NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

August 18, 2016

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Christine M. Radman, Esq.
NYS Department of Health
90 Church Street 4th Floor
New York, New York 10007

Anthony Z. Scher, Esq.
Attorney for Respondent
800 Westchester Avenue, Suite N-641
Rye Brook, New York 10573

Delys St. Hill, M.D.
[redacted]

RE: In the Matter of Delys St. Hill, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 16-286) 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
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

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. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "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., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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

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

Sincerely,

[redacted]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: nm
Enclosure

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

COPY

IN THE MATTER	:	DETERMINATION
	:	
OF	:	AND
	:	
DELYS ST. HILL, M.D.	:	ORDER

BPMC No. 16-286

A Notice of Hearing and Statement of Charges, both dated August 7, 2015, were served upon **DELYS ST. HILL, M.D.** ("Respondent"). **DIANE M. SIXSMITH, M.D.**, Chairperson, **MICHAEL R. GOLDING, M.D.**, and **CONSTANCE DIAMOND, D.A.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) of the Public Health Law of the State of New York ("Public Health Law"). Administrative Law Judge ("ALJ") **WILLIAM J. LYNCH, ESQ.**, served as the Administrative Officer.

The Department of Health, Office of Professional Medical Conduct ("Petitioner" or "the Department") appeared by RICHARD J. ZAHNLEUTER, General Counsel, by **CHRISTINE M. RADMAN, ESQ.**, of Counsel. Respondent was represented by **ANTHONY Z. SCHER, ESQ.** Evidence was received, witnesses sworn and heard, and transcripts of the proceedings were made.

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

PROCEDURAL HISTORY

Pre-Hearing Conference:	September 15, 2015
Hearing Dates:	September 16, 2015 November 5, 2015 November 10, 2015 November 18, 2015 December 1, 2015 January 11, 2016 January 21, 2016 February 3, 2016 February 11, 2016 March 9, 2016 April 4, 2016
Witnesses for Petitioner:	Joseph Carfi, M.D.
Witnesses for Respondent:	Delys St. Hill, M.D. Jorge De Castro Mark Monroe Jacqueline Thelian Harry W. Schwartz, M.D.
Written Submissions Received:	May 26, 2016
Deliberations Held:	June 27, 2016

STATEMENT OF CASE

The Department charged Respondent with thirty specifications of professional misconduct, as defined in § 6530 of the Education Law of the State of New York ("Education Law"). Respondent denied the factual allegations and specifications of professional misconduct. A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. All findings and conclusions set forth below are the unanimous determinations of the Hearing Committee unless otherwise indicated. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding.

Having heard the testimony and considered the documentary evidence presented by Petitioner and Respondent, the Hearing Committee hereby makes the following findings of fact:

1. Respondent was authorized to practice medicine in New York State on or about July 3, 1989, by the issuance of license number 178853. (Dept. Ex. 2).

2. Respondent was the sole Director and officer of We Care Medical, P.C. ("Bronx Medical Practice") which she operated for approximately one year from 2006 to 2007. (Dept. Ex. 3, p.10; T. 685).

3. Respondent worked as a physician at her Bronx Medical Practice and employed two doctors, a physical therapist and clerical staff. (T. 690-691).

4. Respondent sublet space at her Bronx Medical Practice to a chiropractor and an acupuncturist. (T. 692-693).

5. Respondent treated Patient A at her Bronx Medical Practice between April 26, 2007 and July 19, 2007, for injuries related to a motor vehicle accident that occurred on April 6, 2007. (Dept. Ex. 5A and 6A).

6. Respondent treated Patient B at her Bronx Medical Practice between March 21, 2007 and June 19, 2007, for injuries related to a motor vehicle accident that occurred on March 10, 2007. (Dept. Ex. 5B and 6B).

7. Respondent treated Patient C at her Bronx Medical Practice between September 5, 2007 and October 18, 2007, for injuries related to a motor vehicle accident that occurred on September 3, 2007. (Dept. Ex. 5C and 6C).

8. Respondent treated Patient D at her Bronx Medical Practice between January 9, 2007 and October 10, 2007, for injuries related to a motor vehicle accident that occurred on January 2, 2007. (Dept. Ex. 5D and 6D).

9. Respondent treated Patient E at her Bronx Medical Practice between January 24, 2007 and June 21, 2007, for injuries related to a motor vehicle accident that occurred on January 22, 2007. (Dept. Ex. 5E and 6E).

10. Respondent treated Patient F, the spouse of Patient E, at her Bronx Medical Practice between January 24, 2007 and August 15, 2007, for injuries related to the same January 22, 2007, motor vehicle accident as Patient E. (Dept. Ex. 5F and 6F).

11. Respondent treated Patient G at her Bronx Medical Practice between December 12, 2006 and June 5, 2007, for injuries related to a motor vehicle accident that occurred on December 8, 2006. (Dept. Ex. 5G and 6G).

12. Respondent closed her Bronx Medical Practice in 2007, and opened another medical practice in Queens County under a distinct corporate entity, Triumph Medical, which she operated from 2007 until approximately 2010. (T. 686).

13. By letter dated February 19, 2008, an investigator with the Office of Professional Medical Conduct ("OPMC") sent a letter to Respondent both at her home address in [redacted] and her Bronx Medical Practice. The letter requested certified copies of the complete medical records of Patients A through G, and advised Respondent that failure to respond within thirty days and make the records available would constitute professional misconduct. (Dept. Ex. 8, p. 1-4).

14. By letter dated March 24, 2008, the OPMC investigator advised Respondent that the records had not been received and made a second request. (Dept. Ex. 8, p. 5).

15. By letter dated March 24, 2008, a letter with Respondent's stamped signature was sent to the OPMC investigator. The letter alleged that the records for Patient A through G were not physically in Respondent's office and requested a 30-day extension to provide the records. (Dept. Ex. 8, p. 6).

16. By letter dated March 28, 2008, the OPMC investigator denied the extension request. (Dept. Ex. 8, p. 7).

17. On April 11, 2008, the OPMC investigator received certified copies of Respondent's complete medical records for Patients A through G. (Dept. Ex. 8, p. 8, and Dept. Ex. 5, and 5A through 5G).

18. Approximately two years later, by letter dated April 9, 2010, the OPMC investigator advised Respondent that the matters under investigation included, inter alia, her alleged failure to maintain acceptable medical records and the excessive and unnecessary testing and treatment rendered to Patients A through G. The letter offered Respondent an opportunity to be interviewed by the OPMC in order to be provided with an explanation of the issues under investigation, and to submit written comments or expert opinions. (Dept. Ex. 8, p. 19-20).

19. Respondent obtained an attorney to represent her, and the attorney held a telephone conference on June 3, 2010, with the OPMC investigator. Respondent's attorney stated that she had only the first page of the April 9, 2010 letter. The following day, the OPMC investigator faxed a copy of the two-page letter to Respondent's attorney. (Dept. Ex. 8, p. 16-20).

20. Respondent's attorney sent a reply letter acknowledging her receipt of the fax and stating that Respondent wished to decline the opportunity for an interview at that time. (Dept. Ex. 8, p. 21).

21. By letter dated June 25, 2010, a letter with Respondent's stamped signature was sent from her office address in Queens County to

the OPMC investigator with copies of the complete medical records for Patients A through G. (Dept. Ex. 6, and 6A through 6G).

22. On February 17, 2011, Respondent's attorney, as part of ongoing discussions with the OPMC, forwarded a 13-page document written by Respondent. (Dept. Ex. 8, pp. 22-35).

23. Two years later, a second OPMC investigator sent Respondent a letter dated November 14, 2013, offering Respondent another opportunity to be interviewed, but the letter was returned as unclaimed. (Dept. Ex. 9, p. 1-3).

24. On January 23, 2014, the OPMC investigator called Respondent's telephone and left a message for Respondent. The OPMC investigator and Respondent spoke the following day, and a second copy of the letter offering an opportunity for an interview was sent to Respondent. (Dept. Ex. 9, p. 4-8).

25. By letter dated May 12, 2014, the OPMC investigator offered Respondent six available dates in July to be interviewed, but Respondent did not respond. Approximately a month later, the OPMC deemed Respondent's failure to respond as her having declined this opportunity. (Dept. Ex. 9, p. 17-22).

26. Respondent retained Anthony Z. Scher, Esq., as her attorney in this matter. On July 10, 2015, Respondent authorized him to accept service of the Notice of Hearing and Statement of Charges on her behalf. (Dept. Ex. 1, p. 18).

27. Physical Medicine and Rehabilitation (PM&R) is a medical specialty related to the care and treatment of patients who either have pain or a disabling condition such as a spinal cord injury, muscular dystrophy or multiple sclerosis. The approach is holistic and includes an awareness of the medical and surgical issues as well as psychological, vocational and social concerns. Physical therapy, medication, activity modification and medical equipment are often required. (T. 34-39).

28. It is vitally important for a PM&R physician to elicit a proper history from a patient as that will guide the physician's diagnostic path. For example, eliciting an adequate pain history will help the physician differentiate between back pain which is musculoskeletal in nature and back pain which may be reflective of an internal problem. Sometimes, pain may be referred, so a patient complaining of shoulder, left arm or jaw pain may be experiencing a cardiac event. The patient should be asked when the pain started, how it started, how it might be characterized (sharp, shooting, deep, boring, dull, electrical, burning, tingling, etc.), whether or not the pain traveled anywhere and what, if anything, made it better or worse. The physical examination is then guided by the medical history and may focus on particular body parts, as is often the case with motor vehicle accident patients. (T. 36-39, 47, 49, 54).

29. The standard of care is to reexamine and follow a patient to see whether the treatment is effective and to modify treatment if anything is getting worse or changing. (T. 44).

30. Respondent billed the New York State No-Fault Insurance Program ("No-Fault Insurance") for the services which she purportedly provided to Patients A through G. (Dept. Ex. 5A through 5G and 6A through 6G).

31. Patients A through G were of varying ages and conditions when they were treated at Respondent's Bronx Medical Practice. (Dept. Ex. 5A through 5G).

32. It is not typical for motor vehicle accident patients of varying ages and conditions to receive identical rule-out diagnoses and have identical diagnostic tests ordered at their initial visits, regardless of their individual histories and clinical presentation (T. 53).

33. An adequate physical examination will help identify whether or not a motor vehicle accident patient is experiencing radicular pain, known as a pinched nerve, in the neck or back. A radicular complaint is characterized by pain radiating down to the arms from the neck or down to the legs from the lower back, which are clinically more significant injuries than soft tissue injuries which are characterized by more localized pain. (T. 106-116, 546-547, 1887-1888).

34. A reasonably prudent PM&R physician will typically follow a conservative treatment approach with a motor vehicle accident patient

once any acute medical, orthopedic and/or neurosurgical emergencies are ruled out by history and physical examination, before ordering advanced diagnostic studies such as CT scans, MRIs or electrodiagnostic studies. That plan might include anti-inflammatory medication, but almost certainly physical or occupational therapy including therapeutic exercise as tolerated and possible activity modifications with or without assistive devices. It is the standard of care to reexamine and follow the patient in three to four weeks to see if the treatment is efficacious or not. If the patient does not improve or gets worse, a change in medication, therapy intervention and/or more extensive diagnostic testing would need to be considered. (T. 38-52).

35. Electromyography (EMG) and Nerve Conduction Velocity (NCV) studies are electrodiagnostic tests designed to assess the peripheral nervous system which begins at the nerve root just outside the spinal cord and extends down to the extremities. (T. 56-57).

36. NCV studies involve proper positioning of a two-pronged electrical probe on the nerve being tested (sensory or motor) and administering an electric shock to that nerve, which then generates its own signal onto a computerized machine. The clinical information that signal reveals is latency (how long it takes for the nerve signal to get from point of stimulation to the pick-up), amplitude (height of the signal and whether or not it is symmetrical on both sides), and dispersion (width of the signal which can indicate nerve compression). NCV studies have no diagnostic value in determining the presence of

cervical and lumbar radiculopathies. For cervical radiculopathy, an F wave is measured which sends a signal up to the spinal cord and back down. Similarly, an H reflex is measured for lumbar radiculopathy. These tests are suggestive, but alone are not diagnostic of these pathologies. (T. 59-62, 67-68, 73).

37. An EMG is a diagnostic test during which a needle is inserted into a muscle and repeatedly re-positioned to measure electrical activity at rest and upon volition, which is reflective of the function of the nerve that controls the muscle. It is a dynamic test which happens in real time, with the electrical activity appearing on a monitor with an audio component so it also can be heard. (T. 58, 62, 68-70, 561-562).

38. It is a deviation from the standard of care to order tests and/or treatments that are medically unwarranted when ordered. (T. 122-123).

39. Needle testing can be quite painful and patients often refuse it entirely or fail to complete the test. (T. 70-71, 560-562).

40. According to Respondent's expert witness, patients at his facility stop the electromyographer from completing the testing 10 to 20 percent of the time due to the pain. (T. 1943-1945).

41. Respondent purportedly performed extensive needle testing consisting of between 12 to 26 individual needle sticks each on Patients A through G, yet Respondent alleged that none of them either refused the test initially or stopped the test in progress. (T. 561-562).

42. Respondent typically billed No-Fault Insurance $2600 for each purportedly completed electrodiagnostic test per patient. (Dept. Ex. 5A through 5G).

43. The same patient template was utilized at the initial evaluation for all seven patients. (Dept. Ex. 5A through 5G and 6A through 6G; T. 855-859).

44. The medical histories of Patients A through G all contain the identical sentence, "The patient stated they were unprepared for the impact and thus was thrown in various directions at impact." Notably, Patient G was a pedestrian who was struck by a motor vehicle and yet is documented as having reported that he had been "thrown in various directions at impact." (Dept. Ex. 5A through 5G).

Patient A

45. Patient A was a 44-year-old male driver involved in a motor vehicle accident on April 6, 2007. Respondent evaluated him initially on April 26, 2007, and documented that the car was hit on the front side and then on the rear end, that Patient A hit his head on the steering wheel and windshield and his knees on the dashboard, and that Patient A went home to rest after the accident. (Dept. Ex. 5A, pp. 1-5; T. 998).

46. Respondent documented that Patient A had weakness in his lumbar spine (lower back) in flexion and extension. However, both expert witnesses agree that the lower back and buttock muscles cannot be

isolated for assessing lumbar strength in flexion and extension. (T. 109, 1918).

47. Respondent documented palpating both the anterior and posterior paraspinal muscles of Patient A's cervical spine revealing deep and superficial muscle spasm. However, both expert witnesses agree that the anterior paraspinal muscles cannot be physically palpated. (Dept. Ex. 5A, p. 2; T. 113, 1913).

48. Respondent documented performing a foramina compression test (pushing down on top of his head) on Patient A which elicited pain on the left side, but failed to specify if the pain was localized to the neck, indicative of a soft tissue injury, or radiating down beyond the neck to the arms which could be indicative of radiculopathy. (Dept. Ex. 5A, p. 4; T. 106-107).

49. Similarly, Respondent documented the Laseque straight leg raise test to have elicited pain on the left side. Lower back pain, without radiation to the legs, does not suggest radiculopathy. Respondent did not indicate where the pain was, yet improperly documented disc lesion, nerve root impingement or other pathology in Patient A's lumbar spine. (Dept. Ex. 5A, p. 3; T. 109-110).

50. The Fabere-Patrick test is designed to assess hip pathology, yet Respondent performed the test on Patient A, eliciting pain on the left side, improperly diagnosing lumbosacral root lesion. (T. 110, 1924).

51. Respondent documented 13 Diagnosis codes for Patient A: Headaches, Cervical Myalgia, Cervical spine sprain/strain, Cervical disc displacement, Rule-out cervical radiculitis/radiculopathy, Thoracic sprain/strain, Rule-out thoracic radiculitis/radiculopathy, Lumbar myalgia, Lumbosacral sprain/strain, Rule-out lumbosacral disc displacement, Rule-out lumbosacral radiculitis/radiculopathy, Sciatica and Left wrist sprain/strain. (Dept. Ex. 5A, p. 4).

52. Given that Patient A's neurological examination on April 26, 2007, was normal with no paralysis, no focal motor weakness, no sensory deficit and no reflex asymmetries, there was no hard evidence on physical exam for the rule-out of the radiculitis/radiculopathy diagnoses. (Dept. Ex. 5A, p. 5; T. 115-119).

53. There was no support in Patient A's medical record for Respondent's diagnosis of left wrist sprain/strain, her order for a wrist brace or her order for a cold water circulating unit. (T. 932-934, 115).

54. On May 24, 2007, Respondent purportedly evaluated Patient A and billed No-Fault Insurance for a comprehensive consultation evaluation. On that same date, Respondent performed NCV and EMG studies on Patient A's upper and lower extremities. (Dept. Ex. 5A, pp. 10-11, 39, 42).

55. A medical consultation has three elements. A physician must: (1) receive a referral for the patient from another physician or medical

professional, (2) render a service, and (3) send a report to the referring doctor. (T. 142-143, 1699).

56. American Medical Society Current Procedural Terminology (CPT) category one codes include sets of codes for three sub categories: new patient, established patient and consultation, each of which contain five different levels of service. A consultation code pays more than the new or established patient codes. (T. 303, 1695-1701, 1705-1706, 1737-1739, 1741).

57. The May 24, 2007 patient encounter was not a consultation. Respondent's intent to deceive No-Fault Insurance when falsely stating that this was a consultation is inferred based on the fact that a healthcare practitioner had not referred Patient A to Respondent and the fact that Respondent would be paid more by No-Fault Insurance for a consultation than for a new or established patient visit. (Dept. Ex. 5A, pp. 10-11, 42; T. 1737).

58. At the May 24, 2007 visit, Respondent documented that Patient A was now purportedly experiencing some weakness in his upper and lower extremities and that the pain in his lower back and neck was worsening "over the past 7 weeks," after which she performed electrodiagnostic tests on Patient A. (Dept. Ex. 5A, pp. 10-11; T. 125-127).

59. Patient A's EMG report listed 20 muscles tested bilaterally with the needle probe and Respondent's finding of left lumbar radiculopathy and cervical myositis. Respondent's failure to make any adjustment to the treatment regime despite Patient A's worsening

condition taken together with her electrodiagnostic testing results was a deviation from the standard of care. (Dept. Ex. 5A, pp. 10-12; T. 140-141).

60. On June 13, 2007, Respondent performed or had ordered the performance of computerized range of motion studies for Patient A, for which she billed No-Fault Insurance $319.97. This test for Patient A was redundant and medically unnecessary. As such, it is inferred that the computerized range of motion studies were used solely for the purpose of increased billing. (T. 121, 1940-1941).

Patient B

61. Patient B was a 57-year-old male driver involved in a motor vehicle accident on March 10, 2007. Respondent's employee, Vadim Miloradovich, M.D. ("Respondent's Employee"), who received his formal training in surgery but performed PM&R work for Respondent, initially evaluated Patient B on March 21, 2007. He used the template supplied by Respondent for documenting the history and physicals for Patients B through G. The template begins with "Thank you for this referral;" however, there is no indication in any of these patients' records of a referral from any other medical professional. (Dept. Ex. 5B, pp. 1-5, 49, and 5C through 5G; T. 326-327, 401, 427, 1129-1130).

62. Respondent was responsible for ensuring that the medical care and treatment of the patients seen within her solely owned medical practice, including Patients B through G, conformed to the standard of care. This is especially true because Respondent performed

electrodiagnostic testing on Patients B through G, after they were initially evaluated by her employee who ordered the tests. (T. 326-327, 401, 427).

63. It is documented in Patient B's medical record that he was the driver and went home to rest after the accident, but four days later went to Jacobi Hospital where he received a medical exam, x-rays (non-specified) and medication (non-specified). (Dept. Ex. 5B, pp. 1-5; T. 216-218).

64. Just as Respondent documented for Patient A, Respondent's Employee documented that Patient B had weakness in his lumbar spine (lower back) in flexion and extension. (Dept. Ex. 5B, p 3).

65. Just as Respondent documented for Patient A, Respondent's Employee documented that he palpated both the anterior and posterior paraspinal muscles of Patient B's cervical spine revealing deep and superficial muscle spasm. However as previously stated, the anterior paraspinal muscles cannot be physically palpated. (Dept. Ex. 5B, p 2; T. 113, 1913).

66. Just as Respondent documented for Patient A, Respondent's Employee documented performing a foramina compression test on Patient B, which purportedly elicited pain bilaterally, but he also failed to specify anything else about the pain, yet noted inappropriately that it was indicative of "the presence of a nerve root lesion." (Dept. Ex. 5B, p. 2).

67. Just as Respondent documented for Patient A, Respondent's Employee documented 13 Diagnosis codes for Patient B: Tension/stress reaction to pain, Cervical Myalgia, Cervical spine sprain/strain, Cervical disc displacement, Rule-out cervical radiculitis/radiculopathy, Thoracic sprain/strain, Rule/out thoracic radiculitis/radiculopathy, Lumbar myalgia, Lumbosacral sprain/strain, Rule-out lumbosacral disc displacement, Rule-out lumbosacral radiculitis/radiculopathy, left shoulder pain and left shoulder sprain/strain. (Dept. Ex. 5B, p. 4).

68. Given that Patient B's neurological examination was normal with no paralysis or atrophy, no sensory deficit, normal reflexes and no radicular complaints (for example, no report of pain from the neck traveling down to the arms or lower back pain radiating down to the legs), there was no support in the record for ruling out the various radiculitis/radiculopathy diagnoses. Therefore, ordering cervical and lumbar MRIs and electrodiagnostic testing of upper and lower extremities at Patient B's initial visit, just eleven days after his accident with no evidence of medical, orthopedic and neurological emergencies, was medically unwarranted. (Dept. Ex. 5B, p. 1, 3; T. 228-229).

69. Ordering physical therapy and activity modifications for Patient B was within the standard of care, yet given the inadequacy of the physical examination of Patient B's shoulder, there was no support in the record for the left shoulder sprain/strain diagnosis or the

ordering of a cold water circulating unit for it. (Dept. Ex. 5B, p. 5; T. 233).

70. On April 12, 2007, Respondent purportedly evaluated Patient B, billed No-Fault Insurance for a comprehensive consultation evaluation, and then performed NCV and EMG studies on Patient B's upper and lower extremities. There was no referring healthcare practitioner requesting a consultation. Therefore, this patient encounter was not a consultation. Respondent's intent to deceive No-Fault Insurance when falsely stating that this was a consultation is inferred based on the fact that a healthcare practitioner had not referred Patient B to Respondent and the fact that Respondent would be paid more by No-Fault Insurance for a consultation than for a new or established patient visit. (Dept. Ex. 5B, pp. 9-10, 42; T. 1737).

71. At the April 12, 2007 visit, Respondent documented that Patient B was now purportedly experiencing some weakness in his upper and lower extremities, although his range of motion in his neck, lower back and left shoulder was within normal limits. His pain was documented as consistent over four weeks in his neck but worse in his lower back. Respondent performed cervical and lumbar electrodiagnostic tests on Patient B. (Dept. Ex. 5B, pp. 9-10; T. 234- 235).

72. The EMG report lists 20 muscles tested bilaterally with the needle probe, and Respondent purportedly found left cervical radiculopathy and bilateral lumbar radiculopathy. Respondent failed to make any adjustments to the treatment regime despite Patient B's

worsening condition and abnormal electrodiagnostic tests results, which is a deviation from the standard of care. (Dept. Ex. 5B, pp. 9-19; T. 246-247.

73. On March 22, 2007, almost three weeks before the electrodiagnostic tests, Patient B underwent an MRI of his cervical spine. It showed "posterocentral disc protrusion at C5-C6 effacing the ventral spinal subarachnoid space," which meant that the protrusion was central and not lateral, therefore not pressing on a nerve and not touching the spinal cord. The anatomy of the spine does not support this diagnosis. Similarly, Patient B underwent a lumbar MRI two days before the electrodiagnostic tests, which showed "nothing compressing a nerve." The reason medical tests are performed is to discover or confirm a clinical diagnosis for the purpose of efficaciously providing/adjusting treatment. However, Respondent performed electrodiagnostic tests on Patient B with no medical justification. (Dept. Ex. 5B, pp. 19, 22; T. 248-249).

74. There are striking similarities between the histories and physical examinations, diagnoses, ordered tests and treatments in Patient A's medical records initially evaluated by Respondent and those in Patient B's medical records initially evaluated by Respondent's Employee. This documentation purportedly provided the justification for the electrodiagnostic tests administered and billed to No-Fault Insurance by Respondent. (Dept. Ex. 5B).

Patient C

75. Patient C was a 56-year-old male bus driver involved in a motor vehicle accident on September 3, 2007. Respondent's Employee initially evaluated him on September 5, 2007, and he hand wrote his notes on the template supplied by Respondent for Patient B's history and physical examination. (Dept. Ex. 5C, pp. 1-8).

76. No accident details are documented except for its date and that Patient C was the driver. Patient C reportedly went home to rest after the accident. (Dept. Ex. 5C, p. 1).

77. The purported injuries sustained by Patient C resulted in intermittent headaches, constant lower back and right knee pain and anterior chest wall pain increasing with breathing and coughing. (Dept. Ex. 5C, pp. 1-2; T. 314-316).

78. Respondent's Employee documented the straight leg raise test as eliciting pain bilaterally but failed to indicate if the pain was isolated to the back or radiating down the leg, and he documented that Patient C had right knee tenderness at the "midjoint" (although Respondent used that term in her template, she acknowledged it was a "misnomer" and not an anatomical point in the knee [T. 1341]), but failed to perform any examination of the patient's knee to assess for instability, meniscus signs, etc. (Dept. Ex. 5C, pp. 5-6; T. 318-319).

79. Patient C did not complain of any neck pain and his medical record indicates that Respondent's Employee's orthopedic examination of his cervical spine was within normal limits. (Dept. Ex. 5C, pp. 3-4).

80. Respondent's Employee documented nine Diagnosis codes for Patient C: Headaches, Tension/stress reaction to pain, Thoracic sprain/strain, Rule/out thoracic radiculitis/radiculopathy, Lumbar myalgia, Lumbosacral sprain/strain, Rule-out lumbosacral disc displacement, Rule-out lumbosacral radiculitis/radiculopathy and Rule-out knee ligament tear/meniscus tear. (Dept. Ex. 5C, pp. 6-7).

81. Given that Patient C's neurological examination was essentially normal (save for a notation that might suggest some sort of non-specific sensory deficit in the right leg), there was no support in the record for ruling out of the various radiculitis/radiculopathy diagnoses. Although Respondent's Employee's recommendation for electrodiagnostic tests was qualified with "if needed," ordering a lumbar MRI just two days after Patient C's automobile accident with no evidence of any medical, orthopedic or neurological emergencies and an MRI of his right knee, given Respondent's Employee's failure to examine it in any meaningful way, was medically unwarranted. (Dept. Ex. 5C, pp. 6-7; TR, pp. 320-321).

82. Ordering physical therapy and activity modifications for Patient C was within the standard of care, yet given the inadequacy of the physical examination of Patient C's right knee, there was no support in the record for the rule-out right knee ligament tear/meniscus tear diagnosis or ordering a cold water circulating unit for it. (Dept. Ex. 5C, p. 7-8; T. 322-323).

83. On September 27, 2007, Respondent purportedly evaluated Patient C, billed No-Fault Insurance for a comprehensive consultation evaluation, and then performed NCV and EMG studies on Patient C's upper and lower extremities. This was not a consultation. Respondent's intent to deceive No-Fault Insurance when falsely stating that this was a consultation is inferred based on the fact that a healthcare practitioner had not referred Patient C to Respondent and the fact that Respondent would be paid more by No-Fault Insurance for a consultation than for a new or established patient visit. (Dept. Ex. 5C, pp. 14-15, 37; T. 1737).

84. Respondent treated Patient C on September 27, 2007, which was three and a half weeks after his accident. Despite the fact that Patient C had no neck complaints when initially examined by Respondent's Employee on September 5 and his cervical exam was within normal limits, Respondent documented that Patient C has had neck pain radiating to his upper back for three and a half weeks and that it had been getting worse. Patient C received a computerized range of motion (ROM) test (billed separately to No-Fault Insurance for $319.97) that same day that Respondent purportedly performed a full history and physical on him. Additionally, the computerized ROM test purportedly revealed that Patient C's neck rotation and excursion were severely impaired, in fact noting that he could not turn his head to the left at all. And yet, Patient C's cervical electrodiagnostic tests findings were entirely normal. Respondent's testimony attempting to explain the inconsistency

between the September 5th and September 27th documentation was not credible. Respondent created this fiction to justify her performing cervical electrodiagnostic tests on Patient C. Respondent's intent to deceive is inferred based on the inconsistency in the patient's medical record and Respondent's billing for this unwarranted testing. (Dept. Ex. 5C, p. 9, 14; T. 1363-1367).

85. Respondent documented essentially normal neurological and orthopedic exams for Patient C on September 27, 2007. Moreover, Respondent's examination of Patient C's lumbar spine revealed that any sensory deficit that may have been appreciated at Patient C's initial evaluation had resolved. Both the cervical and lumbar electrodiagnostic tests were medically unwarranted when Respondent performed them. (Dept. Ex. 5C, p. 14-15; T. 325-326).

86. Respondent had NCV tests performed on Patient C, which she was responsible to ensure were properly performed and interpreted. The F wave results for the right and left peroneal nerves show a latency asymmetry that Respondent failed to appropriately document. (Dept. Ex. 5C, p. 18).

87. The EMG report lists 24 muscles tested bilaterally with the needle probe and Respondent purportedly found cervical myofascitis and bilateral lumbar radiculopathy. Respondent's failure to make any adjustments to the treatment regime despite Patient C's purported worsening condition along with the abnormal electrodiagnostic tests

results was a deviation from the standard of care. (Dept. Ex. 5C, pp. 14-16; T. 345-347).

Patient D

88. Patient D was a 37-year-old male construction worker who was involved in a motor vehicle accident on January 2, 2007, in which the car was hit on the left side. Respondent's Employee initially evaluated him eight days later on January 10, 2007. He used the template supplied by Respondent for Patient D's history and physical examination, yet documented falsely that he was evaluating Patient D for a neurological consultation. This was not a consultation. Respondent's intent to deceive No-Fault Insurance when falsely stating that this was a consultation is inferred based on the fact that a healthcare practitioner had not referred Patient D to the Respondent and the fact that Respondent would be paid more by No-Fault Insurance for a consultation than for a new or established patient visit. Respondent's Employee documented that Patient D went home to rest after the accident and then came to Respondent's Bronx Medical Practice complaining of constant lower back and knee pain. (Dept. Ex. 5D, pp. 1-4, 42; T. 378-380, 1737).

89. Respondent's Employee noted that Patient D was in a car accident five years prior, but no details were provided. His physical examination indicated, in one section, that Patient D's gait was not antalgic, yet in another that it was antalgic and that Patient D was limping on his left leg. The patient's neurological exam was normal.

Respondent's Employee indicated that the straight leg test elicited pain on the left side with no further description. He noted that Patient D was weak on the left side when toe walking which he documented was indicative of lumbar disc pathology, despite the left knee complaint. There is no orthopedic examination of the left knee. (Dept. Ex. 5D, pp. 1-4; T. 380-385).

90. Respondent's Employee documented eight diagnosis codes for Patient D: Tension/stress reaction to pain, Lumbar myalgia, Lumbosacral sprain/strain, Rule-out lumbosacral disc displacement, Rule-out lumbosacral radiculitis/radiculopathy, Sciatica on left, Rule-out knee ligament tear/meniscus tear and left knee sprain/strain. (Dept. Ex. 5D, p. 3).

91. Given that Patient D's neurological examination was essentially normal, there was no support in the record for ruling out the various radiculitis/radiculopathy diagnoses. Therefore, ordering of a lumbar MRI just eight days after Patient D's automobile accident with no evidence of any medical, orthopedic or neurological emergencies and an MRI of his left knee, given Respondent's Employee's failure to examine it in any meaningful way, was medically unwarranted. Respondent's Employee's recommendation for electrodiagnostic tests was premature. Additionally, there was no medical reason to order an x-ray of Patient D's knee six days after he received an MRI for that very knee. (Dept. Ex. 5D, p. 4, 6; T. 385-387).

92. Ordering physical therapy and activity modifications for Patient D was within the standard of care, but there was no support in the record for the rule-out right knee ligament tear/meniscus tear and left knee sprain/strain diagnoses or the ordering of a cold water circulating unit, given the inadequacy of the physical examination of Patient D's left knee. (Dept. Ex. 5D, pp. 7-8; T. 322-323).

93. Respondent billed No-Fault Insurance for three successive computerized ROM tests on February 8, 2007, March 7, 2007 and April 5, 2007, that were medically unnecessary. (Dept. Ex. 6D, pp. 62, 73, 81; T. 387-389).

94. On January 18, 2007, Respondent purportedly evaluated Patient D, billed No-Fault Insurance for a comprehensive consultation evaluation, and then performed NCV and EMG studies on Patient D's lower extremities. This patient encounter was not a consultation. Respondent's intent to deceive No-Fault Insurance when falsely stating that this was a consultation is inferred based on the fact that a healthcare practitioner had not referred Patient D to the Respondent and the fact that Respondent would be paid more by No-Fault Insurance for a consultation than for a new or established patient visit. (Dept. Ex. 5D, pp. 22, 80; T. 1737).

95. Respondent documented essentially normal neurological and orthopedic exams for Patient D on January 18, 2007. He was no longer limping, his toe and heal walking within functional limits, his muscle power was 4+/5, and sensory exam was normal. The lumbar

electrodiagnostic tests were medically unwarranted when Respondent performed them. (Dept. Ex. 5D, p. 22; T. 325-326).

96. The EMG report lists 12 muscles tested bilaterally with the needle probe, and Respondent purportedly found left L5S1 radiculopathy, yet she failed to make any adjustments to the treatment regime despite Patient D's purported worsening condition along with her found abnormal electrodiagnostic tests results. This was a deviation from the standard of care. (Dept. Ex. 5D, pp. 22; T. 398-400).

Patient E

97. Patient E was a 45-year-old man who was involved in a motor vehicle accident on January 22, 2007, in which the car was hit on the front left side. Respondent's Employee initially evaluated him two days later on January 24, 2007, and he used the template supplied by Respondent for Patient E's history and physical examination. Respondent's Employee documented that Patient E went home to rest after the accident then came to the Respondent's Bronx Medical Practice, complaining of constant lower back, neck and left knee pain. (Dept. Ex. 5E, pp. 1-5; T. 429-433).

98. The patient's neurological exam was normal. Respondent's Employee indicated that the foramina compression test elicited pain bilaterally, with no further description, and that the straight leg raise elicited pain bilaterally, with no further description. He did not perform manual range of motion tests on either Patient E's cervical or lumbar spines. There is no orthopedic examination of the complained

of left knee. Respondent's Employee indicated that Patient E was limping. (Dept. Ex. 5E, pp. 1-5; T. 429-436).

99. Respondent's Employee documented 10 Diagnosis codes for Patient E: Tension/stress reaction to pain, Cervical myalgia, Cervical spine sprain/strain, Cervical disc displacement, Rule-out cervical radiculitis/radiculopathy, Lumbar myalgia, Lumbosacral sprain/strain, Rule-out lumbosacral disc displacement, Rule-out lumbosacral radiculitis/radiculopathy, left knee sprain/strain. (Dept. Ex. 5E, p. 4).

100. Given that Patient E's neurological examination was normal, there was no support in the record for ruling out of the various radiculitis/radiculopathy diagnoses. Therefore, ordering cervical and lumbar MRIs just two days after Patient E's automobile accident with no evidence of any medical, orthopedic or neurological emergencies and an MRI of his left knee, given Respondent's Employee's failure to examine it in any meaningful way, was medically unwarranted. Respondent's Employee's recommendation for electrodiagnostic tests was premature. (Dept. Ex. 5E, p. 4; T. 436-437).

101. Ordering physical therapy and activity modifications for Patient E was within the standard of care, but given the inadequacy of the physical examination of Patient E's left knee, there was no support in the record for the left knee sprain/strain diagnosis or the ordering of a cold water circulating for it. Additionally, the cervical collar was not indicated absent any measurement of cervical range of motion.

And there in no justification in the record for multiple biofeedback treatments amounting to $994.68 in fees billed to No-Fault Insurance. (Dept. Ex. 5E, pp. 4-5; T. 438-439).

102. Respondent billed No-Fault Insurance for three successive computerized ROM tests (each at $319.97), the first one dated one week after Patient E's initial evaluation, then in late February and late March, that were medically unnecessary. (Dept. Ex. 5E, pp. 65, 76, 83; T. 440-441).

103. On February 22, 2007, Respondent purportedly evaluated Patient E, billed No-Fault Insurance for a comprehensive consultation evaluation, and then performed NCV and EMG studies on Patient E's upper and lower extremities. This patient encounter was not a consultation. Respondent's intent to deceive No-Fault Insurance when falsely stating that this was a consultation is inferred based on the fact that a healthcare practitioner had not referred Patient E to Respondent and the fact that Respondent would be paid more by No-Fault Insurance for a consultation than for a new or established patient visit. (Dept. Ex. 5E, pp. 43-44, 74; T. 1737).

104. Respondent documented essentially normal neurological and orthopedic exams for Patient E on February 22, 2007. He was no longer limping. His toe and heal walking was within functional limits, global strength measured 4/5, and reflex and sensory exams were intact. The upper and lower electrodiagnostic tests were medically unwarranted when Respondent performed them. (Dept. Ex. 5E, pp. 43-44; T. 442-444).

105. Respondent had NCV tests performed on Patient E, and she was responsible to ensure were properly performed and interpreted. The F waves for the right and left median nerves show a latency asymmetry that Respondent failed to appropriately document. (Dept. Ex. 5E, p. 47; T. 446-447).

106. The EMG report lists 24 muscles tested bilaterally with the needle probe and Respondent purportedly found lumbar and cervical myofascitis, but she failed to make any adjustments to the treatment regime despite Patient E's purported worsening condition, which is a deviation from the standard of care. (Dept. Ex. 5E, pp. 43-44).

Patient F

107. Patient F was a 43-year-old woman who was a rear seat passenger in the same motor vehicle accident on January 22, 2007 as Patient E. Respondent's Employee initially evaluated her two days later on January 24, 2007. He used the template supplied by Respondent for Patient F's history and physical examination. Respondent's Employee documented that Patient F went home to rest after the accident then came to Respondent's Bronx Medical Practice, complaining of constant lower back and neck pain. (Dept. Ex. 5F, pp. 1-5; T. 500-503).

108. The patient's neurological exam was normal. Respondent's Employee indicated that the foramina compression test elicited pain bilaterally with no further description, and that the straight leg raise elicited pain bilaterally with no further description. He did not perform manual range of motion tests on either Patient F's cervical or

lumbar spines. Respondent's Employee indicated that Patient F was limping. (Dept. Ex. 5F, pp. 1-5; T. 503-509).

109. Respondent's Employee documented 12 Diagnosis codes for Patient F: Tension/stress reaction to pain, Cervical myalgia, Cervical spine sprain/strain, Cervical disc displacement, Rule-out cervical radiculitis/radiculopathy, Thoracic sprain/strain, Rule-out thoracic radiculopathy/radiculitis, Lumbar myalgia, Lumbosacral sprain/strain, Rule-out lumbosacral disc displacement, Rule-out lumbosacral radiculitis/radiculopathy, and sciatica. (Dept. Ex. 5F, p. 4).

110. Given that Patient F's neurological examination was normal, there was no support in the record for ruling out the various radiculitis/radiculopathy diagnoses, and no complaints Patient F made were consistent with sciatica. Therefore, ordering cervical and lumbar MRIs just two days after Patient F's automobile accident with no evidence of any medical, orthopedic or neurological emergencies was medically unwarranted. Respondent's Employee's recommendation for electrodiagnostic tests was premature. (Dept. Ex. 5F, p. 4; T. 510-511).

111. Patient F had an MRI of her cervical spine on the same day that Respondent's Employee documented that recommendation at her initial visit at Respondent's Bronx Medical Practice. (Dept. Ex. 6F, pp. 3-4).

112. Ordering physical therapy and activity modifications for Patient F was within the standard of care, but ordering a cold water

circulating is completely without support as the record does not even indicate the injury it was possibly intended to treat. (Dept. Ex. 5F, p 5; T. 512).

113. Respondent billed No-Fault Insurance for three successive computerized ROM tests (the first on February 8, 2007 at $411.39 and each subsequent one at $319.97), that were medically unnecessary and medically inappropriately. Her range of motion was first assessed more than two weeks after her initial visit to Respondent's Bronx Medical Practice following the motor vehicle accident. (Dept. Ex. 5F, pp. 56, 67, 84; T. 513-514).

114. On February 15, 2007, Respondent purportedly evaluated Patient F, billed No-Fault Insurance for a comprehensive consultation evaluation, and then performed NCV and EMG studies on Patient F's upper and lower extremities. This patient encounter was not a consultation. Respondent's intent to deceive No-Fault Insurance when falsely stating that this was a consultation is inferred based on the fact that a healthcare practitioner had not referred Patient F to Respondent and the fact that Respondent would be paid more by No-Fault Insurance for a consultation than for a new or established patient visit. (Dept. Ex. 5F, pp. 31-32, 62; T. 1737).

115. Respondent documented essentially normal neurological and orthopedic exams for Patient F's cervical spine on February 15, 2007. She had no radiation of pain to her arms, had a global strength of 4+/5, and her reflex and sensory exams were intact. The upper

electrodiagnostic tests were medically unwarranted when Respondent performed them. For the lower extremity electrodiagnostic tests, Respondent documented that Patient F was no longer limping, her toe and heal walking was within functional limits, global strength measured 4/5, and reflex and sensory exams were intact, but Respondent documented that Patient F complained of weakness and pain in her legs, which is a true radicular complaint. Therefore, there was reasonable medical justification for the lumbar electrodiagnostic tests. (Dept. Ex. 5F, pp. 31-32; T. 515-516).

116. The EMG report lists 24 muscles tested bilaterally with the needle probe and Respondent purportedly found lumbar and cervical myofascitis, but she failed to make any adjustments to the treatment regime despite Patient F's purported worsening condition, which is a deviation from the standard of care. (Dept. Ex. 5F, pp. 32-33).

Patient G

117. Patient G was a 22-year-old pedestrian hit by a car going in reverse on December 8, 2006. Respondent's Employee documented in the medical history of the record that Patient G lost consciousness and was taken to "St. Roosevelt Hospital" [sic] where he received a medical exam, x-rays of his right knee, and medication (not specified) before being released. Respondent's Employee initially evaluated Patient G five days after the accident, and he used the template supplied by Respondent for Patient G's history and physical examination. Respondent's Employee documented that Patient G came to Respondent's

Bronx Medical Practice complaining of intermittent headaches, constant neck pain, lower back pain with numbness and pins and needles sensations traveling down to his right thigh and right knee and left ankle pain. (Dept. Ex. 5G, pp. 1-5; T. 544-545).

118. Patient G's neurological exam was normal. Respondent's Employee indicated that the foramina compression test elicited pain bilaterally with no further description, and that the straight leg raise elicited pain bilaterally with no further description. He did not perform manual range of motion tests on either Patient G's cervical or lumbar spines. Respondent's Employee indicated that Patient G was limping in one section of the record and documented that his gait was normal in another. He did not adequately examine Patient G's knee and did not even mention his ankle in the physical examination except to say it was sprained. (Dept. Ex. 5G, pp. 1-5; T. 546-550).

119. Respondent's Employee documented 15 diagnosis codes for Patient G: Headaches, Anxiety, Tension/stress reaction to pain, Post-concussion syndrome, Cervical myalgia, Cervical spine sprain/strain, Cervical disc displacement, Rule-out cervical radiculitis/radiculopathy, Lumbar myalgia, Lumbosacral sprain/strain, Rule-out lumbosacral disc displacement, Rule-out lumbosacral radiculitis/radiculopathy, Sciatica, right sided, Rule-out right knee ligament tear/meniscus tear, right knee sprain/strain and injury to left ankle. (Dept. Ex. 5G, p. 4).

120. There was no support in the record for Patient G having Anxiety, Tension/stress reaction to pain and right knee/left ankle diagnoses, given that Respondent's Employee did not examine the knee or ankle. Ordering an x-ray of Patient G's left ankle is also without support in the record. Intermittent headaches alone did not justify a brain MRI especially in light of the fact that the cranial nerve portion of the neurological exam was normal. Ordering cervical and lumbar MRIs just five days after Patient G's automobile accident with no evidence of any medical, orthopedic or neurological emergencies was medically unwarranted. Respondent's Employee's recommendation for electrodiagnostic tests was premature. (Dept. Ex. 5G, pp. 4-5; T. 550-553).

121. Ordering physical therapy and activity modifications for Patient G was within the standard of care, but ordering both left and right knee braces (especially the left as there is absolutely nothing in the record to indicate that Patient G injured his left knee) is without support in the record. (Dept. Ex. 5G, p. 5; T. 551).

122. Respondent billed No-Fault Insurance for three successive computerized ROM tests, the first on December 20, 2006, then late January 2007 and late February 2007 that were medically unnecessary. (Dept. Ex. 5G, pp. 55, 66, 72; T. 555-557).

123. Respondent billed No-Fault Insurance for a December 20, 2006 manual muscle test, scheduled one week after Patient G had his initial visit at Respondent's Bronx Medical Practice. There was no medical

reason to perform a separate manual muscle strength test and a computerized range of motion test on Patient G, both after his purportedly complete physical examination the week before. Testing a motor vehicle accident victim's range of motion and muscle strength is a standard part of an adequate comprehensive examination. Respondent billed No-Fault Insurance $563.99 for those two tests on the same day. (Dept. Ex. 5G, pp. 42-44, 45-48, 55; T. 555-557).

124. On January 4, 2007, Respondent purportedly evaluated Patient G, billed No-Fault Insurance for a comprehensive consultation evaluation, and then performed NCV and EMG studies on Patient G's upper and lower extremities. This patient encounter was not a consultation. Respondent's intent to deceive No-Fault Insurance when falsely stating that this was a consultation is inferred based on the fact that a healthcare practitioner had not referred Patient G to Respondent and the fact that Respondent would be paid more by No-Fault Insurance for a consultation than for a new or established patient visit. (Dept. Ex. 5G, pp. 22-23, 58; T. 1737).

125. The upper and lower electrodiagnostic tests were reasonably medically justified given Patient G's worsening complaints of numbness and weakness in his right thigh and radiating pain from the neck to the shoulders and worsening pain with overhead activities. Nonetheless, both tests were negative for radiculopathies. (Dept. Ex. 5G, pp. 22-23; T. 557-558).

126. The EMG report lists 26 muscles tested bilaterally with the needle probe and Respondent purportedly found lumbar and cervical myofascitis, yet Respondent failed to make any adjustments to the treatment regime despite Patient G's purported worsening condition, which is a deviation from the standard of care. (Dept. Ex. 5G, pp. 32-33; T. 1849-1852).

127. Respondent's Employee ordered x-rays of Patient G's cervical and lumbar spines which were performed on January 12, 2007, showing no evidence of fracture. Patient G already had received MRIs of his cervical and lumbar spines on December 22, 2006 and January 8, 2007, respectively. There was no medical justification for ordering x-rays which unnecessarily exposed Patient G to radiation. (Dept. Ex. 6G, pp. 1, 4-5, 7-8; T. 572).

CONCLUSIONS OF LAW

As required by PHL § 230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Statement of Charges were more probable than not. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department (See Prince, Richardson on Evidence § 3-206). Having considered the complete record in this matter, the Hearing Committee concludes that the Department has

established 22 of the 30 specifications contained in the Statement of Charges. The sustained specifications include professional misconduct by practicing the profession with negligence on more than one occasion, ordering excessive tests and treatments not warranted by the condition of the patient, fraudulent practice, and failing to maintain a record which accurately reflects the evaluation and treatment of the patient. The Hearing Committee made these conclusions of law pursuant to the factual findings listed above, and all conclusions resulted from a unanimous vote of the Hearing Committee unless specifically noted otherwise.

The Department's expert witness, Joseph Carfi, M.D. has been a board certified PM&R specialist for over 30 years. He received his medical school education from the Mount Sinai School of Medicine and trained at The Rusk Institute at NYU. Dr. Carfi was in academic medicine at Mount Sinai, becoming Assistant Professor of Rehabilitation Medicine, then Associate Clinical Director of the Department. Subsequent to that, he became the Medical Director of a brain injury facility while developing a private physiatry practice, which since 1992 became his primary focus. Currently, Dr. Carfi also engages in forensic matters including performing independent medical evaluations, disability evaluations, an expert for the Department and an expert in civil litigation matters. The Hearing Committee found Dr. Carfi's testimony to be credible and consistent with the medical records in evidence.

Dr. Carfi testified regarding data mismatches between waveforms and the corresponding numerical data for the nerve conduction tests in evidence. In her testimony, Respondent explained that the gain (voltage) had been adjusted so the value ascribed to the boxes within the graphs changed, thereby changing the waves' appearances, but the numerical values remained consistent. There was no scale on the nerve test graphs indicating that the voltage had been adjusted. Unfortunately, Respondent had declined the opportunity for an interview which would have provided a prehearing opportunity to provide this explanation. Upon consideration of this information, the Hearing Committee concludes that the waveforms and the corresponding data did match.

Respondent's expert witness, Harry W. Schwartz, M.D., has been a board certified PM&R specialist for over 25 years. He received his medical school education from the University of Pennsylvania School of medicine and trained (after an internship in internal medicine at Cooper Hospital University Medical Center in New Jersey) at the Hospital of the University of Pennsylvania system of Rehabilitation Medicine, which included various community hospitals and the Veteran's Administration Medical Center. Following that, Dr. Schwartz has been working at the Moss Rehab Center in Philadelphia. He served as the spinal cord director for about 17 years and is currently doing more administrative work as a liaison for the center to secure payments for services and equipment from insurance companies. The Hearing Committee found that Dr. Schwartz was knowledgeable in this area of medical practice; however, they also

found that Dr. Schwartz frequently evaded answering questions when his testimony might be adverse to Respondent or confirm damaging testimony given by the Department's expert. Although he was very knowledgeable, his testimony was given less weight because he was less forthright with his testimony than the Department's expert witness.

The record establishes that Respondent through her solely owned medical corporation followed a pattern of fraudulently billing at the higher rate paid to a consultant even though no referral from another healthcare practitioner existed. She and her employee made unsupported diagnoses for these seven patients, and she then performed unnecessary tests, including invasive electrodiagnostic tests. Respondent claimed that the testing was required to identify the source of the pain experienced by her patients, yet she never ordered even a prescribed analgesic or anti-inflammatory medication, nor did she modify their treatment even as their purported medical conditions worsened. Her pattern of practice with these seven patients demonstrated that her sole motivation for seeing these patients was her own financial benefit.

The OPMC first put Respondent on notice of its investigation when an investigator sent a February 19, 2008 letter requesting the complete medical records of seven of Respondent's patients. In the hearing record, those patients are referred to as Patients A through G. In April 2008, Respondent sent Exhibits 5A through 5G to the OPMC with a certification by her employee that the records of Patients A through G were "complete, true and exact copies of the original medical records."

Then in 2010, Respondent sent Exhibits 6A through 6G to the OPMC, which were almost identical to the previously received records but contained some physical therapy flow sheets. The Hearing Committee concluded that the medical records in evidence were Respondent's complete medical records for Patients A through G.

In her testimony before the Hearing Committee, Respondent claimed that she was not aware of the OPMC's 2008 request for patient medical records, and that her employee sent Exhibits 5A through 5G which were merely billing records to the OPMC without her knowledge. Respondent further claimed that she was unware of a letter sent by her office with her signature stamp to the OPMC requesting an extension of time to provide the medical records though she contended that the letter was likely written by her office manager or an employee who she had designated to handle the mail sent to her Bronx Office. The Hearing Committee found that Respondent's testimony regarding her alleged lack of awareness of the 2008 OPMC request for medical records was not credible. The 2008 letters from the OPMC which informed Respondent of an investigation and possible charges of misconduct were not routine correspondence, and it is most likely that Respondent either received the letters herself or that her employees brought the matter to her attention. The 2008 responsive letter from Respondent to the OPMC is further evidence that Respondent was aware of the OPMC investigation whether that letter was written by Respondent herself, Respondent's

office manager or the employee she designated to handle mail for her Bronx Medical Practice.

Regarding Exhibits 6A through 6G which the OPMC received in 2010, Respondent acknowledged that she was aware of this submission but claimed that she sent copies of only the billing records instead of the complete medical records because she erroneously believed that the OPMC was only concerned with billing related issues. The Hearing Committee found that this claim was also incredible. In 2010, Respondent admittedly was aware of the investigation because she had retained an attorney who corresponded with the OPMC, and Respondent knew that the investigation was not limited to billing issues because the correspondence from the OPMC indicated that the matters under investigation included, inter alia, her alleged failure to maintain acceptable medical records.

At the hearing, Respondent further claimed that she had placed a complete set of medical records for Patients A through G, containing extensive documentation, in a storage facility when she closed her Bronx Medical Practice in 2007. Respondent contended that she reasonably believed that the OPMC investigation had been closed in November 2013 (T. 757-758), so she shredded all her records for the Bronx office, including those for Patients A through G. The Hearing Committee recognized that a physician is not required to maintain patient records beyond six years from the last date of treatment, but concluded that Respondent had never maintained any additional medical documentation

other than the exhibits received in evidence at the hearing. Respondent's testimony to the contrary was not credible. She knew that the OPMC investigation was not limited to billing issues, and she and/or her employee submitted Exhibits 5A through 5G and 6A through 6G to the OPMC as the complete medical record for those patients.

In her post-hearing memorandum, Respondent acknowledged that there was no statute of limitations in the misconduct forum, but contended that this administrative prosecution was precluded by the legal doctrine known as laches. To the contrary, the doctrine of laches also does not apply to physician disciplinary proceedings (see, Matter of Schoenbach v DeBuono, 262 A.D.2d 820, 823, lv denied 94 NY.2d 756). In order to establish a due process violation, the Respondent had the evidentiary burden to make a showing of actual prejudice caused by the delay between her care of these patients and the filing of charges (see, Matter of Pearl v New York State Board for Professional Medical Conduct, 295 A.D.2d. 764). The Respondent attempted to prove actual prejudice by claiming that she had permissibly destroyed the complete medical records of the patients charged because six years had passed since she last rendered treatment, but the Hearing Committee found that the Respondent's complete medical records for these patients were in evidence and that her testimony about destroying records was a fiction designed to conceal her fraudulent practice and evade responsibility for her professional misconduct. In any event, a claim of unreasonable

delay occurring before a hearing is noticed must be pursued in a proceeding pursuant to Article 78 of the Civil Practice Law and Rules.

The pattern of nearly identical medical histories and physical examinations of Patients A through G was evidence of Respondent's having fraudulently created medical records to fit a formula for motor vehicle accident patients in order to justify over-diagnosis and unnecessary testing and treatment. The Hearing Committee found that the medical histories, physical examinations and reports recorded by Respondent and her employee were formulaic and designed to justify unnecessary tests and treatments. These facts and circumstances led the Hearing Committee to infer that Respondent misrepresented these patients' conditions in her medical records with an intent to deceive No-Fault Insurance in order to maximize her insurance reimbursement.

Respondent submitted insurance reimbursement claims for Patients A through G at the higher rate allowed for a consultation, and she testified that these patients had most likely been referred to her for a consultation by a chiropractor who leased office space from her. She claimed that a report in the patient records which ends with the sentence "THANK YOU for the courtesy of this consult" proved that the patient had been referred to her, and she alleged that she had permissibly destroyed the referral letter from that chiropractor or any other practitioner and the cover letters which would have accompanied the reports. As previously stated, Respondent's claim that the patient records in evidence were not the complete records was not credible.

Therefore, her claim that she was serving as a consultant to another practitioner for these seven patients was also not credible. Respondent asserted at hearing that 50 percent of her patients were referred to her for consultations by a chiropractor, Dr. Nguyen, that Dr. Nguyen rented space from her in her Bronx Medical Practice, but that he was not her employee. Aside from the fact that none of the patient medical records in evidence contained any documentation of a referral, the Hearing Committee did not find it credible that a PM&R physician was merely in the role of a consultant for a chiropractor when the patients involved had all been injured in automobile accidents. Respondent's intent to deceive was inferred because Respondent was paid a higher fee by alleging that she was a consultant.

The Department also contended that Respondent fraudulently billed No-Fault Insurance $38.61 for several patients under CPT code 99212, for a follow-up visit of an established patient on the very same day she had billed inappropriately for a consult. Respondent countered that the second billing was permissible because the patients had all left her office after the electrodiagnostic tests and returned later in the day for a visit to obtain results. Based on the record before it, the Hearing Committee was unable to determine whether or not these patients had left the office and returned later in the day. Therefore, the Hearing Committee did not sustain the Department's allegation that these follow-up visits were fraudulent.

Respondent also claimed that the recommendations for MRIs, x-rays and electrodiagnostic tests documented in the patent medical records were not actually orders. She stated that, Dr. Nguyen, the chiropractor who subleased space from her was the person who actually ordered many of the tests, and that her practice would "defer" those patients back to him for his determination as to whether or not the patient actually needed the test or tests "out of respect" (T. 1816). The Committee finds Respondent's testimony in this regard self-serving and lacking in credibility. It reflects Respondent's attempts to deny responsibility for having ordered unnecessary diagnostic tests.

In her testimony, Respondent also attempted to justify her actions by shifting responsibility to other health care practitioners. For example, in attempting to explain an x-ray ordered for Patient G, Respondent claimed that it was her practice to routinely call the radiologist if a patient complained of worsening symptoms after a clean MRI, and that the radiologist might have suggested ordering a plain x-ray. The Hearing Committee did not find this testimony credible.

Respondent's post-hearing memorandum contended that the "OPMC was legally obligated to prove that the medical record, taken as a whole, lacked objectively meaningful medical information such that if the physician providing care suddenly became unavailable for some reason, the medical record would not permit continuity of care through a transfer to a new physician." However, the cases cited in the brief do not impose this obligation upon the OPMC. In Matter of Schwarz v Board

of Regents, 89 A.D.2d 711, the Court stated the purpose of the recordkeeping requirement was, at least in part, to provide meaningful information to a new physician. In the Matter of Camperlengo v Barrell, 164 A.D.2d 633, the issue before the Court was whether an expedited professional misconduct hearing procedure could be used when a psychiatrist had been found guilty of failing to maintain adequate records under the Medicaid regulations. Neither of these cases impose the legal obligation claimed in Respondent's memorandum or limits the meaning of Education Law § 6530(32).

Specifications

The First Specification charged Respondent with professional misconduct for practicing medicine with negligence on more than one occasion in her care of Patients A through G, in violation of New York Education Law § 6530(3). Negligence is defined as the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances and involves a deviation from acceptable medical standards in the treatment of patients. As indicated in the finding of fact above, the Department established by a preponderance of the evidence that Respondent's practice of medicine showed a pattern of providing a course of treatment for these patients which maximized her reimbursement instead of rendering appropriate care as determined by each patient's individual medical condition. Accordingly, the First Specification is sustained.

The Second Specification charged Respondent with professional misconduct for practicing medicine with incompetence in her care of Patient A through G, in violation of New York Education Law § 6530(5). Incompetence is a lack of the skill or knowledge necessary to practice the profession. Although the Department established that the Respondent lacked knowledge on some specific matters, the Hearing Committee found that her misconduct towards these patients was due to her negligence and fraud. Therefore, the Second Specification is not sustained.

The Third through Ninth Specifications charged Respondent with professional misconduct for ordering excessive tests for Patient A through G, which were not warranted by the condition of those patients in violation of Education Law § 6530(35). As indicated in the findings of fact above, Respondent repeatedly administered tests on Patient A through G which were either non-diagnostic or normal, and Respondent frequently demonstrated little attempt to adjust her treatment to take into consideration the results of those tests. Accordingly, these Specifications are sustained.

The Tenth through Sixteenth Specifications charged Respondent with professional misconduct for practicing medicine fraudulently in regard to Patients A through G in violation of Education Law § 6530(2). Fraudulent practice is the intentional misrepresentation or concealment of a known fact. As indicated above in the findings of fact, Respondent misrepresented these patients' histories and physical examinations to justify her medical billing. The Hearing Committee inferred

Respondent's knowledge of the falsity of these records and her intent to deceive No Fault Insurance based on Respondent's pattern of administering tests with no regard for the results achieved as well as her testimony regarding the patient records submitted at the hearing. As such, these Specifications are sustained.

The Seventeenth through Twenty-Third Specifications charged Respondent with professional misconduct for filing a false report in regard to Patient A through G, in violation of Education Law § 6530(21). The Hearing Committee determined that these specifications are duplicative of the seven prior specifications charging the Respondent with fraud. Accordingly, these latter Specifications are not sustained.

The Twenty-Fourth through Thirtieth Specifications charged Respondent with failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in violation of Education Law § 6530(32). As indicated in the findings of fact, the Department established by a preponderance of the evidence that the Respondent failed to document an adequate treatment plan for these patients. As such, these Specifications are sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee considered the full spectrum of penalties available pursuant to statute, including revocation, suspension, probation, censure, and the imposition of civil penalties. Physicians must comply with the highest ethical standards, and integrity is as

important to the practice of medicine as medical competence. The Hearing Committee found that Respondent lacked credibility, showed no remorse for her misconduct and failed to take any responsibility for her actions. The record shows that Respondent guided the manner in which these patients would be evaluated and treated to maximize reimbursement from No-Fault Insurance, rather than rendering appropriate care as determined by each patient's individual and specific medical conditions and needs. This pattern is found consistently throughout the seven patient records in this case.

One Hearing Committee member felt that Respondent's license should be revoked, but the remaining two Committee members were persuaded that Respondent could provide competent medical care in the field of PM&R medicine so long she was prevented from using financial gain as the sole guiding force of her patient care by imposing a period of suspension, placing a permanent limitation, and ensuring that a practice monitor reviewed the care she provided during a period of probation.

In order to provide some legally binding mechanism which would prevent Respondent from subjecting patients to unnecessary testing and from fraudulently billing for her medical services, the Respondent's license must be permanently limited to the practice of medicine in an PHL Article 28 facility which will allow for greater oversight and remove Respondent from handling money and direct billing. In addition, a practice monitor must be in place during a five-year probationary period to review the medical care that Respondent provides and ensure

that the treatment provided to her patients meets the standard of care of her profession.

ORDER

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

1. The First, Third through Sixteenth, and Twenty-fourth through Thirtieth Specifications of professional misconduct, as set forth in the Statement of Charges are SUSTAINED;

2. Respondent's license to practice medicine is wholly suspended for a period of 90 days;

3. Respondent's license to practice medicine is permanently limited to restrict Respondent to practice in a facility that holds a license under PHL Article 28;

4. Following the 90-day actual suspension, Respondent is placed on probation for a period of five years and shall abide by the terms of probation annexed as attachment A;

5. During the period of probation, Respondent shall practice medicine only when monitored by a licensed physician as detailed in paragraph seven of Attachment A;

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

DATED: Albany, New York
August 17, 2016

[redacted]

DIANE M. SIXSMITH, M.D. (CHAIR)

MICHAEL R. GOLDING, M.D.
CONSTANCE DIAMOND, D.A.

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Delys St. Hill, M.D.
[redacted]

ATTACHMENT A

Terms of Probation

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

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

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

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

5. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if she is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30 day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume and Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in the Determination and Order or as are necessary to protect the public health.

6. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or

electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

7. During the probationary period, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Any medical practice in violation of this term shall constitute the unauthorized practice of medicine.

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

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

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

d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC within 30 days after the effective date of this Order.

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

APPENDIX I

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

IN THE MATTER OF DELYS ST. HILL, M.D.	STATEMENT OF CHARGES

DELYS ST. HILL, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 3, 1989, by the issuance of license number 178853 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From on or about April 26, 2007 through on or about July 19, 2007, Respondent treated Patient A at her solely owned We Care Medical, P.C. office for alleged injuries reportedly sustained in an April 6, 2007 motor vehicle accident. Patient A's medical care was billed to the New York No-Fault Insurance Program by Respondent. Respondent deviated from medically accepted standards of care in that she:

1. Failed to perform and document an adequate history and physical examination,
2. Ordered and/or performed diagnostic testing that was inconsistent with the documented history and physical and/or was medically unnecessary.
   a. Respondent did so with intent to deceive.
3. Performed diagnostic testing that was technically flawed and failed to adequately address the result(s) and/or properly repeat the test; or in the alternative,

(6)

4. Documented performing diagnostic testing that she did not, in fact, perform.
   a. Respondent did so with intent to deceive.
5. Ordered excessive treatment and/or supplies not warranted by the patient's condition.
   a. Respondent did so with intent to deceive.
6. Failed to adequately modify Patient A's treatment and/or plan of care when his condition worsened,
7. Failed to maintain a record that accurately reflects the evaluation of Patient A, and
8. Inappropriately billed for services that were not or were improperly provided.
   a. Respondent did so with the intent to deceive.

B. From on or about March 21, 2007 through on or about June 19, 2007, Respondent treated Patient B at her solely owned We Care Medical, P.C. office for alleged injuries reportedly sustained in a March 10, 2007 motor vehicle accident. Patient B's medical care was billed to the New York No-Fault Insurance Program by Respondent. Respondent deviated from medically accepted standards of care in that she:

1. Performed diagnostic testing that was inconsistent with the documented history and physical and/or was medically unnecessary.
   a. Respondent did so with intent to deceive.
2. Performed diagnostic testing that was technically flawed and failed to adequately address the result(s) and/or properly repeat the test; or in the alternative,
3. Documented performing diagnostic testing that she did not, in fact, perform.

a. Respondent did so with intent to deceive.

4. Provided and billed for excessive treatment and/or supplies not warranted by the patient's condition.
   a. Respondent did so with intent to deceive.
5. Failed to adequately modify Patient B's treatment and/or plan of care when his condition worsened,
6. Failed to maintain a record that accurately reflects the evaluation of Patient B and
7. Inappropriately billed for services that were not or were improperly provided.
   a. Respondent did so with the intent to deceive.

C. From on or about September 5, 2007 through on or about October 18, 2007, Respondent treated Patient C at her solely owned We Care Medical, P.C. office for alleged injuries reportedly sustained in a September 3, 2007 motor vehicle accident. Patient C's medical care was billed to the New York No-Fault Insurance Program by Respondent. Respondent deviated from medically accepted standards of care in that she:

1. Performed diagnostic testing that was inconsistent with the documented history and physical and/or was medically unnecessary,
   a. Respondent did so with intent to deceive.
2. Performed diagnostic testing that was technically flawed and failed to adequately address the result(s) and/or properly repeat the test; or in the alternative,
3. Documented performing diagnostic testing that she did not, in fact, perform.
   a. Respondent did so with intent to deceive.

4. Provided and billed for excessive treatment and/or supplies not warranted by the patient's condition.
   a. Respondent did so with intent to deceive.
5. Failed to adequately modify Patient C's treatment and/or plan of care when his condition worsened,
6. Failed to maintain a record that accurately reflects the evaluation of Patient C, and
7. Inappropriately billed for services that were not or were improperly provided.
   a. Respondent did so with the intent to deceive.

D. From on or about January 9, 2007 through on or about October 10, 2007, Respondent treated Patient D at her solely owned We Care Medical, P.C. office for alleged injuries reportedly sustained in a January 2, 2007 motor vehicle accident. Patient D's medical care was billed to the New York No-Fault Insurance Program by Respondent. Respondent deviated from medically accepted standards of care in that she:

1. Performed diagnostic testing that was inconsistent with the documented history and physical and/or was medically unnecessary.
   a. Respondent did so with intent to deceive.
2. Provided and billed for excessive treatment and/or supplies not warranted by the patient's condition.
   a. Respondent did so with intent to deceive.
3. Failed to adequately modify Patient D's treatment and/or plan of care when his condition worsened,
4. Failed to maintain a record that accurately reflects the evaluation of Patient D, and

5. Inappropriately billed for services that were not or were improperly provided.
   a. Respondent did so with the intent to deceive.

E. From on or about January 24, 2007 through on or about June 21, 2007, Respondent treated Patient E at her solely owned We Care Medical, P.C. office for alleged injuries reportedly sustained in a January 22, 2007 motor vehicle accident. Patient E's medical care was billed to the New York No-Fault Insurance Program by Respondent. Respondent deviated from medically accepted standards of care in that she:

1. Performed diagnostic testing that was inconsistent with the documented history and physical and/or was medically unnecessary.
   a. Respondent did so with intent to deceive.
2. Performed diagnostic testing and failed adequately address positive electro diagnostic findings and/or clinically follow-up in the care and treatment of Patient E,
3. Performed diagnostic testing that was technically flawed and failed to adequately address the result(s) and/or properly repeat the test; or in the alternative,
4. Documented performing diagnostic testing that she did not, in fact, perform.
   a. Respondent did so with intent to deceive.
5. Provided and billed for excessive treatment and/or supplies not warranted by the patient's condition.
   a. Respondent did so with intent to deceive.
6. Failed to adequately modify Patient E's treatment and/or plan of care when his condition worsened,

7. Failed to maintain a record that accurately reflects the evaluation of Patient E, and
8. Inappropriately billed for services that were not or were improperly provided.
   a. Respondent did so with the intent to deceive.

F. From on or about January 24, 2007 through on or about August 15, 2007, Respondent treated Patient F at her solely owned We Care Medical, P.C. office for alleged injuries reportedly sustained in a January 22, 2007 motor vehicle accident. Patient F's medical care was billed to the New York No-Fault Insurance Program by Respondent. Respondent deviated from medically accepted standards of care in that she:

1. Performed diagnostic testing that was inconsistent with the documented history and physical and/or was medically unnecessary.
   a. Respondent did so with intent to deceive.
2. Performed diagnostic testing that was technically flawed and failed to adequately address the result(s) and/or properly repeat the test; or in the alternative,
3. Documented performing diagnostic testing that she did not, in fact, perform.
   a. Respondent did so with intent to deceive.
4. Provided and billed for excessive treatment and/or supplies not warranted by the patient's condition.
   a. Respondent did so with intent to deceive.
5. Failed to adequately modify Patient F's treatment and/or plan of care when his condition worsened,
6. Failed to maintain a record that accurately reflects the evaluation of Patient F and

7. Inappropriately billed for services that were not or were improperly provided.
   a. Respondent did so with intent to deceive.

G. From on or about December 12, 2006 through on or about June 5, 2007, Respondent treated Patient G at her solely owned We Care Medical, P.C. office for alleged injuries reportedly sustained in a December 8, 2006 motor vehicle accident. Patient G's medical care was billed to the New York No-Fault Insurance Program by Respondent. Respondent deviated from medically accepted standards of care in that she:

1. Provided and billed for diagnostic testing that was inconsistent with the documented history and physical and/or was medically unnecessary.
   a. Respondent did so with intent to deceive.
2. Performed diagnostic testing that was technically flawed and failed to adequately address the result(s) and/or properly repeat the test; or in the alternative,
3. Documented performing diagnostic testing that she did not, in fact, perform.
   a. Respondent did so with intent to deceive.
4. Provided and billed for excessive treatment and/or supplies not warranted by the patient's condition.
   a. Respondent did so with intent to deceive.
5. Failed to adequately modify Patient G's treatment and/or plan of care when his condition worsened,
6. Failed to maintain a record that accurately reflects the evaluation of Patient G and
7. Inappropriately billed for services that were not or were improperly provided.

a. Respondent did so with intent to deceive.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. Paragraphs A, A(1), A(3), A(6), A(7), B, B(2), B(5), B(6), C, C(2), C(5), C(6), D, D(3), D(4), E, E(2), E(3), E(6), E(7), F, F(2), F(5), F(6), G, G(2), G(5) and G(6).

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

2. Paragraphs A, A(1), A(3), A(6), A(7), B, B(2), B(5), B(6), C, C(2), C(5), C(6), D, D(3), D(4), E, E(2), E(3), E(6), E(7), F, F(2), F(5), F(6), G, G(2), G(5) and G(6).

THIRD THROUGH NINTH SPECIFICATIONS

UNWARRANTED TESTS/TREATMENT

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

3. Paragraphs A, A (2) and (5).
4. Paragraphs B, B (1) and (4).
5. Paragraphs C, C (1) and (5).
6. Paragraphs D, D (1) and (2).
7. Paragraphs E, E (1) and (5).
8. Paragraphs F, F (1) and (4).
9. Paragraphs G, G (1) and (4).

TENTH THROUGH SIXTEENTH SPECIFICATIONS

FRAUDULENT PRACTICE

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

10. Paragraphs A, A (2) and (2) (a), A (4) and (4) (a), A (5) and (5) (a) and A (8) and (8) (a).
11. Paragraphs B, B (1) and (1) (a), B (4) and (4) (a) and B (7) and (7) (a).
12. Paragraphs C, C (1) and (1) (a), C (4) and (4) (a), C (5) and (5) (a) and C (8) and (8) (a).

13. Paragraphs D, D (1) and (1) (a), D (2) and (2) (a) and D (5) and (5) (a).

14. Paragraphs E, E (1) and (1) (a), E (4) and (4) (a), E (5) and (5) (a) and E (8) and (8) (a).

15. Paragraphs F, F (1) and (1) (a), F (3) and (3) (a), F (4) and (4) (a) and F (7) and (7) (a).

16. Paragraphs G, G (1) and (1) (a), G (3) and (3) (a), G (4) and (4) (a) and G (7) and (7) (a).

SEVENTEENTH THROUGH TWENTY-THIRD SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

17. Paragraphs A, A (2), (4), (5) and (8).

18. Paragraphs B, B (1), (4) and (7).

19. Paragraphs C, C (1), (4), (5) and (8).

20. Paragraphs D, D (1), (2) and (5).

21. Paragraphs E, E (1), (4), (5) and (8).

22. Paragraphs F, F (1), (3), (4) and (7).

23. Paragraphs G, G (1), (3), (4) and (7).

TWENTY-FOURTH THROUGH THIRTIETH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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

24. Paragraphs A and A (7).

25. Paragraphs B and B (6).

26. Paragraphs C and C (7).

27. Paragraphs D and D (4).

28. Paragraphs E and E (7).

29. Paragraphs F and F (6).

30. Paragraphs G and G (6).

DATE: August 7, 2015
New York, New York

[redacted]

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct