # 1-A]).

[9] Education Law §6530(35) - (Thirteenth through Eighteenth Specifications in the Second Amended Statement of Charges [Department's Exhibit # 1-A]).

[10] Education Law §6530(32) - (Nineteenth through Twenty-Fifth Specifications in the Second Amended Statement of Charges [Department's Exhibit # 1-A]).

The Factual Allegations, Charges, and Specifications of professional misconduct result from Respondent's alleged acts and conduct from 1994 through 2005, and also involve seven (7) specific patients.

Respondent denies all factual allegations and all specifications of misconduct contained in the Second Amended Statement of Charges (Respondent's answer, dated June 10, 2008, to the May 13, 2008 Amended Statement of Charges is equally applicable to the September 26, 2008 Second Amended Statement of Charges). A copy of the Second Amended Statement of Charges is attached to this Determination and Order as Appendix 1.

SIGNIFICANT RULINGS

Respondent was Board Certified in Anesthesiology in 1995 and recently re-certified in 2007. Based on Respondent's certifications, her testimony and the testimony of the experts, the Hearing Committee concluded that Respondent had the requisite skills in her specialty and treated her patients using those skills. Because the Hearing Committee was satisfied with Respondent's medical skills, on February 24, 2009 (the 17th day of the Hearing) the Hearing Committee issued an Interim Decision as follows:

> The hearing committee is of the opinion and concludes that the medical care provided to Patients C, D, E, F and G meets minimal standards of care based on the records that we have and the testimony of both experts and Dr. Anghel to date. Therefore, we see no reason to receive additional cumulative testimony from Dr. Anghel regarding the medical care and treatment provided to Patients C, D, E, F and G. We will hear questions about non-cumulative information such as anything new that we don't have or have already heard regarding Patient D [T-4546-4547].

In addition, the AO's response to the Department's clarifying questions was that the evidence presented indicated that what Respondent did was medically indicated and justified [T-4645-4646].

FINDINGS OF FACT

The following Findings of Fact (**Findings**) were made after a review of the entire record available to the Hearing Committee in this matter. These Findings represent documentary evidence and testimony found persuasive by the Hearing Committee. Where there was conflicting evidence the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable, or credible in favor of the cited evidence. The Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence. The Hearing Committee unanimously agreed on all Findings, and all Findings were established by at least a preponderance of the evidence. Findings are referenced in subsequent Findings to reduce, to some extent, duplication. The Findings referenced should be read together with the subsequent Findings.

1. Respondent was licensed to practice medicine in New York State on August 13, 1987 by the issuance of license number 171848 by the New York State Education Department (Department's Exhibit # 2)[11].

2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent and has jurisdiction over Respondent's license and this disciplinary proceeding (determination made by the ALJ; Respondent had no objection regarding service effected on her); (P.H.L. §230[10][d]); [P.H.T-8, 53-54].

3. Respondent operated a Physician Office Laboratory ("**POL**") from 1995 continuously through on or about November 30, 2004. Respondent's POL was located at her office, 294 Jerusalem Avenue, Hempstead, New York ("**Jerusalem Ave**"). Then Respondent moved the POL to her current office at 2410 Hempstead Turnpike, East Meadow, New York ("**Hempstead Turnpike**"); [T-387-391; testimony of Ms. Heaphy and Respondent]; (Department's Exhibit # 4).

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[11] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit #) or by Dr. Anghel (Respondent's Exhibit #).

4. Under the P.H.L., all entities performing laboratory testing must hold a State permit. A POL, however, is exempt from this requirement and, instead, is subject to the jurisdiction of Federal Law and regulation. The Clinical Laboratory Improvement Amendment of 1988 ("**CLIA**") (CFR Part 493 and 42 USC 263), extends Federal regulation to all laboratories, including POLs. (ALJ's Exhibit # 9).

5. Under CLIA, the Federal Government contracts with the states for oversight and implementation of the law. In New York State, the Physician Office Laboratory Enforcement Program ("**POLEP**") is responsible for the oversight and implementation of CLIA regulations for all POLs, including: the database administration of all the required certification types, surveillance and inspections, compliance, as well as investigation and recommendations of enforcement actions to the Federal Government [T-377-378].

6. The office laboratory testing done by Respondent came under the category of high complexity and required a Certificate of Compliance (Department's Exhibit # 3); [T-382-383].

7. In the interest of public safety, the requirements for a Certificate of Compliance include: an application to CLIA; routine inspections every two years; participation in proficiency testing; and the need to meet a variety of quality control standards set forth in the law [T-379-385].

8. In order to meet the above requirements, the physician operating a POL must contract with an independent vendor for proficiency testing, where the vendor sends to the POL unknown samples for testing on her office equipment. If the testing proves incorrect, the information is forwarded to POLEP, who then acts to bring the POL into compliance. In addition, the POL is required to run quality controls daily as well as routinely perform calibrations. Records of these testing results, as well as laboratory orders, test results, patient records and all raw data, are required to be maintained by the physician. These records, and random checks of patient charts, are reviewed during on site inspections by POLEP [T-384-386].

9. From 1995 though 2003 Respondent avoided the CLIA requirements. and the costs associated with them[12], by failing to obtain CLIA certification [Testimony of Heckert, Heaphy, and Huggins]; (Department's Exhibits # 3, # 4, and # 4-A).

10. At some point between December 2003 and January 2004 Respondent disposed of all her laboratory records (except for some of the testing strips contained in individual patient records), and disposed of her laboratory equipment. This purging was done shortly after hearing from POLEP staff requesting a site visit and documentation [Testimony of Heckert, Heaphy, and Huggins, T-2612-2613, 2660-2664]; (Department's Exhibits # 3, # 4, and # 4-A).

11. From 1995 though 2003 Respondent's primary use of her laboratory machine was for billing purposes and the submission of claims, rather than to obtain meaningful, needed or accurate blood work results on her patients [Testimony of Heckert, Heaphy, and Huggins]; (Department's Exhibits # 3, # 4, and # 4-A).

12. The medical records for Patients A, and C through F[13], demonstrate that, regardless of the documented medical complaint and/or diagnosis that Respondent wrote in the patient's medical records, the exact same laboratory tests were done each time. There was no variation in how the laboratory tests were run. The machine ran only a chemistry and a lipid panel (single panel process). The machine would print out the lab strips seen in each patient chart for Patients' A, and C through F (Department's Exhibits # 5, # 5-A, # 7 through # 11); [T-2635-2636, 2659].

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[12] The cost associated with a Certificate of Compliance are a registration fee and a compliance bill. The compliance bill is calculated based on volume of testing (number of tests performed during a survey cycle) as reported by the surveyor at the time of the site visit. The more tests done during any given period, the higher the compliance bill [T-471-472].

[13] Patient G's primary insurer was Medicare. Respondent was aware of Medicare's database (Medicare maintains a database of CLIA registrations) and Respondent did not submit claims for laboratory testing as a POL for Patient G.

13. Despite this single panel process, Respondent would repeatedly bill separately for individual tests. This practice is inappropriate, and constitutes billing for tests not performed and billing twice for the same test {Transferase (AST)(SGOT) - CPT 84450 is part of the Comprehensive metabolic panel (Executive Profile - CPT 80053)}; [T-5024-5025].

(a) For example: Patient C

Date	CPT[14]	CPT Description	Billed
8/29/2003	80053[15]	Executive Profile	$275.00
8/29/2003	80061[16]	Lipid Panel	$180.00
8/29/2003	82150[17]	Assay of Amylase	$ 85.00
8/29/2003	82248[18]	Bilirubin Direct	$ 48.00
8/29/2003	82977[19]	Assay of GGT	$ 95.00
8/29/2003	83721[20]	Blood Lipoprotein Assay	$135.00
8/29/2003	84450[21]	Transferase (AST)(SGOT)	$ 95.00
			Total Billed: $913.00

(Department's Exhibits # 7, pgs 74 and 75; # 12, # 12-A, pg. 27).

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[14] **Current Procedural Terminology** (The CPT codes for 1995 through 2007 were available to the Hearing Committee for review during deliberations) (I.H.T-550-551].

[15] CPT 2003 Standard Edition - American Medical Association - Page 249 - 80053 - Comprehensive metabolic panel. This panel must include the following: Albumin (82040), Bilirubin (82247), Calcium (82310), Carbon dioxide (bicarbonate (82374), Chloride (82435), Creatinine (82565), Glucose (82497), Phosphatase, alkaline (84075), Potassium (84132), Protein, total (84155), Sodium (84295), Transferase, alanine amino (ALT) (SGPT) (84460), Transferase, aspartate amino (AST) (SGOT) (84450), Urea Nitrogen (BUN) (84520) ...

[16] CPT 2003 Standard Edition - American Medical Association - Page 250 - 80061 - Lipid Panel. This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478) ...

[17] CPT 2003 Standard Edition - American Medical Association - Page 255 - 82150 - Amylase

[18] CPT 2003 Standard Edition - American Medical Association - Page 255 - 82248 - Bilirubin direct

[19] CPT 2003 Standard Edition - American Medical Association - Page 259 - 82977 - Glutamyltransferase, gamma (GGT)

[20] CPT 2003 Standard Edition - American Medical Association - Page 261 - 83721 - Lipoprotein, direct measurement, LDL cholesterol ...

[21] CPT 2003 Standard Edition - American Medical Association - Page 265 - 84450 - Transferase, aspartate amino (AST) (SGOT) ...

14. Although each individual test may have appeared to have been medically indicated by the medical records maintained or fabricated by Respondent, the duplications, the false billings, and the excessive number of tests ordered and performed by Respondent using her own laboratory equipment was unwarranted under the circumstances set forth in each patient's medical records (Department's Exhibits # 5, # 5-A, # 7 through # 11).

15. Respondent also inflated her billing by claims of a multitude of blood draws via arterial puncture instead of vena punctures on each one of the seven patients. Respondent repeatedly diagnosed Volume Depletion in Patients C through G in connection with her alleged need to perform an arterial puncture and included a note in the patient's record of poor venous access (Department's Exhibits # 7 through # 11).

16. From November 17, 1999 through June 2, 2005 Respondent billed for 54 Arterial punctures of Patient C (54 separate visits - 54 diagnoses of Volume Depletion), withdrawal of blood for diagnosis (CPT 36600) (CPT 1999 Standard Edition - American Medical Association - Under the category and page heading of Cardiovascular System/Surgery at Page 149 - 36600 Arterial puncture, withdrawal of blood for diagnosis - Service includes Surgical Procedure Only - This definition listing remained the same from 1999 through 2003. In 2004 under the category and page heading of Cardiovascular System/Surgery at page 122 - 36600 Arterial puncture, withdrawal of blood for diagnosis [same for 2005 at page 127]) (Department's Exhibits # 7, # 12, and # 12-A); (also Department's Exhibit # 33 - [I.H.T-545-547]).

17. From July 7, 1998 through November 8, 2005 Respondent billed for 75 Arterial punctures of Patient D (75 separate visits - 40 diagnoses of Volume Depletion), withdrawal of blood for diagnosis (CPT 36600) (CPT 1998 description is the same as the 1999 Edition at page 159) (Department's Exhibits # 8, # 12, # 12-A, and # 33).

18. From October 5, 1999 through April 20, 2005 Respondent billed for 27 Arterial punctures of Patient E (27 separate visits - 17 diagnoses of Volume Depletion), withdrawal of blood for diagnosis (CPT 36600) (Department's Exhibits # 9, # 12, # 12-A, and # 33).

19. From December 11, 1998 through July 10, 2003 Respondent billed for 23 Arterial punctures of Patient F (23 separate visits - 15 diagnoses of Volume Depletion), withdrawal of blood for diagnosis (CPT 36600) (Department's Exhibits # 10, # 12, # 12-A, and # 33).

20. From September 8, 1996 through February 4, 2003 Respondent billed for 7 Arterial punctures of Patient G (7 separate visits - 1 diagnosis of Volume Depletion), withdrawal of blood for diagnosis (CPT 36600) (CPT 1996 and 1997 descriptions are the same as the 1999 Edition at page 150, and 152 respectively) (Department's Exhibits # 11, # 12, # 12-A, and # 33).

21. The medical records maintained by Respondent provide no evidence to support neither poor venous access nor volume depletion. Mild volume depletion would not have any significant effect on obtaining venous access and manifests itself in mere thirst. Orthostatic changes can occur with moderate volume depletion, in which case the patient would present with high heart rate, irritability, fatigue, weakness and blood pressure issues and such significant dehydration may prevent blood drawn via vena puncture. None of the seven patients ever presented in such a condition [T-831-832]; (Department's Exhibits # 5, # 6, # 7 through # 12, # 12-A, and # 33).

22. If the patient is already volume depleted and I then dilate their blood vessels through the use of a thoracic epidural, it would have a potentially even more profound effect on the patient's blood pressure and health. There is a contraindication to performing injection procedures when a patient doesn't have venous access. If the risk is hypotension and the risk is even heightened further by dehydration, I assuredly would be prudent to have IV access on such a patient, make sure that they are properly hydrated, then go ahead and do the procedure, that way if I got into trouble, I could give immediate medications to resuscitate. The

alternative would be doing a procedure on somebody who is volume depleted, run into a problem, already have a problem when the patient was in, so to speak, good health or presenting health, getting an IV, now, I have a world of trouble [T1288-1290].

23. Respondent continuously performed injection procedures on Patients C through G despite her claim of "poor venous access" and diagnoses of volume depletion (Department's Exhibits # 5, # 6, # 7 through # 12, # 12-A, and # 33).

24. Performing an arterial puncture in an office setting is highly unusual. It is even highly unusual in a hospital setting [T-895-897].

25. On January 5, 2004 Respondent did not perform an arterial puncture on Patient B but billed Patient B's insurance company for an Arterial puncture (CPT 36600) (Department's Exhibit # 6-A); [T252-254, 269].

26. The billing and insurance payments for an arterial puncture is substantially greater than the billing and insurance payments for a venous puncture (Department's Exhibits # 6-A, # 7 through # 12, # 12-A, # 33); [Testimony of Stephano, and Respondent]; [T4087].

27. Respondent billed for arterial punctures on at least 187 occasions in a ten year period (1996-2005). Respondent did not perform the 187 arterial punctures that she billed for (Department's Exhibits # 6, # 6-A, # 7 through # 12, # 12-A, # 33); [Testimony of Patient B, and Dr. Petranker].

28. There is no substantiation in the medical records maintained by Respondent of Patients B though G of poor venous access and the need to perform arterial punctures so often. There is no evidence in the medical records maintained by Respondent to justify dehydration and continual diagnoses of volume depletion. (Department's Exhibits # 6, # 6-A, # 7 through # 12, # 12-A, # 33); [T-1264-1267, 1273-1275, 1277, 1287-1291, 1598-1599, 1611-1612, 1845].

29. From July 17, 1995 through September 12, 1999 Respondent billed for 31 Office consultations for Patient C under CPT 99245 (office visit for a new or established patient which requires the following three (3) components [a comprehensive history, a comprehensive examination; and medical decision making of high complexity] (CPT 1995 Standard Edition - American Medical Association - at Page 20[22]) - This definition listing remained the same from 1995 through 1999 (except that the examples were deleted in 1999); (Department's Exhibits # 7, # 12, # 12, # 12-A, # 33).

30. CPT 99245 "is the very top....it will pay the most of all of the evaluation and management codes and it is typically charged at the highest rate because it represents the most comprehensive service for that patient." [T-970-971].

31. The medical records of Patient C, as maintained by Respondent, do not reflect a comprehensive history or a comprehensive examination. The medical records of Patient C, as maintained by Respondent, are devoid of coordination of care with other providers. Respondent billed for services that she did not provide (Department's Exhibits # 7, # 12, # 12-A, # 33); [T-755-757, 970-971].

32. From January 13, 1997 through January 17, 2002 Respondent billed for 20 Office consultations for Patient D under CPT 99245 (see Findings # 29 & # 30); (Department's Exhibits # 8, # 12, # 12-A, # 33).

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[22] The description includes "Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family." The definition continues with examples.

33. The medical records of Patient D, as maintained by Respondent, do not reflect a comprehensive history or a comprehensive examination. The medical records of Patient D, as maintained by Respondent, are devoid of coordination of care with other providers. Respondent billed for services that she did not provide (Department's Exhibits # 8, # 12, # 12-A, # 33); [T-755-757, 970-971].

34. On October 5, 1999 Respondent billed for an Office consultation for Patient E under CPT 99245 (see Findings # 29 & # 30); (Department's Exhibits # 9, # 12, # 12-A, # 33).

35. The medical records of Patient E, as maintained by Respondent, do not reflect a comprehensive history or a comprehensive examination. The medical records of Patient E, as maintained by Respondent, are devoid of coordination of care with other providers. Respondent billed for services that she did not provide (Department's Exhibits # 9, # 12, # 12-A, # 33); [T-755-757, 970-971].

36. From May 4, 1998 through January 6, 2003 Respondent billed for 11 Office consultations for Patient F under CPT 99245 (see Findings # 29 & # 30); (Department's Exhibits # 10, # 12, # 12-A, # 33).

37. The medical records of Patient F, as maintained by Respondent, do not reflect a comprehensive history or a comprehensive examination. The medical records of Patient F, as maintained by Respondent, are devoid of coordination of care with other providers. Respondent billed for services that she did not provide (Department's Exhibits # 10, # 12, # 12-A, # 33); [T-755-757, 970-971].

38. From January 3, 1995 through August 8, 1997 Respondent billed for 22 Office consultations for Patient G under CPT 99245 (see Findings # 29 & # 30); (Department's Exhibits # 11, # 12, # 12-A, # 33).

39. The medical records of Patient G, as maintained by Respondent, do not reflect a comprehensive history or a comprehensive examination. The medical records of Patient G, as maintained by Respondent, are devoid of coordination of care with other providers. Respondent billed for services that she did not provide (Department's Exhibits # 11, # 12, # 12-A, # 33); [T-755-757, 970-971].

Patient A

40. Respondent first saw Patient A at her Jerusalem Avenue office on October 11, 2001. Subsequently, Patient A had four additional office visits: October 15, 2001; October 22, 2001; October 29, 2001, and a last visit on November 5, 2001 (Department's Exhibit #5).

41. Patient A had a primary care physician, Dr. Deiparine, who apparently referred Patient A to Respondent for pain management evaluation regarding chronic lower back pain. There is no formal referral contained in Respondent's office record and Respondent admits that she was informed by the patient, not the physician, regarding the recommendation (Department's Exhibit # 5); [T-709, 2386-2387).

42. Patient A presented on the first visit with reports from recent consultations with both a neurologist and neurosurgeon, along with the results of diagnostic testing regarding the patient's lower back problems. In pertinent part, Patient A had suffered from chronic back pain, with intermittent exacerbation since 1996. An MRI performed in June, 2001 revealed a disc bulge with an annular tear at L 4/5. She underwent a series of 3 lumbar epidural nerve blocks by another physician, just 3 months prior to seeing Respondent, with only 50% relief. The reports indicate that the patient had been on various medications for her pain, including Motrin, Valium, Robaxin, Medrol dose pack and Neurontin. Based on the neurosurgeons's orders, Patient A had a myelogram study followed by an "exquisitely positive discogram" just 6 days prior to seeing Respondent. The neurosurgeon's report, dated September 12, 2001 has a recommendation that Patient A may "benefit from posterior interbody fusion if the discograms are positive."

(Department's Exhibit # 5-A); [T- 2391-2392].

43. There is no indication in Respondent's notes that she considered and reviewed the reports with any requisite degree of care. Given the extent of prior treatment as evidenced by the reports, Respondent should have contacted the neurosurgeon regarding potential surgical intervention and had a more thoughtful conversation with the patient regarding the benefits of surgery versus pain management intervention. Respondent failed to determine, prior to performing an injection procedure, the amount of the patient's steroid load to date and the amount used in prior treatments [T-706-708, 711, 714-715, 2919-2923].

44. An appropriate medical history must include a complete and accurate documentation of medications, including dosage. Respondent did not reconcile the patient's historical medications with current prescriptions nor consider switches in medication, such as Valium to Elavil. Respondent repeatedly failed to adequately and appropriately note a dosing schedule in her record and to account, on each visit for the medications the patient was actually taking (Department's Exhibit # 5); [T-740-743, 782-783].

45. An adequate history further requires full documentation of social history; psychosocial functioning; activities of daily living and what causes pain or makes it better; how pain affects functioning; onset, quality and duration of the pain; whether pain is intermittent or constant; and what treatments have worked in the past and with what degree of sustained relief, if any. Respondent did not do this (Department's Exhibit # 5); [T-675-676, 713-715, 2835-2845].

46. Respondent failed to explore with the patient, and document complaints and issues checked by the patient on the Health Questionnaire form. For example, there was no note with respect to the areas of depression; numbness and tingling sensation; weight loss; fatigue and stress incontinence [T-769-770, 2938-2948].

47. On the initial visit, Respondent recorded random notes regarding the medications Neurontin and Elavil on the margin of the first page entry. Respondent then wrote a plan which merely states, "Neurontin", "Elavil". It is unclear whether the medication references are historical or currently prescribed and what the dosages are (Department's Exhibit # 5); [T-740-741, 2959-2963].

48. On the second visit (October 15, 2001) Respondent noted a history of Motrin and gave a dose for Neurontin and Elavil. However, Respondent's plan for that date does not mention Motrin and merely states, "gradually increase Neurontin and Elavil as tolerated" The increase in dosage was not recorded (Department's Exhibit # 5); [T-740-742].

49. On subsequent visits, history notes must include medications, changes in all areas noted in the previous findings and a review of what has worked and what has not. Respondent did not do this (Department's Exhibit # 5); [T-718-719, 745].

50. On October 22, 2001, Respondent wrote a note which mentions Toprol XL and Vioxx 25 mg. Respondent makes no reference to these medications thereafter. Her "scribble" notes for October 15, 2001, done on a HCFA form (Respondent's Exhibit H), indicates Toprol 100. Respondent acknowledged that this was prescribed by Dr. Deiparine (Department's Exhibit # 5); [- 2498-2499].

51. Respondent failed to assess and note the effectiveness, use and compliance with Neurontin by the patient. Further, it is clear that Respondent's treatment was not working given the patient had no sustained pain relief with Neurontin and steroid injections over such a short period of time (Department's Exhibit # 5); [T-764-768].

52. Respondent gave Patient A steroid injections on each visit. Respondent failed to consider the potential detrimental effect of the steroid load in this patient [T-805-806].

53. On October 29, 2001, Respondent made essentially the same notations regarding medication noted previously, except that she did not mention Vioxx (Department's Exhibit # 5).

54. On the last visit of November 5, 2001, Respondent notes "didn't start Accupril", followed by, "suspect non-compliance with blood pressure medications". Respondent failed to note when she prescribed the Accupril and the reason for changing the patient's medication (Department's Exhibit # 5).

55. An appropriate physical examination for pain includes evaluation of muscle mass, motor evaluation, gait, sensory and neurological examination. A full initial examination is done to evaluate and determine the origin and nature of the condition or disease process, and to determine the manifestations of the pain. Follow up examinations should evaluate whether treatment is succeeding and to reassess modalities of treatment [T-676-677, 2948-2950].

56. It is incumbent on a physician to make reasonable attempts to determine the etiology of a patient's pain prior to proceeding with treatment. It is also necessary for the treating physician, once treatment is decided on, to continually evaluate whether it is effective for the patient and whether or not other modalities are more viable options. Respondent failed to do this [T-1204, 2928-2929, 2932-2936].

57. Respondent failed to document an adequate and complete physical examination at any of Patient A's visits (Department's Exhibit # 5); [T-720-721].

58. The quantity of local anesthetics and steroids used in an injection procedure has the potential to cause hemodynamic changes in the patient. The standard of care requires that the patient's blood pressure and heart rate are appropriately monitored. Following the procedure, a patient must be continuously observed for a period of time and their vital signs obtained at a minimum of 5 minute intervals. The actual vital signs must then be recorded in the chart. With the exception of the procedure done on the October 15, 2001 visit, Respondent merely noted "VSS" (vital signs stable), at the end of each procedure (Department's Exhibit # 5); [T-683-686, 768, 782-783, 818, 861].

59. When a physician sees a patient in consultation as a referral from another physician, it is customary and in accordance with the accepted standards of care for the consulting physician to send a written report to the referring physician. Respondent did not do so (Department's Exhibit # 5); [T-756-766, 819, 1199-2000, 2876-2879].

60. Respondent billed and submitted a claim to Vytra for office visits under codes for consultation. She billed the initial visit of October 11, 2001 as a Comprehensive Medical Consultation of High Complexity (CPT 99245). The medical records of Patient A, as maintained by Respondent, do not reflect a comprehensive history or a comprehensive examination. The medical records of Patient A, as maintained by Respondent, are devoid of coordination of care with other providers. Respondent knowingly billed for services that she did not provide (Department's Exhibit # 5).

61. In 2001 Respondent knowingly billed and submitted false claims to Vytra for supplies as follows: Full box of betadine swabs (A4247) on visits of October 11, October 15, and October 22, 2001 at $160 each, and for two boxes of betadine swabs on October 29, 2001 at $320; one pair of gloves (A4927) at $130 each on October 11, October 15 and October 22, and for two pairs of sterile gloves on October 29, 2001 at $260 (Department's Exhibit # 5); (Hearing Committee's Exhibit # 2).

62. Respondent additionally knowingly billed and submitted false claims to Vytra for needles as follows: For October 11, (A4215) at $140; on October 15 (A4215) at $140; on October 22 (A4215) at $140, syringe with needle, 1cc at $60, syringe with needle, 3cc at $60 and syringe with needle, 5cc or greater at $110. On October 22, 2001, Respondent billed and claimed for the same category of supplies, but at double the amount, totaling $740 (Department's Exhibit # 5; (Hearing Committee's Exhibit # 2).

63. For the last visit of November 5, 2001, Respondent knowingly billed and falsely claimed diagnoses of volume depletion, chronic pancreatitis and hepatitis. Respondent made no mention of these diagnoses or suggestive findings in the medical record of this visit (Department's Exhibit # 5); [T-830-834, 3038-3042].

64. Respondent knowingly used the volume depletion diagnosis to justify performing an arterial puncture instead of a routine venipuncture, and the chronic pancreatitis and hepatitis diagnoses to justify performing unnecessary laboratory work in her illegal POL (Department's Exhibit # 5).

65. Respondent knowingly and willfully created a medical record which does not accurately reflect the medical care and treatment rendered to Patient A (Department's Exhibit # 5); [T-2838-2849].

Patient B

66. Patient B saw Respondent for one visit at her Hempstead Turnpike office on January 5, 2004. Patient B complained of severe pain in her hip resulting from a flare up of systemic lupus [T-229].

67. Patient B testified that she self-referred to Respondent. Patient B was under the care of a rheumatologist at the time who suggested that she might try pain management, but did not recommend a specific physician [T-230-231, 268-269, 280-281].

68. Respondent identified her brother, Daniel Anghel, M.D., as a referring physician on the electronic claim submission she used to separate out her claims for a high level consultation office visit (CPT 99245) and an arterial puncture (CPT 36600). On two other claim forms, for an injection and medications, Respondent listed herself as the referring physician. Patient B did not know Daniel Anghel, M.D. and had never been treated by him (Department's Exhibit #6-C); [T-232].

69. Respondent sent a billing statement for Patient B to Mr. Stephano at United Health Care (**UHC**) on which Respondent listed a different referring physician, Nicholas James, M.D. Patient B did not know this physician either (Department's Exhibit # 6-C).

70. Patient B testified that her office visit on January 5, 2004 lasted approximately 30 minutes [T-257].

71. Respondent submitted a claim to the Empire Plan (UHC) for the office visit using the CPT code 99245, a high level comprehensive office visit as a consultant. This claim was not truthful [T-268-269, 899].

72. Patient B testified that she had been under the care of a rheumatologist continuously from the time she was initially diagnosed with lupus, eight years prior to seeing Respondent. She saw him regularly, along with her internist. Because of her condition, and the medications she takes, Patient B has blood work done approximately every six weeks. She testified that she had blood work done by the rheumatologist about two weeks prior to seeing Respondent [T- 233-234, 238-239, 251-252].

73. Patient B testified that Respondent told her that she wanted to draw blood, stating it was merely routine for her to do so. Respondent made no mention to Patient B of any concerns regarding diabetes, chronic prednisone use, liver dysfunction or kidney dysfunction, as indicated in Respondent's medical record for the patient (Department's Exhibit # 6); [T-249-251].

74. Respondent did not contact Patient B regarding the results of the blood tests, nor did she communicate with Patient B's primary care physician [T-892-893]; (Department's Exhibit # 6).

75. Patient B testified that she was placed on Elavil by her rheumatologist when her pain started, just prior to seeing Respondent. She has never been under the care of a psychiatrist nor has she ever suffered or been diagnosed with depression [T-236-237, 299-300].

76. Patient B testified that Respondent briefly went over her history and discussed where her pain was located. She then made a recommendation to do an injection [T-242-244].

77. Respondent failed to obtain an adequate and relevant history from Patient B. Respondent did not connect the patient's pain to Lupus, nor did she address the patient's complaints of pain in her hands. Respondent failed to take a complete history of the patient's use of Elavil and to take a complete family history [T-853-860, 878-879].

78. Patient B testified that Respondent's physical examination consisted of listening to her heart and taking her blood pressure. She never took off her street clothes. Respondent did not do an abdominal examination, did not examine her extremities, do leg lifts, reflexes nor examine the spine. Respondent did not observe Patient B's gait [T-245-246, 355-356].

79. The neurological examination that Respondent performed was inadequate. Respondent failed to conduct an assessment sufficient to conclude that the patient suffered from multi lumbar radiculopathic pain [T-870-872].

80. Respondent diagnosed Patient B with drug related side effects, volume depletion and lumbosacral neuritis. There was no justification for these diagnoses (Department's Exhibit # 6); [T-260-261, 267, 894, 898].

81. Patient B testified that she believed that Respondent performed a facet injection, rather than an epidural injection. Patient B based this belief on her prior experience and the fact that she did not feel any numbness after the injection and was able to get off the table quickly and drive herself back to work. Further, the needle she observed was shorter than one used for an epidural [T-255-257, 310-314, 889-890].

82. Respondent did not check Patient B's blood pressure after the injection procedure and made no record of vital signs post procedure (Department's Exhibit # 6); [T-256-257, 890].

83. Patient B was surprised to receive an Explanation of Benefits (**EOB**) with a reimbursement check from the Empire Plan. She was led to believe that Respondent was a participating provider, and Patient B had made a co-payment at the time of her visit. Patient B is also a certified coding specialist. On reviewing the EOB, Patient B noted that Respondent had falsely claimed for a high level consultation office visit and an epidural injection. Patient B also noted false diagnostic codes were used and that Respondent had claimed to have performed an arterial puncture, which was similarly untrue (Department's Exhibit # 6-D); [T-228, 265-270].

Patient C

84. Respondent undertook the care and treatment of Patient C from January 17, 1995 through the date of his death on June 10, 2005 at age 59. Patient C' s last visit with Respondent was on June 7, 2005. Respondent only maintained an office record for Patient C from April 4, 2003 through June 7, 2005. (Department's Exhibits #7, # 12, # 12-A, # 29).

85. Respondent frequently failed to note an appropriate history in the medical records of the patient. Key pieces of relevant history regarding the noted chief complaints were missing (Department's Exhibit # 7); [T-1268, 1298, 1313-1314, 1319-1322].

86. Respondent repeatedly submitted claims to Empire, with diagnoses of hypertensive heart disease, hepatitis, hyper lipidemia, adverse effects of medical or biological substances, diabetes, dizziness and giddiness, asthma, myalgia and myositis, abdominal pain, nausea and vomiting, lymphosarcoma of intrathoracic lymph nodes, migraine, palpitations, acute respiratory failure, cholecystitis, chronic pancreatitis, proteinuria, precordial pain and obstructive bronchitis. Respondent's records for Patient C do not support these diagnoses (Department's Exhibits # 7, # 12, # 12-A); [T-1264, 1271-1272, 1280-1283, 1317-1319].

Patient D

87. Respondent undertook the care and treatment of Patient D from October 18, 1996 through on or about November 11, 2004. Respondent only maintained an office record for Patient D from December 18, 2000 through November 11, 2004 (Department's Exhibits # 8, # 12, # 12-A).

88. Respondent repeatedly submitted claims to Empire, with diagnoses of volume depletion, unspecified mononeuritis of upper limb, dizziness and giddiness, hematuria, hypertensive heart disease, asthma, cardiac dysrythmias, chest pain, hyperlipidemia, hepatitis, adverse effect of medical or biological substance, nausea and vomiting, abdominal pain, migraine, palpations, acute respiratory failure, diabetes, cholecystitis, chronic pancreatitis, proteinuria, precordial pain, and hypoglycemia. Respondent's records for Patient D do not support these diagnoses (Department's Exhibits # 8, # 12, # 12-A); [T-1490-1497, 1512-1515, 1521-1523, 1527].

Patient E

89. Respondent undertook the care and treatment of Patient E from October 5, 1999 through on or about July 23, 2007. Respondent only maintained an office record for Patient E from March 27, 2001 through July 23, 2007 (Department's Exhibits # 9, # 12, # 12-A).

90. Respondent repeatedly submitted claims to Empire, with diagnoses of volume depletion, hypertensive heart disease, cardiac dysrythmias, asthma, chest pain, acute pericarditis, hyperlipidemia, hepatitis, adverse effect of medical or biological substance, nausea and vomiting, abdominal pain, migraine, palpitations, chronic myringitis, diabetes, cholecystitis, chronic pancreatitis, proteinuria, and precordial pain. Respondent's records for Patient E do not support these diagnoses.(Department's Exhibits # 9, # 12, # 12-A); [T-1597, 1600-1602, 1610-1613].

Patient F

91. Respondent undertook the care and treatment of Patient F from May 4, 1998 through on or about July 11, 2003. Respondent only maintained an office record for Patient F from March 27, 2001 through July 11, 2003 (Department's Exhibits # 10, # 12, # 12-A).

92. Respondent repeatedly submitted claims to Empire with diagnoses of volume depletion, pain in soft tissue of limbs, asthma, chest pain, dizziness and giddiness, hyperlipidemia, hepatitis, adverse effect of medical or biological substances, nausea and vomiting, abdominal pain, migraine, palpitation, diabetes, chronic pancreatitis, and precordial pain. Respondent's records for Patient F do not support these diagnoses (Department Exhibits # 10, # 12, # 12-A); [T-1690-1692, 1706-1710, 1715].

Patient G

93. Respondent undertook the care and treatment of Patient G from October 26, 1994 through on or about November 29, 2004. Respondent only maintained an office record for Patient G from December 18, 2000 through November 29, 2004 (Department's Exhibits # 11, # 12, # 12-A).

94. Respondent repeatedly submitted claims to Empire with diagnoses of volume depletion, asthma, chest pain, congestive heart failure, syncope and collapse, coronary atherosclerosis, hypertension, hypertensive heart disease, cardiac dysrythmias, acute respiratory failure, adverse effect of medical or biological substance, nausea and vomiting, palpations, diabetes, cholecystitis, precordial pain, and renal colic. Respondent's records for Patient G do not support these diagnoses (Department's Exhibits # 11, # 12, # 12-A); [T-1722, 1724-1725, 1736-1743].

CONCLUSIONS OF LAW

The rationale for the Hearing Committee's conclusions is set forth below.

Respondent is charged with Twenty-Five (25) Specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However §6530 does not provide definitions or explanations of some of the misconduct charged in this matter.

The ALJ provided to the Hearing Committee certain instructions and definitions of medical misconduct as alleged in this proceeding. These instructions and definitions were obtained from a memoranda entitled Definitions of Professional Misconduct under the New York Education Law[23] (ALJ's Exhibit # 2). During the course of its deliberations on these charges, the Hearing Committee considered the following instructions from the ALJ:

1. The Hearing Committee's determination is limited to the Factual Allegations and the Charges set forth in the Second Amended Statement of Charges.

Preponderance of the Evidence

2. The burden of proof in this proceeding rests on the Department. The Department must establish by a fair preponderance of the credible evidence that the allegations made are true. Credible evidence means the testimony or exhibits found worthy to be believed. Preponderance of the evidence means that the allegation presented is more likely than not to have occurred (more likely true than not true). The evidence that supports the claim must appeal to the Hearing Committee as more nearly representing what took place than the evidence opposed to its claim. The Specifications of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence. The Hearing Committee understands that the Department must establish each and every element of the Charges by a preponderance of the evidence.

Intent

3. For those charges that require a finding of intent, the Committee must determine the state of mind with which the act was done. If a person acts voluntarily with a desire to bring about a result, she is said to have intended that result. Further, although she has no desire to bring about the result, if she does the act knowing, with substantial certainty, that the result will follow, she is also said to have intended that result.

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[23] Copies of these definitions (ALJ Exhibits # 2) were provided to both parties at the Pre-Hearing conference [P.H.T-10-11]; [T-5-6].

Witness Testimony

4. The Committee must determine the credibility of the witnesses in weighing each witness's testimony. First, the Hearing Committee considered whether the testimony was supported or contradicted by other independent objective evidence, if any. When the evidence was conflicting and presented a clear-cut issue as to the veracity of the opposing witnesses, it was for the Hearing Committee to pass on the credibility of the witnesses and base its inference on what it accepted as the truth. Where a witness's credibility is at issue, the Committee may properly credit one portion of the witness's testimony and, at the same time, reject another. The Hearing Committee also understood that we had the option of completely rejecting the testimony of a witness where we found that the witness testified falsely on a material issue.

Practicing the Profession Fraudulently

5. Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact in connection with the practice of medicine. An individual's knowledge that she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts. In order to support the charge that medicine has been practiced fraudulently, the Department must prove by a preponderance of the evidence that (1) Dr. Anghel made a false representation, whether by words, conduct, or concealment of that which should have been disclosed; (2) Dr. Anghel knew that the representation was false; and (3) Dr. Anghel intended to mislead through the false representation (ALJ Exhibit # 2).

There need not be either actual reliance on or actual injury caused by the misrepresentation to constitute the fraudulent practice of medicine. The focus is on the licensee's conduct in attempting to induce reliance, and not on whether the physician succeeds in causing reliance or whether any gain to the physician occurs to the detriment of the patient or to others. There is no requirement that someone actually be misled, as long as the intent of the "misrepresentation or concealment of fact" is present. Fraud can also be established from evidence that a person made a statement or representation with reckless disregard as to its truth.

The Hearing Committee used ordinary English usage and understanding for all other terms and allegations. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony presented, the Hearing Committee evaluated all the witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility.

Credibility Determination

The Department called Dr. Stephan Petranker as its expert witness. Dr. Petranker is board certified in anesthesiology, and is the Chair of the Department of Anesthesiology and pain management at Woodhull Hospital and Mental Health Center.

The Hearing Committee found Dr. Petranker's testimony to be credible and objective. Dr. Petranker's testimony was clear and focused. He was careful not to overreach in stating his opinions. The Hearing Committee found him to be a highly credible witness.

The Department called several other witnesses. Thomas Heckert, Jr. testified on behalf of the Department regarding Respondent's operation of a Physician Office Laboratory (POL). Mr. Heckert is the Director of the New York State Physician Office Laboratory Enforcement Program (POLEP) within the Department of Health. The Committee found Mr. Heckert to be a credible witness.

Eileen M. Heaphy is a senior investigator with the Wadsworth Center Laboratory, Investigative Services. Ms. Heaphy testified regarding Respondent's operation of a POL. The Committee found her to be a very credible witness as well. Michael Stephano, manager of the Special Investigations Unit for the Empire Plan, testified on behalf of the Department. He also produced two of the Department's exhibits (Department's Exhibits #12 and 12-a).

Department's Exhibit # 12 is a computer disk with numerous data which is printed as a spreadsheet (Department's Exhibit # 12-A) which document the numerous claims filed by Respondent concerning Patients C through G. The Hearing Committee found Mr. Stephano to be

a credible witness, found the documents he produced to be reliable and sufficiently accurate to establish the allegations of the Statement of Charges by more than a preponderance of the evidence. The Hearing Committee gave appropriate weight to the evidence contained in Department's Exhibits #12 and # 12-A in conjunction with the credible testimony.

Respondent presented several witnesses in her defense. Charles E. Argoff, M.D. testified as an expert witness. He is a professor of neurology, and a full time member of the Department of Neurology at Albany Medical Center. The Committee was very disturbed by Dr. Argoff's testimony. Dr. Argoff had known Respondent for approximately 15 years prior to his testimony, and had met her at various pain management conferences. Until the time of his testimony, Dr. Argoff was under the impression that Respondent confined her practice to pain management [T-2887-2890].

Dr. Argoff's replies to questions were non-responsive to the question posed, tangential, evasive and contrived. Apparently it did not matter to Dr. Argoff if the question was posed by Respondent's counsel, the Department's counsel or the Hearing Committee. His responses (which can not be classified as answers) were rambling, unclear, evasive and almost always equivocal. He even contradicted his own published writings, in an attempt to support Respondent. Dr. Argoff testified about the lack of necessity for a sensory examination in cases of suspected neuropathic pain. However, in his published article, Dr. Argoff wrote that "all patients suspected of neuropathic pain should...receive a pain specific sensory examination." His article then outlined the specific history and physical examination requirements testified to by Dr. Petranker [T-2860-2862, 2864-2869, 3186-3191].

Although Dr. Argoff has excellent credentials and appeared to be highly skilled and intelligent, the Hearing Committee found his testimony to be an embarrassment to the medical profession. Dr. Argoff's testimony was not reliable or efficient. The Hearing Committee gave little weight to Dr. Argoff's testimony.

Daniel Anghel, M.D., Respondent's brother, testified as a fact witness on Respondent's behalf. Dr. Daniel Anghel's testimony was fabricated to protect his sister, sometimes at the expense of his wife. The Committee found his testimony not credible. Dawn Huggins, a former employee of Respondent, testified regarding the operation of the POL. The Committee found Ms. Huggins' testimony credible, but not helpful to Respondent. Jacqueline Thelian, CPC, testified on behalf of Respondent. Ms. Thelian is a certified professional coder and instructor regarding coding rules and regulations. The Committee found Ms. Thelian to be a credible witness.

Respondent testified on her own behalf. Respondent was belligerent, uncooperative and deceptive throughout her testimony. Despite compelling evidence that she was fully aware of the requirements imposed by CLIA, she knowingly operated her laboratory in violation of the law. Moreover, responsible physicians acting in good faith do not throw away laboratory equipment, log books and other records when informed that the Department of Heath is coming to inspect the laboratory.

Respondent constantly sought to avoid answering questions. She asked questions rather than answer, launched into tirades unrelated to the questions, and otherwise engaged in attempts at obfuscation. The Hearing Committee unanimously concluded that Respondent was intentionally deceitful and totally lacking in credibility.

Willful Failure to Comply with Federal Law and Regulations

Respondent continuously operated a Physician Office Laboratory (POL) from 1995 through on or about November 30, 2003. Operators of POLs are subject to the requirements of the Clinical Laboratory Improvement Amendment of 1988 (CLIA), CFR Part 493 and 42 USC 263. The law imposes a number of oversight requirements. Operators are subject to routine inspections, participation in proficiency testing, and are also required to meet certain quality control standards. Respondent avoided these requirements and the costs associated with compliance by failing to obtain CLIA certification.

Respondent is a participating provider for the Medicare program. Medicare, unlike other third party payers such as UHC, and the Empire Plan, maintains a database of CLIA laboratories. Medicare will not reimburse for claims for laboratory work not performed in CLIA certified laboratories [T-4869-4870, 4997-4998].

Of all the patients whose care is at issue, only Patient G had Medicare as a primary insurer. Significantly, this was the only patient for which Respondent did not submit claims for laboratory testing. Respondent admitted that she was fully aware of the requirements for participating in the Medicare program.

Moreover, Respondent had practiced with her brother, Daniel Anghel, M.D. during 1993 - July, 1995. Daniel Anghel operated a CLIA certified laboratory during that period. Respondent was listed on the certification documents as the technical consultant for the laboratory. Therefore, she was presented as being responsible for regulatory compliance.

Following the receipt of a complaint from the Empire Plan regarding Respondent's claims for laboratory testing, Eileen Heaphy, a senior investigator for the Wadsworth Center Laboratory, scheduled a site visit for January 7, 2004. Respondent was told to have available all required documents for operation of a laboratory [T-624-627]. When Ms. Heaphy arrived at Respondent's office on January 7, Respondent informed her that she threw all of her records in the trash, and "disposed" of her equipment [T-528-536, 570-572]. These are not the actions of a physician who may have committed an innocent error. Rather, they are more emblematic of a guilty individual who knows she is about to be caught.

Based on the entire record available to the Hearing Committee, we inferred that Respondent was quite aware of CLIA, and its requirements. The Committee concluded that Respondent intentionally chose to avoid compliance and intentionally did not obtain certification of her POL. As a result, the Committee concluded that Respondent willfully failed to comply with the provisions of federal law governing the operation of POLS, in violation of Education Law §6530(16), and voted

to sustain the Twelfth Specification of professional misconduct set forth in the Second Amended Statement of Charges.

Failure to Maintain Records

One of the major purposes of medical record keeping is to provide an accurate rendering of patient encounters. The details of the history and the description of the physical findings, both positive and negative, should be drawn carefully enough so that if the physician were not present herself, any other health professional would be able to tell from the record exactly what was going on with the patient and what thoughts the physician had regarding diagnosis and treatment. A proper medical record must document an evaluation and plan of treatment, monitor the treatment over time, provide continuity of care among healthcare providers, allow for quality of care evaluation and claim review [T-727-729-733, 2838-2849].

A physician is required by law to keep patient records for six years after the last visit (ALJ Exhibit #11); [T. 4817-4818]. Moreover, generally accepted standards of practice mandate that all records, from the beginning of treatment forward, need to be available, in order to establish what has been done for the patient, and to trace the evolution of disease [T. 1260-1262].

Notwithstanding the requirements of both law and accepted standards of practice, Respondent failed to keep records for Patients C through G for the requisite periods of time. Respondent testified that she saw no need to maintain her records. She went so far as to state that even if she had maintained her records, they would be of no use since she would never refer back to them [T. 4222-4227]. The medical records maintained by Respondent lack accuracy, veracity, clarity and usefulness. The records and testimony clearly established that Respondent's medical records served mainly as a vehicle to support her claims for insurance reimbursement, rather than to provide meaningful medical information. As a result, the Hearing Committee concluded that Respondent failed to maintain medical records which accurately reflected the medical care and treatment rendered to Patients A through G, in violation of Education Law §6530(32). Accordingly,

the Committee voted to sustain the Nineteenth through Twenty-fifth Specifications of professional misconduct.

Excessive Tests and Treatment

The evidence overwhelmingly established that Respondent's primary motive in operating a laboratory was to generate reimbursable insurance claims, rather than to obtain accurate, meaningful and necessary laboratory results for her patients. The records for Patients A and C through F demonstrate that, regardless of the documented medical complaint and/or diagnosis noted in the records, the exact same laboratory tests were done each time.

Dawn Huggins, a former employee of Respondent's, testified convincingly that during the five years of her employment, she and other employees, none of whom were trained as technicians, operated the laboratory equipment. She also testified that no service was ever done on the machine, nor were any parts replaced [T-2610-2612, 2630, 2632-2633, 2663-2664]. Moreover, there was no evidence of any proficiency testing ever being performed, and all records were destroyed by Respondent before they could be reviewed.

The lack of care for the equipment's accuracy provides strong evidence that Respondent's primary use of the laboratory was to generate revenue, not to provide patient care. The Hearing Committee notes that the failure to comply with CLIA is not just a paper failure. The lack of accuracy of medical equipment has potentially grave consequences to each and every patient tested. The Hearing Committee concluded that Respondent ordered excessive tests not warranted by the condition of the Patients A, and C through F, in violation of Education Law §6530(35), and sustained the Thirteenth through Seventeenth specifications of professional misconduct.

Fraudulent Practice

As noted previously, regardless of the documented medical complaints or diagnoses, Respondent performed the same laboratory tests over and over. Her laboratory equipment only performed chemistry and lipid panels. Despite this single panel process, Respondent repeatedly

billed separately for individual tests. Respondent's own coding expert, Jacqueline Thelian, stated that this constitutes billing for tests not performed. [T. 5024-5025].

Respondent further inflated her billing for Patients A through G by claims of repeated blood draws via arterial puncture rather than by venipuncture. In each instance, Respondent diagnosed volume depletion and noted "poor venous access". However, there was no evidence in the records to support these claims. Mild volume depletion would not have any significant effect on venous access. Moderate volume depletion might necessitate arterial punctures. However, in such cases the patients present with high heart rate, irritability, fatigue, weakness, blood pressure issues, and significant dehydration. There is no evidence that any of the named patients presented with such significant volume depletion [T-831-832].

In any event, giving a local anesthetic injection to a patient who is significantly volume depleted would be contraindicated, given the potential negative effects on the patient's blood pressure. Nevertheless, Respondent continuously performed injection procedures in the face of the alleged "poor venous access" and "volume depletion".

It is highly unusual for a physician to perform an arterial puncture in a hospital setting. It is even more unusual in a private office. Respondent billed for over 180 arterial punctures on the seven patients at issue in this case. The testimony established that insurance payments for arterial punctures are substantially higher than those for venous punctures. The Hearing Committee concluded that the preponderance of the evidence demonstrates that Respondent merely billed for the more expensive procedure, in order to maximize her income.

Another example of Respondent's false billings is the repeated use of the highest level of consultation code (CPT 99245). Dr. Petranker testified that a comprehensive visit warranting use of CPT 99245 would include coordination of multiple providers, dealing with multiple complex diseases, developing a treatment plan, documenting a long and complex history and a report back to the referring physician [T-755-757].

Respondent submitted claims for CPT 99245 level consultations on at least 87 occasions for Patients A through G (including 31 claims for Patient C during a 4 year period). The medical records do not reflect any comprehensive history or comprehensive examination. The records maintained by Respondent are devoid of any evidence of coordination of care, or reports to referring physicians. The Hearing Committee concluded that these claims were false, and that Respondent knowingly submitted these false claims.

Respondent, like all physicians, uses ICD9 diagnostic codes to justify the medical necessity of the various tests and procedures performed. In each and every case at issue Respondent repeatedly used ICD9 codes for such medical conditions as hepatitis, chronic pancreatitis, hyperlipidemia, adverse effects of medication or substances, and diabetes, to justify her billing for blood draws and laboratory and other diagnostic procedures. However, the medical records do not indicate any follow-up on these diagnoses subsequent to the tests. The diagnoses often continued in the records for years without any correlation to the record and no support in the lab results. (Department's Exhibits # 5, # 7 through # 11, # 12, # 12-A); [T-1274-1275, 1280-1284, 1317-1319].

Respondent claimed that her repeated use of diagnoses, such as hepatitis or chronic pancreatitis, were "rule out" diagnoses. However, Respondent generally failed to document clinical findings to raise a concern regarding these diagnoses, and she never followed-up. Eventually, the physician must either confirm a diagnosis or definitively rule it out. In some cases, the "rule out" diagnoses continued for years without resolution. If Respondent was providing palliative care as a pain management specialist, the patients' medical records do not indicate so. The Hearing Committee concluded that Respondent was merely citing diagnostic codes in an attempt to justify the claims submitted to the insurance carriers.

Respondent also knowingly billed for assorted supplies, in connection with injection procedures, which she did not use. These supplies included gloves, betadine swabs and alcohol wipes, among others. For example, Respondent submitted claims to Vytra for supplies purportedly

used in treating Patient A as follows: full boxes of betadine swabs on October 11, 15 and 22, 2001, at $160 each, and for two boxes of betadine swabs on October 29, 2001, at $320; one pair of sterile gloves at $130 each on October 11, 15, and 22, 2001, and two pairs of sterile gloves at $260 on October 29, 2001.

Respondent asserted that she billed for entire boxes of swabs even though she only used three per procedure because "the billing code does not designate a package of three. It just says Betadine swabs per box" [T-2521]. However, Ms. Thelian testified that where a code for less than a box does not exist, the physician does not bill, because the supplies would be considered inclusive to the cost of the procedure [T-5061].

Respondent also billed for sterile gloves, using CPT code 4927, for each injection procedure. However, Ms. Thelian noted that in all relevant years, this code applies only to use of gloves during end stage renal disease or dialysis [T-5000-5016]. None of the seven patients in this proceeding were being treated by Respondent for end stage renal disease, nor was she providing dialysis treatments.

Respondent also claimed that the exorbitant amounts claimed for the swabs represented the "cost of doing business" [T-3291-3298, 3302-3303]. When asked how she arrived at the charge for swabs, Respondent stated "I arrived at this amount by what training it took me to be able to do these procedures over time and it is basically the cost of practice, so it is cost-based. That includes just about everything, not just the cost of this month's business, but how I arrived to do business in the position I am in from all the prior training" [T. 4451-4452].

Simply put, Respondent's explanation is gibberish. She essentially pulled dollar figures out of the thin air, and then claimed them as her reasonable and medically necessary expenses.

The above examples which we have drawn from the records are far from an exhaustive listing. The records in evidence for each patient demonstrate hundreds of similarly false claims. As Ms. Thelian testified, insurance companies generally pay on good faith because of the enormous number of claims, the system could not function otherwise [T-4979-4988].

The Hearing Committee concluded that Respondent knowingly submitted numerous false claims for reimbursement for each of the named patients. Further, as previously found, Respondent knowingly submitted false claims for laboratory tests performed unlawfully in her unlicensed laboratory. It does not matter that the insurance companies may not have paid the full amounts claimed by Respondent. By submitting each claim Respondent is indicating that the charges were all medically indicated and necessary for the health of the patient. Respondent knowingly misrepresented the medical care rendered to her patients for the purpose of generating income.

Consequently, the Committee concluded that Respondent engaged in the fraudulent practice of medicine. The Hearing Committee concluded that Respondent practiced the profession of medicine fraudulently in violation of Education Law §6530(2) and sustained the First through Eighth specifications of professional misconduct.

Negligence on More Than One Occasion

Following extensive (17 days) of testimony, the Hearing Committee ruled that the medical care rendered to Patients C through G met minimal standards. However, the Committee found significant flaws in the medical records. Specifically, there were multi-year gaps in the records because they were destroyed by Respondent. Moreover, she has acknowledged that she would not review past medical records in any event. It is well-settled that where there is a relationship between inadequate record-keeping and patient treatment, the failure to keep accurate records may also constitute physician negligence Matter of Bogdan v. New York State Board for Professional Medical Conduct, 195 A.D.2d 86; 606 N.Y.S.2d 381 (3rd Dept. 1993).

Even the testimony of Respondent's expert, Dr. Argoff, indicated the critical needs and reasons to maintain an adequate record:

> Mr. Ducey: ... who is the record put together for primarily?
>
> The Witness: The medical record is designed to allow communication among ... many people. It is a representation of the patient-physician relationship. It is a representation [to] the patient of what he or she can take to

other healthcare providers that need to be done for review. It is a representation of a condition and care to be done for payors to be able to review, and make determinations. ... it also reflects the care and treatment so that regulatory agencies can be comfortable with the style in which a person is practicing.

... the best way to approach it, [is] that many people are going to have access to our records and we should ideally be keeping medical records in such a way that we make it as easy as possible to share information about what actually happened ...

A reasonably prudent physician would not destroy medical records for patients still under treatment, and would also review the records to maintain appropriate continuity of care. The failure by Respondent to maintain medical records for Patient C through G which show a continuity of care, communications to and from other health care providers, and adequate information has a direct impact on those patients' health care and treatment. Thus it is apparent that Respondent is also guilty of negligence on more than one occasion.

The evidentiary record also established that Respondent ordered excessive tests - not for the patient's benefit, but to generate income. The medical records also established that the patients made numerous visits and that tests were administered more often than customary (Testimony of Dr. Petranker). The Hearing Committee concludes that this practice by Respondent was not for the patient's benefit, but for her need to generate income. A reasonably prudent physician would not engage in such predatory behavior, nor would she place her narrow economic interests ahead of the welfare of her patients. This also led the Committee to conclude that Respondent's conduct represented negligence on more than one occasion, and voted to sustain the Ninth specification of professional misconduct. Respondent violated Education Law §6530 (3).

Gross Negligence

The Hearing Committee further concluded that Respondent's misconduct, which was apparently pervasive throughout her practice, demonstrated an especially egregious departure from

the care and treatment which would be rendered by a reasonably prudent physician. The Committee unanimously concluded that in this regard, Respondent's negligence on more than one occasion (as discussed above) rose to the level of gross negligence, and voted to sustain the Eleventh specification. Respondent violated Education Law §6530 (4).

Incompetence on More Than One Occasion

The Department has charged Respondent with practicing the profession with incompetence on more than one occasion. The evidence did not demonstrate a lack of skill or knowledge on Respondent's part. To the contrary, the Respondent was found to be a knowledgeable physician. Unfortunately, she has chosen to use her knowledge for her own unjust enrichment, rather than for the benefit of her patients. In any event, the Committee concluded that the record did not establish that Respondent practiced the profession of medicine with incompetence, as defined. Accordingly, the Committee voted to dismiss the Tenth specification of professional misconduct.

DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented and pursuant to the Findings of Fact, Conclusions of Law, Discussion, and Summary set forth above, the Hearing Committee determines that Respondent's license to practice medicine in New York State should be Revoked. In addition, a $240,000.00 fine should be assessed against Respondent.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including[24]: (1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) A fine not to exceed ten thousand ($10,000.00) dollars on each specification of charges of which the respondent is determined to be guilty; (8) a course of education or training; (9) performance of up to five hundred (500) hours of public service; and (10) probation.

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[24] The Hearing Committee considered the penalties allowed under P.H.L. §230-a, both prior to the changes made by Chapter 477 of the Laws of 2008, and subsequent to the changes. We believe that our penalty determination is the proper penalty under either law.

The Hearing Committee sees no hope that Respondent will change in the future. The overwhelming evidence demonstrated that Respondent's practice was aimed at manipulating the insurance reimbursement system for her benefit. Medical ethics is a foreign concept to Respondent and we see no likelihood of a change in her character.

Although the Hearing Committee has no credible evidence that any of the patients suffered harm, we have little evidence (the medical records maintained by Respondent appeared to be maintained more for billing purposes than for medical communication) that the patients' illnesses, diseases, and other medical presentations were appropriately addressed or resolved by Respondent. The Hearing Committee concludes that the medical records maintained by Respondent were contrived to justify her billing practices. We find it remarkable that Respondent did not take the precautions, as testified to by Dr. Dr. Petranker, that would normally be taken prior to the numerous procedures she performed on Patients A through G and yet, apparently, had no bad outcome. Either Respondent is extremely skilled and lucky or the medical records do not report the bad outcomes.

The Hearing Committee concludes, by a preponderance of the evidence, that Respondent engaged in systematic fraud in billing Patient A through F's insurers, and Medicare for Patient G, for numerous medical services that she did not provide to those patients and/or medical supplies that she did not use on those patients.

Respondent's numerous acts of fraud, pattern of unwarranted testing, and billing greed leads us to conclude that no penalty, other than revocation, would change her behavior and provide adequate protection to the people of the State of New York. Respondent's misconduct cannot be corrected or remedied by a censure or a reprimand, by probation, by performance of public service, or by retraining.

A temporary suspension, limitations on Respondent's license, or monitoring are all inappropriate sanctions in this matter. Respondent has denied any misconduct. Respondent showed no remorse or acknowledgment of any wrong doing. Respondent even found it difficult

to acknowledge that she should have complied with the requirement to maintain medical records for her patients for a period of six years, or that she would do so in the future. And even then, she asserted that she would have no need to ever look at those medical records.

The Committee has no realistic expectation that she would change her practice, were she allowed to keep her medical license.

Integrity is essential to the practice of medicine. It is imperative that physicians deal truthfully not only with patients and other physicians, but with third party insurers and state regulators. This standard and its enforcement is the foundation on which our health care system rests. Physicians who make a habit of placing their own interests above those of the patient population erode our health care system for everyone.

Respondent's fraudulent method of practice is a serious transgression as it belies a fundamental lack of integrity. Physicians are not infallible nor are they held to that standard; however, honesty and accountability are standards that are inviolate. Their breach corrupts the profession, endangers the public, and taints the trust and respect that society places in their physicians, an effect which cannot be minimized.

Respondent's conduct was guided by greed. Respondent billed Patient C's insurance at least $390,515.80. Respondent billed Patient D's insurance at least $215,151.20. Respondent billed Patient E's insurance at least $144,881.85. Respondent billed Patient F's insurance at least $121,064.65. Respondent billed Patient C's insurance at least $72,528.02. For five patients over the period of approximately ten years, Respondent billed at least $944,141.52.

The Hearing Committee believes that the imposition of a monetary penalty is appropriate. A fine of $10,000.00 for each sustained specification of professional misconduct is assessed. The Hearing Committee therefore hereby assesses a fine of $240,000.00 for the 24 specifications sustained, in addition to the revocation of Respondent's license to practice medicine in the state of New York.

The Hearing Committee has determined that Respondent's use of her license to commit fraud, standing alone, provides sufficient grounds to revoke Respondent's license and the imposition of a fine. The excessive tests and treatments ordered by Respondent, done for her own enrichment, standing alone, warrant revocation and the imposition of a fine. The willful and unlawful operation of a physician operated laboratory, standing alone, provides sufficient grounds to revoke Respondent's license and the imposition of a fine. Respondent's failure to maintain accurate records for her patients, which rose to the level of gross negligence, as well as negligence on more than one occasion, also independently provides sufficient grounds to revoke Respondent's license and the imposition of a fine.

The Hearing Committee believes that the penalty imposed should help protect the public, prevent future unprofessional practice by Respondent, deter other licensees from similar temptations, and is in the interest of justice. Moreover, given her total lack of honesty and integrity, we strongly recommend that Respondent never again be allowed to practice medicine in the State of New York.

Taking all of the facts, details, circumstances, and particulars in this matter into consideration, the Hearing Committee determines that the above is the appropriate action under the circumstances. All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein. Specifically, Respondent's arguments are either rendered academic by the Hearing Committee's Determination and Order or have been found to be lacking in merit.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

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

1. The FIRST through NINTH, and ELEVENTH through TWENTY-FIFTH SPECIFICATIONS contained in the Second Amended Statement of Charges (Department's Exhibit # 1-A) are SUSTAINED; and

2. The TENTH SPECIFICATION contained in the Second Amended Statement of Charges (Department's Exhibit # 1-A) is **NOT SUSTAINED**; and

3. Respondent's license to practice medicine in the State of New York is hereby **REVOKED**; and

4. Within thirty (30) days from the effective date of this Determination and Order, Respondent shall pay a fine of **TWO HUNDRED FORTY THOUSAND ($240,000.00) DOLLARS**; and

5. 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 §171[27]; State Finance Law §18; CPLR §5001; Executive Law §32); and

6. This Order shall be effective on personal service on the Respondent or seven (7) days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: **New York**
July, 13 **2009**

Redacted Signature

Sheldon H. Putterman, M.D. (Chair)
Fred S. Levinson, M.D.
James J. Ducey

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APPENDIX 1

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

IN THE MATTER

OF

MARIA-LUCIA ANGHEL, M.D.

SECOND AMENDED STATEMENT OF CHARGES

MARIA-LUCIA ANGHEL, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 13, 1987, by the issuance of license number 171848 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent, at her office located at 294 Jerusalem Avenue, Hempstead, N.Y. 11550, undertook the care and treatment of Patient A (the identity of all patients is set forth in the annexed Appendix) from on or about October 11, 2001 through on or about November 5, 2001, for pain management of the patient's complaints of lower back pain. Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaint from Patient A;
2. Failed to perform and/or note a complete and appropriate physical examination of Patient A;
3. Withdrawn;
4. Withdrawn;
5. Inappropriately and without accepted medical indication and/or justification prescribed and/or maintained Patient A on various medications, to wit:
   a. Neurontin

b. Elavil

c. Motrin

d. Tylenol KL

e. Steroid injections

f. Calcium

g. Vitamin D

h. Toprol XL

i. Vioxx

6. Failed to properly monitor the patient while performing both caudal epidural blocks and/or facet blocks;

7. On the patient's last visit of on or about November 5, 2001, knowingly and willfully drew blood from Patient A for analysis, as set for in paragraph H below. Regarding said laboratory testing, Respondent:

   a. Performed extensive laboratory studies without accepted medically indication and/or justification;

   b. Performed laboratory studies which, if warranted, should have been performed prior to instituting treatment;

   c. Failed to appropriately follow-up on abnormal findings with Patient A and/or the patient's primary care physician;

   d. Knowingly and willfully falsely submitted a claim for in office laboratory work which was unauthorized and/or was not performed on equipment located in her offices;

8. Withdrawn;

9. Withdrawn;

10. On each date of service, knowingly and willfully falsely billed the insurance company for the use of full boxes of betadine swabs, individual needles and pairs of sterile gloves;

11. Failed to appropriately diagnosis and/or note Patient A's conditions and/or to follow up on and/or rule out diagnosis, to wit: chronic pancreatitis, hepatitis and volume depletion.

12. Knowingly and willfully used false diagnosis codes in billing the insurance company for her treatment, procedures and/or office laboratory studies;

13. Knowingly and willfully falsely billed the insurance company for a high level comprehensive office visit, when, in fact, said services were not rendered;

14. Knowingly and willfully submitted false claim statements, for full payment, to Patient A's insurer when Respondent intended to accept from the Patient only the 80% reimbursement amount of usual and customary charges paid by the insurer.

15. Knowingly and willfully created a medical record for Patient A which did not accurately reflect the care and treatment rendered to the patient;

16. Failed to maintain a medical record for Patient A in accordance with accepted medical standards and in a manner which accurately reflects her care and treatment of the patient.

B. On or about January 5, 2004, Respondent, at her office, located at 2410 Hempstead Turnpike, East Meadow, N.Y., undertook the care and treatment of Patient B for pain management of the patient's complaints of pain secondary to arthritis. Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaint from Patient B;
2. Failed to perform and/or note a complete and appropriate physical examination of Patient B;
3. Failed to appropriately follow-up on her finding of cervical spine radiculophathy in Patient B;
4. Knowingly and willfully falsely billed the insurance company for performing an arterial puncture to obtain a blood sample from Patient B, when, in fact, Respondent performed a venipuncture on Patient B;
5. Failed to appropriately diagnosis and/or note Patient B's conditions and/or to follow up on and/or rule out diagnosis, to wit: unspecified reaction to a drug, volume depletion and lumbosacral nueritis;
6. Knowingly and willfully used false diagnosis codes in billing the insurance company for her treatment and/or procedures;
7. Knowingly and willfully falsely billed the insurance company for performing an epidural injection when, in fact, Respondent performed a facet injection on Patient B;
8. Failed to first inject a test dose of epinephrine prior to introducing a local anesthetic into the epidural space of Patient B;
9. Failed to properly monitor the patient while performing the epidural block and/or facet block;
10. Failed to provide Patient B's primary care physician with a consultation report and/or to communicate with said physician in any way;

11. Knowingly and willfully falsely billed Patient B's insurance carrier for a high level comprehensive office visit, when, in fact, said service was not rendered;

12. Knowingly and willfully submitted a false claim statement, for full payment to Patient B's insurer when Respondent intended to accept from the Patient only the 80% reimbursement amount of usual and customary charges paid by the insurer.

13. Knowingly and willfully created a medical record for Patient B which did not accurately reflect the care and treatment rendered to the patient;

14. Failed to maintain a medical record for Patient B in accordance with accepted medical standards and in a manner which accurately reflects her care and treatment of the patient.

C. Respondent undertook the care and treatment of Patient C, located first at 294 Jerusalem Avenue, Hempstead, N.Y. 11550, and then at 2410 Hempstead Turnpike, East Meadow, N.Y. (herein after referred to as, "her offices"), from on or about July 17, 1995 through on or about June 7, 2005. On numerous and repeated occasions, throughout her care and treatment of Patient C, Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaints from Patient C;

2. Failed to perform and/or note a complete and appropriate physical examination of Patient C;

3. Failed to reconcile and/or note a medication history for Patient C and the medications prescribed;

4. Knowingly and willfully drew blood from Patient C for analysis, as set for in paragraph H below. Regarding said laboratory

testing, Respondent:

a. Performed extensive laboratory studies without medically accepted indication and/or justification;

b. Failed to appropriately follow-up on abnormal findings with Patient C and/or the patient's primary care physician;

c. Knowingly and willfully falsely submitted a claim for in office laboratory work which was unauthorized and/or was not performed on equipment located in her offices;

5. Knowingly and willfully falsely billed the insurance company for performing arterial punctures to obtain blood samples from Patient C;

6. Knowingly and willfully falsely billed the insurance company for the use of:

a. full boxes of betadine swabs;

b. needles used for injection procedures;

c. From 1995 through 2001,individual pairs of sterile gloves;

d. From 2002 through 2005, full boxes of sterile gloves

7. Failed to appropriately diagnosis and/or note Patient C's conditions and/or to follow up on and/or rule out diagnosis, to wit: volume depletion, hypertension and hypertensive heart disease, dizziness and giddiness, asthma, myalgia and myosotis, chest pain, hyperlipidemia, hepatitis, adverse effect of medical or biological substance, abdominal pain, nausea and

vomiting, lymphosarcoma of intra thoracic lymph nodes; migraine, palpations, acute respiratory failure, diabetes, cholecystitis, chronic pancreatitis, proteinuria, precordial pain, obstructive bronchitis;

8. On numerous occasions, inappropriately and without accepted medical indication and/or justification, performed caudal epidural and/or nerve blocks on Patient C.
9. Failed to refer, and/or note a referral for, Patient C to a specialist physicians for consultation regarding the diagnosis Respondent made and/or suspected as set forth above;
10. Knowingly and willfully used false diagnosis codes in billing the insurance company for her treatment, procedures and/or office laboratory studies;
11. Knowingly and willfully falsely billed Patient C's insurance carrier for high level comprehensive office visits, when, in fact, said services were not rendered;
12. Failed to maintain a record of treatment for Patient C from on or about July 17, 1995 through on or about April 4, 2003;
13. Knowingly and willfully created a medical record for Patient C which did not accurately reflect the care and treatment rendered to the patient;
14. Failed to maintain a medical record for Patient C in accordance with accepted medical standards and in a manner which accurately reflects her care and treatment of the patient.

D. Respondent undertook the care and treatment of Patient D, at her offices, from on or about October 18,1996 through on or about November 11, 2004.

On numerous and repeated occasions, throughout her care and treatment of Patient D, Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaints from Patient D;
2. Failed to perform and/or note a complete and appropriate physical examination of Patient D;
3. Failed to reconcile and/or note a medication history for Patient D and the medications prescribed;
4. Knowingly and willfully drew blood from Patient D for analysis, as set for in paragraph H below. Regarding said laboratory testing, Respondent:
    a. Performed extensive laboratory studies without medically accepted indication and/or justification;
    b. Failed to appropriately follow-up on abnormal findings with Patient D and/or the patient's primary care physician;
    c. Knowingly and willfully falsely submitted a claim for in office laboratory work which was unauthorized and/or was not performed on equipment located in her offices;
5. Knowingly and willfully falsely billed the insurance company for performing arterial punctures to obtain blood samples from Patient D;
6. Knowingly and willfully falsely billed the insurance company for the use of:
    a. full boxes of betadine swabs;
    b. needles used for injection procedures;

c. From 1996 through 2001,individual pairs of sterile gloves;

d. From 2002 through 2004, full boxes of sterile gloves

7. Failed to appropriately diagnosis and/ or note Patient D's conditions and/or to follow up on and/or rule out diagnosis, to wit: volume depletion, unspecified mononeuritis of upper limb, dizziness and giddiness, hematuria, hypertensive heart disease, asthma, hematuria, cardiac dysrythmias, chest pain, hyperlipidemia, hepatitis, adverse effect of medical or biological substance, nausea and vomiting, abdominal pain, migraine, palpations, acute respiratory failure, diabetes, cholecystitis, chronic pancreatitis, proteinuria, precordial pain, hypoglycemia;

8. On numerous occasions, inappropriately and without accepted medical indication and/or justification, performed caudal epidural and/or nerve blocks on Patient D.

9. Failed to refer, and/or note a referral for, Patient D to specialist physicians for consultation regarding the diagnosis Respondent made and/or suspected as set forth above;

10. Knowingly and willfully used false diagnosis codes in billing the insurance company for her treatment, procedures and/or office laboratory studies;

11. Knowingly and willfully falsely billed Patient D's insurance carrier for high level comprehensive office visits, when, in fact, said services were not rendered;

12. Failed to maintain a record of treatment for Patient D from on or about October 18,1996 through on or about December 18,

2000;

13. Knowingly and willfully created a medical record for Patient D which did not accurately reflect the care and treatment rendered to the patient;

14. Failed to maintain a medical record for Patient D in accordance with accepted medical standards and in a manner which accurately reflects her care and treatment of the patient.

E. Respondent undertook the care and treatment of Patient E, at her offices, from on or about October 5, 1999 through on or about July 23, 2007. On numerous and repeated occasions, throughout her care and treatment of Patient E, Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaints from Patient E;

2. Failed to perform and/or note a complete and appropriate physical examination of Patient E;

3. Failed to reconcile and/or note a medication history for Patient E and the medications prescribed;

4. Knowingly and willfully drew blood from Patient E for analysis, as set for in paragraph H below. Regarding said laboratory testing, Respondent:

   a. Performed extensive laboratory studies without medically accepted indication and/or justification;

   b. Failed to appropriately follow-up on abnormal findings with Patient E and/or the patient's primary care physician;

   c. Knowingly and willfully falsely submitted a claim for

in office laboratory work which was unauthorized and/or was not performed on equipment located in her offices;

5. Knowingly and willfully falsely billed the insurance company for performing arterial punctures to obtain blood samples from Patient E;

6. Knowingly and willfully falsely billed the insurance company for the use of:

   a. full boxes of betadine swabs;

   b. needles used for injection procedures;

   c. From 1998 through 2001,individual pairs of sterile gloves;

   d. From 2002 through 2007, full boxes of sterile gloves

7. Failed to appropriately diagnosis and/or note Patient E's conditions and/or to follow up on and/or rule out diagnosis, to wit: volume depletion, hypertensive heart disease, cardiac dysrythmias, asthma, chest pain, acute per carditis, hyperlipidemia, hepatitis, adverse effect of medical or biological substance, nausea and vomiting, abdominal pain, migraine, palpations, chronic myringitis, diabetes, cholecystitis, chronic pancreatitis, proteinuria, precordial pain;

8. On numerous occasions, inappropriately and without accepted medical indication and/or justification, performed caudal epidural and/or nerve blocks on Patient E.

9. Failed to refer, and/or note a referral for, Patient F to a specialist physicians for consultation regarding the diagnosis Respondent

made and/or suspected as set forth above;

10. Knowingly and willfully used false diagnosis codes in billing the insurance company for her treatment, procedures and/or office laboratory studies;
11. Knowingly and willfully falsely billed Patient E's insurance carrier for high level comprehensive office visits, when, in fact, said services were not rendered;
12. Failed to maintain a record of treatment for Patient E from on or about October 5, 1999 through on or about March 27, 2001;
13. Knowingly and willfully created a medical record for Patient E which did not accurately reflect the care and treatment rendered to the patient;
14. Failed to maintain a medical record for Patient E in accordance with accepted medical standards and in a manner which accurately reflects her care and treatment of the patient.

F. Respondent undertook the care and treatment of Patient F, at her offices, from on or about May 4, 1998 through on or about July 11, 2003. On numerous and repeated occasions, throughout her care and treatment of Patient F, Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaints from Patient F;
2. Failed to perform and/or note a complete and appropriate physical examination of Patient F;
3. Failed to reconcile and/or note a medication history for Patient F and the medications prescribed;
4. Knowingly and willfully drew blood from Patient F for analysis,

as set for in paragraph H below. Regarding said laboratory testing, Respondent:

a. Performed extensive laboratory studies without medically accepted indication and/or justification;

b. Failed to appropriately follow-up on abnormal findings with Patient F and/or the patient's primary care physician;

c. Knowingly and willfully falsely submitted a claim for in office laboratory work which was unauthorized and/or was not performed on equipment located in her offices;

5. Knowingly and willfully falsely billed the insurance company for performing arterial punctures to obtain blood samples from Patient F,

6. Knowingly and willfully falsely billed the insurance company for the use of:

a. full boxes of betadine swabs;

b. needles used for injection procedures;

c. From 1998 through 2001,individual pairs of sterile gloves;

d. From 2002 through 2003, full boxes of sterile gloves

7. Failed to appropriately diagnosis and/or note Patient F's conditions and/or to follow up on and/or rule out diagnosis, to wit volume depletion, pain in soft tissue of limbs, asthma, chest pain, dizziness and giddiness, hyperlipidemia, hepatitis, adverse effect of medical or biological substance, nausea and vomiting,

abdominal pain, migraine, palpations, diabetes, chronic pancreatitis, precordial pain;

8. On numerous occasions, inappropriately and without accepted medical indication and/or justification, performed caudal epidural and/or nerve blocks on Patient F.

9. Failed to refer, and/or note a referral for, Patient F to specialist physicians for consultation regarding the diagnosis Respondent made and/or suspected as set forth above;

10. Knowingly and willfully used false diagnosis codes in billing the insurance company for her treatment, procedures and/or office laboratory studies;

11. Knowingly and willfully falsely billed Patient F's insurance carrier for high level comprehensive office visits, when, in fact, said services were not rendered;

12. Failed to maintain a record of treatment for Patient F from on or about October 5, 1999 through on or about March 27, 2001;

13. Knowingly and willfully created a medical record for Patient F which did not accurately reflect the care and treatment rendered to the patient;

14. Failed to maintain a medical record for Patient F in accordance with accepted medical standards and in a manner which accurately reflects her care and treatment of the patient.

G. Respondent undertook the care and treatment of Patient G, at her offices, from on or about October 26, 1994 through on or about November 29, 2004. On numerous and repeated occasions, throughout her care and treatment of Patient G, Respondent:

1. Failed to obtain and/or note an adequate and complete medical

history, and/or history of current complaint from Patient G;

2. Failed to perform and/or note a complete and appropriate physical examination of Patient G;
3. Failed to reconcile and/or note a medication history for Patient G and the medications prescribed;
4. Knowingly and willfully drew blood from Patient G for analysis, as set for in paragraph H below. Regarding said laboratory testing, Respondent:
   a. Performed extensive laboratory studies without medically accepted indication and/or justification;
   b. Failed to appropriately follow-up on abnormal findings with Patient G and/or the patient's primary care physician;
   c. Knowingly and willfully falsely submitted a claim for in office laboratory work which was unauthorized and/or was not performed on equipment located in her offices;
5. Knowingly and willfully falsely billed the insurance company for performing arterial punctures to obtain blood samples from Patient G;
6. Knowingly and willfully falsely billed the insurance company for the use of:
   a. full boxes of betadine swabs;
   b. needles used for injection procedures;
   c. From 1994 through 2001,individual pairs of sterile gloves;
   d. From 2002 through 2004, full boxes of sterile

gloves

7. Failed to appropriately diagnosis and/or note Patient G's conditions and/or to follow up on and/or rule out diagnosis, to wit: volume depletion, asthma, chest pain, congestive heart failure, syncope and collapse, coronary atherosclerosis, hypertension, hypertensive heart disease, cardiac dysrythmias, acute respiratory failure, adverse effect of medical or biological substance, nausea and vomiting, palpations, diabetes, cholecystitis, precordial pain, renal colic;
8. On numerous occasions, inappropriately and without accepted medical indication and/or justification, performed caudal epidural and/or nerve blocks on Patient G.
9. Failed to refer, and/or note a referral for, Patient G to specialist physicians for consultation regarding the diagnosis Respondent made and/or suspected as set forth above;
10. Knowingly and willfully used false diagnosis codes, in billing the insurance company for her treatment, procedures and/or office laboratory studies;
11. Knowingly and willfully falsely billed Patient G's insurance carrier for high level comprehensive office visits, when, in fact, said services were not rendered;
12. Failed to maintain a record of treatment for Patient G from on or about October 26, 1994 through on or about December 18, 2000;
13. Knowingly and willfully created a medical record for Patient G which did not accurately reflect the care and treatment rendered to the patient;

14. Failed to maintain a medical record for Patient G in accordance with accepted medical standards and in a manner which accurately reflects her care and treatment of the patient.

H. From in or about July, 1995 through in or about April, 2003, Respondent operated a Physician Office Laboratory ("POL") at her offices, Acute & Chronic Pain Management, 294 Jerusalem Avenue, Hempstead, N.Y. 11550, in violation of the Clinical Laboratory Improvement Amendment of 1988, 42 USC Sec. 263(a) and (b) (herein after referred to as "CLIA"), by knowingly and willfully failing to apply for and obtain a Certificate of Compliance to operate a POL. Thereafter, from in or about April, 2003 through in or about November, 2003, Respondent operated a POL at her offices, The Pain Management Center, 2410 Hempstead Turnpike, East Meadow, N.Y. in violation of CLIA, by knowingly and willfully failing to apply for and obtain a Certificate of Compliance to operate a POL. Respondent:

1. Knowingly and willfully falsely billed insurance carriers, as a POL, for laboratory work on Patients A through G, supra;
2. In or about December, 2003, knowingly and willfully and with intent to deceive the New York State Department of Health, Physician Laboratory Evaluation Program, ("POLEP"), disposed of all her POL equipment, laboratory data, records and/or laboratory results upon notification of a complaint and a scheduled site visit to her office of on or about January 7, 2004.
3. Knowingly and willfully falsely billed insurance carriers, as a POL, for laboratory work on Patients A through G, supra, which was never performed;
4. Knowingly and willfully falsely billed insurance carriers, as a

POL, for laboratory work on Patients A through G, supra, when, in fact, said laboratory work was perform on equipment in another physician's office.

SPECIFICATION OF CHARGES

FIRST THROUGH EIGHTH SPECIFICATION

FRAUDULENT PRACTICE

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

1. Paragraphs: A.7, A.7.a - A.7.d, A.10, A.12 - A.15;
2. Paragraphs: B.4, B.6, B.7, B.11 - B.13;
3. Paragraphs: C.4, C.4.a - C.4.c, C.5, C.6, C.6.a - C.6.d, C.9, C.10, C.12;
4. Paragraphs: D.4, D.4.a - D.4.c, D.5, D.6, D.6.a - D.6.d, D.9, D.10, D.12;
5. Paragraphs: E.4, E.4.a - E.4.c, E.5, E.6, E.6.a - E.6.d, E.9, E.10, E.12;
6. Paragraphs: F.4, F.4.a - F.4.c, F.5, F.6, F.6.a - F.6.d, F.9, F.10, F.12;
7. Paragraphs: G.4, G.4.a - G.4.c, G.5, G.6, G.6.a - G.6.d, G.9, G.10, G.12;
8. Paragraphs: H, H.1 - H.4.

NINTH 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:

9. Paragraphs A, A.1, A.2, A.5.a - A.5.i, A.6, A.7.a - A.7.d, A.10 - A.16; B, B.1 - B.14; C, C.1 - C.3, C.4.a - C.4.c, C.5 - C.14; D, D.1 - D.3, D.4.a - D.4.c, D.5 - D.14; E, E.1 - E.3, E.4.a - E.4.c, E.5 - E.14; F, F.1 - F.3, F.4.a - F.4.c, F.5 - F.14; G, G.1 - G.3, G.4.a - G.4.c, G.5 - G.14.

TENTH 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:

10. Paragraphs A, A.1, A.2, A.5.a - A.5.i, A.6, A.7.a - A.7.d, A.10 - A.16; B, B.1 - B.14; C, C.1 - C.3, C.4.a - C.4.c, C.5 - C.14; D, D.1 - D.3, D.4.a - D.4.c, D.5 - D.14; E, E.1 - E.3, E.4.a - E.4.c, E.5 - E.14; F, F.1 - F.3, F.4.a - F.4.c, F.5 - F.14; G, G.1 - G.3, G.4.a - G.4.c, G.5 - G.14.

ELEVENTH SPECIFICATION

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 as alleged in the facts of the following:

11. Paragraphs A, A.1, A.2, A.5.a - A.5.i, A.6, A.7.a - A.7.d, A.10 -

A.16; B, B.1 - B.14; C, C.1 - C.3, C.4.a - C.4.c, C.5 - C.14; D, D.1 - D.3, D.4.a - D.4.c, D.5 - D.14; E, E.1 - E.3, E.4.a - E.4.c, E.5 - E.14; F, F.1 - F.3, F.4.a - F.4.c, F.5 - F.14; G, G.1 - G.3, G.4.a - G.4.c, G.5 - G.14.

TWELFTH SPECIFICATION

WILLFUL FAILURE TO COMPLY WITH FEDERAL LAW AND REGULATIONS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(16) by a willful or grossly negligent failure to comply with substantial provisions of federal regulations governing the practice of medicine as alleged in the facts of the following:

12. Paragraphs: H, H.1 - H.4.

THIRTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

EXCESSIVE TESTS AND TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35) by the ordering of excessive tests and/or treatment not warranted by the condition of the patient, as alleged in the facts of the following:

13. Paragraph A.7.a;
14. Paragraph C.4.a, C.8;
15. Paragraph D.4.a, D.8;
16. Paragraph E.4.a, E.8;
17. Paragraph F.4.a, F.8;
18. Paragraph G.4.a, G.8;

NINETEENTH THROUGH TWENTY-FIFTH 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 the following:

19. Paragraphs: A.1, A.2, A.11, A.15, A.16;
20. Paragraphs: B.1, B.2,, B.6, B.14;
21. Paragraphs: C.1 - C.3, C.7, C.8, C.12 - C.14;
22. Paragraphs: D.1 - D.3, D.7, D.8, D.12 - D.14;
23. Paragraphs: E.1 - E.3, E.7, E.8, E.12 - E.14;
24. Paragraphs: F.1 - F.3, F.7, F.8, F.12 - F.14;
25. Paragraphs: G.1 - G.3, G.7, G.8, G.12 - G.14.

DATED: September 26, 2008
New York, New York

Redacted Signature

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct