Department of Health

ANDREW M. CUOMO
Governor

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

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

December 21, 2017

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Marc S. Nash, Esq.
NYS Department of Health
Corning Tower Room 2512
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O'Connor, O'Connor, Bresee & First, Esqs.
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RE: In the Matter of Paul Hodgeman, P.A.

Dear Parties:

Enclosed please find the Determination and Order (No.17-358) 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), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent 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.

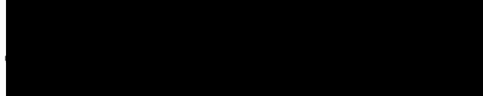
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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

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

Sincerely,



James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: nm

Enclosure

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

IN THE MATTER OF PAUL HODGEMAN, P.A.	DETERMINATION AND ORDER

BPMC-17-358

A Notice of Hearing and Statement of Charges, both dated July 24, 2017, were served upon **PAUL HODGEMAN, P.A.** ("Respondent"). **LYON GREENBERG, M.D.**, Chairperson, **HEIDI MILLER, PA-C**, and **GREGORY THREATTE, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) of the Public Health Law of the State of New York ("Public Health Law"). Administrative Law Judge ("ALJ") **JUDE MULVEY, ESQ.**, served as the Administrative Officer.

The Department of Health, Office of Professional Medical Conduct ("Petitioner" or "the Department") appeared by RICHARD J. ZAHNLEUTER, General Counsel, by **MARC S. NASH, ESQ.**, of Counsel. Respondent was represented by O'CONNOR, O'CONNOR, BRESEE & FIRST, ESQS., by **BAIRD JOSLIN, ESQ.** Evidence was received, witnesses sworn and heard, and transcripts of the proceedings were made.

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

PROCEDURAL HISTORY

Pre-Hearing Conference:	September 5, 2017
Hearing Dates:	September 13, 2017
Witness for Petitioner:	Matthew Sean Loftus, P.A.
Witness for Respondent:	Paul Hodgeman, P.A.
Deliberations Held:	September 13, 2017 December 5, 2017

STATEMENT OF CASE

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

FINDINGS OF FACT

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

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

1. Respondent was licensed to practice as a physician assistant in New York State in approximately June of 1998. (T. 98)

2. On August 13, 2007, Respondent provided medical care to Patient A, a 21-year-old female, at an outpatient clinic operated by Lourdes Memorial Hospital, Binghamton, New York, ("Lourdes Hospital") for follow up treatment of bipolar disorder. Respondent documented that Patient A stated her concern of irregular menses and that she advised him that her most recent period was in November 2016, and that she had not had a gynecological examination in ten years. (Ex. 1, p. 2)

3. On August 17, 2007, Patient A went to Lourdes Hospital and was diagnosed as being pregnant with a mean gestational age of 37 weeks and three days plus or minus three weeks. (Ex. 1, p. 4)

4. Respondent had documented that he examined Patient A's abdomen on August 13, 2007, but he failed to recognize that Patient A was pregnant or to order a human chorionic gonadotropin ("hCG") blood test. Respondent also failed to document that he took Patient A's vital signs. (Ex. 1, p. 2)

5. A reasonably prudent and competent physician assistant would have recognized that Patient A was pregnant when performing a physical examination and would have ordered a hCG test. This was a severe deviation from the standard of care. (T. 22-25, 35)

6. On November 3, 2008, Respondent provided medical care to Patient B, a 37-year-old female, at an outpatient clinic operated by Lourdes Hospital, for a physical examination and PAP smear. (Ex. 2, p. 2)

7. On November 12, 2008, Patient B was admitted to Lourdes Hospital with a full-term pregnancy and delivered a baby that day. (Ex. 2, p. 62)

8. Respondent had documented on November 3, 2007, that he performed a pelvic examination on Patient B and found normal female genitalia without lesion or discharge and that he had obtained a PAP smear without incident. He also documented that he examined Patient B's abdomen, which revealed the abdomen was soft and nontender, but he failed to recognize that Patient B was pregnant or to order a hCG blood test. (Ex. 2, p. 2)

9. A reasonably prudent and competent physician assistant would have recognized that Patient B was pregnant when performing a physical examination and would have ordered a hCG blood test. This was a severe deviation from the standard of care. (T. 38-39)

10. Respondent provided medical care to Patient C, a 40-year-old male, at an outpatient clinic operated by Lourdes Hospital from approximately February 29, 2012, through September 25, 2013, for knee and back pain. (Ex. 3)

11. Respondent failed to obtain and/or document an adequate patient history or physical examination on February 29, 2012. (Ex. 3, p. 34; T. 49)

12. Respondent failed to document Patient C's goals and expectations for functional recovery. (Ex. 3, p. 34; T. 51-52)

13. Respondent prescribed a 30-day supply of the controlled substance Oxycodone 30 mg to Patient C on December 27, 2012. He then prescribed another 30-day supply of Oxycodone 30 mg to Patient C on January 2, 2013, without adequate medical indication and/or without such documentation. (Ex. 3, 35)

14. Respondent prescribed a 30-day supply of the controlled substance Oxycodone 30 mg to Patient C on August 3, 2013. He then prescribed another 30-day supply of Oxycodone 30 mg to Patient C on August 8, 2013, without adequate medical indication and/or without such documentation. (Ex. 3, 35)

15. Respondent prescribed a 30-day supply of the controlled substance Oxycodone 30 mg to Patient C on November 1, 2013. He then prescribed another 30-day supply of Oxycodone 30 mg to Patient C on November 6, 2013, without adequate medical indication and/or without such documentation. (Ex. 3, 35)

16. Respondent prescribed a 30-day supply of the controlled substance Oxycodone/Acetaminophen 10/325 mg to Patient C on April 4, 2013. He then wrote a separate prescription for another 30-day supply of Oxycodone/Acetaminophen 10/325 mg to Patient C on the same day,

without adequate medical indication and/or without such documentation. (Ex. 3, 35)

17. Respondent prescribed excessive amounts of controlled substances to Patient C throughout his course of treatment. A reasonably prudent and competent physician assistant would not have prescribed these amounts of controlled substances, and this was a severe deviation from the standard of care. (Ex. 3-7; T. 56, 59-62)

18. Respondent prescribed both short-acting and long-acting narcotics to Patient C throughout his course of treatment. However, there was no medical indication for prescribing both short-acting and long-acting narcotics concurrently for Patient C. (Ex. 3; T. 63).

19. Respondent prescribed Oxycodone 30 mg to Patient C on November 1, 2013, November 6, 2013 and December 2, 2013, without performing an examination and/or without adequate documentation of such examination. This is a severe deviation from the standard of care required by a physician assistant. (Ex. 3; T. 60-61)

20. Respondent provided medical care to Patient E, a 29-year-old female, at an outpatient clinic operated by Lourdes Hospital from approximately August 2010, through May 2013, for chronic back pain, among other conditions. (Ex. 21)

21. During his course of treatment, Respondent failed to discuss and/or document a discussion with Patient E regarding the risks of pregnancy while taking prescribed substances. (Ex. 21)

22. A reasonably prudent physician assistant would discuss the risks of taking narcotics with a woman of child-bearing years because there are dangers to a developing fetus from those medications, and he would document the discussion. (T. 67)

23. Respondent failed to perform and/or adequately document a urine toxicology screen during Patient E's initial visit. (Ex. 21)

24. During his course of treatment, Respondent failed to adequately document Patient E's progress and/or functional status in response to treatment. (Ex. 21)

25. A reasonably prudent physician assistant would have documented Patient E's functional status in response to treatment. (T. 69)

26. During his course of treatment, Respondent failed to adequately document a treatment plan for the reduction of Patient E's narcotic analgesics. (Ex. 21; T. 69)

27. A reasonably prudent physician assistant would attempt to mitigate the risks of prescribing large amounts of narcotics by, for example, checking cardiac status with an EKG and closely monitoring respiratory status, particularly for a patient with COPD. (T. 70-73)

28. Respondent failed to adequately monitor and/or document Patient E's cardiac status. (Ex. 21; T. 70-73)

29. Respondent provided medical care to Patient F, a 33-year-old female, at an outpatient clinic operated by Lourdes Hospital from

approximately February 2010, through September 2013, for chronic thoracic and lumbar back pain, among other conditions. (Ex. 26)

30. During his course of treatment, Respondent failed to discuss and/or document a discussion with Patient F regarding the risks of pregnancy while taking prescribed substances. (Ex. 26; T. 76)

31. A reasonably prudent physician assistant would discuss the risks of taking narcotics with a woman of child-bearing years because there are dangers to a developing fetus with those medications, and he would document the discussion. (T. 77)

32. During his course of treatment, Respondent did not discuss with Patient F and/or document a discussion regarding the risks of impairment. This failure was a deviation from the standard of care required of a reasonably prudent physician assistant. (Ex. 26; T. 77)

33. During his course of treatment, Respondent failed to adequately document Patient F's progress and/or functional status in response to treatment. This failure was a deviation from the standard of care of a reasonably prudent physician assistant. (Ex. 26; T. 78)

34. Respondent prescribed both short-acting and long-acting narcotics and increased the dosages of these medications for Patient F with no documented medical basis. A reasonably prudent physician assistant would only prescribe these medications concurrently and in increasing dosages if some medical indication existed and was documented. (Ex. 26; T. 78-82)

35. Respondent provided medical care to Patient G, a 45-year-old male, at an outpatient clinic operated by Lourdes Hospital from approximately October 6, 2009, through December of 2013, for chronic pain issues. (Ex. 28)

36. A reasonably prudent physician assistant would obtain a complete medical history and medications during the initial examination of a patient. Respondent failed to perform an adequate initial examination. (Ex. 28, p. 142; T. 84-85)

37. During his course of treatment, Respondent failed to adequately document Patient G's progress and/or functional status in response to treatment. This failure was a deviation from the standard of care of a reasonably prudent physician assistant. (Ex. 28; T. 78)

38. During his initial visit on October 6, 2009, Patient G complained of left wrist and knee pain, after he had tripped and fallen. During a subsequent visit on February 21, 2012, Patient G complained of lower back pain and abdominal discomfort as a result of a motor vehicle accident that occurred the day before. Respondent prescribed continuing and increasing dosages of narcotics without medical indication or documentation. A reasonably prudent physician assistant would reevaluate a patient on an ongoing basis and only prescribe narcotics for which there was a medical indication. (Ex. 28, p. 142,96, 98; T. 89-92)

CONCLUSIONS OF LAW

As required by PHL § 230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing the allegations of misconduct by a preponderance of the evidence. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department (See Prince, Richardson on Evidence § 3-206). Having considered the complete record in this matter, the Hearing Committee concludes that the Department has established the nine specifications contained in the Statement of Charges. The sustained specifications include gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, and failing to maintain a record which accurately reflects the evaluation and treatment of the patient. The Hearing Committee made these conclusions of law pursuant to the factual findings listed above, and all conclusions resulted from a unanimous vote of the Hearing Committee unless specifically noted otherwise.

The Department's expert witness, Matthew Sean Loftus, P.A., completed the physician assistant program at the University of Wisconsin. He is licensed in New York State and has obtained national certification as a physician assistant. He has been employed as a physician assistant at Glens Falls Hospital for 17 years. The Hearing

Committee found his testimony to be credible and consistent with the medical records in evidence.

Respondent did not offer the testimony of an expert witness, but he testified on his own behalf. Respondent obtained his high school equivalency diploma while in the United States Army serving three years active duty. When he was honorably discharged in 1986, he initially attended Broome Community College and then transferred to D'Youville College where he obtained a Bachelor of Science degree in physician assistant studies in 1998. He became a licensed physician assistant in 1998, and he worked as a physician assistant in outpatient clinics of Lourdes Hospital from December 1998 through December 2013.

In his testimony, Respondent acknowledged his deficient practice. He stated that he had a four-week preceptorship in women's health, but that his physician assistant training included no pelvic examinations of a pregnant woman. After the incidents with Patient A and Patient B, he worked with one of the OB-GYNs at Lourdes Hospital for approximately six weeks to become more accustomed to those types of examinations. Respondent also stated that no real training regarding the issues that one can encounter treating pain management patients. He has recently taken course work on opioid prescribing, and he stated that he is now more confident in his ability to appropriately prescribe narcotics.

Respondent has maintained his certification as a physician assistant and is currently employed in skilled nursing facilities in rural upstate New York. Most patients are long term care, but some are

placed there for short term rehabilitation. He stated that he writes refills of prescription that have been ordered by a physician at the skilled nursing facilities, but that he does not initiate prescriptions.

SPECIFICATIONS

At the hearing, the Department withdrew factual allegations D, D1, D2, D3, E6, F6, G5, G6 and G7. The Department also amended paragraphs A, C(3)(a), and G. The Hearing Committee did not consider the withdrawn factual allegations when determining whether the following specifications had been established.

The First through Third Specifications charged the Respondent with professional misconduct for practicing the profession with gross negligence on a particular occasion in his care of Patients A through C. The Department established by a preponderance of the evidence that Respondent's failure to examine and recognize the signs of pregnancy for Patient A and Patient B, and that Respondent's prescribing of excessive amounts and inappropriate types of controlled substances for Patient C were severe deviations from the standard of care. Accordingly, the First through Third Specifications are sustained.

The Fourth through Sixth Specifications charged the Respondent with professional misconduct for practicing the profession with gross incompetence on a particular occasion in his care of Patients A through C. The Department established by a preponderance of the evidence that Respondent's failure to adequately examine Patient A and Patient B to

recognize the signs of pregnancy and that Respondent's prescribing of excessive amounts and inappropriate types of controlled substances demonstrated severe deviations from the standard of care of a reasonably competent physician assistant. Accordingly, the Fourth through Sixth Specifications are sustained.

The Seventh Specification charged Respondent with professional misconduct for practicing medicine with negligence on more than one occasion in his care of Patients A, B, C, E, F and G, in violation of New York Education Law § 6530(3). As indicated in the finding of fact above, the Department established by a preponderance of the evidence that Respondent's practice of medicine showed a pattern of providing a course of treatment for these patients which was not within the standard of care of a reasonably prudent physician assistant. Accordingly, the Seventh Specification is sustained.

The Eighth Specification charged Respondent with professional misconduct for practicing medicine with incompetence in his care of Patient A, B, C, E, F and G, in violation of New York Education Law § 6530(5). As indicated in the finding of fact above, the Department established by a preponderance of the evidence that Respondent's practice of medicine showed a pattern of providing a course of treatment for these patients which was not within the standard of care of a reasonably competent physician assistant. Accordingly, the Eighth Specification is sustained.

The Ninth Specification charged Respondent with failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in violation of Education Law § 6530(32). As indicated in the findings of fact, the Department established by a preponderance of the evidence that the Respondent failed to adequately document his care of these six patients. As such, the Ninth Specification is sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee considered the full spectrum of penalties available pursuant to statute, including revocation, suspension, probation, censure, and the imposition of civil penalties.

Respondent admitted his mistakes and deficits in training as a physician assistant, but contended that those deficiencies have been corrected so that he is now providing a valuable medical service to the residents at the skilled nursing facilities where he is employed. He understood and accepted that there would be a consequence for his misconduct, but asked that a penalty be imposed which would allow him to continue the work that he is currently performing with appropriate supervision. The Department stated that revocation of Respondent's license was warranted, but asked for a suspension and/or probation with monitoring and a substantial limitation on Respondent's ability to prescribe controlled substances, if the panel believed that revocation was not warranted.

The Hearing Committee found that Respondent was a caring practitioner who was honest, accepted responsibility for his actions, and showed remorse. The Hearing Committee was also persuaded that Respondent's improper prescribing of controlled substances was based on his lack of judgment, training and experience, rather than motivated by any fraudulent intent or self-interest. The record shows that Respondent has obtained additional training and experience subsequent to these incidents of professional misconduct, and that he is currently working without further incidents in skilled nursing facilities in rural north country communities that need practitioners.

The Hearing Committee recognized Respondent's prior misconduct, but was confident that Respondent can provide valuable and safe medical care to patients such as the nursing home residents for whom he currently provides care. The Hearing Committee determined that any further misjudgments by Respondent related to the prescription of narcotics can be addressed by limiting the Respondent's license to prevent him from practicing as a physician assistant in a pain management clinic. To ensure that Respondent prescription of narcotics in other settings is appropriate, the Hearing Committee decided to impose a requirement that a supervising physician performs a timely chart review whenever Respondent issues a new prescription for controlled substances or increases the dosage of a controlled substance. For additional confidence that Respondent's practice meets acceptable standards in all areas, the Hearing Committee decided to place

Respondent on probation for five years and impose a requirement that Respondent's practice as a physician assistant be monitored. The Hearing Committee anticipates that Respondent will be able to safely practice as a physician assistant with these conditions in place.

ORDER

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

1. The nine specifications of professional misconduct, as set forth in the Statement of Charges are SUSTAINED;

2. Respondent's license to practice as a physician assistant is suspended for a period of five years, but the suspension is stayed in its entirety and Respondent is placed on probation for five years.

3. Within sixty days of the effective date of this Determination and Order, Respondent shall practice as a physician assistant only when monitored by a licensed physician as detailed in paragraph seven of the terms of probation set forth in Attachment A;.

4. During the period of probation, Respondent shall ensure that a physician performs a chart review of any patient for whom Respondent has issued a new prescription or increased dosage of a controlled substance. The chart review must take place and be documented in the patient record within two weeks of the prescription;

5. Respondent's license to practice as a physician assistant is permanently limited to prohibit Respondent from practicing in a pain management clinic;

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

DATED: Albany, New York
December , 2017

LYON M. GREENBERG, M.D. (CHAIR)

HEIDI B. MILLER, PA-C
GREGORY ALLEN THREATTE, M.D.

TO: Mark Nash, Esq.
Bureau of Professional Medical Conduct
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APPENDIX I

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~~ Patient A delivered her baby on ~~that same date~~. September 2, 2007. Respondent's medical care of Patient A deviated from accepted standards of care as follows: Amended 9/13/17, T. 18

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~~ 27, 2012, and, ~~five~~ six 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.
   Amended 9/13/17, T.9

   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. ~~[illegible] [illegible] 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.~~ Withdrawn 9/13/17, T.66

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.~~ Withdrawn 9/13/17, T. 73

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.~~ Withdrawn 9/13/17, T. 75

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~~ December of 2013, for chronic pain issues. Respondent's medical care of Patient G deviated from accepted standards of care as follows: Amended 9/13/17, T. 9-10

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.~~ Withdrawn 9/13/17, T.92

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).

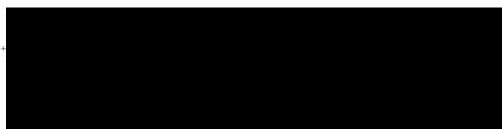
NINTH SPECIFICATION

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



MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct

ATTACHMENT A

Terms of Probation

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

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

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

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

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

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

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

7. Within sixty days of the effective date of this Determination and Order, Respondent shall practice as a physician assistant only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Any medical practice in violation of this term shall constitute the unauthorized practice of medicine.

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

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

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

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

8. During the period of probation, Respondent shall ensure that a physician performs a chart review of any patient for whom Respondent has issued a new prescription or increased dosage of a controlled substance. The chart review must take place and be documented within two weeks of the prescription.

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