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

IN THE MATTER OF KEVIN WEINER, M.D.	NOTICE OF HEARING

TO: Kevin Weiner
262 Nelson Avenue
Staten Island, NY 10304

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on June 30, 2022, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street 4th Floor, NY, NY 10003, or by video conference as directed by the Administrative Law Judge, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing, or by video conference if directed by the Administrative Law Judge and may be represented by counsel who shall be an attorney admitted to practice in New York state. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses

and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

YOU ARE HEREBY ADVISED THAT THE ATTACHED CHARGES WILL BE MADE PUBLIC FIVE BUSINESS DAYS AFTER THEY ARE SERVED.

Department attorney: Initial here-[redacted]

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Riverview Center,150 Broadway - Suite 510, Albany, NY 12204-2719, ATTENTION: HON. JAMES HORAN, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the

Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATE May 20, 2022

[redacted]
HENRY WEINTRAUB
Chief Counsel
Bureau of Professional Medical Conduct

New York, NY

Inquiries should be directed to:
Leslie Eisenberg, Associate Counsel
Bureau of Professional Medical Conduct
[redacted]

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

IN THE MATTER OF KEVIN WEINER, MD

STATEMENT

OF

CHARGES

Kevin Weiner, M.D., the Respondent, was authorized to practice medicine in New York State on or about February 20, 1996, by the issuance of license number 202165 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A from in or about January 2013 through in or about November 2016. Respondent's documented first visit appears to be a revisit. Thereafter, Respondent documented almost monthly visits, during which he continued to prescribe multiple medications (OxyContin, Oxycodone, Flexeril, Relafen and a Z-Pack) simultaneously. Respondent documented performing approximately 12 steroid injections over a 2-year period. (Patient names are listed in the Appendix.) Respondent's care and treatment of the patient deviated from minimally accepted standards of care in that he:

1. Failed to:

   a. appropriately evaluate the patient, including but not limited to, taking and/or noting a thorough history, performing and/or noting a comprehensive physical examination, performing and/or noting manual muscle testing and, ordering and/or reviewing appropriate imaging studies,

   b. properly render a diagnosis prior to instituting treatment with prescription medications,

c. develop, implement, and revise as necessary, a personalized treatment plan,

d. adequately and appropriately follow-up on prior complaints, recommended treatments and/or injections or procedures performed,

e. appropriately monitor the patient while on prescribed medications, including but not limited to, checking and/or documenting I-Stop, ordering and/or documenting urine testing at appropriate intervals, and/or using outcome measures to assess disability level or functional status,

f. reassess the patient's symptoms and/or modify treatment when the patient was not progressing or showing any signs of improvement, and

g. maintain a medical record that accurately reflects the care and treatment rendered to the patient.

2. Inappropriately:

a. prescribed and/or changed medications, without medical rationale or justification,

b. prescribed multiple medications, simultaneously, placing the patient at increased risk,

c. prescribed medications outside the frequency guidelines,

d. performed trigger point injections, without medical rationale or justification,

e. performed injections in the shoulder, which were contraindicated, with a diagnosis of labral and rotator cuff tears, and

f. performed more than 4 steroid injections in a 12-month period.

B. Respondent treated Patient B from in or about July 2013 through in or about November 2016, for complaints of bilateral hand pain, back, shoulder and neck pain. Respondent's documented first visit appears to be a revisit. Thereafter, Respondent documented almost monthly visits, during which he continued to prescribe multiple medications including opioids and methadone. Respondent's care and treatment deviated from minimally accepted standards of care in that he:

1. Failed to:

a. appropriately evaluate the patient, including but not limited to, taking and/or noting a thorough history, performing and/or noting a comprehensive physical examination, performing and/or noting manual muscle testing and, ordering and/or reviewing appropriate imaging studies,

b. properly render a diagnosis prior to instituting treatment with prescription medications,

c. develop, implement, and revise as necessary, a personalized treatment plan,

d. adequately and appropriately follow-up on prior complaints, recommended treatments and/or injections or procedures performed,

e. appropriately monitor the patient while on prescribed medications, including but not limited to, checking and/or documenting I-Stop, ordering and/or documenting urine testing at appropriate intervals, and/or using outcome measures to assess disability level or functional status,

f. reassess the patient's symptoms and/or modify treatment when the patient was not progressing or showing any signs of improvement,

g. order and/or perform a baseline Creatinine,

h. perform an EKG prior to starting methadone and again within 30 days of starting the medication, and

i. maintain a record that accurately reflects the care and treatment of the patient.

2. Inappropriately:

a. prescribed and/or changed medications, without medical rationale or justification,

b. prescribed multiple medications, simultaneously, placing the patient at increased risk, and

c. prescribed medications outside the frequency guideline.

C. Respondent treated Patient C from in or about March 2013, after he was involved in a car accident, through in or about November 2016. Respondent's documented first

visit appears to be a revisit. Thereafter, Respondent documented almost monthly visits, during which he continued to prescribe multiple medications (Viagra, Xanax, Percocet, Adderall, Flonase nasal spray, Norco Concerta, and Medrol Dose Pak) simultaneously. Respondent's care and treatment deviated from minimally accepted standards of care in that he:

1. Failed to:

   a. appropriately evaluate the patient, including but not limited to, taking and/or noting a thorough history, performing and/or noting a comprehensive physical examination, performing and/or noting manual muscle testing and, ordering and/or reviewing appropriate imaging studies,

   b. properly render a diagnosis prior to instituting treatment with prescription medications,

   c. develop, implement, and revise as necessary, a personalized treatment plan,

   d. adequately and appropriately follow-up on prior complaints, recommended treatments and/or injections or procedures performed,

   e. appropriately monitor the patient while on prescribed medications, including but not limited to, checking and/or documenting I-Stop, ordering and/or documenting urine testing, at appropriate intervals, and/or use of outcome measures to assess disability level or functional status,

   f. reassess the patient's symptoms and/or modify treatment when the patient was not progressing or showing any signs of improvement,

   g. identify specifics when recommending an MRI of the leg, and

   h. maintain a record that accurately reflects the care and treatment of the patient.

2. Inappropriately:

   a. prescribed and/or changed medications, without medical rationale or justification,

   b. prescribed multiple medications, simultaneously, placing the patient at increased risk,

c. recommended the patient see a neurosurgeon, based on his lumbar MRI, rather than based on progressive neurologic deficits, loss of bowel and/or bladder control or, failure to respond to medical treatments, and

d. suggested the patient follow-up with a neurosurgeon for EMG, which is routinely performed by a physiatrist.

D. Respondent treated Patient D, who complained of back and knee pain, from in or about January 2013 through in or about November 2013. Respondent's documented first visit appears to be a revisit. Thereafter, Respondent documented almost monthly visits, during which he continued to prescribe multiple medications, including multiple opioids (Exalgo and Percocet, adding Oxycodone in September) and a NSAID (Relafen), as well as Xanax and Voltaren 1% Gel. Respondent performed steroid injections, bilateral sciatic nerve blocks and a right sciatic nerve block, without any documented history of sciatica. Respondent's care and treatment deviated from minimally accepted standards of care in that he:

1. Failed to:

a. appropriately evaluate the patient, including but not limited to, taking and/or noting a thorough history, performing and/or noting a comprehensive physical examination, performing and/or noting manual muscle testing and, ordering and/or reviewing appropriate imaging studies,

b. properly render a diagnosis prior to instituting treatment with prescription medications,

c. develop, implement, and revise, as necessary, a personalized treatment plan,

d. adequately and appropriately follow-up on prior complaints, recommended treatments and/or injections or procedures performed,

e. appropriately monitor the patient while on prescribed medications, including but not limited to, checking and/or documenting I-Stop, ordering and/or documenting urine testing at appropriate intervals, and/or using outcome measures to assess disability level or functional status,

f. reassess the patient's symptoms and/or modify treatment when the patient was not progressing or showing any signs of improvement, and

g. maintain a medical record that accurately reflects the care and treatment rendered to the patient.

2. Inappropriately:

a. prescribed and/or changed medications, without medical rationale or justification,

b. prescribed multiple medications, simultaneously, placing the patient at increased risk,

c. prescribed medications outside the frequency guidelines,

d. performed nerve block injections without medical rationale or justification, and

e. sought authorization for a viscosupplement, Supartz, without knowing the results of the steroid injection.

E. Respondent treated Patient E, who sustained injuries in a motor vehicle accident on February 22, 2016, from February 24, 2016, through March 2, 2017. At the initial visit, Patient E complained of severe knee pain and numbness in the left leg. Respondent performed a left sciatic nerve block and trigger point injections. Patient E then had an MRI of the left knee, which indicated Grade 1 sprain of the anterior cruciate ligament, and, an MRI of the lumbar spine, which showed disc bulge L5-S1. On November 4, 2016, Patient E underwent electrodiagnostic testing which revealed L5-S1 radiculopathy and left tibial motor neuropathy. Respondent recommended an endoscopic microdiscectomy procedure (percutaneous nucleus pulposus decompression and percutaneous intradiscal electrothermal annuloplasty) which was agreed to and performed by Respondent at Downtown Bronx ASC on March 2, 2017. At the conclusion of the procedure, Patient E went into cardiac arrest and died. Respondent's care and treatment deviated from minimally accepted standards of care in that he:

1. Inappropriately:

a. recommended and/or performed endoscopic microdiscectomy, without exhausting all medical spine care treatments,

b. performed microdiscectomy and/or discogram, without medical rationale or justification, and

c. performed endoscopic microdiscectomy without confirming the correct root level.

2. Failed to:

a. order and/or perform a CT scan after completing the discogram.

b. maintain a record that accurately reflects the care and treatment rendered to the patient.

SPECIFICATION OF CHARGES
FIRST-FIFTH SPECIFICATIONS

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. Paragraph A and its subparagraphs.
2. Paragraph B and its subparagraphs.
3. Paragraph C and its subparagraphs.
4. Paragraph D and its subparagraphs.
5. Paragraph E and its subparagraphs.

SIXTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

6. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs and/or Paragraph D and its subparagraphs and/or Paragraph E and its subparagraphs.

SEVENTH-ELEVENTH SPECIFICATIONS

UNWARRANTED TESTS/TREATMENT

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

7. Paragraph A and A2 and its subparagraphs.
8. Paragraph B and B2 and its subparagraphs.
9. Paragraph C and C2 and its subparagraphs.
10. Paragraph D and D2 and its subparagraphs.
11. Paragraph E and E1 and its subparagraphs.

TWELFTH-SIXTEENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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

12. Paragraph A(1)(g).

13. Paragraph B(1)(i).

14. Paragraph C(1)(h).

15. Paragraph D(1)(g).

16. Paragraph E(2)(b).

DATE: May 12, 2022
New York, New York

[redacted]

HENRY WEINTRAUB
Chief Counsel
Bureau of Professional Medical Conduct