STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

March 23, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Claudia Morales Bloch, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Robert Asher, Esq.
295 Madison Avenue
Suite 700
New York, New York 10017

Robert Delbeau, M.D.
34-16 84th Street
Jackson Heights, New York 11372

RE: In the Matter of Robert Delbeau, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 98-54) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

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

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

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER

OF

ROBERT DELBEAU, M.D.

DETERMINATION

AND

ORDER

BPMC-98-54

IRVING S. CAPLAN, Chairman, ERWIN LEAR, M.D. and **DAVID SIBULKIN, M.D.,** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **MICHAEL P. McDERMOTT, ESQ.,** Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges:	September 24, 1997
Pre-Hearing Conference:	October 23, 1997
Hearing Dates:	November 6, 1997 November 20, 1997 November 25, 1997 December 2, 1997 December 16, 1997 January 14, 1998
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York

Date of Deliberations:	February 18, 1998
Petitioner appeared by:	Henry M. Greenberg, Esq. General Counsel NYS Department of Health By: Claudia Morales Bloch, Esq., of Counsel
Respondent appeared by:	Robert Asher, Esq. 295 Madison Avenue Suite 700 New York, New York 10017

WITNESSES

For the Petitioner:	1) Edward Yang, M.D. 2) Harriet S. Gilbert, M.D. 3) Robert A. Shimm, M.D.
For the Respondent:	1) Bernadette Augustin, R.N. 2) Robert Delbeau, M.D., the Respondent 3) Patient F 4) Claude Mathieu, M.D. 5) Patient C 6) Hilary Kern, M.D.

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with negligence on more than one occasion; incompetence on more than one occasion; gross negligence; gross incompetence; fraudulent practice; excessive treatment; failure to maintain a record; failure to register; and criminal conviction.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT

Numbers in parenthesis refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

Pet's. Ex. = Petitioner's Exhibit

Resp's. Ex. = Respondent's Exhibit

F/F = Finding of Fact

Tr. = Transcript

GENERAL FINDINGS

1. Robert Delbeau, M.D., the Respondent, was authorized to practice medicine in New York State on September 20, 1966 by the issuance of license number 097458 by the New York State Education Department (Pet's. Ex. 2A).

FINDINGS AS TO PATIENT A

2. On the initial visit of July 3, 1992, Patient A presented at the Respondent's office with several complaints including, difficulty breathing, bruising without significant trauma, and heart palpitations. On physical examination, the Respondent noted pale conjunctiva and hepatosplenomegaly (Pet's. Ex. 4A).

3. On this initial visit, the Respondent failed to obtain and note a medical history which fully related to Patient A's complaints (Pet's. Ex. 4A; Tr. 318-322).

4. The Respondent also failed to do a system review as part of Patient A's medical history (Pet's. Ex. 4A; Tr. 325-326).

5. The Respondent noted that Patient A was taking medications on her own: aspirin to prevent a heart attack and cyproheptadine to stimulate her appetite. However, he failed to inquire as to how the patient obtained these medications and, in light of her complaints, why her appetite required stimulation (Pet's. Ex. 4A; Tr. 322-324).

6. The Respondent failed to perform and note a complete and adequate physical examination of Patient A. He failed to perform a rectal examination which was medically indicated. The Respondent also failed to perform and note a complete lung examination and an appropriate follow-up examination to the findings of pale conjunctiva and her history of bruising without trauma (Pet's. Ex. 4A; Tr. 333-334, 341-347, 345, 963-965-976, 1179, 1189-1191, 1244-1247).

7. Patient A's history of ecchymosis without trauma indicated an intrinsic underlying hematologic disorder. The chief complaints, the physical findings, and the patient's loss of appetite, should have alerted the Respondent to suspect a hematologic disorder. The Respondent ordered the appropriate laboratory tests at the time of the initial visit (Pet's. Ex. 4A; Tr. 351-353, 355, 357-359, 367).

8. On July 7, 1992, the Respondent received a telephone report of laboratory results on blood which was drawn from Patient A on July 6, 1992. The laboratory report included results of: WBC 1.7, Hgb 2.9, Hct 8.7, RBI .96, platelet count 13,000, iron 496, and iron binding capacity 819. In addition, the polys were drastically reduced to 9 percent which meant that the patients neutrophil count was 153.

The Respondent noted his interpretations of these results as: chronic severe anemia, leukopenia, granulocytopenia, and thrombocytopenia. He prescribed ferrous sulfate for Patient A (Pet's. Ex. 4A).

9. The profoundly abnormal laboratory results, and especially the drastically low neutrophil count, indicated that the patient should have been hospitalized immediately and placed on antibiotics to protect her from developing a fatal sepsis. The Respondent failed to hospitalize the patient (Tr. 368-369).

10. Patient A's profoundly reduced hemoglobin, hematocrit, and platelet count placed the patient at serious risk for life-threatening complications requiring an immediate transfusion, especially in light of her presenting condition. The Respondent disregarded these laboratory results and failed to take any steps toward hospitalization and transfusion (Tr. 369-371, 383-385).

11. The Respondent also failed to arrange for any diagnostic evaluation and/or treatment for Patient A (F/F 10, Pet's. Ex. 4A).

12. After reviewing the laboratory results, the Respondent wrote a long passage in his record interpreting the results, which included an unfounded determination that the patient did not have any blood loss. He also noted, that the patient suffered from numerous "longstanding and quite advanced," serious hematologic disorders, including aleukemic leukemia. Despite this detailed litany of life-threatening conditions, the Respondent did nothing for the patient except to prescribe the ferrous sulfate. (Pet's. Ex. 4A; Tr. 377-380, 385-386, 939-940, 945-946, 948-950, 1207-1208, 1212-1213).

13. The laboratory results showed that Patient A's iron and the iron binding capacity were both substantially elevated, indicating that the patient did not have an iron deficiency. The Respondent's prescribing of ferrous sulfate was inappropriate and without medical justification (Pet's. Ex. 4A; Tr. 374-375, 381-383, 1273-1274).

14. The Respondent acknowledged that he had failed to appreciate the significance of the abnormal laboratory test results and clinical findings so as to act appropriately (Pet's. Ex. 4A; Tr. 1273-1274).

15. The Respondent's office record for Patient A includes entries for July 3, 1992, July 7, 1992, July 17, 1992, July 18, 1992, July 19, 1992, and July 20, 1992. He has admitted that the record he produced to the Department of Health, and in evidence as Pet's. Ex. 4A, is a rewrite and not the original record for the patient.

The Respondent claims to have rewritten the record on July 20, 1992, and then disposed of the original record.

Despite the Respondent's testimony that the rewritten record is substantially the same as the original, the Hearing Committee notes questionable entries, such as, (a) recording a ferritin result which was not available at the time; (b) including an early diagnosis of aleukemic leukemia; (c) falsely claiming that a second blood test was performed; and (e) entries of dates and times inconsistent with the facts (Pet's. Exs. 4A, 4B; Tr. 312-315, 326, 328-329, 348-351, 356-357, 359-361, 375-376, 385, 386, 389-390, 395-403, 939-940, 945-946, 948-950, 1216-1217, 1238-1242).

16. During his initial interview with the Department of Health, Office of Professional Medical Conduct, (OPMC) on July 27, 1995, the Respondent misrepresented that he had written the office record for Patient A contemporaneously with the events (Pet's. Ex. 4A; Tr. 421).

CONCLUSIONS AS TO PATIENT A

The Hearing Committee concludes that the Respondent's care and treatment of Patient A was totally inadequate, grossly mismanaged and constituted an egregious deviation from acceptable standards of medical care.

The Committee further concludes that the Respondent intended to misrepresent his care of the patient in rewriting his office records and destroying the original. The Committee also finds that Respondent willfully misrepresented to agents of the Department of Health that the rewritten record was written contemporaneous with his care of the patient.

FINDINGS OF FACT COMMON TO PATIENTS A THROUGH M

17. From 1987 through the present, the Respondent has confined his medical practice to the type of cases evidenced by the charts for Patients B-M, which he has characterized, interchangeable, as surgery and "soft tissue injury" cases.

While Patients B through M sustained injuries which did not fall under Worker's Compensation, the Respondent used the billing schedule and codes under the Worker's Compensation Board Manual (hereinafter "Manual") for billing purposes. He admitted that he was fully familiar with the various levels of services, instructions, and general information, codes, and conversion factors within the Manual and billing schedule (Pet's. Exs. 17, 17A; Tr. 480-482, 486, 517-520, 558-561, 621-622).

18. A comprehensive examination of a patient is an in-depth evaluation which includes obtaining and recording a complete history of the patient's chief complaint(s), present illness, family history, past medical history, personal history, and system review; performing and noting a complete physical examination; ordering appropriate diagnostic tests; and initiating appropriate treatment (Pet's. Ex. 17; Tr. 49-50, 237-239, 289-292).

19. In each and every case, B-M, the Respondent billed for a comprehensive examination, at the highest allowable payment level under the conversion table in the "Manual", even though he did not perform or note such an examination.

In each case, the Respondent failed to obtain and note a history, and also failed to perform and note a physical examination which would constitute a comprehensive examination (Tr. 49-50, 72, 74, 237-239, 289-292, 698-700, 720, 1143, 1146-1156).

20. A follow-up examination, be it a limited level examination or a brief visit level examination, includes an interval history, assessment of the effectiveness of treatment undergone and any new or resolved symptoms, as well as a focused examination.

Further, a follow-up includes a plan of treatment, with an assessment of whether the modalities of treatment employed are effective, or whether they should be changed or discontinued (Pet's. Exs. 17, 17A; T. 51, 79-80, 86-88).

21. In each of the cases, Patients B-M, the Respondent billed for numerous follow-up examinations on either a limited examination level or a brief examination level of service, when, in most cases he failed to make any entry of the visit in his record, and, on each occasion, admittedly did not examine the patient, but merely talked to them and then administered the same forms of physical therapy.

He admitted that he billed at a higher level when the patient stayed for a longer period of time, often just sleeping (Tr. 558-561, 618-620, 725, 727, 739, 740, 751, 759, 797-800, 1146-1156).

22. The Respondent admitted that he administered the exact same treatment to each patient, i.e., bed rest, Naprosyn (a muscle relaxant) and, on each of the numerous follow-up visits, ultrasound, hot packs, and massage. Each patient, regardless of their injury, got the same treatment.

While acknowledging that this "treatment" was physical therapy and not the practice of medicine, the Respondent claims that it required his skill and knowledge as a surgeon to assess the patient (Tr. 219-221, 232, 243-244, 255-259, 265-266, 281-285, 289-292, 522-523, 548, 614-616, 618-620, 766-767, 788-793).

23. The Respondent's "treatment" to each of the patients, on each of the numerous follow-up visits, for the modalities set forth in F/F # 22, were medically unnecessary and excessive. The types of injuries sustained by Patients B through M are such that they would resolve on their own, and, while physical therapy may be warranted in some cases, there is no medical justification for a physician visit on each occasion, at such frequent intervals, over the period of time as evidenced in each case (Tr. 75-76, 83-85, 88, 94, 156-160, 162, 164-165, 181-182, 186-187, 221-223, 241, 243-244, 289-292, 829-832).

24. The Respondent failed to note a complete history on each of these patient's billed for visits; he failed to note any physical examination on numerous billed for visits; he failed to write any progress note whatsoever on numerous of the billed for visits and; he failed to note the treatment rendered on numerous of the billed for visits (Resp's. Exs. D, D1; Tr. 73-74, 79-82, 93-94, 157-158, 164-165, 181, 183, 194-195, 266-268, 289-292, 553-556, 562, 614-616, 721-722, 725-727, 739-740, 810-813, 1070).

25. In each of these cases, B-M, the Respondent has composed an ostensible final report, made on or about the last visit by the patient.

These reports would seem to outline the patient's condition, clinical course, physical status and diagnosis as of the date of the report. In fact, the report is a recitation of the Respondent's notes from the initial visit, including the diagnoses listed. Each report refers to the patient receiving "physical therapy in the form of massage, hot packs, and ultrasound", and in each report involving injuries resulting from a motor vehicle accident there is the notation:

> "It can be stated with a reasonable degree of medical certainty that the motor vehicle accident of (date) is the competent, producing cause of the symptoms and findings elicited on examination of the above-named patient."

The Respondent acknowledged that the reports were forwarded to each patient's lawyer along with the Respondent's billings. The patient's lawyers then took care of submitting the bills to the appropriate no-fault or other carrier (Pet's. Exs. 5B, 6B, 9B, 11B, 12B, 13B, 14B, 16B; Tr. 63, 92-93, 152-153, 289-292, 459, 461-462, 642-643, 673-678).

26. Frequently, the Respondent made follow-up entries of simply "no change," or "same as above," when there had been numerous undocumented intervening visits (Tr. 75-76, 80-81, 83, 100, 106, 145-146, 159-160).

27. The Respondent never performed a detailed musculoskeletal and neurological examination in any of the cases (Tr. 101, 1058).

FINDINGS AS TO PATIENT B

28. Patient B was in a motor vehicle accident on October 31, 1993, and on that date, she was treated and released from the Emergency Room at Jamaica Hospital.
The emergency record reports a diagnosis of contusion of the right leg. X-rays indicated no evidence of fracture or dislocation (Pet's. Ex. 5A).

29. Patient B was initially seen by the Respondent at his office on November 3, 1993, and between that date and November 17, 1994, the Respondent billed for 35 physician visits, allegedly to treat the injuries sustained by the patient in the motor vehicle accident (Pet's. Exs. 5A, 5B, 5C).

30. On the initial visit, the Respondent failed to obtain and note an adequate history and review of systems. He also failed to perform an adequate physical examination of the patient. On the follow-up visits, he failed to obtain and note any history, and he failed to note any physical examination whatsoever (F/F #s 18, 21, 24; Pet's. Exs. 5B, 5C; Tr. 56-57, 59-61, 64-66, 74-75, 79-80, 86-88, 93, 101).

31. On each of the 34 follow-up visits, the Respondent failed to write a progress note in the patient's chart; he failed to note the purpose of the visit; and he failed to note what treatment was provided (F/F #s 21, 24, 26; Pet's. Ex. 5B; Tr. 67-68, 73-74, 93-94).

32. The Respondent billed for numerous follow-up physician visits which were not medically necessary (F/F #s 22, 23, 26; Pet's. Ex. 5C; Tr. 85, 88, 94, 133, 135-136).

33. On April 6, 1994, the Respondent prepared a report on Patient B in which he stated, "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the lower back and the right knee."

The Respondent's treatment of Patient B, with 35 physician visits during the period November 3, 1993 to March 17, 1994, was excessive and not warranted by the condition of the patient (F/F #s 22, 23, 25-27; Pet's. Exs. 5B, 5C; Tr. 85, 88, 92-94).

34. The Respondent created a record for Patient B which is false and inaccurate and does not reflect the care and treatment rendered (F/F #s 30-33; Pet's. Exs. 5B, 5C; Tr. 85, 88, 92-94).

35. The Respondent failed to maintain a record for Patient B which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered (F/F #s 30-33; Pet's. Ex. 5B).

CONCLUSIONS AS TO PATIENT B

The record indicates that Patient B was seen on 35 occasions during the period November 3, 1993 to March 17, 1994.

The patient showed very little signs of improvement and the Respondent did not re-evaluate the patient or make any changes in therapy. There is no documentation in the record to justify the number of follow-up visits.

Under the circumstances of this case, the Hearing Committee concludes that the Respondent's continued treatment of Patient B was excessive.

The Hearing Committee is convinced that the Respondent provided the excessive number of treatments and/or caused the excessive number of follow-up visits in this case in a deliberate attempt to enhance or exaggerate the nature and extent of the patient's injuries in order to submit additional billings for his own enrichment.

The Hearing Committee concludes that the Respondent, knowingly and with an intent to mislead, submitted false bills for services which were not rendered.

FINDINGS AS TO PATIENT C

36. Patient C was in a motor vehicle accident on May 1, 1993, and on that date, he was treated and released from the Emergency Room at Franklin Medical Center.
X-rays of the lumbosacral and thoracic spine were taken in the emergency room and reported as normal with no evidence of fracture or dislocation (Pet's. Ex. 6A).

37. Patient C was initially seen by the Respondent at his office on May 12, 1993, and between that date and August 20, 1993, the Respondent billed for 37 physician visits, allegedly to treat the injuries sustained by the patient in the motor vehicle accident (Pet's. Exs. 6A, 6B, 6C).

38. On the initial visit, the Respondent failed to obtain and note an adequate history and review of systems. He also failed to perform an adequate physical examination of the patient.
On the follow-up visits, he failed to obtain and note any history, and he failed to note any physical examination whatsoever (Pet's. Ex. 6B; Tr. 151-153).

39. On each of the 36 follow-up visits, the Respondent failed to write a progress note in the patient's chart; he failed to note the purpose of the visit; and he failed to note what treatment was provided (Pet's. Ex. 6B; Tr. 160-162).

40. For the initial visit, the Respondent falsely billed for a comprehensive medical examination of the patient which was not performed (F/F #s 18, 19, 24; Pet's. Exs. 6B, 6C).

41. For each of the 37 follow-up visits, the Respondent falsely billed for a limited exam and treatment which was not performed (F/F #s 20, 21 23; Pet's. Exs. 6B, 6C).

42. The Respondent billed for numerous follow-up physician visits which were not medically necessary (F/F #s 22, 23, 26; Pet's. Exs. 6B, 6C; Tr. 151-152, 156-158, 160-162).

43. On September 20, 1993, the Respondent prepared a report on Patient C in which he stated, "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the lower back and the right flank."

The Respondent's treatment of Patient C, with 37 physician visits during the period May 12, 1993 to August 20, 1993, was excessive and not warranted by the condition of the patient (F/F #s 22, 23, 25, 27; Pet's. Ex. 6B; Tr. 152-153, 164-165).

44. Patient C testified that he presented solely with a complaint of lower back pain; that at the time of the MRI he was better and had been progressing all along; and that nothing had happened during the time in treatment to exacerbate his pain (Tr. 890-899, 909-911, 913-914, 916, 919-920).

45. The Respondent failed to maintain a record for Patient C which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered (F/F #s 38-43; Pet's. Ex. 6B).

CONCLUSIONS AS TO PATIENT C

The record indicates that Patient C was seen by the Respondent on 37 occasions during the period May 12, 1993 to August 20, 1993.

There is no documentation in the record to justify the number of follow-up visits. The Respondent did not re-evaluate the patient or make any changes in therapy.

Under the circumstances of this case, the Hearing Committee concludes that the Respondent's continued treatment of Patient C was excessive.

The Hearing Committee is convinced that the Respondent provided the excessive number of treatments and/or caused the excessive number of follow-up visits in this case in a deliberate attempt to enhance or exaggerate the nature and extent of the patient's injuries in order to submit additional billings for his own enrichment.

The Hearing Committee concludes that the Respondent, knowingly and with intent to mislead, submitted false bills for services which were not rendered.

FINDINGS AS TO PATIENT D

46. A ceiling collapsed on Patient D on March 1, 1995. On March 3, 1995, he was treated and released from the Emergency Room at Mary Immaculate Hospital.
X-rays were taken in the emergency room and reported as indicating no evidence of fractures or dislocations (Pet's. Ex. 7A).

47. Patient D was initially seen by the Respondent at his office on March 3, 1995, and between that date and September 1, 1995, the Respondent billed for 35 physician visits, allegedly to treat the injuries sustained by the patient as a result of the ceiling collapse (Pet's. Exs. 7B, 7C).

48. On the initial visit, the Respondent failed to obtain and note an adequate history and review of systems. He also failed to perform an adequate physical examination of the patient.
On the follow-up visits, he failed to obtain and note any history and he failed to note any physical examination whatsoever (F/F #s 18, 21, 24; Pet's. Exs. 7B, 7C).

49. On each of the 34 follow-up visits, the Respondent failed to write a progress note in the patient's chart; he failed to note the purpose of the visit; and he failed to note what treatment was provided (Pet's. Ex. 7B; Tr. 180-181, 183-185, 194-195).

50. For the initial visit, the Respondent falsely billed for a comprehensive medial examination of the patient which was not performed (F/F #s 18, 19, 24; Pet's. Exs. 7B, 7C; Tr. 179).

51. For each of the 34 follow-up visits, the Respondent falsely billed for a limited exam and treatment which was not performed (F/F #s 20, 21, 23; Pet's. Exs. 7B, 7C).

52. The Respondent billed for numerous follow-up visits which were not medically necessary (F/F #s 22, 23, 26; Pet's. Exs. 7B, 7C; Tr. 181-182).

53. On September 1, 1995, the Respondent prepared a report on Patient D in which he stated, "physical therapy in the form of massage, hot packs, ultrasound was applied to the lower back and the left hip."

The Respondent's treatment of Patient D, with 35 physician visits during the period March 3, 1995 to September 1, 1995 was excessive and not warranted by the condition of the patient (F/F #s 22, 23, 25, 26, 27; Pet's. Ex. 7B).

54. The Respondent created a record for Patient D which is false and inaccurate and does not reflect the care and treatment rendered (F/F #s 48-53; Pet's. Ex. 7B, 7C; Tr. 177-178, 190-191).

55. The Respondent failed to maintain a record for Patient D which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered (F/F #s 48-53; Pet's. Ex. 7B).

CONCLUSIONS AS TO PATIENT D

The records indicate that Patient D was seen by the Respondent on 35 occasions during the period March 3, 1995 to September 1, 1995.

There is no documentation in the record to justify the number of follow-up visits. The Respondent did not re-evaluate the patient or make any changes in therapy.

Under the circumstances of this case, the Hearing Committee concludes that the Respondent's continued treatment of Patient D was excessive.

The Hearing Committee is convinced that the Respondent provided the excessive number of treatments and/or caused the excessive number of follow-up visits in this case in a deliberate attempt to enhance or exaggerate the nature and extent of the patient's injuries in order to submit additional billings for his own enrichment.

The Hearing Committee concludes that the Respondent, knowingly and with an intent to mislead, submitted false bills for services which were not rendered.

FINDINGS AS TO PATIENT E

56. A ceiling collapsed on Patient E on July 5, 1993, and on that date, she was treated and released from the Emergency Room at Queens Hospital Center.

X-rays of the cervical spine and right shoulder were taken in the emergency room and reported as normal with no evidence of fracture or dislocation (Pet's. Ex. 8A).

57. Patient E was initially seen by the Respondent at his office on July 8, 1993, and between that date and February 7, 1994, the Respondent billed for 37 physician visits, allegedly to treat the injuries sustained by the patient as a result of the ceiling collapse (Pet's. Exs. 8A, 8B, 8C).

58. On the initial visit, the Respondent failed to obtain and note an adequate history and review of systems. He also failed to perform an adequate physical examination of the patient. On the follow-up visits, he failed to obtain and note any history, and he failed to note any physical examination whatsoever (F/F #s 18, 20, 21, 24, 26; Pet's. Ex. 8B; Tr. 218-219).

59. On each of the 36 follow-up visits, the Respondent failed to write a progress note in the patient's chart; he failed to note the purpose of the visit; and he failed to note what treatment was provided (F/F #s 21, 24, 26; Pet's. Ex. 8B).

60. For the initial visit, the Respondent submitted a false bill for a comprehensive medical examination of the patient which was not performed (F/F #s 18, 19, 24; Pet's. Exs. 8B, 8C).

61. For each of the 36 follow-up visits, the Respondent submitted a false bill for a limited exam and treatment which was not performed (F/F #s 20, 21, 23; Pet's. Exs. 8B, 8C).

62. The Respondent billed for numerous follow-up physician visits which were not medically necessary (F/F #s 22, 23, 26; Pet's. Exs. 8B, 8C).

63. On February 7, 1994, the Respondent prepared a report on Patient E in which he stated, "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the upper back and the right and left shoulder."
The Respondent's treatment of Patient E, with 37 physician visits during the period July 8, 1993 and February 7, 1994, was excessive and not warranted by the condition of the patient (F/F #s 22, 23, 25, 27; Pet's. Exs. 8B, 8C; Tr. 221-225).

64. The Respondent created a record for Patient E which is false and inaccurate and does not reflect the care and treatment rendered (F/F #s 58-63; Pet's. Ex. 8B, 8C; Tr. 219-225).

65. The Respondent failed to maintain a record for Patient E which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered (F/F #s 58-63; Pet's. Ex. 8B).

CONCLUSIONS AS TO PATIENT E

The records indicate that Patient E was seen by the Respondent on 37 occasions during the period July 8, 1993 to February 7, 1994.

There is no documentation in the record to justify the number of follow-up visits. The Respondent did not re-evaluate the patient or make any changes in therapy.

Under the circumstances of this case, the Hearing Committee concludes that the Respondent's continued treatment of Patient E was excessive.

The Hearing Committee is convinced that the Respondent provided the excessive number of treatments and/or caused the excessive number of follow-up visits in this case in a deliberate attempt to enhance or exaggerate the nature and extent of the patient's injuries in order to submit additional billings for his own enrichment.

The Hearing Committee concludes that the Respondent, knowingly and with an intent to mislead, submitted false bills for services which were not rendered.

FINDINGS AS TO PATIENT F

66. Patient F was in a motor vehicle accident on October 9, 1994, and on that date, she was treated and released from the Emergency Room at Queens Hospital Center.
X-rays were taken in the emergency room and reported as normal with no evidence of fractures or dislocations (Pet's. Ex. 9A).

67. Patient F was initially seen by the Respondent at his office on October 10, 1994, and between that date and March 10, 1995, the Respondent billed for 46 physician visits, allegedly to treat the injuries sustained by the patient as a result of the motor vehicle accident (Pet's. Exs. 9A, 9B, 9C).

68. On the initial visit, the Respondent failed to obtain and note an adequate history and review of systems. He also failed to perform an adequate physical examination of the patient.
On the follow-up visits, he failed to obtain and note any history, and he failed to note any physical examination whatsoever (F/F #s 18-21, 24, 26; Pet's. Ex. 9B; Tr. 235-240, 862-864).

69. On each of the 45 follow-up visits, the Respondent failed to write a progress note in the patient's chart; he failed to note the purpose of the visit; and he failed to note what treatment was provided (F/F #s 21, 24, 26; Pet's. Ex. 6).

70. For the initial visit, the Respondent submitted a false bill for a comprehensive medical examination of the patient which was not performed (F/F #s 18, 19, 24; Pet's. Exs. 9B, 9C; Tr. 235-240).

71. For each of the 45 follow-up visits, the Respondent submitted a false bill for a brief visit which was not performed (F/F #s 20, 21, 23; Pet's. Exs. 9B, 9C; Tr. 241-243).

72. The Respondent billed for numerous follow-up physician visits which were not medically necessary (F/F #s 22, 23, 26; Pet's. Exs. 9B, 9C; Tr. 241-244).

73. On March 10, 1995, the Respondent prepared a report on Patient F in which he stated, "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the right shoulder and the lower back."

The Respondent's treatment of Patient F, with 46 physician visits during the period October 10, 1994 to March 10, 1995, was excessive and not warranted by the condition of the patient (F/F #s 22, 23, 25-27; Pet's. Ex. 9B; Tr. 244).

74. The Respondent created a record for Patient F which is false and inaccurate and does not reflect the care and treatment rendered (F/F #s 68-73; Pet's. Ex. 9B, 9C).

75. The Respondent failed to maintain a record for Patient F which accurately reflects the patient's history, examination, diagnosis, tests and treatment rendered (F/F #s 68-73; Pet's. Ex. 9B).

CONCLUSIONS AS TO PATIENT F

The records indicate that Patient F was seen by the Respondent on 46 occasions during the period October 10, 1994 to March 10, 1995.

There is no documentation in the record to justify the number of follow-up visits. The Respondent did not re-evaluate the patient or make any changes in therapy.

Under the circumstances of this case, the Hearing Committee concludes that the Respondent's continued treatment of Patient F was excessive.

The Hearing Committee is convinced that the Respondent provided the excessive number of treatments and/or caused the excessive number of follow-up visits in this case in a deliberate attempt to enhance or exaggerate the nature and extent of the patient's injuries in order to submit additional billings for his own enrichment.

The Hearing Committee concludes that the Respondent, knowingly and with intent to mislead, submitted false bills for service which were not rendered.

FINDINGS AS TO PATIENT G

76. A ceiling collapsed on Patient G on March 27, 1993, and on that date, she was treated and released from the Emergency Room at Kings County Hospital (Pet's. Ex. 10A).

77. Patient G was initially seen by the Respondent at his office on April 6, 1993, and between that date and May 18, 1993, the Respondent billed for 5 physician visits, allegedly to treat the injuries sustained by the patient as a result of ceiling collapse (Pet's. Ex. 10B).

78. On the initial visit, the Respondent failed to obtain and note an adequate history and review of systems. He also failed to perform an adequate physical examination of the patient. On the follow-up visits, he failed to obtain and note any history, and he failed to note any physical examination whatsoever (F/F #s 18-21, 24, 26; Pet's. Ex. 10B; Tr. 263-265).

79. On each of the 4 follow-up visits, the Respondent failed to write a progress note in the patient's chart; he failed to note the purpose of the visit; and he failed to note what treatment was provided (F/F #s 21, 24, 26; Pet's. Ex. 10B).

80. For the initial visit, the Respondent submitted a false bill for a comprehensive medical examination of the patient which was not performed (F/F #s 18, 19, 24; Pet's. Ex. 10B; Tr. 264-265).

81. For each of the 4 follow-up visits, the Respondent submitted a false bill for an intermediate examination which was not performed (F/F #s 20, 21, 23).

82. The Respondent billed for follow-up visits which were not medically necessary (F/F #s 22, 23, 26; Tr. 264-265).

83. On May 31, 1995, the Respondent prepared a report on Patient G in which he stated, "physical therapy in the form of massage, hot packs, ultrasound was applied to the left shoulder and the chest" (Pet's. Ex. 10B).

84. The Respondent noted in his office record that Patient G was not coming to his office as frequently as he wanted, and that he continued to urge her to do so. (Tr. 263-270, 274).

85. The Respondent created a record for Patient G which is false and inaccurate and does not reflect the care and treatment rendered (F/F #s 78-83; Pet's. Ex. 10B).

86. The Respondent failed to maintain a record for Patient G which accurately reflect the patient's history, examination, diagnosis, tests, and treatment rendered (F/F #s 78-83; Pet's. Ex. 10B).

CONCLUSIONS AS TO PATIENT G

The Respondent's records do not accurately and adequately record his care and treatment of Patient G.

The Hearing Committee concludes that the Respondent, knowingly and with intent to mislead, submitted false bills for services which were not rendered.

The Hearing Committee is convinced that the Respondent engaged in an attempt to convince the patient to have additional unnecessary treatments and/or visits so that he could bill for them.

FINDINGS AS TO PATIENT H

87. Patient H was in a motor vehicle accident on October 20, 1993 (Pet's. Ex. 11A).

88. Patient H was initially seen by the Respondent at his office on October 23, 1993, and between that date and April 25, 1994, the Respondent billed for 41 physician visits, allegedly to treat the injuries sustained by the patient as a result of a motor vehicle accident (Pet's. Exs. 11A, 11B).

89. On the initial visit, the Respondent failed to obtain and note an adequate history and review of systems. He also failed to perform an adequate physical examination of the patient. On the follow-up visits, he failed to obtain and note any history, and he failed to note any physical examination whatsoever (F/F #s 18-21, 24, 26; Pet's. Ex. 11A).

90. On each of the 40 follow-up visits, the Respondent failed to write a progress note in the patient's chart; he failed to note the purpose of the visit; and he failed to note what treatment was provided (F/F #s 21, 24, 26; Pet's. Ex. 11).

91. For the initial visit, the Respondent submitted a false bill for an intermediate examination of the patient which was not performed (F/F #s 18, 19, 24; Pet's. Exs. 11A, 11B).

92. For each of the 40 follow-up visits, the Respondent submitted a false bill for a limited exam and treatment which was not performed (F/F #s 20, 21, 23; Pet's. Exs. 11A, 11B).

93. The Respondent billed for numerous follow-up physician visits which were not medically necessary (F/F #s 22, 23, 26; Pet's. Exs. 11A, 11B).

94. The Respondent ordered an MRI of the patient's brain and cervical spine without medical justification (Pet's. Ex. 11A; Tr. 89-91, 289).

95. The Respondent failed to obtain a neurological consult prior to ordering the MRI (Pet's. Ex. 11A; Tr. 113).

96. On March 12, 1994, the Respondent prepared a report on Patient H in which he stated, "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the lower back and the left shoulder."

The Respondent's treatment of Patient H, with 41 physician visits during the period October 23, 1993 to April 25, 1994, was excessive and not warranted by the condition of the patient (F/F #s 22, 23, 25-27; Pet's. Ex. 11A).

97. The Respondent created a record for Patient H which is false and inaccurate and does not reflect the care and treatment rendered (F/F #s 89-96; Pet's. Exs. 11A, 11B).

98. The Respondent failed to maintain a record for Patient H which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered (F/F #s 89-96; Pet's. Ex. 11A).

CONCLUSIONS AS TO PATIENT H

The records indicate that Patient H was seen by the Respondent on 41 occasions during the period October 23, 1993 to April 25, 1993.

There is no documentation in the record to justify the number of follow-up visits. The Respondent did not re-evaluate the patient or make any changes in therapy.

Under the circumstances of this case, the Hearing Committee concludes that the Respondent's continued treatment of Patient H was excessive.

The Hearing Committee is convinced that the Respondent provided the excessive number of treatments and/or caused the excessive number of follow-up visits in this case in a deliberate attempt to enhance or exaggerate the nature and extent of the patient's injuries in order to submit additional billings for his own enrichment.

The Hearing Committee concludes that the Respondent, knowingly and with intent to mislead, submitted false bills for services which were not rendered.

FINDINGS AS TO PATIENT I

99. Patient I was in a motor vehicle accident on March 31, 1995, and according to the Respondent's record, the patient was treated and released from the Emergency Room at Brooklyn Hospital on that date.

X-rays were taken in the emergency room and reported as negative (Pet's. Ex. 12A).

100. Patient I was initially seen by the Respondent at his office on April 5, 1995, and between that date and July 12, 1995, the Respondent billed for 29 physician visits, allegedly to treat the injuries sustained by the patient as a result of the motor vehicle accident (Pet's. Exs. 12A, 12B).

101. On the initial visit, the Respondent failed to obtain and note an adequate history and review of systems. He also failed to perform an adequate physical examination of the patient. On the follow-up visits, he failed to obtain and note any history, and he failed to note any physical examination whatsoever (F/F #s 18-21, 24, 26; Pet's. Ex. 12A).

102. On each of the 28 follow-up visits, the Respondent failed to write a progress note in the patient's chart; he failed to note the purpose of the visit; and he failed to note what treatment was provided (F/F #s 21, 24, 26).

103. For the initial visit, the Respondent submitted a false bill for a high level intermediate examination of the patient which was not performed (F/F #s 18, 19, 24; Pet's. Exs. 12A, 12B).

104. For each of the 28 follow-up visits, the Respondent submitted a false bill for a limited exam and treatment which was not performed (F/F #s 20, 21, 23; Pet's. Exs. 12A, 12B).

105. The Respondent billed for numerous follow-up physician visits which were not medically necessary (F/F #s 22, 23, 26; Pet's. Exs. 12A, 12B).

106. On the last visit of July 12, 1995, the Respondent falsely billed for a comprehensive examination "reevaluation" narrative report which was not performed (Pet's. Exs. 12A, 12B).

107. On July 12, 1995, the Respondent prepared a report on Patient I in which he stated, "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the left shoulder and the lower back."

The Respondent's treatment of Patient I, with 29 physician visits during the period April 5, 1995 to July 12, 1995, was excessive and not warranted by the condition of the patient (F/F #s 22, 23, 25-27; Pet's. Exs. 12A, 12B).

108. The Respondent created a record for Patient I which is false and inaccurate and does not reflect the care and treatment rendered (F/F #s 101-107; Pet's. Exs. 12A, 12B).

109. The Respondent failed to maintain a record for Patient I which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered (F/F #s 101-107; Pet's. Exs. 12A).

CONCLUSIONS AS TO PATIENT I

The records indicate that Patient I was seen by the Respondent on 29 occasions during the period April 5, 1995 to July 12, 1995.

There is no documentation in the record to justify the number of follow-up visits. The Respondent did not re-evaluate the patient or make any changes in therapy.

Under the circumstances of this case, the Hearing Committee concludes that the Respondent's continued treatment of Patient I was excessive.

The Hearing Committee is convinced that the Respondent provided the excessive number of treatments and/or caused the excessive number of follow-up visits in this case in a deliberate attempt to enhance or exaggerate the nature and extent of the patient's injuries in order to submit additional billings for his own enrichment.

The Hearing Committee concludes that the Respondent, knowingly and with intent to mislead, submitted false bills for services which were not rendered.

FINDINGS AS TO PATIENT J

110. Patient J was in a motor vehicle accident on March 6, 1993, and on that date, she was treated and released from the Emergency Room at Queens Hospital Center.
X-rays of the chest and right ribs, right tibia/fibula, and cervical spine were negative for fracture (Pet's. Ex. 13A).

111. Patient J was initially seen by the Respondent at his office on March 11, 1993, and between that date and August 25, 1993, the Respondent billed for 34 physician visits, allegedly to treat the injuries sustained by the patient as a result of the motor vehicle accident (Pet's. Exs. 13A, 13B).

112. On the initial visit, the Respondent failed to obtain and note an adequate history and review of systems. He also failed to perform an adequate physical examination of the patient.
On the follow-up visits, he failed to obtain and note any history, and he failed to note any physical examination whatsoever (F/F #s 18-21, 24, 27; Pet's. Ex. 13B).

113. On each of the 33 follow-up visits, the Respondent failed to write a progress note in the patient's chart; he failed to note the purpose of the visit; and he failed to note what treatment was provided (F/F #s 21-24, 26; Pet's. Ex. 13B).

114. For the initial visit, the Respondent submitted a false bill for a comprehensive medical examination of the patient which was not performed (F/F #s 18, 19, 24; Pet's. Exs. 13B, 13C).

115. For each of the 33 follow-up visits, the Respondent submitted a false bill for a limited exam and treatment which was not performed (Pet's. Exs. 13B, 13C).

116. The Respondent billed for numerous follow-up physician visits which were not medically necessary (F/F #s 22, 23, 26; Pet's. Exs. 13B, 13C).

117. On August 27, 1993, the Respondent prepared a report on Patient J in which he stated, "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the chest and the lower back."

The Respondent's treatment of Patient J, with 34 physician visits during the period March 11, 1993 to August 25, 1993, was excessive and not warranted by the condition of the patient (F/F #s 22, 23, 25, 27; Pet's. Ex. 13B).

118. The Respondent created a record for Patient J which is false and inaccurate and does not reflect the care and treatment rendered (F/F #s 112-117; Pet's. Ex. 13B).

119. The Respondent failed to maintain a record for Patient J which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered (F/F #s 112-117; Pet's. Ex. 13B).

CONCLUSIONS AS TO PATIENT J

The records indicate that Patient J was seen by the Respondent on 34 occasions during the period March 11, 1993 to August 25, 1993.

There is no documentation in the record to justify the number of follow-up visits. The Respondent did not re-evaluate the patient or make any changes in therapy.

Under the circumstances of this case, the Hearing Committee concludes that the Respondent's continued treatment of Patient J was excessive.

The Hearing Committee is convinced that the Respondent provided the excessive number of treatments and/or caused the excessive number of follow-up visits in this case in a deliberate attempt to enhance or exaggerate the nature and extent of the patient's injuries in order to submit additional billings for his own enrichment.

The Hearing Committee concludes that the Respondent, knowingly and with intent to mislead, submitted false bills for services which were not rendered.

FINDINGS AS TO PATIENT K

120. Patient K was in a motor vehicle accident on June 18, 1993, and on June 19, 1993, she was treated and released from the Emergency Room at Mary Immaculate Hospital (Pet's. Ex. 14A).

121. Patient K was initially seen by the Respondent at his office on June 21, 1993, and between that date and December 14, 1993, the Respondent billed for 35 physician visits, allegedly to treat the injuries sustained by the patient as a result of the motor vehicle accident (Pet's. Exs. 14B, 14C).

122. On the initial visit, the Respondent failed to obtain and note an adequate history and review of systems. He also failed to perform an adequate physical examination of the patient. On the follow-up visits, he failed to obtain and note any history, and he failed to note any physical examination whatsoever (F/F #s 18-21, 24, 26; Pet's. Ex. 14B).

123. On each of the 34 follow-up visits, the Respondent failed to write a progress note in the patient's chart; he failed to note the purpose of the visit; and he failed to note what treatment was provided (F/F #s 21, 24, 26; Pet's. Ex. 14B)

124. For the initial visit, the Respondent submitted a false bill for a comprehensive medical examination of the patient which was not performed (F/F #s 18, 19, 24; Pet's. Ex. 14B).

125. For each of the 34 follow-up visits, the Respondent submitted a false bill for a limited exam and treatment which was not performed (F/F #s 20, 21, 23; Pet's. Exs. 14B, 14C).

126. The Respondent billed for numerous follow-up physician visits which were not medically necessary (F/F #s 22, 23, 26; Pet's. Exs. 14B, 14C).

127. On December 14, 1993, the Respondent prepared a report on Patient K in which he stated, "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the right shoulder and the upper back."

The Respondent's treatment of Patient K, with 35 physician visits during the period June 21, 1993 to December 14, 1993, was excessive and not warranted by the condition of the patient (F/F #s 22, 23, 25-27; Pet's. Ex. 14B).

128. The Respondent created a record for Patient K which is false and inaccurate and does not reflect the care and treatment rendered (F/F #s 122-127; Pet's. Ex. 14B, 14C).

129. The Respondent failed to maintain a record for Patient K which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered (F/F #s 122-127; Pet's. Ex. 14B).

CONCLUSIONS AS TO PATIENT K

The records indicate that Patient K was seen by the Respondent on 35 occasions during the period June 21, 1993 to December 19, 1993.

There is no documentation in the record to justify the number of follow-up visits. The Respondent did not re-evaluate the patient or make any changes in therapy.

Under the circumstances of this case, the Hearing Committee concludes that the Respondent's continued treatment of Patient K was excessive.

The Hearing Committee is convinced that the Respondent provided the excessive number of treatments and/or caused the excessive number of follow-up visits in this case in a deliberate attempt to enhance or exaggerate the nature and extent of the patient's injuries in order to submit additional billings for his own enrichment.

The Hearing Committee concludes that the Respondent, knowingly and with intent to mislead, submitted false bills for services which were not rendered.

FINDINGS AS TO PATIENT L

130. On April 24, 1992, Patient L jumped to the ground from a second floor fire escape during a building fire, and on that date she was treated and released from the Emergency Room at Long Island College Hospital.

X-rays of the lumbosacral spine were taken in the emergency room and reported no fractures (Pet's. Ex. 15A).

131. Patient L was initially seen by the Respondent at his office on May 1, 1992, and between that date and September 1, 1992, the Respondent billed for 14 physician visits, allegedly to treat the injuries sustained by the patient as a result of her jumping from the second floor to the ground (Pet's. Exs. 15B, 15C).

132. On the initial visit, the Respondent failed to obtain and note an adequate history and review of systems. He also failed to perform an adequate physical examination of the patient. On the follow-up visits, he failed to obtain and note any history, and he failed to note any physical examination whatsoever (F/F #s 18-21, 24, 26; Pet's. Ex. 15B).

133. On each of the 13 follow-up visits, the Respondent failed to write a progress note in the patient's chart; he failed to note the purpose of the visit; and he failed to note what treatment was provided (F/F #s 21, 24, 26; Pet's. Ex. 15B).

134. For the initial visit, the Respondent submitted a false bill for a comprehensive medical examination of the patient which was not performed (F/F #s 18, 19, 24; Pet's. Exs. 15B, 15C).

135. On each of the 13 follow-up visits, the Respondent submitted a false bill for a limited exam and treatment which was not performed (F/F #s 20, 21, 23; Pet's. Exs. 15B, 15C).

136. The Respondent billed for numerous follow-up physician visits which were not medically necessary (F/F #s 22, 23, 26; Pet's. Exs. 15B, 15C).

137. On April 29, 1992, the Respondent prepared a report on Patient L in which he stated, "physical therapy in the form of massage, hot packs, ultrasound was applied to the lower back, the left thigh and the left ankle."
The Respondent's treatment of Patient L, with 14 physician visits during the period May 1, 1992 to September 1, 1992, was excessive and not warranted by the condition of the patient (F/F #s 22, 23, 25-27; Pet's. Exs. 15B, 15C).

138. The Respondent created a record for Patient L which is false and inaccurate and does not reflect the care and treatment rendered (F/F #s 132-137; Pet's. Ex. 15B, 15C).

139. The Respondent failed to maintain a record for Patient L which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered (F/F #s 132-137; Pet's. Ex. 15B).

CONCLUSIONS AS TO PATIENT L

The records indicate that Patient L was seen by the Respondent on 14 occasions during the period May 1, 1992 to September 1, 1992.

There is no documentation in the record to justify the number of follow-up visits. The Respondent did not re-evaluate the patient or make any changes in therapy.

Under the circumstances of this case, the Hearing Committee concludes that the Respondent's continued treatment of Patient L was excessive.

The Hearing Committee is convinced that the Respondent provided the excessive number of treatments and/or caused the excessive number of follow-up visits in this case in a deliberate attempt to enhance or exaggerate the nature and extent of the patient's injuries in order to submit additional billings for his own enrichment.

The Hearing Committee concludes that the Respondent, knowingly and with intent to mislead, submitted false bills for services which were not rendered.

FINDINGS AS TO PATIENT M

140. Patient M was in a motor vehicle accident on September 16, 1993, and on that date, he was treated and released from the Emergency Room at Queens Hospital Center (Pet's. Ex. 16A).

141. Patient M was initially seen by the Respondent at his office on September 17, 1993, and between that date and February 22, 1994, the Respondent billed for 32 physician visits, allegedly to treat the injuries sustained by the patient as a result of the motor vehicle accident (Pet's. Exs. 16B, 16C).

142. On the initial visit, the Respondent failed to obtain and note an adequate history and review of systems. He also failed to perform an adequate physical examination of the patient. On the follow-up visits, he failed to obtain and note any history, and he failed to note any physical examination whatsoever (F/F #s 18-21, 24, 26; Pet's. Ex. 16B).

143. On each of the 31 follow-up visits, the Respondent failed to write a progress note in the patient's chart; he failed to note the purpose of the visit; and he failed to note what treatment was provided (F/F #s 21, 24, 26; Pet's. Ex. 16B).

144. For the initial visit, the Respondent submitted a false bill for a comprehensive medical examination of the patient which was not performed (F/F #s 18, 19, 24; Pet's. Exs. 16B, 16C).

145. For each of the 31 follow-up visits, the Respondent submitted a false bill for a brief visit which was not performed (F/F #s 20, 21, 23; Pet's. Exs. 16B, 16C).

146. The Respondent billed for numerous follow-up physician visits which were not medically necessary (F/F #s 22 23, 26; Pet's. Exs. 16B, 16C).

147. On February 22, 1994, the Respondent prepared a report on Patient M in which he stated, "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck." The Respondent's treatment of Patient M, with 32 physician visits during the period September 17, 1993 to February 22, 1994, was excessive and not warranted by the condition of the patient (F/F #s 22, 23, 25-27; Pet's. Ex. 16B).

148. The Respondent created a record for Patient M which is false and inaccurate and does not reflect the care and treatment rendered (F/F #s 142-147; Pet's. Exs. 16B, 16C).

149. The Respondent failed to maintain a record for Patient M which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered (F/F #s 142-147; Pet's. Ex. 16B).

CONCLUSIONS AS TO PATIENT M

The records indicate that Patient M was seen by the Respondent on 32 occasions during the period September 17, 1993 to February 22, 1994.

There is no documentation in the record to justify the number of follow-up visits. The Respondent did not re-evaluate the patient or make any changes in therapy.

Under the circumstances of this case, the Hearing Committee concludes that the Respondent's continued treatment of Patient M was excessive.

The Hearing Committee is convinced that the Respondent provided the excessive number of treatments and/or caused the excessive number of follow-up visits in this case in a deliberate attempt to enhance or exaggerate the nature and extent of the patient's injuries in order to submit additional billings for his own enrichment.

The Hearing Committee concludes that the Respondent, knowingly and with intent to mislead, submitted false bills for services which were not rendered.

FINDINGS ON THE ISSUE OF THE RESPONDENT'S CRIMINAL CONVICTION

150. On September 14, 1992, the Respondent was convicted of one count of having violated New York Tax Law Section 1801(a), in that, with intent to evade payment of any tax imposed, he failed to file his income tax return on or before the required date (Pet's. Ex. 3).

CONCLUSIONS ON THE ISSUE OF THE RESPONDENT'S CRIMINAL CONVICTION

In mitigation of this charge the Respondent offered excuses of ill health and personal problems for his failure to file New York State income tax returns for 1988, 1989 and 1990. He gave a bout of lichen planus (skin rash) which developed in 1989, and an unrelated brief hospitalization in 1990, as excuses for his failures to file his State Income tax returns.

The Committee finds that these instances of personal difficulty do not excuse the Respondent's failure to file his New York State income tax return.

The Hearing Committee concludes that the Respondent wilfully failed to file New York State income tax returns.

FINDINGS ON THE ISSUE OF THE RESPONDENT'S WILFUL FAILURE TO REGISTER

151. During the period December 31, 1994 through April 17, 1996, and while he continued in the active practice of medicine in the State of New York, the Respondent failed to register for the practice of medicine with the State Education Department (Pet's. Exs. 2A, 2B, 2C).

152. At the time of his pleas and conviction, on September 14, 1992, (F/F # 150), the Respondent was informed by his attorney that he would have to report the conviction when he re-registered. The Respondent was obligated to register before the expiration date of December 31, 1994 but he did not register until April 17, 1996.

Between December 31, 1994 and April 17, 1996, the Respondent had two interviews with OPMC where the issue of his failure to register was presented to him. He told an OPMC investigator and Medical Coordinator, Robert Shimm, M.D., that he had submitted papers for registration when in fact he had not done so (Pet's. Exs. 2A, 2B, 2C); Tr. 420, 580-593, 650-652, 662-664, 678-683, 687-688).

CONCLUSIONS ON THE ISSUE OF THE RESPONDENT'S WILFUL FAILURE TO REGISTER

The Hearing Committee determines that the Respondent's excuses for failing to register, i.e. skipped his mind; he needed to take a trip to Florida; he had to take the infection control course prior to registering, are unacceptable.

The Hearing Committee concludes that the Respondent willfully failed to register and continued to practice medicine during the period, December 31, 1994 to April 17, 1996.

VOTE OF THE HEARING COMMITTEE

(ALL VOTES WERE UNANIMOUS UNLESS OTHERWISE SPECIFIED)

FIRST SPECIFICATION: NEGLIGENCE ON MORE THAN ONE OCCASION

SUSTAINED as to all of the charges specified in the Statement of Charges, except for those charges specified in Paragraphs A(1)(b), A(1)(c), A(1)(d).

SECOND SPECIFICATION: INCOMPETENCE ON MORE THAN ONE OCCASION

SUSTAINED as to those charges specified in Paragraphs A(2)(a), A(2)(b), A(2)(c), A(2)(d), A(2)(e), A(2)(f), A(2)(g) A(2)(h) of the Statement of Charges.

NOT SUSTAINED as to all of the other charges alleging incompetence.

THIRD THROUGH FIFTEENTH SPECIFICATIONS: GROSS NEGLIGENCE

SUSTAINED as to those charges specified in Paragraphs A(2)(a), A(2)(b), A(2)(c), A(2)(d), A(2)(e), A(2)(f), A(2)(g) A(2)(h) of the Statement of Charges.

NOT SUSTAINED as to all of the other charges alleging gross negligence.

SIXTEENTH THROUGH TWENTY-EIGHTH SPECIFICATIONS:

GROSS INCOMPETENCE

SUSTAINED as to those charges specified in Paragraphs A(2)(a), A(2)(b), A(2)(c), A(2)(d), A(2)(e), A(2)(f), A(2)(g) A(2)(h) of the Statement of Charges.

NOT SUSTAINED as to all of the other charges alleging gross incompetence.

TWENTY-NINTH THROUGH FORTY-FIRST SPECIFICATIONS:

FRAUDULENT PRACTICE

SUSTAINED as to all of the charges alleging fraudulent practice.

FORTY-SECOND THROUGH FIFTY-THIRD SPECIFICATIONS:

EXCESSIVE TREATMENT

SUSTAINED as to all of the charges alleging excessive treatment.

FIFTY-FOURTH THROUGH SIXTY-SIXTH SPECIFICATIONS:

FAILURE TO MAINTAIN A RECORD

SUSTAINED as to all of the charges alleging failure to maintain a record.

SIXTY-SEVENTH SPECIFICATION: WILLFUL FAILURE TO REGISTER

SUSTAINED as to the charge specified in Paragraph N of the Statement of Charges.

SIXTY-EIGHTH SPECIFICATION: CRIMINAL CONVICTION (N.Y.S.)

SUSTAINED as to the charge specified in Paragraph O of the Statement of Charges.

DETERMINATION OF THE HEARING COMMITTEE

After a review of the entire record in this case, the Hearing Committee has voted unanimously (3-0) to sustain:

96 Charges of Negligence on More Than One Occasion

8 Charges of Incompetence on More Than One Occasion

8 Charges of Gross Negligence

8 Charges of Gross Incompetence

96 Charges of Fraudulent Practice

25 Charges of Excessive Treatment

64 Charges of Failing to Maintain a Record

1 Charge of Willful Failure to Register

1 Charge of Criminal Conviction

The Hearing Committee determines unanimously (3-0) that the only appropriate penalty in this case is REVOCATION.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondent's license to practice medicine in New York State is hereby **REVOKED.**

2. This Order shall be effective upon service on the Respondent or the respondent's attorney by personal service or certified or registered mail.

DATED: Malone, New York
3-17 1998

IRVING S. CAPLAN
Chairman

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

IN THE MATTER OF ROBERT DELBEAU, M.D.	STATEMENT OF CHARGES

ROBERT DELBEAU, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 20, 1966, by the issuance of license number 097458 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Between on or about July 3, 1992 and on or about July 20, 1992, Respondent undertook the care and treatment of Patient A at his office located at 175-61 Hillside Avenue, Jamaica, N.Y. 11432 (hereinafter referred to as "Respondent's offices"). (The identity's of Patients A through M are listed in the Appendix annexed hereto).

1. On or about the first visit of July 3, 1992, Patient A presented at Respondent's office with complaints of, inter alia, fatigue, difficulty breathing, bruising without significant trauma, and heart palpitations. On physical examination, Respondent noted hepatosplenomegaly. Respondent failed:

   a. To perform and note a complete and adequate physical examination, including failing to do a rectal examination,

b. To perform, and/or arrange for, an adequate and immediate work-up and diagnostic evaluation of the patient, including immediate laboratory blood tests,

c. To hospitalize the patient,

d. To arrange for immediate consultation with an hematologist.

A(1)(2) TO OBTAIN AND NOTE A COMPLETE AND ADEQUATE HISTORY

2. On or about July 7, 1992, Respondent received a report of laboratory results on blood which was drawn from Patient A on or about July 6, 1992. The laboratory report included results of: WBC 1.7, Hgb 2.9, Hct 8.7, RBI .96, platelet count 13, iron 496, and iron binding capacity 819. Respondent noted his interpretations of these results as: chronic severe anemia, leukopenia, granulocytopenia, and thrombocytopenia. Respondent prescribed ferrous sulfate. At this time, Respondent failed to medically act and respond appropriately to the laboratory and clinical findings in that he:

a. Failed to hospitalize Patient A,

b. Failed to arrange for any diagnostic evaluation and/or treatment,

c. Failed to arrive at a medically justified diagnosis and/or plan of treatment,

d. Inappropriately and without medical justification prescribed ferrous sulfate,

e. Failed to appreciate and/or demonstrate knowledge of the significance of the abnormal laboratory test results and clinical findings so as to act appropriately,

f. Failed to appreciate and/or recognize the risks to Patient A of the profound neutropenia that was present,

g. Inappropriately and without medical justification concluded that Patient A suffered from a chronic neutropenia and/or thrombocytopenia,

h. Failed, in any medically justifiable way, to follow-up on the patient's clinical presentation and abnormal laboratory test results.

3. Respondent's office record for Patient A includes entries for July 3, 1992, July 7, 1992, July 17, 1992, July 18, 1992, July 20, 1992, and July 19, 1992. Respondent willfully misrepresented to the Department of Health that he had written his office record for Patient A contemporaneously with the events he purports to have

occurred and which he recorded therein.

4. Respondent created a record for Patient A which is false and inaccurate and does not legitimately reflect the care and treatment rendered by Respondent to Patient A.

5. Respondent failed to maintain a record for Patient A which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

B. Patient B reportedly had been in a motor vehicle accident on or about October 31, 1993 and, on that date, was treated and released from the Emergency Room at Jamaica Hospital. The emergency record reports a diagnosis of contusion of the right leg, x-rays of which indicated no evidence of fracture or dislocation. Between on or about November 3, 1993 and March 17, 1994, Respondent undertook the care and treatment of Patient B at Respondent's office. During this period of time, Respondent saw Patient B at his office on or about 35 occasions, allegedly to treat injuries sustained by the patient in the aforementioned motor vehicle accident.

1. On the initial visit of on or about November 3, 1993, Respondent failed to obtain and/or note an adequate history and review of systems; and on each subsequent visit thereafter, Respondent failed to obtain and/or note any history.

2. On the initial visit of on or about November 3, 1993, Respondent failed to perform and/or note an adequate physical examination of

the patient, and on each subsequent visit thereafter, Respondent failed to perform and/or note any physical examination.

3. On each of the approximate 34 subsequent visits after the initial visit of on or about November 3, 1993, Respondent failed to write a progress note in his chart, failed to note the purpose of the visit and what treatment, if any, was provided.

4. On or about November 3, 1993, Respondent knowingly falsely billed for a comprehensive medical examination of the patient (code 90020) which was never performed.

5. On each of the approximate 34 subsequent visits after the initial visit of on or about November 3, 1993, Respondent knowingly falsely billed for limited exam ~~and~~ AND/OR treatment (code 90050) which was never performed and which, even if performed, was not medically necessary.

6. On or about April 6, 1994, and following his last billed for visit by Patient B of March 17, 1994, Respondent prepared a report in which Respondent stated that "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the lower back and the right knee." Respondent's treatment of the patient in this regard, at frequent intervals over the period of time referred to in paragraph B, supra, was excessive and not warranted by the condition of the patient.

a. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to bill for said treatment and/or visits.

b. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to enhance the nature of Patient B's injuries resulting from the motor vehicle accident Patient B was involved in.

7. Respondent created a record for Patient B which is false and inaccurate and does not legitimately reflect the care and treatment rendered by Respondent to Patient B.

8. Respondent failed to maintain a record for Patient B which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

C. Patient C reportedly had been in a motor vehicle accident on or about May 1, 1993 and, on that date, was treated and released from the Emergency Room at Franklin Hospital Medical Center. X-rays of the lumbosacral and thoracic spine were taken in the emergency room and reported as normal with no evidence of fracture or dislocation. Between on or about May 12, 1993 and August 20, 1993, Respondent undertook the care and treatment of Patient C at Respondent's office. During this period of time, Respondent saw Patient C

at his office on or about 37 occasions, allegedly to treat injuries sustained by the patient in the aforementioned motor vehicle accident.

1. On the initial visit of on or about May 12, 1993, Respondent failed to obtain and/or note an adequate history and review of systems; and on each subsequent visit thereafter, Respondent failed to obtain and/or note any history.

2. On the initial visit of on or about May 12, 1993, Respondent failed to perform and/or note an adequate physical examination of the patient, and on each subsequent visit thereafter, Respondent failed to perform and/or note any physical examination.

3. On each of the approximate 36 subsequent visits after the initial visit of on or about May 12, 1993, Respondent failed to write a progress note in his chart, failed to note the purpose of the visit and what treatment, if any, was provided.

4. On or about May 12, 1993, Respondent knowingly falsely billed for a comprehensive medical examination of the patient (code 90020) which was never performed.

5. On each of the approximate 36 subsequent visits after the initial visit of on or about May 12, 1993, Respondent knowingly falsely billed for limited exam ~~and~~ AND/OR treatment (code 90050) which was never performed and which, even if performed, was not medically necessary.

6. On or about September 20, 1993, and following his last billed for visit by Patient C of August 20, 1993, Respondent prepared a report in which Respondent stated that "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the lower back and the right flank." Respondent's treatment of the patient in this regard, at frequent intervals over the period of time referred to in paragraph C, supra, was excessive and not warranted by the condition of the patient.

   a. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to bill for said treatment and/or visits.

   b. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to enhance the nature of Patient C's injuries resulting from the motor vehicle accident Patient C was involved in.

7. Respondent created a record for Patient C which is false and inaccurate and does not legitimately reflect the care and treatment rendered by Respondent to Patient C.

8. Respondent failed to maintain a record for Patient C which accurately reflects the patient's history, examination, diagnosis,

tests, and treatment rendered.

D. Patient D reportedly had a ceiling collapse above him on or March 1, 1995. He was treated and released from the Emergency Room at Mary Immaculate Hospital on or about March 3, 1995. X-rays were taken in the emergency room and reported as indicating no evidence of fractures or dislocations. Between on or about March 3, 1995 and September 1, 1995, Respondent undertook the care and treatment of Patient D at Respondent's office. During this period of time, Respondent saw Patient D at his office on or about 35 occasions, allegedly to treat injuries sustained by the patient in the aforementioned accident.

1. On the initial visit of on or about March 3, 1995, Respondent failed to obtain and/or note an adequate history and review of systems; and on each subsequent visit thereafter, Respondent failed to obtain and/or note any history.

2. On the initial visit of on or about March 3, 1995, Respondent failed to perform and/or note an adequate physical examination of the patient, and on each subsequent visit thereafter, Respondent failed to perform and/or note any physical examination.

3. On each of the approximate 36 subsequent visits after the initial visit of on or about March 3, 1995, Respondent failed to write a progress note in his chart, failed to note the purpose of the visit and what treatment, if any, was provided.

4. On or about March 3, 1995, Respondent knowingly falsely billed for a comprehensive medical examination of the patient (code 90020) which was never performed.

5. On each of the approximate 36 subsequent visits after the initial visit of on or about March 3, 1995, Respondent knowingly falsely billed for limited exam ~~and~~ AND/OR treatment (code 90050) which was never performed and which, even if performed, was not medically necessary.

6. On or about September 1, 1995, the date of the last billed for visit by Patient D, Respondent prepared a report in which Respondent summarized his alleged care and treatment of the patient. Respondent's treatment of the patient, at frequent intervals over the period of time referred to in paragraph D, supra, was excessive and not warranted by the condition of the patient.

   a. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to bill for said treatment and/or visits.

   b. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to enhance the nature of Patient D's injuries resulting from the accident Patient D was involved in.

7. Respondent created a record for Patient D which is false and inaccurate and does not legitimately reflect the care and treatment rendered by Respondent to Patient D.

8. Respondent failed to maintain a record for Patient D which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

E. Patient E reportedly had a ceiling collapse above her on or about July 5, 1993, and, on that date, was treated and released from the Emergency Room at Queens Hospital Center. X-rays of the cervical spine and right shoulder were taken in the emergency room and reported as normal with no evidence of fracture or dislocation. Between on or about July 8,1993 and February 7, 1994, Respondent undertook the care and treatment of Patient E at Respondent's office. During this period of time, Respondent saw Patient E at his office on or about 37 occasions, allegedly to treat injuries sustained by the patient in the aforementioned accident.

1. On the initial visit of on or about July 8, 1993, Respondent failed to obtain and/or note an adequate history and review of systems; and on each subsequent visit thereafter, Respondent failed to obtain and/or note any history.

2. On the initial visit of on or about July 8, 1993, Respondent failed to perform and/or note an adequate physical examination of the patient, and on each subsequent visit thereafter, Respondent

failed to perform and/or note any physical examination.

3. On each of the approximate 36 subsequent visits after the initial visit of on or about July 8, 1993, Respondent failed to write a progress note in his chart, failed to note the purpose of the visit and what treatment, if any, was provided.

4. On or about July 8, 1993, Respondent knowingly falsely billed for a comprehensive medical examination of the patient (code 90020) which was never performed.

5. On each of the approximate 36 subsequent visits after the initial visit of on or about July 8, 1993, Respondent knowingly falsely billed for limited exam ~~and~~ AND/OR treatment (code 90050) which was never performed and which, even if performed, was not medically necessary.

6. On or about February 7, 1994, the date of his last billed for visit by Patient E, Respondent prepared a report in which Respondent stated that "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the upper back and the right and left shoulder." Respondent's treatment of the patient in this regard, at frequent intervals over the period of time referred to in paragraph E, supra, was excessive and not warranted by the condition of the patient.

a. Respondent knowingly provided said excessive

treatment and/or caused said frequent and excessive number of visits so as to bill for said treatment and/or visits.

b. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to enhance the nature of Patient E's injuries resulting from the accident Patient E was involved in.

7. Respondent created a record for Patient E which is false and inaccurate and does not legitimately reflect the care and treatment rendered by Respondent to Patient E.

8. Respondent failed to maintain a record for Patient E which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

F. Patient F reportedly had been in a motor vehicle accident on or about October 9, 1994 and, on that date, was treated and released from the Emergency Room at Queens Hospital Center. X-rays were taken in the emergency room and reported as normal with no evidence of fractures or dislocations. Between on or about October 10, 1994 and March 10, 1995, Respondent undertook the care and treatment of Patient F at Respondent's office. During this period of time, Respondent saw Patient F at his office on or about 46 occasions, allegedly to treat injuries sustained by the patient in the aforementioned motor vehicle accident.

1. On the initial visit of on or about October 10 1994, Respondent failed to obtain and/or note an adequate history and review of systems; and on each subsequent visit thereafter, Respondent failed to obtain and/or note any history.

2. On the initial visit of on or about October 10, 1994, Respondent failed to perform and/or note an adequate physical examination of the patient, and on each subsequent visit thereafter, Respondent failed to perform and/or note any physical examination.

3. On each of the approximate 45 subsequent visits after the initial visit of on or about October 10, 1994, Respondent failed to write a progress note in his chart, failed to note the purpose of the visit and what treatment, if any, was provided.

4. On or about October 10, 1994, Respondent knowingly falsely billed for a comprehensive medical examination of the patient (code 90020) which was never performed.

5. On each of the approximate 45 subsequent visits after the initial visit of on or about October 10, 1994, Respondent knowingly falsely billed for a brief visit (code 90040) which was never performed and which, even if performed, was not medically necessary.

6. On or about March 10, 1995, the date of his last billed for visit by

Patient F, Respondent prepared a report in which Respondent stated that "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the right shoulder and the lower back." Respondent's treatment of the patient in this regard, at frequent intervals over the period of time referred to in paragraph F, supra, was excessive and not warranted by the condition of the patient.

a. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to bill for said treatment and/or visits.

b. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to enhance the nature of Patient F's injuries resulting from the motor vehicle accident Patient F was involved in.

7. Respondent created a record for Patient F which is false and inaccurate and does not legitimately reflect the care and treatment rendered by Respondent to Patient F.

8. Respondent failed to maintain a record for Patient F which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

G. Patient G reportedly had a ceiling collapse above her on or about March 27, 1993, and, on that date, was treated and released from the Emergency Room at Kings County Hospital. Between on or about April 6, 1993 and May 18, 1993, Respondent undertook the care and treatment of Patient G at Respondent's office. During this period of time, Respondent saw Patient G at his office on or about 5 occasions, allegedly to treat injuries sustained by the patient in the aforementioned accident.

1. On the initial visit of on or about April 6, 1993, Respondent failed to obtain and/or note an adequate history and review of systems; and on each subsequent visit thereafter, Respondent failed to obtain and/or note any history.

2. On the initial visit of on or about April 6, 1993, Respondent failed to perform and/or note an adequate physical examination of the patient, and on each subsequent visit thereafter, Respondent failed to perform and/or note any physical examination.

3. On each of the approximate 4 subsequent visits after the initial visit of on or about April 6, 1993, Respondent failed to write a progress note in his chart, failed to note the purpose of the visit and what treatment, if any, was provided.

4. On or about April 6, 1993, Respondent knowingly falsely billed for a comprehensive medical examination of the patient (code 90020) which was never performed.

5. On each of the approximate 4 subsequent visits after the initial visit of on or about April 6, 1993, Respondent knowingly falsely billed for intermediate examination (code 90050) which was never performed and which, even if performed, was not medically necessary.

6. On or about May 31, 1995, and following his last billed for visit by Patient G of May 18, 1993, Respondent prepared a report in which Respondent stated that "physical therapy in the form of massage, hot packs, ultrasound was applied to the left shoulder and the chest." Respondent's treatment of the patient in this regard, at frequent intervals over the period of time referred to in paragraph G, supra, was excessive and not warranted by the condition of the patient.

   a. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to bill for said treatment and/or visits.

   b. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to enhance the nature of Patient G's injuries resulting from the accident Patient G was involved in.

7. Respondent created a record for Patient G which is false and inaccurate and does not legitimately reflect the care and treatment rendered by Respondent to Patient G.

8. Respondent failed to maintain a record for Patient G which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

H. Patient H reportedly had been in a motor vehicle accident on or about October 20, 1993. Between on or about October 23, 1993 and April 25, 1994, Respondent undertook the care and treatment of Patient H at Respondent's office. During this period of time, Respondent saw Patient H at his office on or about 41 occasions, allegedly to treat injuries sustained by the patient in the aforementioned motor vehicle accident.

1. On the initial visit of on or about October 23, 1993, Respondent failed to obtain and/or note an adequate history and review of systems; and on each subsequent visit thereafter, Respondent failed to obtain and/or note any history.

2. On the initial visit of on or about October 23, 1993, Respondent failed to perform and/or note an adequate physical examination of the patient, and on each subsequent visit thereafter, Respondent failed to perform and/or note any physical examination.

3. On each of the approximate 40 subsequent visits after the initial visit of on or about October 23, 1993, Respondent failed to write a

progress note in his chart, failed to note the purpose of the visit and what treatment, if any, was provided.

4. On or about October 23, 1993, Respondent knowingly falsely billed for an intermediate examination of the patient (code 90060) which was never performed.

5. On each of the approximate 40 subsequent visits after the initial visit of on or about October 23, 1993, Respondent knowingly falsely billed for limited exam ~~and~~ AND/OR treatment (code 90050) which was never performed and which, even if performed, was not medically necessary.

6. Respondent ordered an MRI of the patient's brain and cervical spine which was unnecessary and was done without medical justification, in that he failed to perform any neurological evaluation.

7. Respondent failed to obtain a neurological consult prior to ordering an MRI.

8. On or about March 12, 1994, Respondent prepared a report in which Respondent summarized his alleged care and treatment of the patient. Respondent's treatment of the patient at frequent intervals over the period of time referred to in paragraph H, supra, was excessive and not warranted by the condition of the patient.

a. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to bill for said treatment and/or visits.

b. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to enhance the nature of Patient H's injuries resulting from the motor vehicle accident Patient H was involved in.

9. Respondent created a record for Patient H which is false and inaccurate and does not legitimately reflect the care and treatment rendered by Respondent to Patient H.

10. Respondent failed to maintain a record for Patient H which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

I. Patient I reportedly had been in a motor vehicle accident on or about March 31, 1995. According to Respondent's record, the patient was treated and released from the Emergency Room at Brooklyn Hospital on the date of the accident, and x-rays were taken in the emergency room and reported as negative. Between on or about April 5, 1995 and July 12, 1995, Respondent undertook the care and treatment of Patient I at Respondent's office. During this period of time, Respondent saw Patient I at his office on or about 29 occasions, allegedly to treat injuries sustained by the patient in the

aforementioned motor vehicle accident.

1. On the initial visit of on or about April 5, 1995, Respondent failed to obtain and/or note an adequate history and review of systems; and on each subsequent visit thereafter, Respondent failed to obtain and/or note any history.

2. On the initial visit of on or about April 5, 1995, Respondent failed to perform and/or note an adequate physical examination of the patient, and on each subsequent visit thereafter, Respondent failed to perform and/or note any physical examination.

3. On each of the approximate 28 subsequent visits after the initial visit of on or about April 5, 1995, Respondent failed to write a progress note in his chart, failed to note the purpose of the visit and what treatment, if any, was provided.

4. On or about April 5, 1995, Respondent knowingly falsely billed for an intermediate examination of the patient (code 90060) which was never performed.

5. On each of the approximate 28 subsequent visits after the initial visit of on or about April 5, 1995, Respondent knowingly falsely billed for limited exam ~~and~~ AND/OR treatment (code 90050) which was never performed and which, even if performed, was not medically necessary.

6. On or about July 12, 1995, Respondent knowingly falsely billed for a comprehensive examination reevaluation narrative report (code 90020) which was never performed.

7. On or about July 12, 1995, the date of his last billed for visit by Patient I, Respondent prepared a report in which Respondent stated that "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the left shoulder and the lower back." Respondent's treatment of the patient in this regard, at frequent intervals over the period of time referred to in paragraph I, supra, was excessive and not warranted by the condition of the patient.

   a. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to bill for said treatment and/or visits.

   b. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to enhance the nature of Patient I's injuries resulting from the motor vehicle accident Patient I was involved in.

8. Respondent created a record for Patient I which is false and inaccurate and does not legitimately reflect the care and treatment rendered by Respondent to Patient I.

9. Respondent failed to maintain a record for Patient I which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

J. Patient J reportedly had been in a motor vehicle accident on or about March 6, 1993 and, on that date, was treated and released from the Emergency Room at Queens Hospital Center. X-rays of the chest and right ribs, right tibia/fibula, and cervical spine were negative for fracture. Between on or about March 11, 1993 and August 25, 1993, Respondent undertook the care and treatment of Patient J at Respondent's office. During this period of time, Respondent saw Patient J at his office on or about 34 occasions, allegedly to treat injuries sustained by the patient in the aforementioned motor vehicle accident.

1. On the initial visit of on or about March 11, 1993, Respondent failed to obtain and/or note an adequate history and review of systems; and on each subsequent visit thereafter, Respondent failed to obtain and/or note any history.

2. On the initial visit of on or about March 11, 1993, Respondent failed to perform and/or note an adequate physical examination of the patient, and on each subsequent visit thereafter, Respondent failed to perform and/or note any physical examination.

3. On each of the approximate 33 subsequent visits after the initial visit of on or about March 11, 1993, Respondent failed to write a progress note in his chart, failed to note the purpose of the visit

and what treatment, if any, was provided.

4. On or about March 11, 1993, Respondent knowingly falsely billed for a comprehensive medical examination of the patient (code 90020) which was never performed.

5. On each of the approximate 33 subsequent visits after the initial visit of on or about March 11, 1993, Respondent knowingly falsely billed for limited exam ~~and~~ AND/OR treatment (code 90050) which was never performed and which, even if performed, was not medically necessary.

6. On or about August 27, 1993, and following his last billed for visit by Patient J of August 25, 1993, Respondent prepared a report in which Respondent stated that "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the chest and the lower back." Respondent's treatment of the patient in this regard, at frequent intervals over the period of time referred to in paragraph J, supra, was excessive and not warranted by the condition of the patient.

   a. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to bill for said treatment and/or visits.

   b. Respondent knowingly provided said excessive

treatment and/or caused said frequent and excessive number of visits so as to enhance the nature of Patient J's injuries resulting from the motor vehicle accident Patient J was involved in.

7. Respondent created a record for Patient J which is false and inaccurate and does not legitimately reflect the care and treatment rendered by Respondent to Patient J.

8. Respondent failed to maintain a record for Patient J which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

K. Patient K reportedly had been in a motor vehicle accident on or about June 18, 1993 and, on June 19, 1993, was treated and released from the Emergency Room at Mary Immaculate Hospital. Between on or about June 21, 1993 and December 14, 1993, Respondent undertook the care and treatment of Patient K at Respondent's office. During this period of time, Respondent saw Patient K at his office on or about 35 occasions, allegedly to treat injuries sustained by the patient in the aforementioned motor vehicle accident.

1. On the initial visit of on or about June 21, 1993, Respondent failed to obtain and/or note an adequate history and review of systems; and on each subsequent visit thereafter, Respondent failed to obtain and/or note any history.

2. On the initial visit of on or about June 21, 1993, Respondent failed to perform and/or note an adequate physical examination of the patient, and on each subsequent visit thereafter, Respondent failed to perform and/or note any physical examination.

3. On each of the approximate 34 subsequent visits after the initial visit of on or about June 21, 1993, Respondent failed to write a progress note in his chart, failed to note the purpose of the visit and what treatment, if any, was provided.

4. On or about June 21, 1993, Respondent knowingly falsely billed for a comprehensive medical examination of the patient (code 90020) which was never performed.

5. On each of the approximate 34 subsequent visits after the initial visit of on or about June 21, 1993, Respondent knowingly falsely billed for limited exam ~~and~~ AND/OR treatment (code 90050) which was never performed and which, even if performed, was not medically necessary.

6. On or about December 14, 1993, the date of his last billed for visit by Patient K, Respondent prepared a report in which Respondent stated that "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck, the right shoulder and the upper back." Respondent's treatment of the patient in this regard, at frequent intervals over the period of time referred

to in paragraph K, supra, was excessive and not warranted by the condition of the patient.

a. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to bill for said treatment and/or visits.

b. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to enhance the nature of Patient K's injuries resulting from the motor vehicle accident Patient K was involved in.

7. Respondent created a record for Patient K which is false and inaccurate and does not legitimately reflect the care and treatment rendered by Respondent to Patient K.

8. Respondent failed to maintain a record for Patient K which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

L. Patient L reportedly, on or about April 24, 1992, was caused to jump to the ground from a second floor fire escape during a building fire and, on that date, was treated and released from the Emergency Room at Long Island College Hospital. X-rays of the lumbosacral spine were taken in the emergency room and reported no fractures. Between on or about May 1, 1992 and September

1, 1992, Respondent undertook the care and treatment of Patient L at Respondent's office. During this period of time, Respondent saw Patient L at his office on or about 14 occasions, allegedly to treat injuries sustained by the patient in the aforementioned accident.

1. On the initial visit of on or about May 1, 1992, Respondent failed to obtain and/or note an adequate history and review of systems; and on each subsequent visit thereafter, Respondent failed to obtain and/or note any history.

2. On the initial visit of on or about May 1, 1992, Respondent failed to perform and/or note an adequate physical examination of the patient, and on each subsequent visit thereafter, Respondent failed to perform and/or note any physical examination.

3. On each of the approximate 13 subsequent visits after the initial visit of on or about May 1, 1992, Respondent failed to write a progress note in his chart, failed to note the purpose of the visit and what treatment, if any, was provided.

4. On or about May 1, 1992, Respondent knowingly falsely billed for a comprehensive medical examination of the patient (code 90020) which was never performed.

5. On each of the approximate 13 subsequent visits after the initial visit of on or about May 1, 1992, Respondent knowingly falsely billed for limited exam ~~and~~ AND/OR treatment (code 90050) which was

never performed and which, even if performed, was not medically necessary.

6. On or about April 29, 1992, and following his last billed for visit by Patient L of September 1, 1992, Respondent prepared a report in which Respondent stated that "physical therapy in the form of massage, hot packs, ultrasound was applied to the lower back the left thigh and the left ankle." Respondent's treatment of the patient in this regard, at frequent intervals over the period of time referred to in paragraph L, supra, was excessive and not warranted by the condition of the patient.

   a. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to bill for said treatment and/or visits.

   b. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to enhance the nature of Patient L's injuries resulting from the accident Patient L was involved in.

7. Respondent created a record for Patient L which is false and inaccurate and does not legitimately reflect the care and treatment rendered by Respondent to Patient L.

8. Respondent failed to maintain a record for Patient L which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

M. Patient M reportedly had been in a motor vehicle accident on or about September 16, 1993 and, on that date, was treated and released from the Emergency Room at Queens Hospital Center. Between on or about September 17, 1993 and February 22, 1994, Respondent undertook the care and treatment of Patient M at Respondent's office. During this period of time, Respondent saw Patient M at his office on or about 32 occasions, allegedly to treat injuries sustained by the patient in the aforementioned motor vehicle accident.

1. On the initial visit of on or about September 17, 1993, Respondent failed to obtain and/or note an adequate history and review of systems; and on each subsequent visit thereafter, Respondent failed to obtain and/or note any history.

2. On the initial visit of on or about September 17, 1993, Respondent failed to perform and/or note an adequate physical examination of the patient, and on each subsequent visit thereafter, Respondent failed to perform and/or note any physical examination.

3. On each of the approximate 31 subsequent visits after the initial visit of on or about September 17, 1993, Respondent failed to write a progress note in his chart, failed to note the purpose of the

visit and what treatment, if any, was provided.

4. On or about September 17, 1993, Respondent knowingly falsely billed for a comprehensive medical examination of the patient (code 90020) which was never performed.

5. On each of the approximate 31 subsequent visits after the initial visit of on or about September 17, 1993, Respondent knowingly falsely billed for a brief visit (code 90040) which was never performed and which, even if performed, was not medically necessary.

6. On or about February 22, 1994, the date of the last billed for visit by Patient M, Respondent prepared a report in which Respondent stated that "physical therapy in the form of massage, hot packs, ultrasound was applied to the neck." Respondent's treatment of the patient in this regard, at frequent intervals over the period of time referred to in paragraph M, supra, was excessive and not warranted by the condition of the patient.

   a. Respondent knowingly provided said excessive treatment and/or caused said frequent and excessive number of visits so as to bill for said treatment and/or visits.

   b. Respondent knowingly provided said excessive treatment and/or caused said frequent and

excessive number of visits so as to enhance the nature of Patient M's injuries resulting from the motor vehicle accident Patient M was involved in.

7. Respondent created a record for Patient M which is false and inaccurate and does not legitimately reflect the care and treatment rendered by Respondent to Patient M.

8. Respondent failed to maintain a record for Patient M which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

N. During the period from December 31, 1994 through April 17, 1996, and while he remained in the active practice of medicine in the State of New York, Respondent willfully failed to register for the practice of medicine with the New York State Department of Education.

O. On or about September 14, 1992, Respondent was convicted of one count of having violated New York Tax Law Section 1801(a), in that, with intent to evade payment of any tax imposed, he failed to file his income tax return on or before the required date.

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) (McKinney Supp. 1997) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. The facts in paragraphs A, A(1)(a) through A(1)(d), A(2), A(2)(a) through A(2)(h), A(4), A(5), B, B(1), B(2), B(3), B(5), B(6), B(7), B(8), C, C(1), C(2), C(3), C(5), C(6), C(7), C(8), D, D(1), D(2), D(3), D(5), D(6), D(7), D(8), E, E(1), E(2), E(3), E(5), E(6), E(7), E(8), F, F(1), F(2), F(3), F(5), F(6), F(7), F(8), G, G(1), G(2), G(3), G(5), G(6), G(7), G(8), H, H(1), H(2), H(3), H(5), H(6), H(7), H(8), H(9), H(10), I, I(1), I(2), I(3), I(5), I(7), I(8), I(9), J, J(1), J(2), J(3), J(5), J(6), J(7), J(8), K, K(1), K(2), K(3), K(5), K(6), K(7), K(8), L, L(1), L(2), L(3), L(5), L(6), L(7), L(8), M, M(1), M(2), M(3), M(5), M(6), M(7), and M(8).

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) (McKinney Supp. 1997) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. The facts in paragraphs A, A(1)(a) through A(1)(d), A(2), A(2)(a)

through A(2)(h), A(4), A(5), B, B(1), B(2), B(3), B(5), B(6), B(7), B(8), C, C(1), C(2), C(3), C(5), C(6), C(7), C(8), D, D(1), D(2), D(3), D(5), D(6), D(7), D(8), E, E(1), E(2), E(3), E(5), E(6), E(7), E(8), F, F(1), F(2), F(3), F(5), F(6), F(7), F(8), G, G(1), G(2), G(3), G(5), G(6), G(7), G(8), H, H(1), H(2), H(3), H(5), H(6), H(7), H(8), H(9), H(10), I, I(1), I(2), I(3), I(5), I(7), I(8), I(9), J, J(1), J(2), J(3), J(5), J(6), J(7), J(8), K, K(1), K(2), K(3), K(5), K(6), K(7), K(8), L, L(1), L(2), L(3), L(5), L(6), L(7), L(8), M, M(1), M(2), M(3), M(5), M(6), M(7), and M(8).

THIRD THROUGH FIFTEENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1997) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

3. The facts in paragraphs A, A(1)(a) through A(1)(d), A(1)(e), A(2), A(2)(a) through A(2)(h), A(4), A(5).

4. The facts in paragraphs B, B(1), B(2), B(3), B(5), B(6), B(7), B(8).

5. The facts in paragraphs C, C(1), C(2), C(3), C(5), C(6), C(7), C(8).

6. The facts in paragraphs D, D(1), D(2), D(3), D(5), D(6), D(7), D(8).

7. The facts in paragraphs E, E(1), E(2), E(3), E(5), E(6), E(7), E(8).

8. The facts in paragraphs F, F(1), F(2), F(3), F(5), F(6), F(7), F(8).

9. The facts in paragraphs G, G(1), G(2), G(3), G(5), G(6), G(7), G(8).

10. The facts in paragraphs H, H(1), H(2), H(3), H(5), H(6), H(7), H(8), H(9), H(10).

11. The facts in paragraphs I, I(1), I(2), I(3), I(5), I(7), I(8), I(9).

12. The facts in paragraphs J, J(1), J(2), J(3), J(5), J(6), J(7), J(8).

13. The facts in paragraphs K, K(1), K(2), K(3), K(5), K(6), K(7), K(8).

14. The facts in paragraphs L, L(1), L(2), L(3), L(5), L(6), L(7), L(8).

15. The facts in paragraphs M, M(1), M(2), M(3), M(5), M(6), M(7), and M(8).

SIXTEENTH THROUGH TWENTY-EIGHTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6) (McKinney Supp. 1997) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

16. The facts in paragraphs A, A(1)(a) through A(1)(d), A(1)(e), A(2), A(2)(a) through A(2)(h), A(4), and A(5).

17. The facts in paragraphs B, B(1), B(2), B(3), B(5), B(6), B(7), and B(8).

18. The facts in paragraphs C, C(1), C(2), C(3), C(5), C(6), C(7), and C(8).

19. The facts in paragraphs D, D(1), D(2), D(3), D(5), D(6), D(7), and D(8).

20. The facts in paragraphs E, E(1), E(2), E(3), E(5), E(6), E(7), and E(8).

21. The facts in paragraphs F, F(1), F(2), F(3), F(5), F(6), F(7), and F(8).

22. The facts in paragraphs G, G(1), G(2), G(3), G(5), G(6), G(7), and G(8).

23. The facts in paragraphs H, H(1), H(2), H(3), H(5), H(6), H(7), H(8), H(9), and H(10).

24. The facts in paragraphs I, I(1), I(2), I(3), I(5), I(7), I(8), and I(9).

25. The facts in paragraphs J, J(1), J(2), J(3), J(5), J(6), J(7), and

J(8).

26. The facts in paragraphs K, K(1), K(2), K(3), K(5), K(6), K(7), and K(8).

27. The facts in paragraphs L, L(1), L(2), L(3), L(5), L(6), L(7), and L(8).

28. The facts in paragraphs M, M(1), M(2), M(3), M(5), M(6), M(7), and M(8).

TWENTY-NINTH THROUGH FORTY-FIRST SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) (McKinney Supp. 1997) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

29. The facts in paragraphs A(3), A(4), and A(5).

30. The facts in paragraphs B, B(4), B(5), B(6), B(6)(a), B(6)(b), B(7), and B(8).

31. The facts in paragraphs C, C(4), C(5), C(6), C(6)(a), C(6)(b), C(7) and C(8).

32. The facts in paragraphs D, D(4), D(5), D(6), D(6)(a), D(6)(b), D(7), and D(8).

33. The facts in paragraphs E, E(4), E(5), E(6), E(6)(a), E(6)(b), E(7), and E(8).

34. The facts in paragraphs F, F(4), F(5), F(6), F(6)(a), F(6)(b), F(7), and F(8).

35. The facts in paragraphs G, G(4), G(5), G(6), G(6)(a), G(6)(b), G(7), and G(8).

36. The facts in paragraphs H, H(4), H(5), H(6), H(8), H(8)(a), H(8)(b), H(9), and H(10).

37. The facts in paragraphs I, I(4), I(5), I(6), I(7), I(7)(a), I(7)(b), I(8), and I(9).

38. The facts in paragraphs J, J(4), J(5), J(6), J(6)(a), J(6)(b), J(7), and J(8).

39. The facts in paragraphs K, K(4), K(5), K(6), K(6)(a), K(6)(b), K(7), and K(8).

40. The facts in paragraphs L, L(4), L(5), L(6), L(6)(a), L(6)(b), L(7), and L(8).

41. The facts in paragraphs M, M(4), M(5), M(6), M(6)(a), M(6)(b), M(7), and M(8).

FORTY-SECOND THROUGH FIFTY-THIRD SPECIFICATIONS

EXCESSIVE TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35) (McKinney Supp. 1997) by ordering excessive teats, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

42. The facts in paragraphs B, B(5), and B(6).

43. The facts in paragraphs C, C(5), and C(6).

44. The facts in paragraphs D, D(5), and D(6).

45. The facts in paragraphs E, E(5), and E(6).

46. The facts in paragraphs F, F(5), and F(6).

47. The facts in paragraphs G, G(5), and G(6).

48. The facts in paragraphs H, H(5), H(6), and H(8).

49. The facts in paragraphs I, I(5), and I(7).

50. The facts in paragraphs J, J(5), and J(6).

51. The facts in paragraphs K, K(5), and K(6).

52. The facts in paragraphs L, L(5), and L(6).

53. The facts in paragraphs M, M(5), and M(6).

FIFTY-FOURTH THROUGH SIXTY-SIXTH SPECIFICATIONS

FAILURE TO MAINTAIN A RECORD

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) (McKinney Supp. 1997) 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:

54. The facts in paragraphs A(1)(a), A(3), A(4),and A(5).

55. The facts in paragraphs B(1), B(2), B(3), B(7),and B(8).

56. The facts in paragraphs C(1), C(2), C(3), C(7), and C(8).

57. The facts in paragraphs D(1), D(2), D(3), D(7), and D(8).

58. The facts in paragraphs E(1), E(2), E(3), E(7), and E(8).

59. The facts in paragraphs F(1), F(2), F(3), F(7), and F(8).

60. The facts in paragraphs G(1), G(2), G(3), G(7), and G(8).

61. The facts in paragraphs H(1), H(2), H(3), H(9), and H(10).

62. The facts in paragraphs I(1), I(2), I(3), I(8), and I(9).

63. The facts in paragraphs J(1), J(2), J(3), J(7), and J(8).

64. The facts in paragraphs K(1), K(2), K(3), K(7), and K(8).

65. The facts in paragraphs L(1), L(2), L(3), L(7), and L(8).

66. The facts in paragraphs M(1), M(2), M(3), M(7), and M(8).

SIXTY-SEVENTH SPECIFICATION

WILLFUL FAILURE TO REGISTER

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(12) (McKinney Supp. 1997) by willfully failing to register with the department of education, as alleged in the facts of:

67. The facts in paragraph N.

SIXTY-EIGHTH SPECIFICATION

CRIMINAL CONVICTION (N.Y.S.)

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(9)(a)(i)(McKinney Supp. 1997) by having been convicted of committing an act constituting a crime under New York state law as alleged in the facts of the following:

68. The facts in paragraph O.

DATED: September 24, 1997
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct