STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H. , Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

September 27, 2001

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dean Cory Mitchell, M.D.
1 Ross Lane
Hewlett Neck, New York 11598

Anthony Z. Scher, Esq.
Wood & Scher
The Harwood Building
14 Harwood Court
Scarsdale, New York 10583

Kevin Roe, Esq.
NYS Department of Health
Corning Tower Room 2509
Empire State Plaza
Albany, New York 12237

RE: In the Matter of Dean Cory Mitchell, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 01-120) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

In the Matter of

Dean Cory Mitchell, M.D. (Respondent)

A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)

COPY

Administrative Review Board (ARB)

Determination and Order No. 01-120

Before ARB Members Grossman, Lynch, Pellman, Price and Briber
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): **Kevin C. Roe, Esq.**
For the Respondent: **Anthony Z. Scher, Esq.**

After a hearing below, a BPMC Committee found that the Respondent practiced with negligence on more than one occasion in treating certain patients. The Committee voted to censure and reprimand the Respondent and to place him on probation for eighteen months. In this proceeding pursuant to N.Y. Pub. Health Law §230-c (4)(a)(McKinney's Supp. 2001), both parties ask the ARB to nullify or modify that Determination. The Petitioner asks that we sustain additional charges and revoke the Respondent's License to practice medicine in New York State. The Respondent asks that we overturn the Committee, dismiss the negligence findings and eliminate the penalty the Committee imposed. After reviewing the record and the parties' review submissions, the ARB affirms the Determination that the Respondent practiced with negligence on more than one occasion. We overturn the Committee and hold that the Respondent practiced with fraud and engaged in conduct that evidenced moral unfitness. We overturn the Committee and suspend the Respondent's License for two years, stay the suspension for eighteen months and place the Respondent on probation for those eighteen months. We fine the Respondent $40,000.00.

Committee Determination on the Charges

The Petitioner commenced the proceeding by filing charges with BPMC alleging that the Respondent violated N. Y. Educ. Law §§ 6530(2-6) & 6530(20) (McKinney 2001) by committing professional misconduct under the following specifications:

- practicing medicine fraudulently,
- practicing medicine with negligence on more than one occasion,
- practicing medicine with gross negligence,
- practicing medicine with incompetence on more than one occasion,
- practicing medicine with gross incompetence, and,
- engaging in conduct that evidences moral unfitness.

The charges involved the care the Respondent provided to seven persons, Patients A-G and the billings that the Respondent submitted to an insurer concerning the care for those Patients. The record refers to the Patients by initials to protect privacy. The Respondent denied the charges and a hearing ensued before the Committee that rendered the Determination now on review.

The Committee dismissed the fraud and moral unfitness charges. The Petitioner alleged that the Respondent billed falsely for office visits, submitted billings for procedures using a different insurance code and altered a patient record. On those charges, the Committee sustained only Factual Allegations C7, D5 and E5, that alleged that the Respondent billed falsely for two or more immunotherapy injections for Patients C, D and E (Billing Code 95117), when each Patient received only one injection each (Billing Code 95115). The Committee referred to those billings as errors that resulted from the Respondent's inadvertence, sloppiness and office-staff carelessness. The Committed also concluded that one insurer, Blue Cross, shared in responsibility for the billings by failing to call the Respondent's attention to the billings, even though Blue Cross received copies of the records for these Patients and knew how many injections each Patient received. The Committee found no fraudulent intent by the Respondent as far as altering one record and the Committee found no billing for unnecessary medical

treatments. The Committee noted that Blue Cross examined the patient records in each case at issue and denied no billings as without necessity.

On the negligence and incompetence charges, the Committee dismissed the charges alleging gross negligence, gross incompetence and incompetence on more than one occasion. The Committee sustained the charge that the Respondent practiced with negligence on more than one occasion and sustained Factual Allegations that charged that the Respondent:

- failed to perform periodic reviews to evaluate patient progress and efficacy of treatment for Patients A, C, D, F and G (Factual Allegations A4, C5, D5, F5 & G5),
- ordered or administered medication without justification to Patient A (Factual Allegation A5), and,
- failed to perform or document adequate physical examinations for Patients B, F and D (Factual Allegations B2, D1 and F2).

The Committee found that the Respondent's conduct resulted from carelessness in documentation, lack of attention to detail and inadequate supervision over staff in maintaining records and evaluating patient progress. The Committee voted to censure and reprimand the Respondent and to place him on probation for eighteen months under the terms that appear in the Committee's Order. The Committee noted that documentary evidence and the Respondent's testimony indicated that the Respondent improved his record keeping and billing substantially.

Review History and Issues

The Committee rendered their Determination on May 11, 2001. This proceeding commenced on May 30, 2001, when the ARB received the Petitioner's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and response brief and the Respondent's brief and response brief. The record closed when the ARB received the Petitioner's response brief on August 7, 2001.

The Petitioner argues that the Committee rendered a legally insufficient Determination by failing to specify the definitions for misconduct on which they relied and in failing to adopt sufficient findings of fact to explain their Determination. The Petitioner asks the ARB to adopt extensive findings of fact in addition to the findings the Committee adopted. The Petitioner also argues that the Committee failed to make any response to the charges at Factual Allegation A3 and that the Committee made a factual error in discussing the testimony by the Respondent's expert, Dr. Macris. As to the charge on altering a record, the Petitioner argued that the Committee made differing findings that resulted from the Committee's error in reading the hearing record. The Petitioner also alleges error by the Committee for dismissing the charges regarding the billings for the immunotherapy injections. The Petitioner argues that the billings for the injections constituted fraud. As to the charge that the Respondent billed falsely for unnecessary office visits or visits that never occurred, the Petitioner argued that the Committee erred in their finding about what constituted an office visit and that the Committee failed to determine issues that the pleadings and proof raised. The Petitioner also asks that the ARB delete references in the Committee's Determination referring to Blue Cross. The Petitioner then asks that, once the ARB has made the substantial modifications to the Determination, that the ARB change the penalty to license revocation.

The Respondent argues that the Committee erred by finding the Respondent failed to perform periodic reviews of the immunotherapy to Patients A, C, D, F and G. As to the charges the Committee sustained regarding evaluations on Patients B, D and F, the Respondent argues that the Committee erred in converting record keeping deficiencies into negligence. The Petitioner also argues that the Committee erred in finding that the Respondent ordered or administered Triamcinolone to Patient A without adequate medical justification. The Respondent

asks that the ARB overturn the Committee, dismiss the charges that the Committee sustained and affirm the Committee's Determination to dismiss all other charges.

Determination

The ARB has considered the record and the parties' briefs. In reviewing a Committee's Determination pursuant to N.Y. Pub. Health Law § 230-c (McKinney's Supp. 2001), the ARB determines: whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law; and, whether the Penalty is appropriate and within the scope of penalties which § 230-a permits. The ARB may substitute our judgement for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993); in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 A.D.2d 940, 613 NYS 2d 759 (3rd Dept. 1994); and in determining credibility, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). We elect to exercise that authority and to substitute our judgement in this case as to both the charges and the penalty.

We affirm the Committee's Determination that the Respondent practiced with negligence on more than one occasion, but we modify the Determination to dismiss Factual Allegation A4. We modify the Determination further by sustaining Factual Allegation F7, concerning billing for immunotherapy injections. We overturn the Committee and sustain charges that the billing for the immunotherapy injections to Patients C, E, F and G constituted fraud in practice and evidenced moral unfitness. We overturn the Committee Determination on penalty. We vote 5-0 to suspend the Respondent's License for two years. We vote 4-1 to stay that suspension for the final eighteen months and we place the Respondent on probation during those eighteen months

under the terms that appear in the Committee's Order. In addition, we vote 5-0 to fine the Respondent $40,000.00.

Fraud and Moral Unfitness: At Findings of Facts (FF) 30, 43, 50 and 59, the Committee found that the Respondent billed for two or more immunotherapy injections for Patients C, E, F and G, when the Respondent gave only one injection to the Patients. The Respondent filed seven such false billings for Patient F and twenty-six such billings for Patient G (FF 50 and 59). At FF 43, the Committee found that the Respondent billed for two immunotherapy injections for Patient E, but that the Respondent administered neither. The Committee's FF 30, 43 and 59 provided the basis for the Committee to sustain Factual Allegations C7, E5 and G6 and the Committee did sustain those Factual Allegations. The Committee's FF 50 also provided the basis for the Committee to sustain Factual Allegation F7, that charged billing for two immunotherapy injections on occasions when the Respondent administered only one injection. We hold that the Committee made a Determination inconsistent with FF 50 in dismissing Factual Allegation F7. We overturn the Committee and sustain Factual Allegation F7. The ARB holds further that FF 30, 43, 50 and 59 provide sufficient grounds on which to sustain the charges that the Respondent practiced fraudulently and engaged in conduct that evidenced moral unfitness.

We hold that the Committee erred in dismissing the fraud and moral unfitness charges, because the Committee's judgement lacked support from the record. The Committee concluded that no fraud occurred because the billings resulted from carelessness in using billing codes. The Committee's FF 43, however, found that the Respondent billed for injections to Patient E that never occurred. Also, the Committee's conclusion at page 13 noted that as the Respondent administered no injections to Patient E, no basis existed to bill under any code. The Committee,

therefore, made a determination inconsistent with their conclusions and with FF 43, when the Committee dismissed the fraud and moral unfitness charges concerning the immunotherapy billings for Patient E. At page 13 in the Determination, the Committee also stated that Blue Cross provided the Respondent no guidance with respect to his problem. The Respondent admitted in his hearing testimony, however, that Blue Cross advised him that he was billing for services not rendered and the Respondent stopped submitting such billings to Blue Cross. The Respondent also admitted that he continued submitting such billings to another insurer, GHI for Patient C, after receiving the billing advise from Blue Cross [Hearing Transcript pages 2804 and 2808]. The Committee made no reference to the GHI billings. In assessing expert credibility, the Committee found that the Respondent's expert, Dr. Macris, testified more credibly on billing issues than the Petitioner's expert. The Committee indicated they made that judgement because Dr. Macris had reviewed the Respondent's billing records. As the Petitioner's brief points out, however, Dr. Macris testified at hearing that he never reviewed the Respondent's billing practices [Hearing Transcript 902-903] and Dr. Macris gave no direct testimony about the Respondent's billing practices.

The ARB owes the Committee, as fact-finder, deference in the Committee's judgements on credibility. In this case, however, the Committee erred in finding that the false billings resulted from carelessness rather than fraudulent intent, because the Committee made that judgement in conflict with their own findings and conclusions and in conflict with the record. The billings for Patients C and E resulted clearly from something other than carelessness in using codes or from a failure by Blue Cross to provide assistance. The findings relating to Patients C and E, together with those for Patients F and G, establish a pattern of false billings. We infer that

the Respondent submitted those false billings knowingly and with intent to mislead the insurers. Such conduct amounted to fraud in practice and evidenced moral unfitness.

The Petitioner also challenged the Committee's Determination to dismiss the charge that the Respondent committed fraud by submitting a medical record that changed the date on which Patient F received an immunotherapy injection. The Committee found that the Respondent corrected the date [FF 49, 51]. We see no reason to overturn the Committee. The Respondent never submitted a billing for therapy on two dates, when therapy occurred on only one date. The alteration in the record involved the one date on which the therapy occurred. We see no error by the Committee and no basis in the findings on which to infer that the Respondent acted knowingly, with intent to mislead.

The Petitioner also asked the ARB to overturn the Committee's Determination to dismiss Factual Allegations that charged that the Respondent billed for unnecessary office visits or office visits that never occurred. The Petitioner argued that the Committee based their Determination to dismiss on an incorrect definition for office visit. Although, we agree with the Petitioner that the Committee gave a poor definition for what constitutes an office visit, no findings exist in the Committee's Determination on which to sustain additional billing charges, even if we substituted the definition for office visit the Petitioner suggests. The Petitioner concedes that the Committee Determination provides insufficient grounds to overturn the Committee on the additional billing charges and the Petitioner asks that the ARB draft our own Hearing Committee Determination and use that document as the basis to sustain the charges. We decline the request. Under N. Y. Pub. Health Law §§ 230(10)(g)(1) & 230c-(a)(4)(McKinney Supp. 2001), the Committees make findings of fact and the ARB reviews those findings. The ARB may correct errors by Committees, Matter of Brigham v. DeBuono, 288 A.D.2d 870, N.Y.S.2d (3rd Dept. 1996). The

ARB has exercised that authority in the past by amending or deleting some clearly erroneous Committee findings or conclusions, as we did in this case concerning the immunotherapy billings. The ARB has never made a single new finding of fact in any prior case. In this case, the Petitioner requests that the ARB exceed our authority by adopting extensive additional findings of fact. We affirm the Committee's Determination to dismiss the charges relating to the additional billings.

The Committee may have based their Determination to dismiss the additional billing charges on a poor definition for an office visit. The Committee may have also based the Determination on a poorly drawn charge. The Factual Allegations charged that the Respondent billed for unnecessary visits or visits that never occurred. The Petitioner's brief argues in effect, however, that the evidence proved that the Respondent billed for services different than the Respondent rendered, rather than unnecessary services or services never rendered. The Committee may also have made their Determination to dismiss because they found the evidence unconvincing. Regardless the reason for the dismissal, no factual findings in the Committee's Determination provide a ground on which to sustain additional charges.

Negligence On More Than One Occasion: The Respondent's brief at Point I argued that the Committee dismissed the fraud charges relating to the immunotherapy injections, but that the Committee had found improperly that the conduct constituted negligent billing. We have already held that the immunotherapy billings constituted fraud and evidenced moral unfitness.

The Respondent's brief at Point II challenged the Committee's Determination that the Respondent failed to perform periodic reviews on the immunotherapy that Patients A, C, D, F and G received. We affirm the Committee's Determination, except as to Patient A. Testimony by the Petitioner's expert, Dr. Dworetzky, proved that the Respondent failed to evaluate Patients C,

D, F and G and that the failure to evaluate fell below the accepted standard of care. The Committee found that testimony credible and used that testimony as the basis for FF 28, 36, 48 and 58. The Committee's FF 28, 36, 48 and 58 establish that the Respondent failed to review patient progress and the efficacy of the treatment process and established that the Respondent practiced with negligence on more than one occasion in treating Patientss C, D, F and G. No FF established that the Respondent failed to perform the evaluation for Patient A. We overturn the Committee's Determination sustaining Factual Allegation A4, that had alleged the failure to evaluate Patient A.

At Point III in his brief, the Respondent argued that the Committee elevated record keeping allegations to negligence without requisite testimony. We disagree. The Committee FF 20, 32 and 45 establish that the Respondent failed to document or perform adequate physicals on Patients B, F, and D. We conclude that the failure to document an adequate physical indicates that the adequate physical never occurred. The failure to perform the adequate physical examinations on those Patients constituted negligence on more than one occasion.

In the Respondent's brief at Point IV, the Respondent challenged the Committee's Determination that the Respondent prescribed medication for Patient A without justification. We affirm the Committee's Determination to sustain Factual Allegation A5 that charged prescribing the medication to Patient A without justification. The testimony by Dr. Dworetzky and the medical record for the Patient indicate that no justification existed in the record for prescribing triamcinolone to Patient A. That evidence formed the basis for the Committee's FF 16. As no justification appeared in the record, we conclude that no justification existed for the prescription. Prescribing medication without justification constituted negligence.

The Petitioner's brief asked that we overturn the Committee and sustain Factual Allegation A3 that charged that the Respondent ordered or administered immunotherapy without justification to Patient A. We affirm the Committee's Determination to dismiss Factual Allegation A3 and we hold that no FF by the Committee supports that Allegation. The Petitioner's brief concedes that no FF supports the Allegation and the Petitioner asks once again that the ARB adopt findings of fact. We refuse the request, for the reasons we noted above in our discussion on the additional billing charges.

Penalty: The Committee voted to censure and reprimand the Respondent and the Committee placed the Respondent on probation for eighteen months under the terms that appear in the Committee's Order. The Committee noted that the Respondent had improved his practice, especially as to billing and record keeping. The Committee also used their Determination to act beyond their jurisdiction and editorialize about the obligation for payers to make prompt payment and to establish appeal mechanisms to settle billing disagreements. We find the Committee's Determination on penalty inappropriate and inconsistent with their findings.

As we noted above, in addition to establishing that the Respondent practiced with negligence on more than one occasion, the Committee's findings and conclusions established that the Respondent practiced fraudulently and evidenced moral unfitness in the immunotherapy billings for Patients C, E, F and G. We conclude 5-0 that the Respondent's carelessness and the fraudulent billings warrant a two year suspension. By a 4-1 vote, we stay that suspension for the last eighteen months. The majority holds that the Respondent's conduct requires an actual suspension to provide the Respondent a wake-up call that he must change his practice. The dissenting member would stay the entire suspension, because he believes that the Respondent has demonstrated already that he has improved his practice following intervention. By a 5-0 vote, the

ARB fines the Respondent $40,000.00 for the fraudulent billings. This penalty represents a $10,000.00 fine for each Patient for whom the Respondent submitted the fraudulent billings. We find a monetary penalty appropriate in cases in which a Respondent used his License to obtain reimbursement through deliberate misrepresentation.

ORDER

NOW, with this Determination as our basis, the ARB renders the following **ORDER:**

1. The ARB affirms the Committee's Determination that the Respondent practiced with negligence on more than one occasion, but we modify the Determination to dismiss Factual Allegation A4.
2. The ARB overturns the Committee and sustains Factual Allegation F7 and we overturn the Committee and sustain the charges that the Respondent practiced fraudulently and engaged in conduct that evidenced moral unfitness in the immunotherapy billings for Patient C, E, F and G.
3. The ARB overturns the Committee and we vote to suspend the Respondent's License for two years. We vote further to stay that suspension for the final eighteen months and to place the Respondent on probation for those months under the terms that appear in the Committee's Order.
4. The ARB fines the Respondent $40,000.00.
5. The Respondent shall pay that fine to the Bureau of Accounts Management, New York State Department of Health, Erastus Corning II Building, Room 1258, Empire State Plaza, Albany, New York, 12237, due within thirty (30) days of the effective date of this Order.

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

Robert M. Briber
Thea Graves Pellman
Winston S. Price, M.D.
Stanley L. Grossman, M.D.
Therese G. Lynch, M.D.

In the Matter of Dean Cory Mitchell, M.D.

Robert M. Briber, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Mitchell.

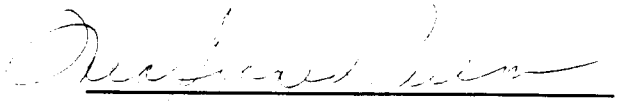
Dated: September 4, 2001

Robert M. Briber

In the Matter of Dean Cory Mitchell, M.D.

Thea Graves Pellman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Mitchell.

Dated: 9/27, **2001**

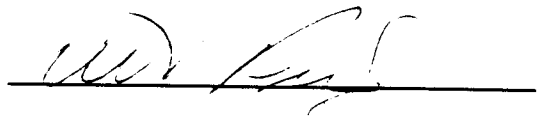


Thea Graves Pellman

In the Matter of Dean Cory Mitchell, M.D.

Winston S. Price, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Mitchell.

Dated: 9/24, **2001**



Winston S. Price, M.D.

In the Matter of Dean Cory Mitchell, M.D.

Stanley L. Grossman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Mitchell.

Dated: September 6, 2001

S L Grossman M.D.

Stanley L Grossman, M.D.

In the Matter of Dean Cory Mitchell, M.D.

Therese G. Lynch, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Mitchell.

Dated: Sept - 4, **2001**

Therese G Lynch M.D

Therese G. Lynch, M.D.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H. , Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

May 11, 2001

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dr. Dean Cory Mitchell, M.D.
1 Ross Lane
Hewlett Neck, New York 11598

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Long Beach, New York 11561

Kevin C. Roe, Esq.
NYS Department of Health
ESP – Corning Tower – Room 2509
Albany, New York 12237

RE: In the Matter of Dean Cory Mitchell, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 01-120) 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.

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.

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:cah
Enclosure

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

IN THE MATTER OF

OF

DEAN CORY MITCHELL, M.D.

DETERMINATION

AND

ORDER

BPMC #01-120

COPY

ELEANOR COHN KANE, M.D., Chairperson, **MR. CHARLES F. AHLERS**, and **RAVINDER MAMTANI, 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 Sections 230(10)(e) and 230(12) of the Public Health Law. **ELLEN B. SIMON, ESQ.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SECOND AMENDED STATEMENT OF CHARGES

The Second Amended Statement of Charges essentially charges the Respondent with professional misconduct by reason of having practiced with gross negligence and gross incompetence, by having practiced with negligence on more than one occasion and with incompetence on more than one occasion, and by having committed fraud. The charges are more specifically set forth in the Second Amended Statement of Charges, a copy of which is attached to and made a part of this Determination and Order.

SUMMARY OF THE PROCEEDINGS

Amended Statement of Charges Dated:	August 1, 2000
Second Amended Statement of Charges Dated:	August 23, 2000
Prehearing Conference:	May 11, 2000
Hearing Dates:	May 19, 2000

June 1, 2000
June 9, 2000
July 5, 2000
July 20, 2000
July 26, 2000
August 9, 2000
August 23, 2000
September 8, 2000
September 20, 2000
September 27, 2000
October 4, 2000
October 27, 2000
November 1, 2000
November 3, 2000
November 15, 2000
December 1, 2000
December 6, 2000

Deliberation Dates:

January 24, 2001
January 31, 2001
February 14, 2001
February 16, 2001

Place of Hearing:

NYS Department of Health
5 Penn Plaza
New York, New York

Petitioner Appeared By:

Donald P. Behrens, Jr., Esq.
General Counsel
NYS Department of Health
By: Kevin C. Roe, Esq.
Associate Counsel

Respondent Appeared By:

Garfunkel, Wild & Travis, P.C.
111 Great Neck Road
Great Neck, New York 11021
By: David E. Steckler, Esq.

Law Offices of Elovich & Adell
164 West Park Avenue
Long Beach, New York 11561
By: Lawrence E. Elovich, Esq.

WITNESSES

For the Department:

Murray Dworetzky, M.D.

Joseph L. Guy, Ph.D.
Respondent
Ms. Sheri Modell
Donald W. Aaronson, M.D.
Mr. Vincent LaBianca
Ileene Stern, L.P.N.
Patricia Mangi, R.N.

For the Respondent:

Respondent
Nicholas Macris, M.D.
Mr. Joseph Cain
Norman Geller, M.D.
Ms. Sheri Modell
Mr. Ernest Matarasso

Affirmation of Member of the Hearing Committee

Ravinder Mamtani, M.D., a duly appointed member of the State Board for Professional Medical Conduct and of its Hearing Committee designated to hear the matter of Dean Cory Mitchell, M.D., hereby affirms that he was absent from the hearing session conducted on July 5, 2000 and from a brief part of the session conducted on November 3, 2000. Dr. Mamtani affirms that he has read and considered the transcripts of the proceedings of, and the evidence received at, such whole or partial hearing days prior to deliberations of the Hearing Committee beginning on January 24, 2001.

FINDINGS OF FACT

Numbers in parentheses refer to transcript pages or exhibits and denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited.

GENERAL FINDINGS

1. **DEAN CORY MITCHELL, M.D.,** the Respondent, was authorized to practice medicine in New York State on July 2, 1987, by the issuance of license number 170802 by the New York State Education Department (uncontested; Ex. O).

2. For approximately two years beginning on August 20, 1996, Respondent was under prepayment review by Blue Cross/Blue Shield (hereinafter "BC"), during which time none of his bills for some 60 of his patients, including those whose cases are the subject of the Second Amended Statement of Charges, were paid or otherwise disposed of until BC had reviewed the corresponding voluminous patient files that Respondent provided [Respondent's Exhibit (hereinafter "Ex.") L (pp. 1315 and 1759 of which establish the inception date of the review)].

3. In May 1997, Norman Geller, M.D., a reviewer at BC, wrote a letter to Respondent

explaining billing and payment policy concerning charges for office visits during which immunotherapy was administered, but that letter did not fully explain BC's reasons for less than full payment to Respondent in other situations [Ex. L, p. 1340; Transcript pages (hereinafter "T") 2562, 2564-2565]. In addition, during the prepayment review period, Respondent's staff had numerous telephone conversations with BC staff to seek clarification of the billing and payment issues, with uncertain and unresolving results (T 3542-3548).

4. In October 1997, Respondent, at his own request, met with Dr. Geller to discuss billing policy issues that BC and Respondent had still not resolved, including billing for office visits when a patient received immunotherapy (T 1438-1439, 2567-2570).

5. It is not certain whether Respondent ever received any adequate explanation of benefits (hereinafter "EOB") with payments from BC. Exhibit L contains several examples of a form (e.g., pp. 000440, 000440A, and 000441) entitled "Provider Explanation of Benefits," but as Dr Geller did not himself send EOBs to Respondent and just assumed that someone at BC did so (T 1432-1433) and Respondent said that he received EOBs but they didn't adequately explain the action that BC took on his bills (T 2555, 3543-3545), there is insufficient evidence to support the finding that BC advised Respondent why he was paid less than he billed for.

6. In order to speed up the BC review of his files, Respondent purchased a scanner and so advised Dr. Geller, by letter of February 4, 1998 (Ex. L, p. 1349).

7. In that same February 1998 letter, Respondent asked Dr. Geller for written examples substantiating that Respondent was not complying with BC billing guidelines (Ex. L, p. 1349). Dr. Geller did not reply to that letter except to fax to Respondent a page containing BC's immunotherapy policy (Ex. L, p. 1311; T 2609-2610).

8. On August 7, 1998, Respondent finally sent a letter to BC's chief executive officer, Dr. Michael Stocker, seeking his help in clarifying billing issues that BC still had not resolved for Respondent (Ex. N). No reply to that letter was produced in evidence.

Patient A

9. Respondent treated Patient A from on or about July 18, 1995, to on or about November 4, 1998, at his office, 3227 Long Beach Road, Oceanside, New York (Ex. 2).

10. Respondent took and recorded an adequate medical history of Patient A (Ex. 2, pp. 71, 73).

11. At the initial office visit Respondent performed a pulmonary function test and failed to repeat that single-breath forced expiratory test after Patient A had inhaled a bronchodilator (Ex. 2, p. 69; T 62-63). It is not necessary, however, to repeat such a test if the initial test shows the Patient's FEV1, or forced expiratory volume, to be 70 percent or more of predicted normal (T 911-913). Patient A's FEV1 was within the lower limits of the normal range (T 375, 771).

12. No further information regarding the surgical evaluation by Dr. Kerner that Respondent requested appears in Patient A's medical record (Ex. 2).

13. After his first evaluation on July 18, 1995, Patient A was not seen again at Respondent's office until September 19, 1995, when he complained of severe nasal congestion. A partial physical examination was documented and acute sinusitis was diagnosed. An injection, possibly triamcinolone, although the name is illegible, was given intramuscularly (Ex. 2, p. 7).

14. Patient A was next seen at Respondent's office on October 30, 1995. The severity of his problem was noted as stable. Physical examination noted that the ears, throat, chest, and skin were normal. No other physical examination was performed or documented. A diagnosis of rhinitis was circled (Ex. 2, p. 8).

15. Respondent's Licensed Practical Nurse, Ileene Stern, sporadically evaluated Patient A for progress and efficacy of his treatment plan (Ex. 2).

16. On September 16, 1998, Respondent ordered and/or administered triamcinolone to Patient A (Ex. 2, p. 66), but there is no note that Respondent evaluated him (T 866-869).

17. Respondent's bills for office visits by Patient A reflected visits during which Respondent provided one or more of a range of services of varying nature and degree, including evaluation and management, procedures, preventive services, and consultation (Exs. 2 and 2A).

Patient B

18. Respondent treated Patient B from on or about February 6, 1997 to on or about November 12, 1998, at his office (Ex. 3).

19. Respondent took and recorded a history of Patient B that was sufficient to allow him to determine what treatment, if any, was appropriate for the patient (Ex. 3; T 336-339, 921-924, 3112-3117).

20. With respect to a physical examination, Respondent noted only the patient's height, weight, and blood pressure (Ex. 3; T 344-349, 964-969).

21. At Patient B's initial visit, Respondent failed to repeat single-breath forced expiratory tests after the patient had inhaled a bronchodilator (Ex. 3; see also paragraph 11 above).

22. Respondent's bills for office visits by Patient B reflected visits during which Respondent provided one or more of a range of services of varying nature and degree, including evaluation and management, procedures, preventive services, and consultation (Exs. 2 and 2A).

Patient C

23. Respondent treated Patient C from on or about May 25, 1994, to on or about November 30, 1998, at his office (Ex. 4).

24. Respondent obtained and documented an adequate medical history of Patient C (Ex. 4, p. 7; T 361-367, 1003, 1012-1027, 3168-3170).

25. Respondent performed and documented an adequate physical examination of Patient C [Ex. 4, p. 12; T 367, 1005, 1025-1056 (particularly 1029-1031), 3170-3171].

26. Although it was done only a moment or two after the first such test, Respondent did repeat a single-breath forced expiratory test after Patient C had inhaled a bronchodilator (Ex. 4, pp. 103-104; T 369-370, 373-376, 1006, 3171-3173).

27. Respondent was justified in administering immunotherapy to Patient C (T 1002, 1041-1042, 3159-3161).

28. Respondent failed himself to perform periodic reviews to evaluate Patient C's progress and the efficacy of his treatment plan (T 190-191, 382, 387-390, 3162-3168).

29. Respondent's bills for office visits by Patient C reflected visits during which Respondent provided one or more of a range of services of varying nature and degree, including evaluation and management, procedures, preventive services, and consultation (Exs. 4 and 4A).

30. Respondent erroneously billed for two or more immunotherapy injections by using CPT code 95117 when he gave only one such injection to Patient C and should instead have used code 95115 (Ex. 4A, pp. 5-9; T 605-607).

Patient D

31. Respondent treated Patient D from on or about April 11, 1996, to on or about August 25, 1998, at his office (Ex. 5).

32. Respondent failed to obtain and/or document an adequate history of Patient D (Ex. 5, pp. 8-9; T 116-120).

33. Although the examination was not documented in the usual way, Respondent's letter to Patient D's referring physician represents Respondent's having conducted an adequate physical examination (Ex. 5, p. 15).

34. Respondent failed to repeat a single-breath forced expiratory test after Patient D had inhaled a bronchodilator (Ex. 5; T 123, 125), but repetition of such a test was not necessary (T 1071-1072).

35. Respondent's treatment of Patient D with immunotherapy was justified because the

patient was allergic to environmental factors that he could not reasonably avoid (Ex. 5, pp. 6-7, 11, 15; T 1072).

36. Respondent failed himself to perform periodic reviews to evaluate Patient D's progress and the efficacy of his treatment plan (Ex. 5, pp. 16-24, 39-65). He did, however, on at least one occasion, at the August 25, 1998 visit, perform and document a reasonable evaluation (Ex. 5, p. 67).

37. Respondent's bills for office visits by Patient D reflected visits during which Respondent provided one or more of a range of services of varying nature and degree, including evaluation and management, procedures, preventive services, and consultation (Exs. 5 and 5A).

Patient E

38. Respondent treated Patient E from on or about April 8, 1997, to on or about May 8, 1997, at his office (Ex. 6).

39. Respondent did not see Patient E at her initial office visit on May 8, 1997; she was seen, instead, by Dr. Hecht, who worked for Respondent and who obtained and documented a history and performed and documented a physical examination (Ex. 6, pp. 8-9).

40. Respondent failed to repeat single-breath forced expiratory tests after inhalation of a bronchodilator. However, Patient E had tachycardia; accordingly, administration of a bronchodilator was potentially dangerous and therefore inadvisable. Repeating a pulmonary function test after inhalation of a bronchodilator was not only unnecessary for Patient E but would have put her at risk (T 1135-1137, 3348-3349).

41. There is no documentation that Patient E received any immunotherapy (Ex. 6). On April 22, 1997, Dr. Hecht indicated that if Patient E saw a cardiologist who approved it, immunotherapy would be administered (Ex. 6, p. 13). On May 8, 1997, when Respondent saw Patient E himself, he did not order immunotherapy (Ex. 6, p. 14).

42. In the record of Patient E's first visit, on April 8, 1997, under the heading "medical decisionmaking," RAST is checked. The RAST tests were performed on April 9 and the results reported on April 12 (Ex. 6, pp. 15-18). In a patient with clinically diagnosed arrhythmia, giving RAST tests is safer than doing a skin test (T 419).

43. On April 22, 1997, Respondent billed Patient E for two immunotherapy injections but administered neither of them (Ex. 6, p. 27; see paragraph 41 above.)

Patient F

44. Respondent treated Patient F from on or about August 19, 1997, to on or about June 28, 1998, at his office.

45. Respondent failed to perform and/or document an adequate physical examination of Patient F (Ex. 7, p. 11; T 1162-1163, 3393-3394).

46. Respondent performed two single-breath forced expiratory tests on Patient F, administered only a few minutes apart, before and after the patient had inhaled a bronchodilator. But, as in other cases, because Patient F's FEV1 was 90 percent of the predicted value, repeating the test was not medically necessary (Ex. 7, pp. 14-15; T 1160-1161).

47. Patient F had a history of treatment for allergy and was counseled by Respondent to try to prevent exposure to dust at home, but he still faced allergens at work. The patient also had been treated with an antihistamine, but that apparently did not give him sufficient relief (Ex. 7, pp. 8, 12-13; T 1156, 3383-3385). Accordingly, immunotherapy was justified.

48. Patient F's record is full of pages that are blank and/or without a signature (Ex. 7, pp. 16-47), which indicates that Respondent did not himself perform periodic reviews to evaluate the patient's progress and the efficacy of his treatment plan.

49. Respondent sent to BC, Patient F's health insurance carrier, a bill for immunotherapy administered to Patient F on November 6, 1997 [Ex. 7C (injection record); Ex. 7A, p.1]. Respondent later notified BC that the date of November 6 was mistaken and that he would send a corrected injection record reflecting the actual date of administration, which was October 30, 1997 (T 3413-3445). Patient F was in Respondent's office on both October 30 and November 6, 1997 (Ex. 7, pp. 23-24; Exs. W, W-1, and Y).

50. Respondent billed BC for two or more injections of immunotherapy by using CPT code 95117 on August 26, September 2, September 9, September 16, September 25, October 2, and October 23, 1997 (Ex. 7A). Only one injection was given on each of those dates (Ex. 7, pp. 6-7). The use of code 95117 was false, inaccurate, and inappropriate (Ex. 7A, p. 1; T 602-604).

51. Respondent billed BC for immunotherapy administered to Patient F on November 6, 1997 (T 3413-3417). Respondent discovered that that therapy had in fact been given on October 30, 1997, not on November 6, and advised BC that he would send them a corrected injection record (T 3413-3417). Respondent then sent to BC what was apparently a copy of the original injection record on which copy he had obliterated the November 6 date and substituted October 30, 1997. Respondent did not alter the original injection record. The BC records confirm their receipt of two separate injection records for Patient F; they contain handwritten notes "1st submission" and "2nd submission" (Ex. L, pp. 1359-1360). Those BC records in evidence, however, do not indicate the injection dates clearly because the copies are so poor.

52. Respondent knew, because he was under BC's prepayment review, that he would have to submit a copy of his patient record to justify his billing. He hid nothing from BC concerning the October 30, 1997 immunotherapy and did not knowingly alter a record

with intent to deceive (see paragraphs 2 and 49 above).

Patient G

53. Respondent treated Patient G from on or about January 9, 1997, to on or about September 4, 1997, at his office (Ex. 8).

54. Respondent obtained an adequate medical history of Patient G (Ex. 8, pp. 5-9; T 1183-1186).

55. Respondent performed and documented an adequate physical examination of Patient G (Ex. 8, p 13; T 1196-1199).

56. Respondent failed to repeat a single-breath forced expiratory test after Patient G had inhaled a bronchodilator, but, as the patient's FEV1 was within an acceptable range of the predicted value, repeating the test was not necessary (Ex. 8, p. 12; T 1187-1188).

57. Patient G had a history of congenital glaucoma, which increased the risk of treating him with nasal cortisone decongestants and antihistamines. Respondent's treatment of Patient G with immunotherapy was justified (Ex. 8, pp. 5-9; T 1182, 1184-1186, 3502-3506).

58. Respondent's office record for Patient G contains many pages that are blank and/or without signatures, indicating that Respondent failed himself to perform periodic reviews to evaluate the patient's progress and the efficacy of his treatment plan (Ex. 8, pp. 14-40).

59. Patient G received one injection of immunotherapy on January 28, February 11, February 18, February 25, March 4, March 13, March 18, March 25, April 1, April 8, April 15, April 22, April 29, May 6, May 13, May 20, May 27, June 10, June 17, June 24, July 3, July 10, July 15, July 29, August 12, and September 4, 1997 (Ex. 8, p. 3). Respondent submitted claims to BC, Patient G's health insurance carrier, for immunotherapy by using CPT code 95117 (two or more injections) for each of those dates (Ex. 8A, pp. 1-5; T 610-611).

60. Respondent's bills for office visits by Patient G reflected visits during which Respondent provided one or more of a range of services of varying nature and degree, including evaluation and management, procedures, preventive services, and consultation (Exs. 8 and 8A).

AFFIRMATIVE DEFENSES

Respondent has interposed the seven affirmative defenses enumerated below (Ex. F-1), as to which the Hearing Committee finds as follows:

Defense 1. The State's purported expert did not judge Respondent's records according to objective and applicable standards of practice, in that he is not an expert concerning those

standards.

Finding: The Hearing Committee finds that Murray Dworetzky, M.D., the Department's expert witness, appeared as a medical witness and as such judged Respondent's medical records according to objective and applicable standards of practice. Dr. Dworetzky's own report of his review of Respondent's records (Ex. 11) gives no indication that he reviewed Respondent's billing records.

Defense 2. The Department, through the exercise of good faith conduct and reasonable diligence, could have established facts that Respondent was falsely accused, and that the inquiry concerning Respondent is tainted by personal and pecuniary interests. The Department was informed concerning these issues, and intentionally failed to perform a full and fair inquiry of the allegations respecting Respondent, thereby committing procedural and substantive due process violations.

Finding: The Hearing Committee finds that there is insufficient evidence to determine the truth of this allegation.

Defense 3. Respondent's documentation and billing practices comply with applicable standards set and followed by, inter alia, managed care and insurance plans, and New York State, in that an "acceptable error level" is used in New York (and insurance) audit and enforcement actions.

Finding: In order to determine an "acceptable error level," the Hearing Committee would need to see all of Respondent's patient files and billing records or a representative sample of them, the billing errors in that population or sample, and similar information relating to other similarly situated medical practices. Since such specific testimony was not elicited from Sheri Modell, Ernest Matarasso, or any other witness, the Committee is unable to reach a determination as to this allegation.

Defense 4. Any billing errors of Respondent were caused, in whole or in part, by inaccurate and ever-changing instructions from carriers and managed care plans, and such errors do not, as a matter of law, constitute gross negligence, gross incompetence, negligence on more than one occasion, fraud and/or moral unfitness, given Respondent's ongoing, good faith attempts to bill accurately and correctly.

Finding: There was evidence presented that Blue Cross/Blue Shield did not provide adequate information to Respondent in justification of actions it took on reimbursement (see General Findings 3-8 above). There was also evidence that Respondent was negligent in giving attention to accepted billing practices in the profession (see, e.g., Findings 27, 47, 54, and 63). The Hearing Committee therefore finds tht there is reason to fault both BC and Respondent with respect to adequacy of billing and reimbursement practices.

Defense 5. The errors attributed to Dr. Mitchell are common among doctors with insurance company and managed care panel affiliations, and, as such, may not be considered to be leglly negligent, in that such carriers acknowledge that providers will

make errors both in documentation and billing.

Finding: As with respect to Respondent's third affirmative defense, the Hearing Committee finds that there is insufficient specific and quantitative evidence to permit it to determine whether Respondent's errors in billing were within the acceptable practices of the medical profession.

Defense 6. Factual allegation "F8" is asserted with actual knowledge of its falsity. The term "whited out" is used to inflame the hearing panel, and to create prejudice against Respondent.

Finding: As discussed in Finding 55 above, the Hearing Committee finds that careful analysis of the relevant exhibits and all the related testimony reveals that the charge that Respondent falsely altered a copy of Patient F's medical record as alleged has no substance and offers no significant basis for judgment of Respondent's professional conduct. The Committee finds that there was no serious, willful alteration by Respondent and no apparent illicit motivation on the part of the Department in making the allegation.

Defense 7. The Amended Statement of Charges asserts (at paragraphs A6, B4, C6, and G7) that "Respondent falsely billed for numerous office visits which were either unnecessary or did not occur."

(a) These charges were initially made in the first Statement of Charges (in October 1999) and were dropped, presumably after internal review by the Department, after Dr. Mitchell requested such a review.

(b) The billings in question were submitted to Blue Cross, yet the Department called no Blue Cross witnesses to testify on its direct case. Absent affirmative testimonial assertions of falsity (from the recipients of the questioned billing), a claim of false billing cannot be established. Indeed, the Department changed its witness list to delete these Blue Cross witnesses.

(c) The Department was put on notice that Blue Cross received all underlying medical records from Dr. Mitchell (including the approximately 135 billings covered by allegations A6, B4, C6, and G7). Blue Cross thus accepted the billings with actual knowledge of the contents of the underlying medical records, and no fraud can therefore be asserted or found, since there was no material misstatement or omission by Dr. Mitchell, and no detrimental reliance by Blue Cross.

Finding: The Department has asked the Hearing Committee to endorse the following definition of "office visit" (page 3, paragraph 6 of the Department's post-hearing brief) and therefore to find that

> "Office visit" is a term of art used in the practice of medicine to describe the provision of evaluation and management services. Evaluation and management services are defined by the CPT code in terms of history, physical examination, and medical decision making. In order to bill for an office visit, a physician . . . must use the evaluation and management codes (99211-99214) contained in the CPT. If evaluation and management services are not provided, then no office visit occurred.

The Hearing Committee finds that "office visit" is not a term of art. Rather, the term is one commonly understood by the medical community to mean a visit during which services of varying nature and degree are provided, including evaluation and management, procedures, preventive services, and consultation. In order to bill for an office visit, a physician must not necessarily have provided only evaluation and management services. Moreover, according to BC's own records, Dr. Geller denied no payments to Respondent for lack of medical necessity (Ex. L). The Hearing Committee therefore cannot and does not sustain the charge that Respondent falsely billed for numerous office visits that were either unnecessary or did not occur.

CONCLUSIONS

Credibility

The Hearing Committee found the Department's expert, Dr. Murray Dworetzky, who had reviewed only Respondent's patient records, to be a credible witness as to the standard of care appropriate to a board certified allergist.

The Committee found that Respondent's expert, Dr. Nicholas Macris, was also, overall, a credible witness as to standard of care. Since he had reviewed not only Respondent's patient records but also his billing records, he was able to respond more particularly than Dr. Dworetzky could to questions about treatment and billing for that treatment.

As to Dr. Norman Geller, the Hearing Committee found that overall he described accurately and in detail his own review for BC of Respondent's billing and patient records. He was not able to offer, however, a detailed explanation of the chronology and processes involved in claims submission and review. For example, when asked specifically how EOBs and information contained in them were conveyed to Respondent, Dr. Geller couldn't answer and said only that he assumed that someone at BC advised Respondent of action taken on his bills (T 1432-1433, 1600).

Sheri Modell testified about errors in coding on bills and in documentation that occur in physicians' practices. She also testified about a review of Respondent's medical records conducted by Health ROI. The Hearing Committee did not rely much on Ms. Modell's testimony because she had no independent knowledge of the patient record evaluations, which had been done by others at Health ROI, but had only compiled a report based on those others' findings. The Committee did find that, in its finding of inadequate recordkeeping and office procedures and in its recording of improvements made in such practices, the Health ROI study was consistent with the documentary evidence presented—i.e., that when Respondent was made aware of such inadequacies, he took steps to remedy them.

Patricia Mangi offered specifics of methodology and procedures followed during her tenure at Health ROI in its review of Respondent's patient and billing records. The Hearing Committee found her testimony to be detailed, direct, and very credible.

As to Respondent himself, the Hearing Committee found him to be direct, truthful, and very cooperative in meeting the Committee's requests for additional documentation, such as original appointment books and office sign-in sheets relating to Patient F. Through Respondent's demeanor and testimony, the Committee is convinced that if BC had been more prompt and explicit in explaining the action it took on his billings, Respondent would have complied with what was expected of him. The Committee is further persuaded as to Respondent's good faith by the fact that no evidence was offered that BC ever responded to his letter to its CEO (Ex. N) seeking his help in clarifying unresolved billing issues.

The Hearing Committee carefully considered as well the testimony of Dr. Joseph Guy, Dr. Donald Aaronson, Vincent LaBianca, Ileene Stern, Joseph Cain, and Ernest Matarasso in reaching its determination as to the charges.

Fraud

With respect to the charge that Respondent falsely used CPT code 95117 to bill for two immunotherapy injections when he gave only one and so should have used code 95115, the Committee finds no fraud. BC received bills showing 95117 instead of 95115 for only a period between 1997 and 1998, during which time Respondent was using a billing form (Ex. Q) that had no column in it for 95115. In order to show what had been administered, Respondent put a "1" in the box indicating the number of injections (T 2533-2541). When BC did pay Respondent, often only after many months, the accompanying EOBs never explained that there was any problem with using 95117 and putting a "1" in the box when 95115 was the appropriate code. The Committee finds that Respondent's errors were the result of inadvertence, sloppiness, and office-staff carelessness. In any case, BC had all the patient records and could determine from them how many injections had actually been given. Finally, at no time did Dr. Geller ever write to Respondent to explain what was expected of him with respect to this problem; neither could he explain satisfactorily to the Committee why not.

Moral unfitness

Because the Hearing Committee is persuaded that Respondent had no fraudulent intent and committed no fraud, the Committee also finds no evidence of Respondent's moral unfitness to practice medicine.

Of all the charges against Respondent, the Hearing Committee finds that the only substantive ones supported by a preponderance of the credible evidence before it are A4, A5, B2, C5, C7, D1, D5, most of E5 (i.e., Respondent's bill did show code 95117, for two injections, but actually no injections were administered, so that use of code 95115 would also have been in error), F2, F5, G5, and G6. The Committee therefore concludes that the majority of the charges cannot be sustained.

VOTE OF THE HEARING COMMITTEE

In view of the foregoing, the Hearing Committee concludes as to the specifications and votes unanimously as follows:

FIRST THROUGH SEVENTH SPECIFICATIONS
Gross negligence
NOT SUSTAINED

EIGHTH THROUGH FOURTEENTH SPECIFICATIONS
Gross incompetence
NOT SUSTAINED

FIFTEENTH SPECIFICATION
Negligence on more than one occasion
SUSTAINED

SIXTEENTH SPECIFICATION
Incompetence on more than one occasion
NOT SUSTAINED

SEVENTEENTH THROUGH TWENTY-EIGHTH SPECIFICATIONS
Fraud
NOT SUSTAINED

TWENTY-NINTH THROUGH FORTIETH SPECIFICATIONS
Moral unfitness
NOT SUSTAINED

DETERMINATION OF THE HEARING COMMITTEE

The Hearing Committee has considered not only the entire record in this matter but as well its overall impression of the Respondent through his testimony and demeanor during eighteen days of hearing. As a result, the Committee concludes that the charges sustained, taken together, do not warrant revocation, as the Department proposes, or even suspension of Respondent's license. The Committee believes, however, that those charges portray a physician whose practice reflects carelessness in documentation, lack of attention to detail, and inadequate supervision of his staff in proper maintenance of records and in evaluation of patients' progress.

The Hearing Committee recognizes, however, that the charges are based upon cases and circumstances as much as five and six years old, and we note both documentary evidence [e.g., of Respondent's continual revision of his billing forms to comply with proper billing practice as he was made aware of its requirements (Exs. P, Q, and R)] and Respondent's testimony that, especially with respect to recordkeeping and billing, his current practice is substantially improved. It is nonetheless the view of the Committee

that even today Respondent's practice should, for a time, be monitored for his compliance with the accepted standards of his profession.

The Committee emphasizes that this determination has been preceded by an extremely long and complex proceeding at the center of which lies an issue that currently agitates and preoccupies all health insurers and many practitioners: the proper classification of services and the proper assignment of charges therefor. Despite the publication of professionally endorsed guides to practitioners about allowances by insurers, and the conduct of many meetings that advise practitioners, much uncertainty continues, and the practices of the insurers have been far from optimal. At a time of very basic and substantial change in the financing of health care generally, all practitioners must accept more stringent demands of recordkeeping and accountability. All insurers must accept the responsibility for prompt payment of valid charges and prompt and clear explanation of any reasons for discrepancies between billings and payments. When disagreements occur between payers and payees, there must be a clearly available, sensible, objective, and efficient appeal mechanism that is well enough made to command respect by both parties.

In view of all the foregoing and after seriously considering all possible sanctions, the Committee determines that Respondent shall be censured and reprimanded and that for a period of eighteen months he shall be put on probation, subject to the terms and conditions ordered below.

This penalty represents the Determination of the Hearing Committee, as does its unanimous vote on the charges and specifications.

ORDER

Based upon the foregoing, it is hereby ordered that:

Respondent is hereby censured and reprimanded and placed on probation for a period of eighteen (18) months, subject to the following terms and conditions:

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

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street – Suite 303, Troy, New York 12180-2299. Such notice shall include a full description of any employment and practice; professional and residential addresses and telephone numbers within or without New York State; and any and all investigations, charges, convictions, or disciplinary actions by any local, state, or federal agency, institution, or facility, within thirty (30) days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall meet in person with a person designated by the Director of OMPC as requested by the Director.

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

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

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

7. Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty ("practice monitor"), proposed by Respondent and subject to written approval of the Director of OPMC.

8. Respondent shall make available to the practice monitor any and all records or access to his practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, at random and unannounced, at least once a month and shall examine a selection of no fewer than twenty-five (25) records maintained by Respondent, including patient records, billing records, prescribing information, and office records. The review will determine whether Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any deviation from such standards of medical care that the monitor may perceive or any refusal to cooperate with the monitor shall be reported within twenty-four (24) hours to OPMC.

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

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

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

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

Dated: Rhinebeck, New York
May 7 , 2001

ELEANOR COHN KANE, M.D.
Chairperson
RAVINDER MAMTANI, M.D.
CHARLES F. AHLERS

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APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER

OF

DEAN CORY MITCHELL, M.D.

----------X

2D AMENDED

STATEMENT

OF

CHARGES

DEAN CORY MITCHELL, M.D., the Respondent, was authorized to practice medicine in New York State on July 2, 1987, by the issuance of license 170802 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (Patients are identified in the appendix) from on or about July 18, 1995, to November 4, 1998, at his office, 3227 Long Beach Road, Oceanside, New York and/or 315 West 57th Street, New York, New York. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.
2. Respondent failed to repeat single breath forced expiratory tests after inhalation of a bronchodilator.
3. Respondent ordered and/or administered immunotherapy without adequate medical justification.

4. Respondent failed to perform periodic reviews to evaluate patient progress and efficacy of the treatment plan.
5. Respondent ordered and/or administered triamcinolone without adequate medical justification.
6. Respondent falsely billed for numerous office visits which were either unnecessary or did not occur.

B. Respondent treated Patient B from on or about February 6, 1997, to on or about November 12, 1998, at his office. Respondent's care and treatment failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.
2. Respondent failed to perform and/or document an adequate physical examination.
3. Respondent failed to repeat single breath forced expiratory tests after inhalation of a bronchodilator.
4. Respondent falsely billed for numerous office visits which were either unnecessary or did not occur.

C. Respondent treated Patient C from on or about May 25, 1994, to on or about November 30, 1998, at his office. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.
2. Respondent failed to perform and/or document an adequate physical examination.
3. Respondent failed to repeat single breath forced expiratory tests after inhalation of a bronchodilator.
4. Respondent ordered and/or administered immunotherapy without adequate medical justification.
5. Respondent failed to perform periodic reviews to evaluate patient progress and efficacy of the treatment plan.
6. Respondent falsely billed for numerous office visits which were either unnecessary or did not occur.
7. Respondent falsely billed for two or more immunotherapy injections (CPT code 95117) when only one immunotherapy injection (CPT code 95115) was given.

D. Respondent treated Patient D from on or about April 11, 1996, to on or about August 25, 1998, at his office. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.
2. Respondent failed to perform and/or document an adequate physical examination.
3. Respondent failed to repeat single breath forced

expiratory tests after inhalation of a bronchodilator.

4. Respondent ordered and/or administered immunotherapy without adequate medical justification.
5. Respondent failed to perform periodic reviews to evaluate patient progress and efficacy of the treatment plan.
7. Respondent falsely billed for numerous office visits which were either unnecessary or did not occur.

E. Respondent treated Patient E from on or about April 8, 1997, to on or about May 8, 1997, at his office. Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.
2. Respondent failed to repeat single breath forced expiratory tests after inhalation of a bronchodilator.
3. Respondent ordered and/or administered immunotherapy without adequate medical justification.
4. Respondent ordered and/or performed RAST determinations without adequate medical justification.
5. Respondent falsely billed for two or more immunotherapy injections (CPT code 95117) when only one immunotherapy injection (CPT code 95115)was given on April 22, 1997.

F. Respondent treated Patient F from on or about August 19, 1997, to on or about June 25, 1998, at his office. Respondent's care and treatment of Patient F failed to meet acceptable standards of medical care, in that:

2. Respondent failed to perform and/or document an adequate physical examination.
3. Respondent failed to repeat single breath forced expiratory tests after inhalation of a bronchodilator.
4. Respondent ordered and/or administered immunotherapy without adequate medical justification.
5. Respondent failed to perform periodic reviews to evaluate patient progress and efficacy of the treatment plan.
6. Respondent falsely billed for immunotherapy injection on October 30, 1997.
7. Respondent falsely billed for two or more immunotherapy injections (CPT code 95117) when only one immunotherapy injection (CPT code 95115) was given.
8. Respondent falsely altered a copy of the medical record by obliterating the November 6, 1997 date of office visit and substituting October 30, 1997.

G. Respondent treated Patient G from on or about January 9, 1997, to on or about September 4, 1997, at his office. Respondent's care and treatment of Patient G failed

to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history.
2. Respondent failed to perform and/or document an adequate physical examination.
3. Respondent failed to repeat single breath forced expiratory tests after inhalation of a bronchodilator.
4. Respondent ordered and/or administered immunotherapy without adequate medical justification.
5. Respondent failed to perform periodic reviews to evaluate patient progress and efficacy of the treatment plan.
6. Respondent falsely billed for two or more immunotherapy injections (CPT code 95117) when only one immunotherapy injection (CPT code 95115) was given.
7. Respondent falsely billed for numerous office visits which were either unnecessary or did not occur.

SPECIFICATIONS

FIRST THROUGH SEVENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with gross negligence on a particular occasion in violation of New York Education Law §6530(4), in that Petitioner charges:

1. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, and/or A.6.
2. The facts in Paragraphs B and B.1, B.2, B.3, and/or B.4.
3. The facts in Paragraphs C and C.1, C.2, C.3, C.4, C.5, C.6, and/or C.7.
4. The facts in Paragraphs D and D.1, D.2, D.3, D.4, D.5, and/or D.7.
5. The facts in Paragraphs E and E.1, E.2, E.3, E.4, and/or E.5.
6. The facts in Paragraphs F and F.2, F.3, F.4, F.5, F.6, F.7, and/or F.8.
7. The facts in Paragraphs G and G.1, G.2, G.3, G.4, G.5, G.6, and/or G.7.

EIGHTH THROUGH FOURTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence on a particular occasion in violation of New York Education Law

§6530(6), in that Petitioner charges:

8. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, and/or A.6.

9. The facts in Paragraphs B and B.1, B.2, B.3, and/or B.4.

10. The facts in Paragraphs C and C.1, C.2, C.3, C.4, C.5, C.6, and/or C.7.

11. The facts in Paragraphs D and D.1, D.2, D.3, D.4, D.5, and/or D.7.

12. The facts in Paragraphs E and E.1, E.2, E.3, E.4, and/or E.5.

13. The facts in Paragraphs F and F.2, F.3, F.4, F.5, F.6, F.7, and/or F.8.

14. The facts in Paragraphs G and G.1, G.2, G.3, G.4, G.5, G.6, and/or G.7.

FIFTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of New York Education Law §6530(3), in that Petitioner charges two or more of the following:

15. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6, A.6; B and B.1, B.2, B.3, B.4; C and C.1, C.2, C.3, C.4, C.5, C.6, C.7; D and D.1, D.2, D.3, D.4, D.5, D.7; E and E.1, E.2, E.3, E.4, E.5; F and F.2, F.3, F.4, F.5, F.6, F.7, F.8; and/or G and G.1, G.2, G.3, G.4, G.5, G.6, G.7.

SIXTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more than one occasion in violation of New York Education Law §6530(5), in that Petitioner charges two or more of the following:

16. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6, A.6; B and B.1, B.2, B.3, B.4; C and C.1, C.2, C.3, C.4, C.5, C.6, C.7; D and D.1, D.2, D.3, D.4, D.5, D.7; E and E.1, E.2, E.3, E.4, E.5; F and F.2, F.3, F.4, F.5, F.6, F.7, F.8; and/or G and G.1, G.2, G.3, G.4, G.5, G.6, G.7.

SEVENTEENTH THROUGH TWENTY-EIGHTH SPECIFICATIONS

FRAUD

Respondent is charged with practicing the profession fraudulently in violation of New York Education Law §6530(2), in that Petitioner charges:

17. The facts in Paragraphs A and A.6.
18. The facts in Paragraphs B and B.4.
19. The facts in Paragraphs C and C.6.
20. The facts in Paragraphs C and C.7.
22. The facts in Paragraphs D and D.7.
23. The facts in Paragraphs E and E.5.
24. The facts in Paragraphs F and F.6.
25. The facts in Paragraphs F and F.7.
26. The facts in Paragraphs F and F.8.
27. The facts in Paragraphs G and G.6.
28. The facts in Paragraphs G and G.7.

TWENTY-NINTH THROUGH FORTIETH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine in violation of New York Education Law §6530(20), in that Petitioner charges:

The allegations of the seventeenth through twenty-ninth specifications are repeated as if fully set forth herein.

DATED: AUGUST 22, 2000
Albany, New York

/s/ PETER D. VAN BUREN
PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct