These charges are only allegations which may be contested by the licensee in an Administrative hearing.

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

IN THE MATTER OF PAUL HODGEMAN, P.A.	STATEMENT OF CHARGES

PAUL HODGEMAN, P.A., Respondent, was licensed to practice as a physician assistant in New York State on July 21, 1998, by the issuance of license number 006485 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A, (patients are identified in attached Appendix A) a 21 year old female patient at the time of treatment at Lourdes Memorial Hospital, Binghamton, New York, on or about August 13, 2007, for follow up treatment of bipolar disorder and concern of irregular menses. During the examination, Patient A advised Respondent her most recent period was last November and that she had not had a gynecological examination in ten years. Respondent examined Patient A's abdomen, which he found to be benign. In regard to Patient A's complaints of irregular menses, Respondent ordered a variety of blood work and stated that he would follow up with Patient A in three months unless otherwise indicated. The blood work which Respondent ordered did not include a hCG test. Three days later, on August 16, 2007, Patient A arrived at the Emergency Department of Lourdes Memorial Hospital with a full-term pregnancy and delivered her baby on that same date. Respondent's medical care of Patient A deviated from accepted standards of care as follows:

1. Respondent failed to perform and/or document an adequate physical examination of Patient A on August 13, 2007.

2. Respondent, during his examination of August 13, 2007, failed to recognize or document signs of pregnancy during the examination of Patient A.

3. Respondent, although he ordered several tests on August 13, 2007, failed to request, perform, and/or document he requested or performed hCG blood work to determine if Patient A was pregnant.

4. Respondent failed to maintain a record that accurately reflected the evaluation and treatment of Patient A on August 13, 2007.

B. Respondent provided medical care to Patient B, a 37 year old female patient at the time of treatment at Lourdes Memorial Hospital, Binghamton, New York, on or about November 3, 2008, for a physical and PAP smear. During the examination, Respondent performed a pelvic examination and found normal female genitalia without lesion or discharge and PAP obtained without incident. Respondent's examination of Patient B's abdomen revealed the abdomen was soft and nontender. Respondent's plan was to reassess Patient B in three months unless otherwise indicated. Respondent did not order Patient B undergo any blood work, including an hCG test. Nine days later, on November 12, 2008, Patient B presented at Lourdes Memorial Hospital with a full-term pregnancy and delivered a baby on the same date. Respondent's medical care of Patient B deviated from accepted standards of care as follows:

1. Respondent failed to perform and/or document an adequate examination of Patient B on November 3, 2008.

2. Respondent failed to recognize and/or document signs of pregnancy during the examination of Patient B on November 3, 2008.

3. Respondent failed to maintain a record that accurately reflected the evaluation and treatment of Patient B on November 3, 2008.

C. Respondent provided medical care to Patient C, a 40 year old male patient at the time of treatment at Lourdes Memorial Hospital, Binghamton, New York, at various times from on or about February 29, 2012, to on or about September 25, 2013, for back and left knee pain. Respondent's medical care of Patient C deviated from accepted standards of care as follows:

1. Respondent failed to obtain and/or document an adequate history for Patient C during his first examination on February 29, 2012.

2. Respondent, initially and throughout the course of treatment of Patient C, failed to adequately document Patient C's goals and expectations for functional recovery.

3. Respondent prescribed Patient C controlled substances to Patient C contrary to accepted medical standards of care as follows:

   a. Respondent prescribed a thirty (30) day supply of the controlled substance Oxycodone 30mg on December 28, 2012, and, five days later, wrote a separate thirty (30) day supply of Oxycodone 30mg on January 2, 2013, without adequate medical indication and/or without documentation such medication was indicated.

   b. Respondent prescribed a thirty (30) day supply of the controlled substance Oxycodone 30mg on August 3, 2013, and, five days later, wrote a separate thirty (30) day supply of Oxycodone 30mg on August 8, 2013, without adequate medical indication and/or without documentation such medication was indicated.

   c. Respondent prescribed a thirty (30) day supply of the controlled substance Oxycodone 30mg on November 1, 2013, and, five days later, wrote a separate thirty (30) day supply of Oxycodone 30mg on November 6, 2013, without adequate medical indication and/or without documentation such medication was indicated.

   d. Respondent prescribed a thirty (30) day supply of the controlled substance Oxycodone/Acetaminophen 10/325mg on April 4, 2013,

and on the same date, wrote a separate prescription for a thirty (30) day supply of the same controlled substance without adequate medical indication and/or without documentation such medication was indicated.

e Respondent, throughout his course of treatment of Patient C, prescribed excessive amounts of controlled substances.

f. Respondent prescribed inappropriate types of controlled substances without medical indication.

g. Respondent improperly prescribed Oxycodone in longer-acting preparation concurrent with shorter-acting preparation without medical indication and/or without adequate documentation such medication was indicated.

4. Respondent prescribed Oxycodone 30mg to Patient C on November 1, 2013, November 6, 2013, and/or December 2, 2013, without performing an examination and/or without adequate documentation of such examination.

5. Respondent, throughout his course of treatment of Patient C, failed to adequately document Patient C's progress and/or functional status in response to treatment.

6. Respondent, throughout his course of treatment of Patient C, failed to adequately document and/or discuss non-narcotic treatment options with Patient C, and/or failed to document such discussion.

7. Respondent failed to refer Patient C to a pain management specialist and/or adequately document such discussion or referral.

D. Respondent provided medical care to Patient D, a 35 year old female patient at the time of treatment at Lourdes Memorial Hospital, Binghamton, New York, at various times from on or about December 2010, to on or about September 2013,

for low back pain and knee pain among other conditions. Respondent's medical care of Patient D deviated from accepted standards of care as follows:

1. Respondent, throughout his course of treatment of Patient D, failed to adequately perform and/or document a physical examinations of Patient D to support his diagnoses.

2. Respondent prescribed narcotic analgesics to Patient D contrary to accepted standards of care as follows:

    a. Respondent prescribed excessive amounts of narcotic analgesics to Patient D without adequate medical indication and/or without documentation such medication was indicated.

    b. Respondent inappropriately prescribed multiple opioids to Patient D rather than prescribing one long-acting agent for long-term treatment of chronic pain, and/or without adequate documentation such medication was indicated.

3. Respondent, throughout his course of treatment of Patient D, failed to adequately document Patient D's progress and/or functional status in response to treatment.

E. Respondent provided medical care to Patient E, a 29 year old female patient at the time of treatment at Lourdes Memorial Hospital, Binghamton, New York, at various times from on or about August 2010, to on or about May 2013, for chronic back pain, among other conditions. Respondent's medical care of Patient E deviated from accepted standards of care as follows:

1. Respondent, throughout his course of treatment of Patient E, failed to discuss and/or document any such discussion of the risks of pregnancy while Patient E was taking controlled substances.

2. Respondent failed to perform and/or adequately document a urine toxicology screen at Patient E's initial visit.

3. Respondent, throughout his course of treatment of Patient E, failed to adequately document Patient E's progress and/or functional status in response to treatment.

4. Respondent, throughout his course of treatment of Patient E, failed to adequately document a treatment plan for reduction of narcotic analgesics.

5. Respondent failed to adequately monitor and/or document Patient E's cardiac status despite prescribing Patient E high doses of methadone, which dosage had increased during Respondent's treatment of Patient E.

6. Respondent, throughout his course of treatment of Patient E, failed to maintain a record that accurately reflected the evaluation and treatment of Patient E.

F. Respondent provided medical care to Patient F, a 33 year old female patient at the time of treatment at Lourdes Memorial Hospital, Binghamton, New York, at various times from on or about February 2010, to on or about September 2013, for chronic thoracic and lumbar back pain, among other conditions. Respondent's medical care of Patient F deviated from accepted standards of care as follows:

1. Respondent, throughout his course of treatment, failed to discuss and/or document a discussion with Patient F regarding the risk of opioids during pregnancy.

2. Respondent, throughout his course of treatment of Patient F, failed to discuss and/or document a discussion regarding the risks of impairment with Patient F.

3. Respondent, throughout his course of treatment, failed to adequately document a treatment plan for assessing and evaluating Patient F's functional status in response to treatment.

4. Respondent inappropriately prescribed short-acting narcotics without discussing non-narcotic medications and/or therapies with Patient F.

5. Respondent inappropriately prescribed Patient F increasing dosages of narcotic analgesics without medical indication and without adequately documenting such.

6. Respondent failed to maintain a record that accurately reflected the evaluation and treatment of Patient F.

G. Respondent provided medical care to Patient G a 45 year old male patient at the time of treatment at Lourdes Memorial Hospital, Binghamton, New York, at various times from on or about October 6, 2009 to on or about April 2, 2014, for chronic pain issues. Respondent's medical care of Patient G deviated from accepted standards of care as follows:

1. Respondent failed to adequately perform and/or document having performed an initial examination of Patient G.

2. Respondent failed to treat and/or adequately document the progress of Patient G's knee and wrist pain after Patient G presented with neck and low back pain.

3. Respondent inappropriately prescribed narcotic analgesics to Patient G contrary to accepted standards of care as follows:

   a. Respondent prescribed narcotic analgesics for Patient G's knee pain despite an MRI showing no abnormality and/or failed to adequately document such medication was indicated.

   b. Respondent prescribed escalating doses of narcotic analgesics to Patient G without adequate medical indication and/or failed to adequately document such medication was indicated.

c. Respondent, from December 28, 2011, to February 21, 2012, prescribed inappropriate doses of Oxycodone without adequate medical indication and/or without documentation such medication was indicated. In total, Respondent prescribed Patient G one thousand five hundred (1,500) tablets of Oxycodone 30 mg from December 28, 2011 through February 21, 2012.

4. Respondent throughout his course of treatment of Patient G, failed to adequately document Patient G's functional losses and/or progress in response to treatment.

5. Respondent throughout his course of treatment of Patient G, failed to evaluate and/or adequately document alternative causes of Patient G's pain.

6. Respondent failed to adequately treat and/or adequately document the management of Patient G's diabetes mellitus type 2 and coronary artery disease.

7. Respondent failed to maintain a record that accurately reflected the evaluation and treatment of Patient G.

SPECIFICATIONS

FIRST, SECOND, AND THIRD SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. The facts in Paragraphs A and A.2, and/or A and A.3;

2. The facts in Paragraphs B and B.2; and/or

3. The facts in Paragraphs C and C.3(d), and/or C and C.4.

FOURTH, FIFTH, AND SIXTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

4. The facts in Paragraphs A and A.2, and/or A and A.3;

5. The facts in Paragraphs B and B.2; and/or

6. The facts in Paragraphs C and C.3(d), and/or C and C.4.

SEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of the following:

7. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3(a), C and C.3(b), C and C.3(c), C and C.3(d), C and C.3(e), C and C.3(f), C and C.3(g), C and C.4, C and C.5, C and C.6, C and C.7, D and D.1, D and D.2(a), D and D.2(b), D and D.3, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, G and G.1, G and G.2, G and G.3(a), G and G.3(b), G and G.3(c), G and G.4, G and G.5, G and G.6, and/or G and G.7.

EIGHTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of the following:

8. The facts in Paragraphs A and A.2, A and A.3, B and B.2, C and C.3(a), C and C.3(b), C and C.3(c), C, and C.3(d), and/or G and G.3(c).

NINTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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

9. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3(a), C and C.3(b), C and C.3(c), C and C.3(d), C and C.3(e), C and C.3(f), C and C.3(g), C and C.4, C and C.5, C and C.6, C and C.7, D and D.1, D and D.2(a), D and D.2(b), D and D.3, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, G and G.1, G and G.2, G and G.3(a), G and G.3(b), G and G.3(c), G and G.4, G and G.5, G and G.6, and/or G and G.7.

DATE: July 24, 2017
Albany, New York

[redacted]

MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct