New York State Board for Professional Medical Conduct
433 River Street, Suite 303 • Troy, New York 12180-2299 • (518) 402-0863

Antonia C. Novello, M.D., M.P.H.Dr..P.H.
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NYS Department of Health

Dennis P. Whalen
Executive Deputy Commissioner
NYS Department of Health

Dennis J. Graziano, Director
Office of Professional Medical Conduct

William P. Dillon, M.D.
Chair

Denise M. Bolan, R.P.A.
Vice Chair

Ansel R. Marks, M.D., J.D.
Executive Secretary

September 25, 2001

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Anthony Joseph Sarro, M.D.
8210 Avenue J
Brooklyn, New York 11236

RE: License No. 086374

Dear Dr. Sarro:

Enclosed please find Order #BPMC 01-218 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect September 25, 2001.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Hedley Park Place, Suite 303
433 River Street
Troy, New York 12180

If the penalty imposed by the Order is a fine, please write the check payable to the New York State Department of Health. Noting the BPMC Order number on your remittance will assist in proper crediting. Payments should be directed to the following address:

Bureau of Accounts Management
New York State Department of Health
Corning Tower, Room 1258
Empire State Plaza
Albany, New York 12237

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Alexander Bateman, Esq.
Ruskin, Moscou, Evans and Faltischek, P.C.
17 0Old Country Road
Mineola, New York 11501-4366

Terry Sheehan, Esq.

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

IN THE MATTER

OF

ANTHONY JOSEPH SARRO, M.D.

CONSENT

ORDER

BPMC No. 01-218

Upon the proposed agreement of ANTHONY JOSEPH SARRO, M.D. (Respondent) for Consent Order, which application is made a part hereof, it is agreed to and

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: 9/25/01

William P. Dillon, MD

WILLIAM P. DILLON, M.D.
Chair
State Board for Professional
Medical Conduct

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

IN THE MATTER

OF

ANTHONY JOSEPH SARRO, M.D.

CONSENT AGREEMENT AND ORDER

ANTHONY JOSEPH SARRO, M.D., representing all statements herein made to be true, deposes and says:

That on or about September 6, 1961, I was licensed to practice as a physician in the State of New York, having been issued License No. 086374 by the New York State Education Department.

My current address is 8210 Avenue J, Brooklyn, New York 11236, and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I understand that the New York State Board for Professional Medical Conduct has charged me with twenty-six specifications of professional misconduct.

A copy of the Statement of Charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

I cannot successfully defend against at least one of the acts of misconduct alleged. I hereby agree to the following penalty:

> Pursuant to §230-a(2) of the Public Health law, my license to practice medicine in the State of New York shall be suspended for a period of two years with said suspension to be entirely stayed. Pursuant to §230-a(9) of the Public Health Law, I shall be placed on probation for a period of two years, subject to the terms set forth in Exhibit "B," attached hereto. I shall be

subject to a fine in the amount of $10,000, pursuant to §230-a(7) and (9) of the Public Health Law, to be paid within 30 days of the effective date of this order.

I further agree that the Consent Order for which I hereby apply shall impose the following conditions:

That, except during periods of actual suspension, Respondent shall maintain active registration of Respondent's license with the New York State Education Department Division of Professional Licensing Services, and pay all registration fees. This condition shall be in effect beginning thirty days after the effective date of the Consent Order and will continue while the licensee possesses his/her license; and

That Respondent shall fully cooperate in every respect with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigation of all matters regarding Respondent. Respondent shall respond in a timely manner to each and every request by OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall meet with a person designated by the Director of OPMC as directed. Respondent shall respond promptly and provide any and all documents and information within Respondent's control upon the direction of OPMC. This condition shall be in effect beginning upon the effective date of

the Consent Order and will continue while the licensee possesses his/her license.

I hereby stipulate that any failure by me to comply with such conditions shall constitute misconduct as defined by New York State Education Law §6530(29).

I agree that in the event I am charged with professional misconduct in the future, this agreement and order shall be admitted into evidence in that proceeding.

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same. I agree that such order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to me at the address set forth in this agreement, or to my attorney, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the

value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive any right I may have to contest the Consent Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted.

DATED 9-25-01

ANTHONY JOSEPH SARRO, M.D.
RESPONDENT

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: 9/5/01

ALEXANDER BATEMAN, ESQ.
Attorney for Respondent

DATE: 9/7/01

TERRENCE J. SHEEHAN
Associate Counsel
Bureau of Professional
Medical Conduct

DATE: 9/19/01

DENNIS J. GRAZIANO
Director
Office of Professional
Medical Conduct

EXHIBIT "B"

Terms of Probation

1. Respondent shall conduct himself/herself in all ways in a manner befitting his/her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession. Respondent acknowledges that if s/he commits professional misconduct as enumerated in New York State Education Law §6530 or §6531, those acts shall be deemed to be a violation of probation and that an action may be taken against Respondent's license pursuant to New York State Public Health Law §230(19).

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director of the Office of Professional Medical Conduct, New York State Department of Health, 433 River Street, Suite 303, Troy, NY 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].

4. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

5. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

6. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

PRACTICE MONITOR

7. Within thirty days of the effective date of the order, 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.

   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 less than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

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

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

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

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

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

9. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.

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

IN THE MATTER

OF

ANTHONY JOSEPH SARRO, M.D.

STATEMENT

OF

CHARGES

ANTHONY JOSEPH SARRO, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 6, 1961, by the issuance of license number 086374 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Between September 28, 1993 and October 16, 1996, the Respondent treated Patient A (all patients are identified in the annexed Appendix) at his office located at 8210 Avenue J, Brooklyn, New York, for upper respiratory infection and other medical conditions. Respondents care and treatment departed from accepted standards of practice in the following respects:

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondents inappropriately and without proper indication ordered or performed the following tests or procedures:

Exh. "A"

a. Fiberoptic nasal endoscopy on May 24, 1996 and June 5, 1996.

b. Direct laryngoscopy on May 24, 1996 and June 5, 1996.

c. Surgical nasal endoscopy on October 16, 1996.

d. Bilateral maxillary sinus irrigation on May 24, 1996.

e. Cauterization of nasal turbinates on October 16, 1996.

f. Bronchoscopy on June 5, 1996.

g. Undated audiological evaluation.

3. Respondent ordered or performed the tests and procedures listed in paragraphs A(2) (a) - (g), supra, in the knowledge that they were without legitimate medical purpose.

4. Respondent sought payment from Patient A and/or Patient A's insurance carrier for the tests and procedures listed in paragraphs A (2) (a) - (g), in the knowledge that they were without legitimate medical purpose and therefore not properly compensable.

5. Respondent prepared purported "operative reports" for each of the procedures listed in paragraphs A

(2) (a) - (f). These reports constitute sham medical records: for the most part they are form documents used over and over again with only minimal information specific to Patient A.

6. Respondent billed Patient A and/or Patient A's insurance carrier for ear, nose and throat examinations in a fraudulent manner. Instead of billing for a single comprehensive ENT examination, Respondent 'unbundled' the exam into several component parts and improperly billed for each separately.

7. Respondent failed to maintain a record for Patient A which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examinations, diagnoses, treatment plans, rationales for treatment and insurance bills.

B. Between October 12, 1995 and January 31, 1996, the Respondent treated Patient B at his office for nasal septal perforation and other medical conditions. Respondents care and treatment departed from accepted standards of practice in the following respects:

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondents inappropriately and without proper indication ordered or performed the following tests or procedures:

   a. Surgical nasal endoscopy on November 1, 1995.
   b. Fiberoptic nasal endoscopy on October 12, 1995, November 1, 1995.
   c. Diet laryngoscopy on January 31, 1996.
   d. Politzerization under local anexthesia on October 12, 1995, October 18, 1995 and November 1, 1995.
   e. Electric cautery of ulcerated areas on November 1, 1995.
   f. Sinus irrigation on October 12, 1995, October 18, 1995, November 1, 1995 and January 31, 1996.

3. Respondent performed the procedures listed in paragraphs B(2) (a) - (f), supra, in the knowledge that they were without legitimate medical purpose.

4. Respondent sought payment from Patient B and/or Patient B's insurance carrier for the procedures listed in paragraphs B (2) (a) - (f), in the knowledge that they were without legitimate medical purpose and therefore not properly compensable.

5. Respondent prepared purported "operative reports" for each of the procedures listed in paragraphs B (2) (a) - (f). These reports constitute sham medical records: for the most part they are form documents used over and over again with only minimal information specific to Patient B.

6. Respondent billed Patient B and/or Patient B's insurance carrier for ear, nose and throat examinations in a fraudulent manner. Instead of billing for a single comprehensive ENT examination, Respondent 'unbundled' the exam into several component parts and improperly billed for each separately.

7. Respondent failed to maintain a record for Patient B which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examinations, diagnoses, treatment plans, rationales for treatment and insurance bills.

C. Between May 1,1991 and September 25, 1996, the Respondent treated Patient C at his office for various conditions. Respondent's care and treatment departed from accepted standards of practice in the following respects:

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondents inappropriately and without proper indication ordered or performed the following tests or procedures:

   a. Surgical nasal endoscopy on March 14, 1996, April 22, 1996, April 24, 1996, May 29, 1996 and September 25, 1996.
   b. Fiberoptic nasal endoscopy on October 23, 1995, October 30, 1995, June 21, 1995 and January 15, 1996.
   c. Cauterization of nasal turbinates on October 31, 1995 and January 15, 1996.
   d. Electric-cautery of bleeding ulcerated areas on March 14, 1996.
   e. Politzeration under local anesthesia on June 21, 1995, October 23, 1995, January 15, 1996 and March 14, 1996.

f. Myringotomy on October 23, 1995, September 15, 1993 and May 29, 1996.

g. Several audiological evaluations, one dated June 21, 1995, others undated.

3. Respondent ordered or performed the tests and procedures listed in paragraphs C (2) (a) - (g), supra, in the knowledge that they were without legitimate medical purpose.

4. Respondent sought payment from Patient C and/or Patients C's insurance carrier for the procedures listed in paragraphs C (2) 9 (a) - (g), in the knowledge that they were without legitimate medical purpose and therefore not properly compensable.

5. Respondent prepared purported "operative reports" for each of the procedures listed in paragraphs C (2) (a) - (f). These reports constitute sham medical records: for the most part they are form documents used over and over again with only minimal information specific to Patient C.

6. Respondent billed Patient C and/or Patient C's insurance carrier for ear, nose and throat examinations in a fraudulent manner. Instead of

billing for a single comprehensive ENT examination, Respondent 'unbundled' the exam into several component parts and improperly billed for each separately.

7. Respondent failed to maintain a record for patient C which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examinations, diagnoses, treatment plans, rationales for treatment and insurance bills.

D. Between April 26, 1991 and October 30, 1996, the Respondent treated Patient D at his office for various conditions. Respondents care and treatment departed from accepted standards of practice in the following respects:

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondents inappropriately and without proper indication ordered or performed the following tests or procedures:

a. Surgical nasal endoscopy on May 2, 1994, May 18, 1994, October 2, 1995, April 22, 1996 and April 29, 1996.

b. Fiberoptic nasal endoscopy on October 3, 1994.

c. Direct laryngoscopy on February 24, 1992.

d. Debridement and fulguration of intranasal lesions on May 2, 1994, October 2, 1995 and April 22, 1996.

e. Bilateral maxillary sinus irrigation on April 22, 1996.

f. Bronchoscopy on October 3, 1994.

3. Respondent performed the procedures listed in paragraphs D (2) (a) - (f), supra, in the knowledge that they were without legitimate medical purpose.

4. Respondent sought payment from Patient D and/or Patient D's insurance carrier for the procedures listed in paragraphs D (2) (a) - (f), in the knowledge that they were without legitimate medical purpose and therefore not properly compensable.

5. Respondent prepared purported "operative reports" for each of the procedures listed in paragraphs D (2) (a) - (f). These reports constitute sham medical records: for the most part they are form documents used over and

over again with only minimal information specific to Patient D.

6. Respondent billed Patient D and/or Patient D's insurance carrier for ear, nose and throat examinations in a fraudulent manner. Instead of billing for a single comprehensive ENT examination, Respondent 'unbundled' the exam into several component parts and improperly billed for each separately.

7. Respondent failed to maintain a record for Patient D which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examinations, diagnoses, treatment plans, rationales for treatment and insurance bills.

E. Between September 29,1994 and January 12, 1995 the Respondent treated Patient E at his office for certain medical conditions. Respondents care and treatment departed from accepted standards of practice in the following respects:

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondents inappropriately and without proper indication ordered or performed the following tests or procedures:

a. Fiberoptic nasal endoscopy on September 24, 1994.

b. Direct laryngoscopy on September 29, 1994.

c. Bronchoscopy on September 29, 199 and November 16, 1994.

d. Vestibular function tests on January 12, 1995.

3. Respondent ordered or performed the tests and procedures listed in paragraphs E (2) (a) - (d), supra, in the knowledge that they were without legitimate medical purpose.

4. Respondent sought payment from Patient E and/or Patient E's insurance carrier for the tests and procedures listed in paragraphs E (2) (a) - (d), in the knowledge that they were without legitimate medical purpose and therefore not properly compensable.

5. Respondent prepared purported "operative reports" for each of the procedures listed in paragraphs E (2) (a) - (c). These reports constitute sham medical

records: for the most part they are form documents used over and over again with only minimal information specific to Patient E.

6. Respondent billed Patient E and/or Patient E's insurance carrier for ear, nose and throat examinations in a fraudulent manner. Instead of billing for a single comprehensive ENT examination, Respondent 'unbundled' the exam into several component parts and improperly billed for each separately.

7. Respondent failed to maintain a record for Patient E which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examinations, diagnoses, treatment plans, rationales for treatment and insurance bills.

F. Between November 9, 1977 and December 17, 1990, the Respondent treated Patient F at his office for various medical conditions. Respondents care and treatment departed from accepted standards of practice in the following respects:

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondents inappropriately and without proper indication ordered or performed the following tests or procedures:

   a. Direct laryngoscopy on October 1, 1986, December 7, 1988, June 14, 1989, June 19, 1989, March 7, 1990 and December 17, 1990.

   b. Undated audiological evaluation.

3. Respondent ordered or performed the tests and procedurlisted in paragraphs F (2) (a) & (b), supra, in the knowledge that they were without legitimate medical purpose.

4. Respondent sought payment from Patient F and/or Patient F's insurance carrier for the tests and procedures listed in paragraphs F (2) (a) & (b), in the knowledge that they were without legitimate medical purpose and therefore not properly compensable.

5. Respondent failed to maintain a record for Patient F which accurately reflects the evaluation and treatment he provided, including patient complaints, history, physical examinations, diagnoses,

treatment plans, rationales for treatment and insurance bills.

SPECIFICATION OPF CHARGES

FIRST THROUGH SIXTH 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 the following:

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

SEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

7. A and A(1) through A(7), B and B(1) through B(7), C and C(1) through C(7), D and D (1) through D(7), E and E(1) through E(7), and F and F(1) through F(5).

EIGHTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

8. A and A(1) through A(7), B and B(1) through B(7), C and C(1) through C(7), D and D(1) through D(7), E and E(1) through E(7), and F and F(1) through F(5).

NINTH THROUGH FOURTEENTH 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:

9. A and A(2)
10. B and B(2)
11. C and C(2)
12. D and D(2)
13. E and E(2)
14. F and F(2)

FIFTEENTH THROUGH TWENTIETH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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

15. A and A(7)
16. B and B(7)
17. C and C(7)
18. D and D(7)
19. E and E(7)
20. F and F(5)

TWENTY-FIRST THROUGH TWENTY-SIXTH SPECIFICATIONS

MORAL UNFITNESS

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

21. A and A(3), A(4), A(5), A(6)
22. B and B(3), B(4), B(5), B(6)
23. C. and C(3), C(4), C(5),C(6)
24. D and D(3), D(4), D(5), D(6)
25. E and E(3), E(4), E(5), E(6)
26. F and F(3), F(4)

DATED: February , 2001
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct