NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Acting Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

February 17, 2023

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Leslie Eisenberg, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, New York 10007

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Kevin Weiner, M.D.
262 Nelson Avenue
Staten Island, New York 10304

RE: In the Matter of Kevin Weiner, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 23-035) 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:

Jean T. Carney, 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 Judge Carney 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,

[redacted]

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB: cmg
Enclosure

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

COPY

IN THE MATTER OF KEVIN WEINER, M.D.	DETERMINATION AND ORDER BPMC-23-035

The New York State Department of Health, Bureau of Professional Medical Conduct (Department) served Kevin Weiner, M.D. (Respondent) with a Notice of Hearing dated May 20, 2022 and Statement of Charges dated May 12, 2022, pursuant to Public Health Law (PHL) § 230(10)(d)(i). (Exhibit 1.) The Respondent filed an answer. (Exhibit A.) The Department subsequently served an amended Statement of Charges dated September 8, 2022. (Exhibit 1-a.) The Respondent submitted an answer to the amended charges on September 21, 2022. (Exhibit N.)

The Department charged the Respondent with 20 specifications of professional misconduct under New York Education Law § 6530, specifically: practicing the profession of medicine with negligence on more than one occasion (Education Law § 6530(3)); practicing the profession of medicine with incompetence on more than one occasion (Education Law § 6530(5)); ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient (Education Law § 6530(35)); and failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient (Education Law § 6530(32)). The Respondent denied each of the factual allegations and specifications.

This hearing was held via Cisco WebEx videoconference. Pursuant to PHL § 230(10)(e), **JEFFREY PERRY, D.O.**, Chairperson, **GREGORY ALLEN THREATTE, M.D.**, and

MICHAEL N. J. COLÓN, ESQ., duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee. **NATALIE J. BORDEAUX** served as the administrative officer. The Department appeared by Leslie A. Eisenberg, Esq. The Respondent was represented by Jordan Fensterman, Esq.

After considering the entire hearing record, the Hearing Committee hereby issues this Determination and Order, sustaining the charges in part and imposing professional discipline. All findings, conclusions, and determinations are unanimous.

HEARING RECORD

This hearing was held on nine days from September 22 through December 5, 2022. A transcript of the hearing was made. (T 1 – 1999.) The record closed January 18, 2023, upon the parties' submission of post-hearing briefs, and the Hearing Committee deliberated on January 30, 31, and February 10, 2023.

Department witnesses:	Michael C. Geraci, M.D., P.T.
Department exhibits:	1, 1a, 2-10
Respondent witnesses:	Anna Antico Joseph Carfi, M.D. Charles DeMarco, D.C. Ketan Vora, D.O. Kevin Weiner, M.D.
Respondent exhibits:	A-D, E1-E11, F1-F9, G1-G8, H1-H4, I1, J, M, N

FINDINGS OF FACT

1. The Respondent was authorized to practice medicine in the State of New York on February 20, 1996, by the issuance of license number 202165. (Exhibit 1-a.)

2. The Respondent practices physical medicine and rehabilitation (PM&R), also referred to as physiatry. (Exhibit B; T 37-38.)

3. The objective of PM&R is to restore or increase patients' functionality to help them return to engaging in the activities that they want to do. (T 38, 69, 1192.)

STANDARDS OF CARE

4. A reasonably prudent physician first attempts to treat a patient's pain with diagnostic testing, injections, exercise, physical therapy, and/or referrals to other specialists before resorting to prescribing high doses of opioid medication. (T 38-39, 1342-43.)

5. During a patient's first appointment, it is standard of care to review the patient's chief complaint, obtain a detailed personal and social history, conduct a detailed physical examination of the parts of the body complained about, and then create a differential diagnosis as a basis for treatment, from which a personalized treatment plan is then devised. This information should be recorded in the patient's file. (T 44, 1314-15, 1328, 1343-44.)

6. A standard personal and social history includes: (a) the patient's chief complaint; (b) a history of the present illness; (c) the patient's medical history, including prior surgeries; (d) smoking, alcohol use, drug use, and addictions; (e) work history; and (f) success of prior attempted treatments. (T 45-51, 736-37, 1314-15, 1328.)

7. When a patient complains of pain, a reasonably prudent physician uses a pain diagram or other information provided by the patient regarding symptoms to determine the location of symptoms, whether the pain is localized and whether the pain intensifies or abates during certain periods of the day. This information serves as a baseline for the physician to evaluate outcome measures after treatment commences. (T 110-11, 339-40, 547.)

8. A standard physiatry examination includes: (a) the patient's range of motion and strength through manual muscle testing; (b) the patient's strength, reflexes; (c) a sensory exam; and (d) examining the location of the patient's complaint. (T 44-45, 54, 57-58, 163, 1350-51.)

9. The elements of an initial physical examination enable a physician to determine a patient's baseline weakness, strength, and reflexes. (T 582-83.)

10. After obtaining the patient's complete history and conducting a comprehensive physical examination of the musculoskeletal system and the body parts indicated based upon a patient's symptoms, a reasonably prudent physician makes a diagnosis to indicate the patient's possible conditions. (T 58-60.)

11. A reasonably prudent physician uses the working diagnosis (what a physician strongly expects to be the cause of symptoms) and differential diagnosis (probable or possible causes of symptoms) to create the patient's personalized treatment plan, in which the risks and benefits of treatment, including therapy and possible medications, are discussed with the patient. (T 61-64.)

12. A reasonably prudent physician continuously reassesses the care and treatment administered to a patient during the course of their relationship. (T 67-68.)

13. During follow-up appointments, a reasonably prudent physician reviews and documents a patient's chief complaint, and changes from the prior visit, including the patient's pain level, functional abilities, and whether the patient has consulted with other medical providers, and attempted physical therapy. (T 51-52, 69, 761-62.)

14. During follow-up appointments, a reasonably prudent physician performs a detailed physical examination of the specific body parts that are the subject of the patient's complaint. (T 53.)

15. During follow-up appointments, a reasonably prudent physician reviews and documents the medications taken by the patient, and their efficacy. (T 51-52.)

16. During follow-up appointments, a reasonably prudent physician evaluates changes in complaints and symptoms to determine outcome measures (monitoring the efficacy of treatment). (T 339-40.)

17. A reasonably prudent physician measures outcomes for a patient whenever changes in physical therapy, medication, or medication dosage are implemented. (T 340.)

18. A reasonably prudent physician documents reassessment of a patient's pain level and function by reporting any improvements to the pain level and function, things that exacerbate the pain, and obtaining a completed form from the patient regarding pain and function levels. (T 341-42.)

19. Functional improvement is measured by a patient's ability to perform more activities than previously capable. (T 761-62, 1354-55.)

Prescribing Practices

20. Before prescribing any medication for a patient, a reasonably prudent physician must obtain an adequate social and medical history, conduct an adequate physical examination, and devise a working or, at minimum, differential, diagnosis to provide a medical rationale for the prescription. (T 234, 236, 239, 249.)

21. Until 2013, physicians in New York state issued physical prescriptions to patients. (T 237.)

22. Since 2013, physicians issue prescriptions electronically to a pharmacy. (T 237, 239-40.)

23. Upon determining to incorporate medication in a patient's treatment, a reasonably prudent physician first prescribes anti-inflammatory medication to attempt to alleviate the pain. (T 1343.)

24. When a physician prescribes anti-inflammatory medication for a patient, the patient's record should include documentation regarding the patient's inflammation and pain. (T 236.)

25. Before prescribing nerve pain medications such as Neurontin (gabapentin) or Lyrica (pregabalin), a reasonably prudent physician establishes and documents that the patient has a sensitive nerve for which such medication would be indicated. (T 236.)

26. A reasonably prudent physician ensures that all treatments to address a patient's pain have been exhausted before prescribing narcotics or other controlled substances for pain management and that prior unsuccessful attempts at treatment are documented. (T 234, 249.)

27. It is standard of care for a physician to require a patient to sign a pain management contract before prescribing opioids in high doses. (T 555.)

28. A reasonably prudent physician orders urine testing for a patient using controlled substances at least once every three months to monitor their use of prescribed and non-prescribed substances. (T 334-35, 1441.)

29. When urine testing reveals that a patient has used street drugs or other substances that may interfere with their treatment, it is standard of care for a reasonably prudent physician to discharge that patient or, at minimum, perform additional testing shortly thereafter and alter treatment. (T 830-32.)

30. It is standard of care for a reasonably prudent physician to document that a urine test was ordered, and document that the test results were received and reviewed in a patient's records. (T 336.)

31. Since August 27, 2013, a reasonably prudent physician consults I-STOP/PMP (Internet System for Tracking Over-Prescribing – Prescription Monitoring Program) right before every

visit to verify a patient's use of Schedule II, III, and IV controlled substances. (T 52-53, 64-65, 329-30.)

32. It is standard of care for I-STOP/PMP verification to be documented in the patient's chart, either by printing out the screen or by inserting a note in the patient's file that I-STOP/PMP was consulted and that it is consistent with the medications prescribed before prescribing additional controlled substances to a patient. (T 329-30.)

33. Before prescribing opioid medications, a reasonably prudent physician verifies whether a patient is opioid-naïve or whether the patient has previously used opioids, and, if so, the type of medication, strength, and efficacy. (T 853-54.)

34. A reasonably prudent physician slowly increases the dosage of prescribed opioids to minimize the risk of oversedation (including respiratory depression), and changes to blood pressure (usually, hypotension.) (T 241.)

35. The risks associated with prescribing opioid medications are magnified when a physician prescribes multiple opioid medications to the same patient. (T 242-43.)

36. Before prescribing opioids on a long-term basis, a reasonably prudent physician advises the patient of the risks. (T 243-44.)

37. A reasonably prudent physician documents a basis for prescribing opioids on a long-term basis, such as signs of functional improvement. (T 275.)

38. When a patient has shown signs of functional improvement after being prescribed a short-acting opioid medication, it is reasonable for a physician to prescribe a long-acting opioid medication in lieu of the short-acting opioid to decrease the frequency by which the patient takes the medication. (T 286.)

39. A reasonably prudent physician does not prescribe short-acting opioid medications and long-term opioid medications simultaneously. (T 285.)

Patient Records

40. A standard patient record should contain: (a) physical notes of appointments; (b) imaging requested by a physician and other treating physicians; (c) medication records; (d) periodic functional assessments; and (e) the patient's informed consent to any invasive procedure before it is performed. (T 121-22, 305-06.)

41. It is standard practice for a reasonably prudent physician to maintain patient records in chronological order and keep all records pertaining to treatment on a date of service together. (T 120.)

42. A reasonably prudent physician maintains documentation of all communication with a patient's other treating providers in the patient's records. (T 754-55.)

43. When a note in a patient's chart refers to another document, a reasonably prudent physician ensures that the document referred to is placed in the patient's record. (T 120.)

44. It is standard of care for a physician to identify the name and dosage of prescribed medication in a patient's record. (T 584.)

45. Patient records created by a physician should provide another physician reviewing those records with a clear understanding of the patient's conditions and treatments administered. (T 117, 303-04, 326-27, 629.)

46. A reasonably prudent physician obtains records of imaging studies performed on patients, including not only those requested by the physician, but those requested by patients' other treating physicians, and reviews those reports. (T 165-67, 169.)

47. When performing a procedure, a reasonably prudent physician documents: a description of how the procedure was performed, including the patient's positioning; medications used for the procedure, including dosages; and follow-up instructions. (T 304, 1394.)

48. Before performing a nerve block or ganglion block, it is standard of care for a physician to obtain the patient's informed consent (written or verbal) to the procedure after the risks and benefits are explained. If consent is obtained verbally, the physician must document consent in the patient's records. (T 1278-79.)

49. A reasonably prudent physician orders imaging studies and other tests when indicated by an adequate history and physical examination to confirm a diagnosis. (T 169, 183, 800.)

50. It is the responsibility of the ordering physician to follow up with patients to verify that requested imaging was performed and to obtain imaging results. Failure to do so falls below the standard of care. (T 169-70.)

51. When imaging reports are received, a reasonably prudent physician documents that he has reviewed the report and incorporates the results in a patient's treatment. (T 167-68, 593-94, 800.)

52. When lab results of blood testing are received by a physician, it is standard of care to document that the results were reviewed and any changes to the patient's medical or treatment plan resulting from the results. (T 771.)

53. When a physician recommends physical therapy for a patient, it is standard of care for that physician to verify that the patient obtained the recommended physical therapy and obtain information regarding therapy outcomes, which should be included in the patient's record. (T 193.)

54. After referring a patient to another medical provider, a reasonably prudent physician asks the patient whether they consulted with such provider and includes the name and contact information of the referred provider in the patient's records. (T 748.)

PATIENT A

55. The Respondent treated Patient A from May 22, 2008 until April 28, 2022. (Exhibits E4, pp. 10-11, E9, p. 61.)

56. On May 22, 2008, the Respondent's first encounter with Patient A, the Respondent wrote a prescription for Norco, an opioid containing hydrocodone and acetaminophen, in the amount of 5/325 for Patient A. (Exhibit E9, p. 61; T 247, 250-51.)

57. The Respondent did not document his May 22, 2008 encounter with Patient A. (Exhibits 3, E1-E10.)

58. The Respondent did not attempt other treatments, including physical therapy and non-opioid medications before resorting to prescribing an opioid medication for Patient A. (T 291, 536-38.)

59. The Respondent failed to document a medical rationale for prescribing Norco to Patient A on May 22, 2008. (T 248-49.)

60. Patient A is a bridge painter who drives trucks. (T 544.)

61. The Respondent did not warn Patient A not to drive while taking Norco because his behavior behind the wheel would resemble a driver under the influence of alcohol. (T 544.)

62. On June 5, 2008, Patient A was seen by the Respondent for a "follow-up" appointment, as documented in a dictated progress note. (Exhibit E9, p.44.)

63. The Respondent's progress note for the June 5, 2008 date of service does not include a chief complaint indicating the location of Patient A's symptoms during the visit. (Exhibit E9, p. 44; T 116.)

64. The Respondent's documentation for the June 5, 2008 date of service does not list a diagnosis or a working diagnosis, even though the progress note recommends a medication change from Norco to 120 tablets of 5 milligrams of Roxicodone (oxycodone), another opioid. (Exhibit E9, p. 44; T 125-27, 251-52.)

65. The Respondent failed to render a diagnosis for Patient A before instituting treatment. (T 127.)

66. The Respondent failed to document an appropriate medical rationale for changing Patient A's prescription opioid medication on June 5, 2008. (T 253-54.)

67. The Respondent performed a limited physical examination of Patient A on June 5, 2008 that did not include manual muscle testing. (Exhibit E 9, p. 44; T 124.)

68. The Respondent's physical examination of Patient A on June 5, 2008 failed to meet the standard of care for a reasonably prudent physician. (T 145.)

69. The Respondent's documentation for the June 5, 2008 encounter does not include the patient's chief complaint for the follow-up visit and whether the complaint changed from the prior visit, contains a limited physical examination, does not include a diagnosis, and refers to another document (review of systems) that is not included in the patient file. (Exhibit E9, p. 45; T 116, 118-19, 123-25, 254-55.)

70. During Patient A's July 10, 2008 follow-up appointment with the Respondent, he was prescribed 120 tablets of Roxicodone at an increased dosage of 15 milligrams from 5 milligrams originally prescribed. (Exhibit E9, pp. 59-60.)

71. The Respondent's dictated progress note for the July 10, 2008 appointment reports that Patient A "states that Roxicodone 5mg is not helping and has been doubling up on the pills." (Exhibit E9, p. 43.)

72. The Respondent failed to document an appropriate medical rationale for increasing Patient A's prescribed dosage of Roxicodone on July 10, 2008. (T 256-57.)

73. Although the Respondent recommended that Patient A "obtain a cane to help unload his ankle" during the July 10, 2008 appointment (Exhibit E9, p. 43), the Respondent did not follow up with the patient on subsequent appointments as to whether he attempted to use a cane and, if so, whether the cane alleviated his symptoms. (T 1373.)

74. On August 7, 2008, the Respondent prescribed 140 tablets of 15 mg Roxicodone for Patient A, an increase of 20 tablets. (Exhibit E9, p. 58.)

75. On October 7, 2008, the Respondent increased Patient A's prescribed dosage of 140 tablets of Roxicodone from 15 milligrams to 30 milligrams. (Exhibit E9, p. 56.)

76. On November 4, 2008, the Respondent increased Patient A's number of prescribed pills of 30 milligrams of Roxicodone from 140 pills to 160 pills. (Exhibit E9, p. 55.)

77. On December 2, 2008, the Respondent increased Patient A's number of prescribed pills of 30 milligrams of Roxicodone from 160 pills to 180 pills. He continued to prescribe Patient A 180 tablets of 30 milligrams of Roxicodone until June 23, 2009, and then continued to prescribe 120 pills of 30 milligram Roxicodone until at least April 28, 2022. (Exhibits E1, E2, E3, E6, E7, pp. 66-133; E8, E9, pp. 47-54.)

78. The Respondent's records for Patient A do not show the patient's improvement in function despite his prescribing opioid medications long-term. (T 275.)

79. On January 29, 2009, more than seven months after first prescribing opioids for Patient A, the Respondent ordered a urine drug screen. (Exhibit E9, p. 22.)

80. The Respondent's failure to obtain a baseline urine test before prescribing Norco on May 22, 2008 falls below the standard of care for a reasonably prudent physician. (T 336-37.)

81. The Respondent conducted a urine drug screen for Patient A on April 28, 2009 and November 5, 2009. (Exhibit E5, p. 59; Exhibit E9, p. 21.)

82. On December 3, 2009, Patient A was seen by the Respondent for a follow-up appointment. (Exhibit E5, p. 37, E8, p. 76.)

83. The Respondent's December 3, 2009 dictated progress note does not identify the pain medication prescribed for Patient A, along with its dosage and frequency. (Exhibit E5, p. 37; T 270.)

84. The Respondent's December 3, 2009 electronic medical record progress note is not an accurate record of Patient A's status on the December 3, 2009 date of service. (Exhibit E8, p. 76; T 271-72.)

85. On January 28, 2010, Patient A signed his first pain management agreement with the Respondent, despite having already been prescribed opioid medications for more than 18 months. (Exhibit E9, pp. 19-20.)

86. The Respondent's failure to require Patient A to sign a pain management agreement before first prescribing opioids on May 22, 2018, falls below the standard of care for a reasonably prudent physician. (T 555.)

87. The Respondent performed an inadequate physical examination of Patient A during his July 20, 2010 follow-up appointment. (Exhibits E5, p. 29, Exhibit E8, p. 93; T 159.)

88. Although the Respondent's dictated progress note for the July 20, 2010 date of service mentions that Patient A recently underwent surgery on his left foot, the Respondent did not include information from the patient's orthopedic surgeon regarding possible physical restrictions. (Exhibit E5, p. 29; T 160-61.)

89. The Respondent's dictated progress note for the July 20, 2010 date of service does not include a diagnosis despite recommending that the patient continue to use unspecified pain medication. (Exhibit E5, p. 29.)

90. The Respondent's failure to provide a specific diagnosis for the patient's symptoms before determining to continue treatment in the form of unspecified physical therapy and opioid medication falls below the standard of care for a reasonably prudent physician. (Exhibit E5, p. 29, E8, p. 93; T 155, 159.)

91. During the July 20, 2010 appointment, the Respondent failed to ascertain Patient A's physical restrictions post-foot surgery from the patient's orthopedic surgeon regarding recommended exercises and exercises to be avoided. (T 161-62.)

92. In a dictated note for Patient A's November 23, 2010 appointment, the Respondent reported that the patient complained of back pain. (Exhibit E5, p. 25.)

93. In a dictated note and an electronic medical record note for Patient A's January 4, 2011 appointment, the Respondent described the patient's foot pain without mentioning the November 23, 2010 complaint of back pain. (Exhibit E5, p. 23, E8, pp. 171-72.)

94. The Respondent failed to adequately follow up on Patient A's November 23, 2010 complaint of back pain during the January 4, 2011 appointment. (T 174-75, 177.)

95. The Respondent did not conduct urine drug screens for Patient A during the year 2010, despite continuing to prescribe multiple controlled substances, a deviation from the standard of care for a reasonably prudent physician. (T 338.)

96. The Respondent's dictated note for the January 4, 2011 appointment does not contain an adequate history of Patient A's illness and does not provide details about the symptoms experienced by the patient. (Exhibit E5, p. 23; T 176.)

97. In a dictated progress note for Patient A's June 28, 2011 appointment, the Respondent reported that the patient "complains of severe left foot pain that is 10/10" and that the patient will be sent for an x-ray because of the pain. No diagnosis is included in the progress note. (Exhibit E5, p. 16.)

98. The Respondent's electronic medical record for the June 28, 2011 appointment with Patient A does not contain a recommendation for an x-ray. (Exhibit E8, pp. 173-74.)

99. The Respondent's dictated progress note for the July 19, 2011 appointment includes a new complaint of "severe pain and numbness in his hand" (Exhibit E5, p. 15); however, the electronic medical record for the same date of service does not mention the patient's complaint about his hand (Exhibit E8, pp. 166-67).

100. The Respondent failed to evaluate and follow up on Patient A's complaints of pain and numbness in his hand. (T 1375-77.)

101. The Respondent's dictated progress note for Patient A's July 19, 2011 appointment does not report the results of the x-ray recommended on June 28, 2011 or whether the patient obtained the recommended x-ray, even though the note discusses the patient's left foot pain. (Exhibit E5, p. 15.)

102. Patient A was seen by the Respondent on August 4, 2011 for treatment. Although the Respondent's progress note discusses the patient's MRI report, it does not report the results of the x-ray recommended on June 28, 2011 or whether the patient obtained the recommended x-ray. (Exhibit E5, p. 14.)

103. The Respondent failed to adequately follow-up on the previously recommended x-ray, a deviation from the standard of care. (T 184-85.)

104. During Patient A's April 2, 2012 appointment, the Respondent performed trigger point injections into the right upper trapezius, anterior scalene, sternocleidomastoid muscle. (Exhibit E4, p. 149.)

105. Before performing a trigger point injection, a reasonably prudent physician must identify an active trigger point that would respond to the injection. (T 207.)

106. The Respondent's dictated progress note for the April 2, 2012 date of service did not include a diagnosis, did not indicate whether the Respondent found an active trigger point in a specific muscle, did not state whether exercises were attempted before the injection that were not successful, and did not describe how the procedure was performed. (T 203-04, 207-09.)

107. The Respondent's April 2, 2012 dictated progress note for the trigger point injection fails to accurately reflect the care and treatment Patient A received. (T 208.)

108. The Respondent saw Patient A on April 3, 2012 for another appointment but did not follow up with him regarding the trigger point injection administered the day before, a deviation from the standard of care for a reasonably prudent physician. (Exhibit E5, p. 6; T 209-10.)

109. The Respondent did not follow up with Patient A regarding the trigger point injection during the next appointment on May 1, 2012. (Exhibit E5, p. 5; T 210.)

110. The Respondent administered multiple trigger point injections on Patient A without a diagnosis, documented identification of an active trigger point in a specific muscle, descriptions of exercises attempted before the injection that were not successful, documentation that the risks, benefits and alternatives to the trigger point injection were discussed, and a description of how the procedure was performed, a deviation from the standard of care. (T 211.)

111. On June 5, 2012, the Respondent administered a steroid injection into Patient A's left elbow. (Exhibit E5, p. 1.)

112. The Respondent documented the June 5, 2012 appointment with Patient A, in which he reports that the patient's chief complaint is left shoulder and left elbow pain, and that the patient "also has foot pain". (Exhibit E4, pp. 1-2.)

113. The Respondent's June 5, 2012 physical examination of Patient A's right shoulder included measurements of flexion and abduction, but did not include other range of motion testing, and did not include testing of the rotator cuff, the labrum of the shoulder, stability, anterior, posterior, and inferior drawer tests, impingement testing, and manual muscle testing, which falls below the standard of care for a reasonably prudent physician. (T 146-47.)

114. Although the Respondent's dictated progress note for the June 5, 2012 date of service states that the patient's "[r]eview of systems and social history was updated, reviewed with the patient and placed in the chart," the Respondent's records for Patient A do not include that information. (T 144.)

115. The Respondent's progress notes for the June 5, 2012 date of service fail to provide an appropriate medical rationale for the steroid injection administered. (T 224; Exhibits E4, pp. 1-2, E8, pp. 97-98.)

116. The Respondent's progress notes for the June 5, 2012 date of service fail to adequately and appropriately document the steroid injection performed. (T 224.)

117. The Respondent failed to appropriately evaluate Patient A on June 5, 2012 by failing to take and note a thorough history and perform and document a comprehensive physical examination of the patient. (T 143-44.)

118. The Respondent's electronic medical record progress note for Patient A's June 5, 2012 appointment reports that he prescribed the patient 30 milligrams of Roxicodone, without specifying the number of pills, but increased the maximum frequency of use from every four to six hours to use every two to four hours. (Exhibit E8, pp. 97-98.)

119. On June 5, 2012, the Respondent began prescribing Patient A Flexeril, a muscle relaxant, in addition to Roxicodone. The medications are both central nervous system depressants that may lead to respiratory depression or sedation. (Exhibit E8, pp. 97-98; T 279.)

120. The Respondent failed to document an appropriate medical rationale for prescribing Flexeril for Patient A. (Exhibits E4, pp. 1-2, E5, pp. 1-2, E8, pp. 97-98; T 280-81.)

121. During Patient A's next appointment with the Respondent on June 26, 2012, the Respondent did not follow up on the steroid injection administered, a deviation from the standard of care for a reasonably prudent physician. (Exhibit E5, p. 3; T 225.)

122. On February 5, 2013, the Respondent began prescribing Patient A Relafen, a non-steroidal anti-inflammatory medication, in addition to Roxicodone and Flexeril. (Exhibit 3, pp. 5-6; T 282-83.)

123. The Respondent's records for Patient A do not provide an appropriate medical rationale for prescribing Relafen. (T 283.)

124. On April 30, 2013, the Respondent administered a steroid injection into Patient A's right shoulder. (Exhibit 3, p. 7.)

125. The Respondent's dictated note for the April 30, 2013 date of service does not contain a medical basis for the steroid injection administered. (T 217-19.)

126. The Respondent's dictated note for the April 30, 2013 date of service does not specify the steroid used for the injection, including whether the steroid was a particulate or non-particulate, the name of the steroid, and the dosage. It also does not mention the type of anesthesia used, where the injection was made, and post-procedural instructions, a deviation from the standard of care for a reasonably prudent physician. (T 220-21.)

127. The Respondent's electronic medical record for the April 30, 2013 date of service does not mention Patient A's receipt of a steroid injection on that date of service, a deviation from the standard of care for a reasonably prudent physician. (Exhibit 3, pp. 8-10.)

128. When Patient A was next seen by the Respondent on May 28, 2013, the Respondent did not follow up on the steroid injection administered on April 30, 2013, a deviation from the standard of care. (Exhibit E8, p. 134.)

129. From April 30, 2013 through January 7, 2014, Patient A received five steroid injections. (Exhibit 3, pp. 8-31.)

130. The Respondent administered over 12 steroid injections to Patient A between 2013 and 2018. (Exhibit 3, pp. 8-132.)

131. Administration of more than four steroid injections in one year falls below the standard of care, as additional steroid injections increase a patient's risk of systemic osteoporosis. (T 313.)

132. Administration of over 12 documented steroid injections increases the risk of systemic osteoporosis and lowers a patient's immune system, increasing the chances of infection. (T 313-14.)

133. The Respondent's records do not contain an appropriate medical rationale for the steroid injections. (Exhibit 3, pp. 8-48; T 312-13.)

134. The Respondent's records for Patient A do not reflect any follow up by the Respondent after administering the steroid injections. (T 313.)

135. On November 12, 2013, Patient A was seen by the Respondent for complaints of "severe right shoulder pain." (Exhibit 3, p. 20.)

136. The Respondent created two progress notes for the November 12, 2013 date of service – one dictated and one as part of an electronic medical record. (Exhibit 3, pp. 20-23.)

137. The Respondent conducted a limited physical examination of Patient A's right shoulder on November 12, 2013. (Exhibit 3, p. 20; T 130-31, 34.)

138. The Respondent's dictated progress note for the November 12, 2013 date of service does not describe the location of Patient A's right shoulder pain and possible causes of this pain. (Exhibit 3, p. 20; T 131-32.)

139. The Respondent's practice created two dictated progress notes for the November 12, 2013 date of service – one written under the Respondent's name, and the second signed by Dr. Felix Karafin. (Exhibit 3 pp. 20; Exhibit E4, pp. 39-40.)

140. The November 12, 2013 note signed by Dr. Karafin describes neck and back pain, a planned surgery of the cervical spine, information not mentioned in the Respondent's dictated or electronic medical record progress note for the same date. (Exhibit E4, pp. 39-40; T 139-40.)

141. Dr. Karafin's November 12, 2013 physical examination includes Patient A's cervical spine, and mentions limited range of motion of the patient's shoulder but does not explain those limitations. (Exhibit E4, pp. 39-40; T 140.)

142. The Respondent's electronic medical record progress note for the November 12, 2013 date of service includes a diagnosis for patient A's ankle fracture but does not indicate which ankle had fractured. (Exhibit 3, pp. 21-23; T 137-38.)

143. The Respondent's electronic medical record progress note for the November 12, 2013 date of service states that Patient A has had "[n]o change in health since last visit" and that his "[p]ain complaint has not changed," even though the dictated note for the same date discusses shoulder pain that was not previously documented. (Exhibit 3, pp. 21-23; T 138.)

144. During Patient A's February 4, 2014 appointment, the Respondent prescribed 20 milligrams of Oxycontin (a long-acting opioid medication), 40 milligrams of Oxycontin, in addition to 10 milligrams of Flexeril, 30 milligrams of Roxicodone, and 500 milligrams of Relafen. (Exhibit 3, pp. 32-35; T 284-85.)

145. The Respondent's prescribing of Oxycontin (a long-acting opioid medication), in combination with Roxicodone (a short-acting opioid medication), Flexeril (a muscle relaxant), and Relafen, falls below the standard of care for a reasonably prudent physician. (T 285-86.)

146. The Respondent failed to render a diagnosis of Patient A's symptoms before adding Oxycontin to his medication regimen. (T 288.)

147. The Respondent's records for Patient A do not contain an appropriate medical rationale for adding Oxycontin to the patient's medication regimen. (T 286.)

148. No appropriate medical justification is found in Patient A's records, nor does such a justification exist elsewhere, for adding Oxycontin to the patient's medication regimen of Flexeril, Roxicodone, and Relafen. (T 286.)

149. No reasonable basis exists for the Respondent prescribing 20 milligrams of Oxycontin and 40 milligrams of Oxycontin to Patient A on the same date of service. (T 287.)

150. The Respondent continued to prescribe Patient A 40 milligrams of Oxycontin, in addition to 10 milligrams of Flexeril, 30 milligrams of Roxicodone, and 500 milligrams of Relafen through at least January 2016. (Exhibit 3, pp. 32-161; T 287-88.)

151. By continuing to prescribe Oxycontin, Flexeril, Roxicodone, and Relafen to Patient A until on or about January 2016, the Respondent increased the patient's risks of heart attack, stroke, gastrointestinal bleeding, ulceration, respiratory depression, confusion, and lightheadedness. (Exhibit E7, pp. 66-68; T 288.)

152. The Respondent failed to obtain a complete blood count for Patient A any time before or after prescribing these medications to the patient, despite continuing to prescribe all of these medications to the patient until on or about January 2016. (Exhibit E7, pp. 66-68; T 333.)

153. Patient A was seen by the Respondent on June 23, 2014 for treatment. In a dictated progress note, the Respondent repeated the physical therapy recommendation made in the July 19, 2011 progress note for the patient. (Exhibit 3, p. 48.)

154. The June 23, 2014 physical therapy recommendation does not include specific information pertaining to Patient A's conditions. (Exhibit 3, p. 48; T 188-89.)

155. The Respondent's June 23, 2014 progress note does not contain adequate information for another practitioner to understand the treatment rendered to Patient A. (Exhibit 3, p. 48; T 192-93.)

156. During his August 19, 2014 appointment with the Respondent, Patient A received a steroid injection to the left shoulder. (Exhibit 3, pp. 56-59.)

157. The Respondent failed to diagnose Patient A's symptoms before administering the steroid injection to his left shoulder. (T 296.)

158. The Respondent's electronic medical record for the August 19, 2014 date of service does not mention that Patient A received a steroid injection that day. (Exhibit 3, pp. 57-59.)

159. The Respondent failed to follow up on the steroid injection received by Patient A on August 19, 2014. (Exhibit 3, pp. 60-63; T 298, 300-01.)

160. The Respondent's records for Patient A's September 16, 2014 appointment show no functional improvement in the patient. (Exhibit 3, pp. 60-63.)

161. During Patient A's September 16, 2014 appointment, the patient received bilateral sciatic nerve blocks, and trigger point injections in the upper trapezius, anterior scalene, and quadratus lumborum. (Exhibit 3, p. 60.)

162. The Respondent's administration of bilateral sciatic nerve blocks without the patient's prior informed consent, written or verbal, falls below the standard of care for a reasonably prudent physician. (Exhibit 3, p. 60; T 1279-80.)

163. The Respondent's records for Patient A's August 19 and September 16, 2014 appointments do not mention the dosage of medication administered in the injections, a deviation from the standard of care. (Exhibit 3, pp. 56-63.)

164. On February 3, 2015, the Respondent performed a nerve block on Patient A "to help alleviate the pain" without further explanation. (Exhibit 3, pp. 76-79.)

165. The Respondent's notes for the February 3, 2015 date of service state that Patient A received a supraspinatus nerve block, a nerve that does not exist. (Exhibit 3, p. 76; T 303.)

166. The Respondent's notes for the February 3, 2015 date of service do not contain a medical rationale for the nerve block. (Exhibit 3, pp. 76-79; T 303.)

167. The Respondent's records for Patient A do not include documentation of required informed consent before performance of any nerve blocks. (Exhibit 3, pp. 60, 76-79; T 306, 1279-80.)

168. The Respondent's records for Patient A do not contain notes from physical therapists or notes regarding physical therapy outcomes, despite repeated recommendations for the patient to obtain physical therapy. (T 194.)

169. The Respondent's records for Patient A do not include documentation to show that the Respondent's practice consulted I-STOP/PMP between August 27, 2013 and March 31, 2017 to verify the patient's use of controlled substances, a deviation from the standard of care for a reasonably prudent physician. (Exhibit E1, p. 48; Exhibit E4, p. 100; T 331.)

170. Throughout the Respondent's treatment of Patient A, he failed to obtain an adequate social and medical history, and conduct appropriate physical examinations of the patient, both of which fall below the standard of care for a reasonably prudent physician. (T 327-28.)

171. Throughout the course of the Respondent's treatment of Patient A, the Respondent failed to adequately and appropriately follow-up on Patient A's prior complaints and recommended treatments, a deviation from the standard of care for a reasonably prudent physician. (T 132, 328, 343.)

172. Throughout the course of the Respondent's treatment of Patient A, the Respondent failed to develop, implement, and revise a personalized treatment plan for the patient. (T 156, 191.)

173. The Respondent's records for Patient A do not contain documentation showing that the Respondent reviewed the results of imaging he requested for Patient A, a deviation from the standard of care. (T 170-71.)

174. Throughout the course of the Respondent's treatment of Patient A, the Respondent failed to accurately document the care and treatment provided to the patient. (T 327.)

175. The Respondent's progress notes for Patient A do not provide an adequate medical rationale for the opioid prescriptions that continued until the termination of the physician-patient relationship. Although several prescriptions noted that the prescription was indicated to treat chronic intractable pain, the Respondent's documentation does not establish that diagnosis. (Exhibit E2; T 245-46, 256-57, 267-68, 274.)

176. Throughout the course of the Respondent's treatment of Patient A, the Respondent failed to reassess the patient's functional status, despite continuing to prescribe multiple controlled substances. (T 344.)

PATIENT B

177. The Respondent treated Patient B from February 1, 2007 through August 6, 2019. (Exhibits 4, F1-F9.)

178. During his initial evaluation of Patient B on February 1, 2007, the Respondent failed to review the patient's personal and social history or ascertain whether the patient had any allergies. (Exhibit F6, pp.1-2; T 581.)

179. The Respondent failed to perform manual muscle testing of Patient B during the February 1, 2007 initial evaluation, despite reporting that the patient had difficulty opening and closing his hands and raising his left arm, with complaints of numbness in unspecified areas of the body and difficulty with unspecified activities. (Exhibit F6, pp. 1-2; T 581-82.)

180. The Respondent performed reflex testing of Patient B's lower extremity on the February 1, 2007 date of service but failed to perform reflex testing of the patient's upper extremity, even though the patient's chief complaint involved the upper extremity. (Exhibit F6, pp.1-2; T 583.)

181. The Respondent failed to conduct an examination of the cervical spine and a detailed examination of Patient B's left shoulder during the February 1, 2007 initial evaluation that included the rotator cuff, labrum, and testing for impingement and stability. (T 739-40.)

182. Despite Patient B's complaints regarding difficulty with his hands, the Respondent performed only a limited examination of his hands, without a detailed examination of the joints in the hands, and no evaluation of the patient's strength and reflexes in his hands. (Exhibit F6, pp. 1-2; T 741.)

183. On February 1, 2007, the Respondent issued Patient B prescriptions for Ambien, a medication used to treat insomnia, and 180 tablets of 30 mg Roxicodone, a non-starting dose, despite indicating that the patient "would be started on pain medication". (Exhibit F6, pp. 1-3.)

184. The Respondent failed to attempt conservative treatment modalities for Patient B, such as physical therapy, before prescribing Roxicodone for the patient. (T 612.)

185. Before prescribing Roxicodone, the Respondent did not provide Patient B with a pain management contract and did not verbally advise the patient of his responsibilities and the conditions by which the Respondent would continue to prescribe opioid medications. (Exhibit F6, pp. 1-2; T 628.)

186. The Respondent's documentation of his February 1, 2007 evaluation of Patient B fails to identify the medications to be prescribed, stating only that "the patient will be started on pain medication," without mention of a sleep medication. (Exhibit F6, pp. 1-2; T 584.)

187. The Respondent failed to document an appropriate rationale and render a diagnosis for Patient B before instituting pain management treatment and before prescribing sleep medication. (T 583, 589, 612.)

188. The Respondent failed to devise and document an appropriate individualized treatment plan for Patient B during the patient's February 1, 2007 visit. His note includes a non-personalized recommendation for physical therapy using the same wording as was used in Patient A's notes. (Exhibit E5, p. 15, F6, p. 2; T 584-85.)

189. The Respondent prescribed Roxicodone for Patient B from February 1, 2007 until at least March 10, 2016 without medical justification. (Exhibits 4, F1, F4, F5, F6.)

190. The Respondent's documentation of Patient B's February 1, 2007 initial evaluation includes a recommendation for an electromyography (EMG), a diagnostic procedure to assess nerve function. It includes muscle testing for abnormal waves or electrical activity. (T 586-87.)

191. The Respondent also documented his recommendation for an EMG of the upper extremities for Patient B during visits on March 1, 2007 and November 1, 2007. However, the Respondent's records for Patient B do not contain EMG results. (Exhibit F6, pp. 6, 23; T 587, 593, 751.)

192. The Respondent documented a recommendation for an x-ray of Patient B's hands during the February 1, 2007 initial evaluation. (Exhibit F6, pp. 1-2; T 587.)

193. Although Patient B received the requested x-ray of his hands that same day, and the radiological report is included in the patient's record, the Respondent failed to utilize the x-ray results in devising a diagnosis and treatment plan for the patient and did not discuss the x-ray results during the patient's next visit on March 1, 2007. (Exhibit F6, pp.4-6; T 593-94.)

194. The Respondent's progress note for his May 29, 2007 appointment with Patient B describes the visit as a "follow-up for this gentleman who comes in complaining of back pain, elbow pain that is 7/10." Although the patient initially presented himself to the Respondent on February 1, 2007 for complaints of difficulty opening and closing his hands and raising his left arm, the May 29, 2007 note does not discuss the patient's status regarding those initial complaints. (Exhibit F6, pp. 1-2, 12.)

195. In order to diagnose tennis elbow, a reasonably prudent physician assesses a patient's resisted wrist extension, and resisted finger extension with the elbow bent and the elbow straight or flexed and extended. (T 599.)

196. Although the Respondent's progress note for the May 29, 2007 date of service includes a diagnosis of tennis elbow, he did not document the basis for the diagnosis. (Exhibit F6, p. 12.)

197. The Respondent failed to adequately and appropriately follow-upon the Patient B's prior complaints of difficulty opening and closing his hands and raising his left arm during Patient B's May 29, 2007 appointment. (T 594-96.)

198. During Patient B's May 29, 2007 appointment, the Respondent again prescribed the patient Roxicodone, 30 milligrams, 180 tablets, but the Respondent's note for that date of service does not discuss what the patient tried in the past, nor does it provide a specific diagnosis as a rationale for that prescription. (Exhibit F6, pp. 12-13; T 597-98, 612.)

199. During Patient B's May 29, 2007 appointment, the Respondent also prescribed Relafen (an anti-inflammatory), 500 milligrams, 60 tablets, and Lunesta (a medication for insomnia or sleep difficulties) but failed to document a medical rationale for those prescriptions. (Exhibit F6, pp. 12-13; T 598-600.)

200. Although the Respondent repeated his recommendation for physical therapy for Patient B in progress notes for May 27, 2008, June 2, 2009, August 27, 2009, December 22, 2009, January 19, 2010, February 9, 2010, March 18, 2010, and June 10, 2010 dates of service, the patient's record contains no information to suggest that the Respondent ever followed up on that recommendation. (Exhibit F6, pp. 45, 85-86, 93-94, 103, 112, 124, 130, 133, 142; T 587-88, 592-93.)

201. The Respondent's failure to ask Patient B whether he had attempted the recommended physical therapy constitutes a deviation from the standard of care for a reasonably prudent physician. (T 748-49.)

202. Patient B's record includes an August 2, 2007 note by the Respondent, which states that the patient is "still complaining of generalized neck and back pain. He has tried Valium to help alleviate his spasms." The note does not mention the location of the patient's spasms, or how they interfere with his functioning. The note also fails to mention who prescribed the Valium, and the dosing or frequency prescribed. (Exhibit F6, 17; T 600-01.)

203. In the progress note for Patient B's August 21, 2007 appointment, the Respondent again reported that the patient is using Valium, but did not explain who prescribed the medication, and for what condition. (Exhibit F6, p. 18; T 601.)

204. Valium is an addictive medication used as a sleep medication or to treat anxiety that should not be taken more than a few weeks. (T 602-03.)

205. On September 13, 2007, the Respondent prescribed Patient B the following medications: (a) Roxicodone, 30 milligrams, 180 tablets; (b) colace; and (c) Xanax (an anti-anxiety medication), two milligrams, 90 tablets. (Exhibit F6, p. 21; T 604.)

206. The Respondent failed to document a rationale for adding Xanax to Patient B's medication regimen. (T 604.)

207. Patient B's combined use of Roxicodone, Valium, and Xanax, all central nervous system depressants, presented added risks of central nervous system and respiratory depression for the patient. (T 602, 613.)

208. On February 9, 2010, the Respondent first presented a pain management contract to Patient B regarding the patient's responsibilities, despite continuously prescribing controlled substances to this patient since the first appointment on February 1, 2007, a deviation from the standard of care. (Exhibit F4, pp. 1-2; T 628.)

209. From November 8, 2011 through December 5, 2012, the Respondent prescribed Opana, an opioid medication, for Patient B, in addition to Roxicodone and Xanax. (Exhibit F6, pp. 172-73; Exhibit F5, pp. 1-18.)

210. The Respondent increased Patient B's risks of respiratory depression, confusion, and central nervous system depression by prescribing Opana in addition to Xanax and Roxicodone. (T 613.)

211. The Respondent failed to perform an adequate history to justify the Opana prescriptions. (T 607.)

212. Opana is generally not prescribed for more than three months. (T 607.)

213. The Respondent failed to document justification for prescribing Opana for Patient B for more than one year. (T 607.)

214. On January 3, 2013, the Respondent began prescribing methadone for Patient B, in addition to continued prescriptions for Xanax and Roxicodone. (Exhibit F5, p. 20.)

215. The Respondent failed to document an appropriate rationale for prescribing methadone, an opioid medication used for moderate to severe pain. (T 614, 616.)

216. Although the Respondent noted that "[a]n EKG will be required to monitor the patient's QT segment", Patient B's record does not contain documentation to show that the Respondent ordered a baseline EKG for Patient B before prescribing methadone. (T 616-17.)

217. The Respondent continued to prescribe methadone for Patient B until on or about April 16, 2019. (Exhibit F5, p. 246.)

218. On August 7, 2013, the Respondent received the results of Patient B's blood test. He did not discuss those results with the patient during his next appointment on August 13, 2013 or otherwise document that the results were reviewed. (Exhibit F4, pp. 45-49, F5, p. 55; T 771-72.)

219. From August 13, 2013 through November 17, 2015, the Respondent prescribed Ambien, a sleep medication, for Patient B, in addition to continued prescriptions for Xanax, Roxicodone, and methadone. (Exhibit F1; T 608-09.)

220. The Respondent increased Patient B's risks of respiratory depression, confusion, and central nervous system depression by prescribing Ambien in addition to Xanax, Roxicodone, and methadone. (T 613.)

221. From December 15, 2015 through March 10, 2016, the Respondent prescribed Seroquel for Patient B, in addition to continued prescriptions for Roxicodone, Xanax, and Methadone. (Exhibit F1, pp. 120-35.)

222. The Respondent's records for Patient B do not contain a rationale for a prescription of Seroquel, an anti-psychotic medication indicated for diagnoses of schizophrenia or bipolar disorder. (T 608.)

223. Although the Respondent reported recommending that Patient B see a psychiatrist on at least two appointments, and subsequently noted that the patient had seen a psychiatrist, Patient B's records contain no information regarding the psychiatrist, including the name and contact information, and the psychiatrist's recommendations or treatment, omissions that fall below the standard of care. (T 748-49.)

224. The Respondent failed to follow up on his recommendation that Patient B attend a smoking cessation program. (T 750.)

225. Throughout the course of the Respondent's treatment of Patient B, the Respondent failed to appropriately prescribe medications based on appropriate medical rationale. (T 609.)

226. After the I-STOP/PMP was implemented effective August 27, 2013, the Respondent failed to verify Patient B's prescription drug usage on or before each appointment, an omission that falls below the standard of care. (T 757-58.)

227. Throughout the course of the Respondent's treatment of Patient B, the Respondent failed to appropriately document a rationale for making changes to medications prescribed. (T 610.)

228. Throughout the course of the Respondent's treatment of Patient B, from February 1, 2007 through August 6, 2019, the Respondent repeatedly failed to appropriately evaluate the patient by failing to perform or document comprehensive physical examinations. (T 588-59.)

229. Throughout the course of the Respondent's treatment of Patient B, the Respondent repeatedly failed to develop, implement, and revise a personalized treatment plan. (T 590.)

230. Throughout the course of the Respondent's treatment of Patient B, the Respondent repeatedly failed to adequately and appropriately follow-up on Patient B's prior complaints, recommended treatments, and procedures performed. (T 594-96, 750-51.).

231. The Respondent's records for Patient B do not contain documented evidence of functional improvement. Although the Respondent periodically reassessed Patient B's symptoms during the course of treatment, he did not reassess the patient's functionality. (T 618-19.)

232. The Respondent's records for Patient B fall below the standard of care for a reasonably prudent physician. (T 629.)

PATIENT C

233. Patient C's first appointment with the Respondent occurred on September 16, 2009, after the patient had a work-related motor vehicle accident. Although the note reports that the patient had sustained a "crushed right knee", the note offers no information regarding how his knee was crushed and what specifically was injured. (Exhibit G3, pp. 66-67; T 1058.)

234. The Respondent's record for Patient C's September 16, 2009 appointment states that the patient had surgery on September 11 but does not state what surgery. No documentation is contained in the patient's record regarding the surgery or treatment rendered by the surgeon, including pain medications prescribed. (T 786-87, 790-91.)

235. Although the Respondent's progress note for the September 16, 2009 appointment states that Patient C complains of mild neck and back discomfort, the Respondent performed an inadequate physical examination of the cervical and lumbar regions. (T 785-87.)

236. The Respondent recommended physical therapy for Patient C during the initial September 16, 2009 appointment (using language identical to that used in records of Patients A and B), and repeated the recommendation during the patient's November 3 and December 22, 2009 appointments. However, the Respondent did not follow up with the patient to ascertain

whether physical therapy was ever attempted. (Exhibit G3, pp. 66-67; Exhibit G1, pp. 3-4; T 802-03.)

237. During the September 16, 2009 appointment, the Respondent prescribed Patient C Roxicodone, 30 milligrams, and Dilaudid, another opioid medication. (Exhibit G3, p. 65.)

238. The Respondent failed to render a diagnosis for Patient C or provide any medical rationale for the September 16, 2009 prescriptions. (T 787-89.)

239. Prescribing two opioid medications simultaneously, without evaluating the effect of either medication on Patient C, was not appropriate and did not meet the standard of care. (T 789-90.)

240. The Respondent's records for Patient C do not contain a medical justification for his prescribing two opioid medications simultaneously. (T 789-90.)

241. On October 6, 2009, during Patient C's follow-up appointment, the Respondent determined to prescribe the patient Norco and Xanax, noting that the "Roxicodone and Dilaudid were too strong for him." The Respondent did not provide a medical justification for the new prescriptions. (Exhibit G1, p. 1, T 792.)

242. A urine drug screen performed on Patient C on October 6, 2009 revealed that the patient had used opioids (consistent with prescriptions given on September 16, 2009), along with marijuana and Valium, which the Respondent had not prescribed. The Respondent continued to treat and prescribe controlled substances for Patient C. (Exhibit G3, p. 63.)

243. During Patient C's December 22, 2009 appointment with the Respondent, the Respondent recommended that the patient obtain a stationary bike, even though use of such equipment would increase disc pressure. The Respondent did not provide a medical rationale for this recommendation. (Exhibit G1, p. 4; T 795-96.)

244. In a dictated progress note for Patient C's July 5, 2011 appointment, the Respondent reported that the "[r]esults of three urinalysis reported as POSITIVE for cocaine." The three urinalysis test results are not contained in Patient C's records. (Exhibit G1, p. 20; T 828-29.)

245. Despite those test results described in the July 5, 2011 dictated progress note, the Respondent did not discharge the patient and did not alter Patient C's treatment, which falls below the standard of care for a reasonably prudent physician. (T 829-31.)

246. The Respondent did not conduct another urinalysis or urine drug screen for Patient C within a few weeks after the tests reported positive for cocaine, and did not increase the frequency of testing, an omission that falls below the standard of care for a reasonably prudent physician. (T 832.)

247. On October 9, 2012, the Respondent prescribed Patient C the following medications: (a) Viagra, 100 mg; (b) Xanax, 2 mg; (c) Percocet, 10-325 mg; and (d) Norco 10-325 mg. (Exhibit G6, pp. 163-66.)

248. The Respondent's simultaneous prescribing of Xanax, Percocet and Norco presented heightened risks of sedation, respiratory depression, confusion, and memory loss, especially for Patient C, who had listed diagnoses of concussive disorder and traumatic brain injury with short-term memory loss. (T 812-13, 815.)

249. During Patient C's November 18, 2014 appointment, the Respondent indicated that the patient would obtain an x-ray of the right knee "to rule out any internal derangement." (Exhibit 5, p. 108.)

250. The Respondent failed to obtain an adequate history and perform an adequate physical examination of Patient C's right knee on November 18, 2014 to justify his recommendation that the patient obtain an x-ray. (T 798-800.)

251. During Patient C's next appointments on December 16, 2014 and January 13, 2015, the Respondent did not follow up with the patient to verify that he had obtained the recommended x-ray of the right knee. (Exhibit 5, pp. 112, 116.)

252. The Respondent's records for Patient C do not contain x-ray results. (T 802.)

253. On or about November 3, 2015, the Respondent began prescribing Adderall for Patient C, in addition to Flonase, Hydrochlorothiazide, and Norco. (Exhibit G6, pp. 29-34.)

254. The Respondent failed to document an appropriate medical rationale for prescribing Adderall, a medication indicated for attention-deficit/hyperactivity disorder (ADHD) and is prescribed by a psychiatrist or primary care physician. (T 809.)

PATIENT D

255. In lab results dated March 3, 2012, Patient D tested positive for substances that the Respondent had not prescribed. (Exhibit H1, p. 2.)

256. The Respondent continued prescribing opioid medications for Patient D without increasing the frequency of urine testing. (Exhibit H1.)

257. On May 24, 2012, the Respondent performed a right sciatic nerve block and trigger point injections into the gluteus minimus, maximus and quadratus lumborum, without obtaining the patient's prior consent to the right sciatic nerve block. (Exhibit H3, p. 7; T 1279-80.)

258. The Respondent first presented a pain management contract to Patient D on January 22, 2013, despite having prescribed opioid medications for the patient for over one year. (Exhibit H1, p. 3; Exhibit H4; Exhibit 6, p. 3.)

259. During Patient D's January 22, 2013 appointment, the Respondent failed to perform an adequate examination of the patient's left knee and lower back, body parts that the patient reported as the basis for his seeking treatment. (Exhibit 6, pp. 1-2; T 1162-64.)

260. The Respondent's records for the January 22, 2013 date of service fail to meet the applicable standard of care, as they fail to document the performance of an adequate physical examination of the body parts complained of, nor do the records include, at minimum, a differential diagnosis regarding Patient D's lower back pain. (Exhibit 6, pp. 1-2; T 1162-64.)

261. On July 23, 2013, the Respondent performed bilateral sciatic nerve blocks and trigger point injections into Patient D's gluteus minimus and maximus. (Exhibit 6, pp. 32-33.)

262. The Respondent failed to obtain Patient D's consent, verbal or written, prior to performing the nerve blocks on May 24, 2012 and July 23, 2013. (Exhibit H3, p. 7; Exhibit 6, pp. 32-33.)

263. The Respondent failed to appropriately evaluate Patient D before performing the sciatic nerve block on July 23, 2013. (T 1149-50.)

264. The Respondent failed to appropriately document the procedures performed on July 23, 2013 and did not document whether the procedures provided Patient D with any relief. (T 1150.)

PATIENT E

265. Patient E was first seen by the Respondent on February 24, 2016 after a motor vehicle accident two days earlier. He complained of knee pain with numbness in the left leg and swelling. (Exhibit 7, pp. 2-3; T 1947.)

266. The Respondent failed to obtain Patient E's personal and social history during the first appointment on February 24, 2016. (Exhibit 7, pp. 2-3; T 1079.)

267. The Respondent failed to perform a comprehensive physical examination of Patient E, particularly of the knee, the patient's chief complaint, on February 24, 2016. (T 1080-81.)

268. The Respondent failed to perform detailed manual muscle testing of both lower extremities, despite the patient's complaints of numbness in the left leg. (T 1081-82, 1126.)

269. Although the Respondent reported administering a "left sciatic nerve block trigger" in Patient E's "left gluteus minimus, maximus, and quadratus lumborum", he did not document specific information about the procedure and failed to obtain the patient's prior informed consent (written or verbal) to the nerve block procedure. (T 1084-85; 1279-80.)

270. During Patient E's appointment on June 3, 2016, the Respondent failed to adequately describe the location of the patient's pain and failed to adequately examine the patient's knee and lumbar spine. (T 1085-87.)

271. During Patient E's appointment on November 4, 2016, Patient E underwent an electromyography (EMG), which revealed a left L-5 S-1 radiculopathy and a mild left tibial motor neuropathy. The Respondent documented that the patient was given a brief explanation of the endoscopic microdiscectomy procedure and was shown a video, after which the patient agreed to undergo the procedure. (Exhibit 7, pp. 9-11.)

272. The Respondent failed to attempt more conservative treatment for Patient E, including anti-inflammatory medication, other non-steroidal medications, and steroid medications, before recommending an endoscopic microdiscectomy. (T 1093-95, 1102, 1127-31.)

273. The Respondent's records for Patient E fail to demonstrate an appropriate medical indication for an endoscopic microdiscectomy. (T 1102-03.)

274. A discogram is a diagnostic imaging procedure to reveal abnormalities in the spinal discs, requiring the injection of x-ray dye into the center of disc (nucleus) to reproduce the patient's symptoms. (T 1095-98, 1103-04.)

275. On March 2, 2017, the Respondent performed a discogram and an endoscopic microdiscectomy on Patient E, after which the patient experienced cardiorespiratory arrest and died several days later. (Exhibits 7, 8.)

276. The Respondent failed to obtain Patient E's informed consent prior to performing a discogram and an endoscopic microdiscectomy on March 2, 2017. (T 1795.)

DISCUSSION

Testimony of Dr. Geraci

Dr. Geraci is a licensed physician, board certified in physical medicine and rehabilitation, and is also a physical therapist. He has worked as an outpatient PM&R provider since 1989 treating musculoskeletal problems. (Dept. Exhibit 9; T 33-37.) Throughout his career, Dr. Geraci has treated thousands of patients with pain that persists after attempting all possible treatments (referred to by the Respondent as "chronic intractable pain.") Currently, approximately 20% of his patients have this diagnosis. Patients with persistent pain see Dr. Geraci an average of seven visits. (T 86-89.) Approximately five percent of Dr. Geraci's patients continue to be seen by his practice for more than one year, and less than one percent of his patients receive treatment from his practice for over ten years. (T 89-90.) He has not prescribed oxycodone at all for over 10 years, the most recent of which was short-acting, and rarely prescribes long-acting opioid medications. (T 93-94.) Dr. Geraci last prescribed a long-acting opioid medication over 12 years ago. (T 94.)

Dr. Geraci was asked to review the medical records of Patients A-E. Dr. Geraci concluded that the Respondent's records for all five patients bore similar deficiencies. (T 1138-39, 1162-66.) With respect to Patient A, Dr. Geraci determined that the Respondent repeatedly conducted and documented inadequate medical and social histories and physical examinations; and commenced treatment without diagnosing the patient's symptoms and without developing, implementing, and revising a personalized treatment plan. (T 148-49.)

For Patient B, Dr. Geraci also concluded that the Respondent conducted inadequate medical and social histories and physical examinations; prescribed medications before making a diagnosis; failed to develop a personalized treatment plan; and failed to follow up on recommended treatments. In addition, Dr. Geraci found no documentation to show that Patient B had improved functionally during the lengthy course of the Respondent's treatment, despite continued prescriptions of combinations of opioids. Observing that the patient's reports of pain were often quite severe, ranging from 8 to 10 on a pain scale, with the highest possible pain level being 10, Dr. Geraci expressed concern that Patient B may have experienced opioid-induced hyperalgesia, a condition caused by long-term use of opioids in which the patient's pain increases. (T 761-62.) Although the Respondent noted a diagnosis of "chronic intractable pain" on some prescriptions in the records of Patient B, Dr. Geraci found no medical justification for that diagnosis. (T 752.)

After reviewing the Respondent's records for Patient C, Dr. Geraci concluded that over the course of his treatment, the Respondent failed to appropriately evaluate the patient; failed to obtain an adequate social and medical history; failed to perform comprehensive physical examinations with manual muscle testing; failed to appropriately order imaging studies; and failed to review imaging studies ordered. (T 782-83, 852-53.) Dr. Geraci also determined that the Respondent failed to appropriately follow up on Patient C's complaints, procedures, and recommended treatments. (T 796-98.) Dr. Geraci opined that prescribing Patient C with two narcotics shortly after his motor vehicle accident without first attempting more conservative treatments fell below the standard of care for a reasonably prudent physician. (T 843-44.) Regarding the combination of opioid prescriptions given by the Respondent to Patient C, Dr. Geraci found them to be inappropriate, particularly given the patient's diagnoses of concussive

disorder and traumatic brain injury with short-term memory loss, as the narcotics would only worsen the patient's pre-existing symptoms. (T 812-13, 1068.) Regarding urine testing performed on Patient C, Dr. Geraci opined that the Respondent failed to follow up on several disturbing results, including the patient testing positive for marijuana use and subsequently testing positive for cocaine use. (T 828.)

In addition to his general conclusions regarding the Respondent's overall inadequacy of the Respondent's care, treatment, and medical records for each patient, Dr. Geraci determined that the Respondent failed to perform an adequate examination of Patient D before concluding that the patient had sciatica. (T 1139-41.) Dr. Geraci also found that the Respondent failed to attempt conservative treatments before proceeding with injections. (T 1142.)

The Hearing Committee appreciates Dr. Geraci's testimony and insight. They placed substantial weight on his opinions due to the length of his professional practice that continues to date, his detailed review of the submitted patient records, and the thoroughness of his explanations. His opinions are fully supported by the evidence in the patient records. The Hearing Committee is not persuaded by the Respondent's claims that Dr. Geraci's testimony and professional experience should be discredited or discounted because he had not practiced in a busy office located in a densely-populated area, such as Staten Island. (T 73.) Nor are they swayed by the Respondent's suggestions that Dr. Geraci could not adequately assess the Respondent's care and treatment of long-term patients when, on average, he would see patients less than 10 times. Similarly, Dr. Geraci's decisions (a) not to prescribe long-acting opioid medications for more than 12 years; and (b) to stop accepting new patients with Workers' Compensation and no-fault insurance coverage are not viewed by the Hearing Committee as detracting from the quality of the information he provided and his explanation of applicable

standards of care. Dr. Geraci's professional practices reflect sound treatment that restores patients' functionality and enables them to avoid the prescribing of long-term opioid medications.

Although the Respondent argued that Dr. Geraci did not distinguish between acute and chronic pain in his analysis, and referred to chronic intractable pain (which, as discussed below, was never established for any of the patients at issue), the Respondent's argument conflates multiple ideas that neither diminish nor undermine the explanations provided by Dr. Geraci at the hearing.

Testimony of Dr. Carfi

Dr. Carfi is a licensed physician, board certified in physical medicine and rehabilitation. He worked in private practice as a PM&R physician for over 26 years, as an attending physician for over 10 years, and has taught rehabilitation medicine at Mount Sinai School of Medicine since 1986. (Exhibit D.) Dr. Carfi stopped treating patients in 2020. Since then, he has only offered consultation services. (T 1304-05.) Dr. Carfi reviewed case files for the Office for Professional Medical Conduct from 2006 until 2020. However, that association was terminated by OPMC once Dr. Carfi ceased practicing due to the policy that only physicians in active practice review case files. (T 1176, 1305.)

In his own practice, Dr. Carfi prescribed multiple opioids simultaneously for patients with chronic intractable pain. However, he could not recall how many patients under his care received a combination of opioid medications. (T 1331-33.) Dr. Carfi also prescribed narcotics for several patients for multiple years. (T 1348-49.)

Dr. Carfi was retained by the Respondent to review his records for Patients A-D. (T 1169.) Based upon his review of the records, Dr. Carfi determined that the treatment rendered

by the Respondent to those patients, including medications, testing, and follow up on treatment was appropriate. (T 1571-72.) While he acknowledged that the Respondent's records had some shortcomings, Dr. Carfi testified that, when the records were viewed in their entirety, the Respondent's records were adequate to inform another practitioner as to each patient's treatment. (T 1172, 1185, 1215, 1571.) In response to Dr. Geraci's critique regarding the Respondent's use of template language regarding physical therapy recommendations, Dr. Carfi explained that practitioners save time and money by using template language for certain portions of progress notes, and opined that use of such repeat language for multiple patients is acceptable. (T 1228-29, 1412.) Dr. Carfi also reported finding many individualized portions of the Respondent's treatment plans for the patients. (T 1229.)

Dr. Carfi characterized injections as "minor procedures" that do not necessitate a patient's informed consent before they are performed. (T 1279-80, 1391.) However, he also testified that procedures such as epidurals, and nerve blocks would require such consent. (T 1279-80.)

Dr. Carfi testified that the Respondent's testing and treatment of Patient A was appropriate. (T 1411.) He found that the Respondent exceeded minimum requirements for follow-up appointments by seeing the patient monthly. (T 1185-88, 1222.) Dr. Carfi determined that the Respondent did not order unnecessary tests, and that he followed up on ordered tests. (T 1223.) It is Dr. Carfi's opinion that the Respondent's prescribing practices, and monitoring of the patient were appropriate. (T 1188, 1240-41.) Dr. Carfi also found that the Respondent's performance of six urine toxicology screens for Patient A between June 2008 and December 2011 met the standard of care. (T 1242, 1379-80.)

Dr. Carfi concluded that Patient A continued to benefit from the medication prescribed by the Respondent throughout the course of the doctor-patient relationship. (T 1283.) Dr. Carfi found that the Respondent documented inquiries regarding surgical outcomes for Patient A (T 1283, 1285), and that continued prescribing of opioids was appropriate, based upon the patient's need for additional surgeries. (T 1292-93.) Along those same lines, Dr. Carfi testified that the Respondent's documentation on October 7, 2008 that Patient A was "having difficulty ambulating and wearing shoes" (Exhibit E9, p. 40) constituted sufficient medical justification for increasing the patient's Roxicodone prescription from 140 tablets of 15 mg Roxicodone in August 2008 to 140 tablets of 30 mg Roxicodone. (T 1358-59, 1361-63.)

Regarding Patient B, Dr. Carfi testified that the patient's history of injuries and surgical procedures suggested that the patient would continue to experience pain. (T 1414-15, 1417.) With respect to the allegation that the Respondent's initial prescription of Roxicodone at 30 mg for Patient B was inappropriate, Dr. Carfi testified that "it was more likely than not" that the Respondent would not prescribe such a high dosage of Roxicodone to an opioid-naïve patient. (T 1419, 1455.) However, he was unable to identify any portion of Patient B's records that documented the patient's existing use of Roxicodone or other opioids before consulting with the Respondent for treatment. (T 1455.) Similarly, when asked whether he found evidence that Patient B was sedated during the course of treatment with the Respondent, Dr. Carfi replied that he hadn't seen "any reports of sedation, either on the review of systems checklist filled out by the patient, or in any of the clinical notes". (T 1415.) Given the fact that the Respondent is charged with failing to maintain accurate records which accurately reflect the evaluation and treatment of each patient, Dr. Carfi's response also assumed that the Respondent's records include all relevant information, even though both parties and their witnesses agree that not all necessary information

is found in the records. (T 1453-54.) Dr. Carfi concluded that the Respondent followed up on radiological testing by reading the reports and placing them in Patient B's records and referring the patient to specialists as needed. (T 1421-25.)

With respect to Patient C, Dr. Carfi determined that the Respondent appropriately followed up on patient complaints, procedures, and recommended treatments. (T 1466-67.) Dr. Carfi also testified that the Respondent made appropriate referrals to specialists and devised personalized treatment plans for the patient. (T 1468-70, 1472, 1475-77, 1480-81, 1485.) Similar to his conclusions regarding Patient B, Dr. Carfi was satisfied that the Respondent followed up on radiological testing by reading the reports and placing them in Patient C's records. (T 1482-83.)

Similarly, in the limited testimony elicited from Dr. Carfi regarding his review of Patient D's records, Dr. Carfi ultimately acknowledged that his analysis required the assumption that a physical examination had occurred, for instance, on November 14, 2013, a date of service in which the Respondent performed a right sciatic nerve block. Dr. Carfi's assumption rested upon the Respondent's notation that Patient D had pain along the right side notch even though the Respondent did not document a physical examination. (T 1557, 1559, 1565-66; Exhibit 6, p. 50.) He subsequently explained that he is not a pain management physician and has only a general understanding of the procedures discussed at this hearing. Dr. Carfi also admitted that he has never performed a sciatic nerve block. (T 1569-70.)

The Hearing Committee respects Dr. Carfi's experience and found his testimony to be sincere. However, they observed that Dr. Carfi often assumed the basis for the Respondent's treatment decisions (T 1245), and that he frequently used the words (or derivations of the words) "appear", "infer", "assume", "presumption", "probably", "likely", and "guess" in his

explanations regarding his understanding of treatment and procedures performed. (T 1210, 1215, 1263, 1366, 1378, 1418, 1462-63, 1484, 1559.) For instance, when asked whether Patient A, who had undergone foot surgery four days before his May 25, 2010 appointment with the Respondent (Exhibit E5, p. 31), would likely have been prescribed pain medication by the surgeon, Dr. Carfi presumed (notwithstanding his characterization of his analysis as "clear") that the surgeon would know that Patient A was being seen by a PM&R physician and would therefore not prescribe more pain medication. (T 1363-65.) The Respondent's records for Patient A contain no information to support Dr. Carfi's assertion. (T 1366.)

Dr. Carfi's assumptions were predicated on the idea that "[just] because it wasn't documented, doesn't mean it wasn't done" (T 1373), an idea that is not supported by applicable law. The Hearing Committee deems it inappropriate to make such assumptions.

Despite his testimony that chronic intractable pain cannot be diagnosed without exhausting all treatment modalities, Dr. Carfi stated with certainty that Patients A-D were properly diagnosed with chronic intractable pain because the Respondent had included the diagnosis on certain prescriptions. (T 1385, 1418-19, 1433-34.) Dr. Carfi also testified that the diagnosis of chronic intractable pain should be documented in a patient's medical record. (T 1328.) Other than the fact that the chronic intractable pain diagnosis was included on particular prescriptions, he did not identify any other source for that determination, despite this diagnosis being a central issue for this hearing.

Finally, the Hearing Committee found certain aspects of Dr. Carfi's testimony to be inconsistent. For instance, Dr. Carfi initially testified that a proper patient history conducted during an initial patient evaluation did not need to include questions regarding a patient's alcohol and cigarette use (T 1330) despite conceding that opioids, when taken in combination with

alcohol, present heightened risks of respiratory depression (T 1330-31.) While Dr. Carfi also stated that a patient's work "may or may not be relevant" as part of a patient's history (T 1315), he also testified repeatedly that a patient's ability to return to work is important (T 1178, 1192-93, 1316-17, 1354-55, 1414, 1425), the latter opinion seemingly incongruous with the former.

Testimony of Anna Antico

Ms. Antico has worked for the Respondent since 2007, first as a receptionist, and then as the manager of his Staten Island office since 2010. (T 965.) Ms. Antico testified that the Respondent's Staten Island office on Post Avenue, where he continues to see patients, was flooded during Superstorm Sandy, causing the practice to lose many paper records. She attempted to salvage records as much as possible and scan them into electronic files. (T 975-76, 1009.)

Ms. Antico recounted the office's use of four different versions of electronic medical record software, the last of which the Respondent's office has used since approximately 2015. She explained that the electronic medical record program used just before the current system would not allow a change to the Respondent's office address on the records, even though the practice had moved to a new location. (T 973-74.)

Ms. Antico explained that the Respondent had previously employed a Medical Assistant by the name of Brittany Corcillo at the Staten Island office, who had submitted the Respondent's records for Patients A-D to the Office of Professional Medical Conduct in December 2016. Ms. Corcillo was terminated in about 2017 after the Respondent noticed her reporting identical blood pressure and pulse readings for patients over the course of multiple visits. (T 979-81, 997-1000.) In addition, Ms. Antico testified generally that the Respondent recommends exercise routines to his patients and durable medical equipment before prescribing narcotics. (T 984-85.) While the

Hearing Committee found Ms. Antico to be a credible character witness, she offered no information relevant to the charges at issue.

Testimony of Dr. Ketan Vora

The Respondent also presented Ketan Vora, D.O., as an expert witness regarding the discogram and microdiscectomy performed on Patient E. (T 1761-62.) Dr. Vora testified that he has performed "thousands" of these procedures. (T 1844.) Dr. Vora opined that the Respondent's treatment of Patient E, including his recommendation to proceed with a discectomy, was appropriate. In rendering his determination, Dr. Vora considered the different treatment modalities that the Respondent employed before making his recommendation, including physical therapy, prescribing Medrol Dose Packs several times, multiple follow up appointments, and EMG findings showing recurring chronic radiculopathy after treatment was shown to have helped the patient, persistent pain for nearly one year, and a discography replicated the patient's symptoms ("positive discography"). (T 1764-66, 1769.) Dr. Vora noted that Patient E's pain level decreased with physical therapy. (T 1768.) He did not explain why the discogram and endoscopic microdiscectomy were medically necessary for Patient E.

Similar to the opinions expressed by Dr. Carfi, Dr. Vora assumed information that he was not able to identify in the record. Other than the EMG results for Patient E dated November 4, 2016, Dr. Vora was unable to identify documentation in Patient E's medical record that indicated a diagnosis of radiculopathy. Instead, he based his opinion on the operative report, billing records, documents submitted to the patient's no-fault insurer (Exhibit I1, pp. 80, 83), the differential diagnoses listed in the February 24, 2016 progress note, the earliest progress note provided (Exhibit 7, pp. 2-3), and the results of an EMG conducted and reported by Dr. Karafin on November 4, 2016. (T 1778-88.) The post-operative report dated March 2, 2017 does not

provide medical justification for the discogram that was already performed. (Exhibit 7, p. 19; T 1788.) Dr. Vora subsequently testified that Patient E was diagnosed with "a recurring chronic radiculopathy" but was again unable to identify records that supported the diagnosis, instead explaining that he understood the patient's diagnosis to be such, but that he had not found the diagnosis anywhere. (T 1799-1800.)

With respect to treatment modalities attempted before recommending a discectomy, Dr. Vora testified that the patient had received an epidural injection, based upon the information provided in EMG results. However, he conceded that no information exists in the patient record to identify when that procedure was performed or the location of the injection. (T 1803.)

Dr. Vora stated that a discectomy was appropriate for the identified bulge. (T 1769.) He also testified that it is his standard practice to perform discograms and discectomies on the same day, irrespective of whether the discogram is performed for diagnostic or confirmation purposes. (T 1771-72.) Dr. Vora testified that performing a discogram, in which symptoms are confirmed by replicating the pain, without performing a discectomy on the same day is unethical because the patient is left in pain until the discectomy is scheduled. (T 1772-73.)

Dr. Vora agreed that it is the standard of care for a reasonably prudent physician to obtain patient consent before performing a discogram and microdiscectomy. He also testified that he did not see Patient E's consent to the procedures in the patient record. (T 1803.) Although other aspects of his testimony were vague and inconsistent, the Hearing Committee credits Dr. Vora's experience and testimony as an accurate representation that discograms and endoscopic microdiscectomies are frequently performed on the same day.

Testimony of Charles DeMarco, D.C.

The Respondent presented Charles DeMarco, a trained chiropractor and medical device distributor (T 1519-21, 1535-36), as a fact witness regarding the discogram and discectomy performed on Patient E. He testified that there were no complications during the procedure. (T 1533.) The Hearing Committee did not find this witness' testimony relevant to the charges at issue.

Testimony of the Respondent

The Respondent maintains four offices, including the Staten Island office where Patients A-D all received treatment, and a Bronx location where Patient E was seen by the Respondent. (T 1603.) Despite the Respondent's overarching claim that Patients A-E had chronic pain or chronic intractable pain as a means of justifying the appropriateness of his prescribing narcotics, the Respondent characterized Patient A as initially presenting with an acute injury. (T 1689-90.)

The Respondent conceded that his records for Patients A-E were missing information but claimed that no provider ever contacted him with questions regarding his records. (T 1588-89, 1609, 1651-53, 1716-17.) He testified that he began making changes to his recordkeeping after the Office of Professional Medical Conduct (OPMC) informed him that his records were missing information. (T 1610-11, 1630, 1633-34, 1688.)

In response to the concerns raised by Dr. Geraci regarding the Respondent's failure to obtain proper social and medical histories of Patients A-E, the Respondent testified that he had relationships with his patients and knew their conditions and treatment histories very well. (T 1584-85, 1652-53, 1863-64.) The Respondent also testified that several of the patients at issue (Patients A, C, and D) were first seen at Beth Israel Medical Center, where lab tests and comprehensive examinations would have been performed before he saw the patients. (T 1590-

91, 1659, 1889, 1937.) However, that documentation was not included in the records he submitted for Patients A-E. The Respondent testified that he would not prescribe doses of narcotics over and above a starting dose for opioid-naïve patients, and that he only prescribed stronger doses of narcotics for patients who had previously taken those medications. (T 1684, 1725, 1751-52.) Here, too, however, the Respondent offered no documentation or detailed explanations regarding how he verified and documented the patients' history.

The Respondent explained that his examination of his patients starts upon their arrival to his office. He observes patients' movements and reviews office camera footage to verify that patients are being truthful when they describe their pain and physical limitations. (T 1586-87.) The Respondent also stated that he adequately followed up on patient treatment by seeing them on a monthly basis. (T 1584-85.) During the period in which he treated Patients A-E, the Respondent saw between 30 and 40 patients per day. (T 1664.)

In his testimony regarding his practice's conversion from solely relying on transcription services for dictated progress notes to records in which patient records contained dictated progress notes and electronic medical records, the Respondent stated he never relied on the electronic medical records and never submitted those records to other treating providers. (T 1699, 1716-17, 1919.) However, the Hearing Committee noted inconsistencies in this explanation, especially when the Respondent subsequently explained that prescribing information is found in the electronic medical records but is not mentioned in the dictated progress notes. (T 1712.)

Other inconsistencies were noted in the Respondent's electronic medical records. While the Respondent claimed that the medication lists included in the electronic medical records are medications reported to the Respondent, while the refills listed are those written by the

Respondent (T 1160, 1718), a review of the Respondent's corresponding records for those patients shows that the medication lists include prescriptions mainly issued by the Respondent. (T 1161-62.)

The Respondent testified generally as to his review of records before beginning to treat patients, and his overall evaluation. (T 1720-22.) He asserted that his care and treatment of Patients A-E was appropriate, that he developed personalized treatment plans for each patient, that he appropriately monitored the patients, and that he followed up on their complaints. (T 1681-84, 1863-64, 1915-16, 1934-36.) Regarding the Respondent's prescribing of psychiatric medication to Patient B, the Respondent testified that the patient had lost his insurance coverage and was experiencing severe amounts of stress. The Respondent felt obligated to treat the patient's psychological issues. (T 1882-84.) He explained that he monitored the patient monthly because of the high doses of prescribed medications to assess whether Patient B exhibited abnormal behavior, and/or experienced lethargy, constipation, central nervous system depression, or other central nervous system or respiratory issues. (T 1885-86.) Had he not prescribed these medications for Patient B, the Respondent believes that the patient would have sought relief from street drugs. (T 1886-87.)

With respect to his care and treatment he rendered for Patient C, the Respondent testified that the patient was referred to him for pain management with the functional goal of being able to continue to work. (T 1895-97.) He explained that he recommended a stationary bicycle (also referred to as a recumbent or exercise bike) for Patient C to strengthen his legs. (T 1896-97.) The Respondent did not address Dr. Geraci's criticism that use of this bike would increase pressure on the patient's discs.

The Respondent described Patient C as unwilling to consider injections, a Doppler ultrasound to assess the cause of leg swelling, an MRI of the leg to rule out a blood clot, and physical therapy. (T 1897-99.) After those unsuccessful attempts, the Respondent referred Patient C to a neurosurgeon. However, the Respondent testified that his recommendation in the December 3, 2013 progress note for the patient to follow up with a neurosurgeon for an EMG was a typographical error, and that the patient was referred to a neurosurgeon for persistent back pain and abnormal MRI findings. (T 1899-1901.)

The Respondent was satisfied with the care and treatment that he provided to Patient C, particularly because he helped ensure that the patient attained his functional goal of continuing to work. (T 1906-07.) Despite prescribing Concerta and Adderall for Patient C, the Respondent testified that he recommended a psychiatric consultation when the patient wanted to "go off" of the medications. (T 1916.)

In response to questions regarding the treatment rendered to Patient D, the Respondent testified that he performed sciatic nerve blocks on the patient because the patient's insurance did not authorize a second epidural injection. He stated that an epidural is more invasive, and that he would not have done anything differently. (T 1927-31.)

With respect to allegations and charges regarding his treatment of Patient E, the Respondent testified that he recommended surgery for the patient after the patient's unsuccessful attempts to alleviate pain with other treatment, including a sciatic nerve block, physical therapy, and two Medrol dose packs. (T 1956-57.) In response to allegations that the Respondent performed the discogram and microdiscectomy on Patient E without obtaining the patient's prior informed consent, the Respondent pointed to a document in the patient's record entitled, "Patient Notice of Privacy Practices" signed and dated March 2, 2017, the date of the discogram and

microdiscectomy, as the patient's consent to the procedure. (Exhibit 8, pp. 12-15; T 1961-64.) The Hearing Committee has reviewed this document and is not persuaded that the patient consented to the procedures after receiving proper information regarding their risks and benefits.

The Respondent testified that the surgical center obtains the requisite informed consent from patients before procedures are performed, and that he personally obtained the patient's prior informed consent but that he would not have that documentation because it would remain at the ambulatory care center. (T 1965-73.) The Respondent also testified that he had not obtained "an official informed consent like the paperwork" after showing Patient E the video of the procedure in his office but would be required to obtain written consent in order to perform the procedure at the ambulatory surgical center. (T 1969.)

Throughout the hearing, based upon the records for Patients A-E submitted by the Respondent, questions arose regarding the Respondent's relationship to Felix Karafin, another provider in his office, whose name appears on various progress notes in patient records that the Respondent sought to be considered as evidence for this hearing. At times, the Respondent attempted to utilize Dr. Karafin's records as evidence of appropriate patient monitoring (T 1268-71, 1275) and improved recordkeeping by the Respondent, whereas, at other points in the hearing, the Respondent sought to distance himself from documentation, examinations, diagnoses, and treatment rendered by Dr. Karafin. (T 19-20, 1280-83, 1403, 1415-16, 1444, 1492-93, 1501, 1503, 1691-92, 1706-09, 1723, 1953, 1955.) The Respondent testified that Dr. Karafin was "employed" as an independent contractor, based upon his payment relationship. (T 1602, 1606.) However, he also stated that he shares patients with Dr. Karafin (T 1606), and that Patients A-E belonged to both of them. (T 1701.)

When the Respondent was presented with documentation in various patient records showing both his and Dr. Karafin's names on the same record (Exhibit E4, p. 80; Exhibit E7, p. 62; T 1695-98), including an electronic medical record in which the Respondent was listed as the supervising physician, and Dr. Karafin was identified as the "performing" physician for Patient A for treatment on January 7, 2021 (Exhibit E6, pp. 168-69), the Respondent did not offer a satisfactory explanation for the discrepancy and his own documentation, especially for a date of service that occurred more than one year after he had agreed to make changes to his recordkeeping. (T 1700-01.) Similarly, all pain management contracts in Patient A's records were signed by the Respondent. (T 1379; *See, e.g.*, Exhibit E9, p. 2.) The Respondent did not provide a legitimate explanation as to why he would sign pain management contracts involving a patient that he was not seeing when he claimed to have ceased treating that patient and that the now-treating provider was not supervised by him. (T 1702-03.) He did not explain why electronic medical records for Patients A-E contained the Respondent's name, even after Dr. Karafin became involved in their care. (T 1695-98.)

Regarding Patient B, despite the overall contention that others began treating the patient after November 2015, it was the Respondent who discharged the patient from the practice in August 2019. (T 1723-24.) A lab order for Patient C dated September 28, 2021 contained the Respondent's name even though he testified that Dr. Karafin was mainly responsible for the patient's care after March 2017. (T 1912-14.) The evidence shows that the Respondent continued to retain responsibility for the care of Patients A-E, even after Dr. Karafin became involved in their treatment. Similarly, despite testifying that Patient C was "mostly" treated by Dr. Karafin in 2016, when presented with an electronic medical record with his name, the Respondent explained it as an "EMR [electronic medical record] thing." (T 1919.)

Regardless of the precise payment and professional relationship between the Respondent and Dr. Karafin, the documentation in the Respondent's records, as well as the Respondent's testimony, confirm that the Respondent continued to be involved in and retained responsibility for the care and treatment of Patients A-E, even on dates of service in which the patients were seen by Dr. Karafin.

The Hearing Committee found the Respondent to be remarkably calm and casual while testifying, despite the charges at issue. However, his testimony did not provide much insight into the care and treatment provided to Patients A-E. His explanations were broad-based and general, and he spoke with confidence as to his ability to remember specific information about his patients. As will be discussed below, the Hearing Committee does not share his confidence.

CONCLUSIONS

As required by PHL § 230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing the allegations contained in the Statement of Charges 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 [Farrell 11th ed]).

FACTUAL ALLEGATIONS NOT SUSTAINED

Patient A

The Department alleged that the Respondent inappropriately prescribed Oxycodone for Patient A every two to four hours rather than every four to six hours (A.2(c)). The Hearing Committee accepts and agrees with Dr. Carfi's explanation that the prescriptions indicated the maximum number of pills and maximum daily frequency based upon the patient's symptoms but

was not a directive for Patient A to consistently use Oxycodone every two hours. (T 1255-56.) The prescription was not inappropriate because of the maximum allowed frequency but rather because, as discussed below, the Respondent prescribed the opioid medication without a medical rationale.

Patient B

The Department alleged that the Respondent failed to provide any treatment for documented diagnoses, including Reflex Sympathetic Dystrophy (RSD) and/or Complex Regional Pain Syndrome (CRPS) Type 2 (B.1(g)). However, Dr. Geraci testified that the Respondent's records for Patient B do not contain appropriate documentation to support these diagnoses. (T 625.) Furthermore, other than one note found in the patient's record (Exhibit 4, p. 110), no other documentation shows that the Respondent or his office continued to consider Patient B as having a diagnosis of RSD. No documentation is found in the patient's record to show that the Respondent ever deemed CRPS as the patient's differential or working diagnosis.

The Hearing Committee also does not agree with the Department's allegation that the Respondent deviated from accepted standards of care by failing to order and/or perform a baseline creatinine (B.1(h)). No information was offered at the hearing regarding whether obtaining a baseline creatinine level was the standard of care. Dr. Geraci testified that creatinine clearance should be obtained with an opioid dosage increase (T 243) while Dr. Carfi simply testified about different ways of measuring creatinine (T 1235).

The Hearing Committee disagrees with factual allegation B.1(i), that the Respondent deviated from the standard of care by failing to perform an EKG prior to starting methadone and again within 30 days of starting the medication. Although Dr. Geraci's testimony regarding his perception of the applicable standard of care was thorough (T 615-17), the Hearing Committee

finds that his requirements exceed practical bounds and, in this instance, reflect a gold standard, i.e., more than what most practitioners would do, and could reasonably be expected to do, before prescribing methadone.

The allegation that the Respondent inappropriately prescribed medications such as Xanax and Seroquel, more routinely prescribed by a psychiatrist, because the Respondent noted that Patient B was being seen by a psychiatrist (B.2.(c)), is not sustained. While the Hearing Committee acknowledges that these medications are frequently prescribed by a psychiatrist, the patient's record shows that the Respondent saw the patient more frequently than his other providers, thereby rendering the Respondent his de facto primary care physician. Furthermore, the Hearing Committee accepts the Respondent's explanation that Patient B was being seen by a psychiatrist only for evaluations in a custody dispute, rather than for treatment, and that the patient was not receiving psychiatric care. (T 1882-83.) The Hearing Committee is also not swayed by the allegation that the Respondent's prescribing of Roxicodone every two to four hours rather than every four to six hours was inappropriate (B.2(d)), for the same reasons discussed above for factual allegation A.2(c).

Patient C

The Hearing Committee does not sustain the Department's allegation that the Respondent's care and treatment deviated from the standard of care when he failed to identify specifics when recommending an MRI of the leg (C.1(g)). In his progress note dated August 26, 2014, the Respondent wrote "If the symptoms persist, we will obtain an MRI of the right leg." (Exhibit 5, p. 96.) That note could not reasonably be interpreted as a recommendation for an MRI. More likely, the note was intended as a reminder to the Respondent.

In addition, the Hearing Committee does not sustain the allegations that the Respondent inappropriately recommended that the patient see a neurosurgeon (C.2.c), for an EMG (C.2.d). Although the Respondent's progress note for the patient's December 3, 2013 appointment does state that the patient should follow up with a neurosurgeon for an EMG (Exhibit 5, p. 59), a diagnostic procedure routinely performed by physiatrists (T 867-68), the Hearing Committee accepts the Respondent's testimony that the note should simply have indicated that the patient should obtain an EMG. (T 1900.)

Patient D

The Hearing Committee does not sustain the allegation that the Respondent inappropriately prescribed opioids and non-steroidal anti-inflammatory medications simultaneously (D.2.(b)). By including a non-steroidal anti-inflammatory to the patient's regimen, the Respondent addressed the patient's complaints of pain without adding more narcotics, which would multiply the risk of oversedation (including respiratory depression). (T 241.)

For the same reasons discussed regarding allegation A.2(c), the Hearing Committee does not sustain the allegation that the Respondent inappropriately prescribed Percocet every two to four hours rather than every four to six hours (D.2.(c)). In addition, the Hearing Committee does not find that the Respondent performed sciatic nerve block injections without medical indication, as the Respondent documented the patient's pain along the right sciatic notch and triggers palpating along the gluteus minimus and maximus. (Exhibit H3, p. 7.)

Patient E

The Hearing Committee does not sustain the allegation that the Respondent inappropriately performed a discogram and endoscopic microdiscectomy on the same day

(E.2(b)). Although the Hearing Committee greatly appreciated Dr. Geraci's testimony, they found that his explanations did not pertain to an endoscopic microdiscectomy. The Respondent's witness, Dr. Vora, has performed at least 3000 discectomies in combination with discograms. (T 1761.)

Finally, the Hearing Committee does not sustain the allegation that the Respondent inappropriately performed a microdiscectomy without performing a CT scan at the conclusion of the discogram (E.2.(c)). The patient arrested at the conclusion of the endoscopic microdiscectomy, thereby rendering the performance of a CT scan impossible. (Exhibit 8.)

CONCLUSIONS OF LAW[1]

The Respondent is charged with 20 specifications of charges of professional misconduct under Education Law § 6530.

Negligence on More Than One Occasion – Education Law § 6530(3)

The Department's first through fifth specifications charged the Respondent with practicing the profession of medicine with negligence on more than one occasion regarding his treatment and documentation of treatment of Patients A-E. For the reasons set forth below, the Hearing Committee has determined to sustain these specifications.

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. Bogdan v. New York State Board for Professional Medical Conduct, 606 N.Y.S.2d 381 (App. Div. 3d Dep't 1993). Injury, damages, and proximate cause are not essential elements in a medical disciplinary proceeding. Id. An act of

[1] In reaching its determination, the Committee used the definitions set forth in the memorandum entitled "Definitions of Professional Misconduct under the New York State Education Law." In his opening statement on the first hearing date, Committee Chairman Dr. Perry advised the parties that the Committee may use the memorandum to assist them in rendering a determination and invited the parties to "comment or dispute" the explanations provided in the memorandum before the last hearing date. However, neither party disputed or sought modification of the definitions. (T 4-5.)

negligence regarding a single patient repeated on a subsequent occasion constitutes misconduct. Orozco v. Sobol, 557 N.Y.S.2d 738 (App. Div. 3d Dep't 1990.)

The Hearing Committee is not swayed by the Respondent's attempts to assign a different standard of care for a physician practicing in a busy downstate office, as no evidence was shown that such standards differed. The Hearing Committee is therefore also not persuaded by the Respondent's attempts to discount Dr. Geraci's experience and opinions regarding standards of care applicable to physicians practicing PM&R on the grounds that Dr. Geraci has spent his entire career practicing in upstate, Western New York. Dr. Geraci testified that he has maintained an affiliation with multiple physiatrists who practice in New York City, all of whom adhere to the same standards of care to which he testified at this hearing. (T 1060-63.)

The hearing record is replete with instances of the Respondent's failure to exercise the care that would be exercised by a reasonably prudent physician. As will be discussed below in more detail with respect to the charge that the Respondent failed to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, the Hearing Committee relied heavily upon the voluminous records in the hearing record to evaluate whether the Respondent's care and treatment met the applicable standard of care. They found a considerable lack of information in each patient's records. For Patients A-E, the Respondent failed to appropriately evaluate the patient; failed to perform a comprehensive physical examination; failed to render a diagnosis before instituting treatment; failed to develop, implement, and revise a personalized treatment plan; failed to follow-up on prior complaints, recommended treatments, and injections and other procedures performed; and failed to maintain a record for each patient that accurately reflects the care and treatment rendered.

During his first appointment with Patient A on May 22, 2018, the Respondent prescribed an opioid medication (Norco). (Exhibit E9, p. 61.) The Respondent failed to appropriately evaluate the patient; failed to properly render a diagnosis; and failed to develop a personalized treatment plan before issuing that prescription, omissions that clearly fall below the standard of care. The Respondent subsequently increased the prescribed dosage and number of pills without a proper evaluation and medical rationale for the decision. Yet, despite continuously prescribing narcotics to the patient, the Respondent did not present Patient A with a pain management agreement until more than 1 ½ years after the first prescription. (Exhibit E9, pp. 19-20.)

Even as treatment continued in the form of continued prescriptions for opioid medications (eventually, multiple opioids prescribed simultaneously in combination with Flexeril, a muscle relaxant) and interventional procedures, such as multiple trigger point and steroid injections, the Respondent failed to evaluate Patient A's symptoms appropriately and did not document any medical rationale, such as a diagnosis, for the treatment administered. Nor does the record show that he followed up on treatment administered or monitored the patient's progress. To the extent that the Respondent claimed that he had in fact met the applicable standards of care in his treatment of Patient A, he provided no documentation to support it.

Despite the Respondent's testimony at the hearing suggesting that he generally conducts detailed physical examinations of patients (T 1586), the Respondent presented an alternative explanation regarding his treatment of Patient A in his post-hearing brief:

> Physical examination of the same body part that is being treated for chronic intractable pain might cause more damage to a patient, and is not required or indicated when a patient, like Patient A, is awaiting surgery on that body part.

No evidence was found in Patient A's records to support a diagnosis of chronic intractable pain. Moreover, the assertion that a physician might harm a patient by conducting a physical

examination does not absolve the physician from attempting such examination. The records for Patient A do not show any attempt by the Respondent to conduct a comprehensive physical examination of the patient, and do not contain any explanation that the Respondent's ability to examine the patient was limited by the patient's pain.

Finally, it is noted that Patient A wrote a letter in support of the care and treatment that he received from the Respondent. (Exhibit J.) It is not surprising that a patient who has been consistently prescribed narcotics in combination with other medications without much evaluation or consideration, even after questionable lab results, would be pleased with the care rendered. Although Patient A wrote that the Respondent's treatment enabled him to continue working, it is the responsibility of the patient's physician to minimize risks posed by treatment offered through proper evaluations, exhaustion of more conservative treatments, and attempts to eventually taper the patient off the medication. There is no record that the Respondent took any of those actions.

With respect to the charge of negligence on more than one occasion with respect to care and treatment of Patient B, the Respondent consistently failed to appropriately evaluate the patient; failed to render a diagnosis before commencing treatment; prescribed multiple medications without appropriate medical rationale; and failed to appropriately monitor the patient while on multiple medications which, in combination, heightened the patient's risk of oversedation. As with Patient A, the Respondent did not present the patient with a pain management contract before prescribing opioid medications, instead first doing so more than three years after the patient's first appointment. (Exhibit F4, pp.1-2.) None of the omissions described meet the standard of care for a reasonably prudent physician.

The Hearing Committee also finds that the Respondent engaged in negligence on more than one occasion with respect to his care and treatment of Patient C. During the patient's first

appointment, five days after surgery, the Respondent prescribed the patient with two opioid medications without offering any medical explanation. (Exhibit G3, p. 65.) The patient's records for the date of service show no attempt to verify whether the patient's surgeon had prescribed pain medication and for how long, nor did the Respondent document why he prescribed two opioid medications at the patient's first appointment. Even after urine testing performed during the follow-up appointment revealed that the patient was using marijuana and Valium, the Respondent continued to treat and prescribe opioid medication for Patient C. Despite subsequently reporting that the patient tested positive for cocaine in three separate tests (the results were omitted from the patient's records – Exhibit G1, p. 20), the Respondent did not increase the frequency of urine testing and subsequently prescribed the patient two opioid medications simultaneously . (Exhibit G3, pp. 163-66.) Patient C's letter of support (Exhibit M), remarkably similar to Patient A's letter, did not refute the charges and evidence presented by the Department.

Overall, the Hearing Committee's findings regarding the Respondent's treatment of Patient D are similar to its findings regarding Patients A-C. Here too, although lab testing revealed that the patient ingested substances different from what the Respondent prescribed (Exhibit H1, p. 2), the Respondent continued prescribing opioid medications for the patient without testing the patient within 30 days and without increasing the frequency of testing (Exhibit H2).

With respect to the charge of negligence against the Respondent for his care and treatment of Patient E, the Department established that the Respondent failed to appropriately evaluate the patient and that he inappropriately recommended and performed a discogram and

endoscopic microdiscectomy without exhausting all treatments and without appropriate medical indication.

The Respondent provided no evidence to refute the Department's evidence. Dr. Vora's testimony rested largely on assumptions not supported by the evidence in this case.

Incompetence on More than One Occasion – Education Law § 6530(5)

The sixth through tenth specifications charged the Respondent with committing professional misconduct as defined in Education Law § 6530(5) with respect to his treatment and failure to maintain adequate records of his treatment of Patients A-E.

Incompetence is a lack of the requisite skill or knowledge to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 651 N.Y.S.2d 249 (App. Div. 3d Dep't 1996). Regarding Patients A-D, the Hearing Committee does not find that the Respondent lacked the requisite skill to practice medicine but rather that he failed to exercise the requisite care. Accordingly, specifications six, seven, eight and nine are not sustained.

However, the Hearing Committee finds that the Respondent acted incompetently in the treatment rendered to Patient E and corresponding inadequate recordkeeping that included missing informed written consent before undergoing surgery, as alleged in the tenth specification. It is incomprehensible to the Hearing Committee that the Respondent would attempt to pass off a notice of patient privacy practices as evidence of informed written consent for a surgical procedure. The Hearing Committee does not accept the Respondent's nonchalant explanation that the ambulatory care center where the procedures were performed would have obtained the written consent and maintained it in their files. Again, as with his other claims regarding records that might be in existence elsewhere, it was the Respondent's responsibility to maintain those records and provide them to the Hearing Committee for consideration. The

Hearing Committee is simply not allowed to take a vague explanation regarding very serious charges as fact.

Nor did the Respondent maintain any documentation to show that more conservative treatment modalities were attempted and were unsuccessful. The Respondent employed a physical therapist in his Bronx office where Patient E was seen (T 1604), who reported that the patient was tolerating physical therapy and progressing. (Exhibit 7.) No explanation was found in the Respondent's records as to why therapy or any other more conservative treatment was inadequate. Patient E was placed at unnecessary and unjustifiable risk. The Respondent's actions, as well as his testimony, reflected a complete unawareness of the safety issues he created. The Hearing Committee has therefore determined that the Respondent acted with incompetence on more than one occasion with respect to Patient E and sustains specification ten.

Ordering Unwarranted Tests/Treatment– Education Law § 6530(35)

The eleventh through fifteenth specifications charged the Respondent with committing professional misconduct as defined in Education Law § 6530(35) by ordering excessive tests and treatment not warranted by the condition of Patients A-E. The Respondent inappropriately prescribed opioid medications for Patients A-D without proper evaluations and without rendering diagnoses before instituting treatment. By rendering treatment without obtaining necessary information, the Respondent's treatment for those patients was not warranted. With respect to Patient E, the Respondent failed to properly evaluate the patient and exhaust all medical spinal treatments before recommending and performing the discogram and endoscopic microdiscectomy. The discogram and endoscopic microdiscectomy were therefore not warranted by the patient's condition. Accordingly, the Hearing Committee sustains specifications eleven through fifteen.

Failure to Maintain Records- Education Law § 6530(32)

The sixteenth through twentieth specifications charged the Respondent with committing professional misconduct as defined in Education Law § 6530(32) by failing to maintain a record for Patients A-E which accurately reflects the evaluation and treatment of the patient. A medical record which fails to convey objectively meaningful medical information concerning the patient treated to other physicians is inadequate. Gant v. Novello, 754 N.Y.S.2d 746, 750 (App. Div. 3d Dep't 2003); Gonzalez v. New York State Dept. of Health, 648 N.Y.S.2d 827, 831 (App. Div. 3d Dep't 1996).

Despite acknowledging his shortcomings with respect to recordkeeping, the Respondent argued that most of the patients at issue had coverage under Workers' Compensation and/or no-fault insurance, neither of which would have paid claims for services without adequate documentation of treatment and listed diagnoses. (T 1176.) The Respondent explained that progress notes regarding Workers' Compensation claims contained information solely pertaining to the covered body part. (T 1674.) However, other discrepancies are apparent in the patients' records, including a failure to follow up on recommended treatments and patient complaints in records that were not identified as pertaining to Workers' Compensation claims.

The Respondent testified regarding the information reviewed before seeing a patient, testing he performs as part of a physical examination, and questions asked when taking a patient's medical history. (T 1659-60.) The information provided was not specific to any of the patients at issue. Moreover, it did not refute the charges that he failed to maintain records for Patients A-E that accurately reflect the evaluation and treatment of these patients. Had he inserted such information in those patients' records, the Department would not have had a reason to question the treatment, or lack thereof, rendered to Patients A-E.

The Respondent's explanations regarding patient records supported the Department's allegations that another physician reviewing these records would not have adequate information regarding his treatment of the patients. For instance, when asked to describe his evaluation of Patient A from May through August 2008 (the beginning of treatment for this patient), the Respondent was unable to recall what information he requested and obtained for the patient's history, nor was he able to describe the physical examination that he conducted. (T 1681.)

The Respondent also argued that Patient B would not have qualified for Social Security Disability benefits without the submission of adequate records. (T 1434-39, 1736.) This argument is irrelevant to the charge that the Respondent failed to maintain accurate medical records. The Hearing Committee reviewed the records maintained by the Respondent that were provided by the Respondent. It is not authorized to speculate as to what information other entities received for Patients A-E, including records from other providers unaffiliated with the Respondent.

The Respondent emphasized his prior position as chair of the Department of Physical Medicine and Rehabilitation at Beth Israel in arguing that the onus was on the Department to obtain hospital records for patients at issue which the Respondent states were first seen in the hospital setting. (T 1198-1201.) Here too, the Respondent offered conjecture and attempted to add additional requirements for the Department to meet its burden of proof. The Respondent was required to include any relevant information from patient hospital records in his patient records or include copies of the hospital records in his files to enable another treating provider to understand the treatment rendered and continue the patient's care. He failed to provide this information and did not show the Hearing Committee any attempt to procure documentation that he claims should have been in the hospital's possession.

The Respondent testified that his records are kept in chronological order on his computers, and that he is able to access all notes by date of service. (T 1848.) He explained that the records provided for this hearing were out of order because his office needed to print the documents by section, such as prescriptions, office visits. (T 1849.) The Hearing Committee was provided with no evidence to support this assertion, nor does it in any way refute the stated charge. The Respondent provided patient records to this Hearing Committee in an utterly haphazard manner. The records were not provided in any semblance of order, neither in categories, nor by date.

The Respondent was able to organize his exhibits in chronological order for his hearing presentation but made no effort to do so for the Hearing Committee, the factfinders at the hearing. In addition to the patient records being in a state of disarray, the records did not contain a considerable amount of information pertaining to the evaluation and treatment of Patients A-E. The Hearing Committee therefore sustains specifications sixteen through twenty.

HEARING COMMITTEE'S DETERMINATION AS TO PENALTY

The Department recommended revocation of the Respondent's license to practice medicine or, at minimum, a limitation on the nature and scope of the Respondent's practice, including a prohibition on prescribing narcotics, from practicing pain management, and/or another restriction deemed appropriate by the Hearing Committee based upon the sustained charges. (T 1995.)

Although the Respondent sought an outright dismissal of the charges, despite conceding that his recordkeeping needs improvements (T 25-26, 30-31), the Respondent subsequently submitted in his post-hearing brief that, should a penalty be deemed necessary, it be limited to continuing medical education coursework in medical recordkeeping and charting.

After reviewing nearly 3,700 of pages of medical records, the Hearing Committee agrees with the Department that a pattern exists regarding the Respondent's care and treatment that extend beyond the claimed failure to document all steps taken. The Hearing Committee cannot ignore the deficiencies prevalent throughout the records reviewed and the risks presented by the Respondent's casual approach to his practice, including: his claimed memory of all patient details in his head, an implausibility that does not further patient care; a claimed lack of awareness that an employee who self-identified as his office manager responded to a records request from the OPMC; and a consistently substandard approach to evaluating his patient's conditions. Nor can the Hearing Committee overlook the Respondent's failure to properly monitor his patients and alter treatment. Even after abnormal test results, the Respondent continuously prescribed opioid medications for those same patients.

The Respondent prescribed multiple opioid medications simultaneously for Patients A-C, and prescribed opioid medication in tandem with muscle relaxants for Patients A and D. The Respondent failed to obtain the informed consent of patients before performing nerve blocks and failed to present pain management contracts to Patients A-D before he commenced prescribing opioid medications for them. These failings all present risks to patient safety. Furthermore, despite first being asked for patient records by the Office of Professional Medical Conduct (OPMC) in 2016, being interviewed nearly three years later, and appearing for this hearing more than two years after that, the Respondent was unable to produce a substantial amount of information. His casual approach to this hearing mirrored his approach to his practice of medicine.

On the other hand, the Hearing Committee also recognizes that the population served by the Respondent is generally underserved, and that the Respondent has likely had a positive

impact on the lives of some of his patients. The Hearing Committee views the penalty of revocation as overly harsh and disproportionate to the sustained charges but agrees that penalties are imperative to protect patients from the casual and negligent manner with which the Respondent has practiced medicine. The Hearing Committee believes that, with appropriate restrictions, the Respondent will be able to continue to serve an underserved population.

In recognition of the severity of the charges being sustained, the Hearing Committee has determined to suspend the Respondent's license to practice medicine for a period of two years and stay the suspension. Given the glaring deficiencies in the Respondent's medical recordkeeping, the Hearing Committee has also determined to impose a requirement that the Respondent successfully complete a course in medical recordkeeping approved by the Director of OPMC within six months of the effective date of this decision. In addition, given the consistently lax means by which the Respondent prescribed opioid medications and other controlled substances for Patients A-D, the Hearing Committee deems it necessary to permanently preclude the Respondent from prescribing controlled substances.

Finally, given the Respondent's repeated failure to properly evaluate patients before subjecting them to invasive, interventional, and surgical procedures; repeated failure to obtain their prior informed consent to those procedures; and repeated failure to follow up on the efficacy of those procedures, the Hearing Committee deems it necessary to permanently preclude the Respondent from performing all surgical, interventional, and invasive procedures other than electromyography (EMG). This prohibition includes all three categories of procedures (surgical, interventional, and invasive), including procedures that fall within any, all, or some of these three categories. This prohibition explicitly includes, but is in no way limited to, any and all injections.

ORDER

IT IS HEREBY ORDERED THAT:

1. The first through fifth and tenth through twentieth specifications of charges as set forth in the Amended Statement of Charges are sustained.

2. The sixth through ninth specifications of charges as set forth in the Amended Statement of Charges are NOT sustained.

3. Pursuant to PHL § 230-a(2)(a), the Respondent's license to practice medicine in the state of New York is suspended for a period of two years, the entirety of which is stayed.

4. Pursuant to PHL § 230-a(8), the Respondent shall successfully complete a course in medical recordkeeping approved by the Director of the OPMC within six months of the effective date of this order.

5. Pursuant to PHL § 230-a(6), the Respondent is permanently prohibited from prescribing controlled substances.

6. Pursuant to PHL § 230-a(6), the Respondent is permanently prohibited from performing all surgical procedures.

7. Pursuant to PHL § 230-a(6), the Respondent is permanently prohibited from performing all interventional procedures other than electromyography (EMG).

8. Pursuant to PHL § 230-a(6), the Respondent is permanently prohibited from performing all invasive procedures other than electromyography (EMG).

9. This order shall be effective upon service of the Respondent by personal service or by certified mail as required under PHL § 230(10)(h).

DATED: February 17, 2023

_____, New York

[redacted]

JEFFREY PERRY, D.O., Chair
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NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

KEVIN WEINER, MD

AMENDED

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, at least, in or about March 2007 through in or about April 28, 2022. Respondent documented almost monthly visits, during which he prescribed multiple medications including OxyContin, Oxycodone, Flexeril, Relafen and a Z-Pack. Respondent documented performing numerous injections over a 6-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,
   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 controlled and non-controlled 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 including but not limited to failing to obtain and document informed consent for procedures and failing to note details related to procedures performed.

2. Inappropriately:

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

b. prescribed multiple medications including opioids and muscle relaxants, simultaneously, placing the patient at increased risk,

c. prescribed Oxycodone every 2-4 hours rather than every 4-6 hours, and

d. performed injections, without medical rationale or justification.

B. Respondent treated Patient B from, at least, in or about January 2007 through in or about June 2019, when Respondent discharged Patient B for violating his Pain Management Agreement. Respondent documented almost monthly visits, during which he prescribed multiple medications including Roxicodone, Xanax, Ambien, Lunesta, Valium, Methadone, Opana and Seroquel. 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,

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 controlled and non-controlled 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. provide any treatment for documented diagnoses including Reflex Sympathetic Dystrophy (RSD) and/or Complex Regional Pain Syndrome (CRPS) Type 2,

h. order and/or perform a baseline Creatinine,

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

j. 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, including narcotics and sedatives simultaneously, placing the patient at increased risk,

c. prescribed medications including but not limited to an antianxiety (Xanax) and an antipsychotic (Seroquel), more routinely prescribed by a psychiatrist, especially since Respondent noted Patient B was seeing a psychiatrist, and

d. prescribed Roxicodone every 2-4 hours rather than every 4-6 hours.

C. Respondent treated Patient C from, at least, in or about September 2009, through in or about May 2022. Respondent documented almost monthly visits, during which he prescribed multiple medications including Norco, Xanax, Percocet, Adderall, Flonase and Nasocort nasal spray, Viagra, Concerta, Hydrochlorothiazide, and Medrol Dose Pak. 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,

   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 controlled and non-controlled 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 including but not limited to failing to obtain and document informed consent for procedures and failing to note details related to procedures performed.

2. Inappropriately:

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

b. prescribed multiple medications, including narcotics and stimulants 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 from, at least, December 2010 through in or about December 2013. Respondent documented almost monthly visits, during which he prescribed multiple medications, including Exalgo, Percocet, Xanax, Relafen, Oxycodone, Medrol Dose Pak and Voltaren 1% Gel. Respondent performed sciatic nerve blocks 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,

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 controlled and non-controlled 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 including but not limited to failing to obtain and document informed consent for procedures and failing to note details related to procedures performed.

2. Inappropriately:

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

b. prescribed multiple medications, including opioids and a non-steroidal anti-inflammatory, simultaneously, placing the patient at increased risk,

c. prescribed Percocet every 2-4 hours rather than every 4-6 hours, and

d. performed sciatic nerve block injections without medical indication.

E. Respondent treated Patient E, a 32-year-old male, from in or about February 24, 2016, through in or about March 2, 2017, after he sustained injuries to his left leg in a motor vehicle accident on February 22, 2016. 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 injection(s), referred the patient to physical therapy, and prescribed a Medrol Dosepak. In June 2016, Patient E had an MRI of the lumbar spine which revealed disc bulges. In November 2016, after Patient E had electrodiagnostic testing which revealed L5-S1 radiculopathy and mild left tibial motor neuropathy, Respondent recommended endoscopic microdiscectomy. On March 2, 2017, Respondent performed the surgical procedure at Downtown Bronx ASC. At the conclusion of the procedure, Patient E went into cardiac arrest and was transferred to Lincoln hospital. Days later, Patient E died. 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 failing to take and/or note an adequate history, failing to perform and/or note an appropriate

physical exam and/or manual muscle testing, failing to make and/or document an appropriate diagnosis, and failing to develop and/or document an appropriate personalized treatment plan, and

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

2. Inappropriately:

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

b. performed discogram and endoscopic microdiscectomy on the same day, and

c. performed microdiscectomy without performing a CT scan at the conclusion of the discogram, to confirm that microdiscectomy was warranted.

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-TENTH SPECIFICATIONS

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.

7. Paragraph B and its subparagraphs.

8. Paragraph C and its subparagraphs.

9. Paragraph D and its subparagraphs.

10. Paragraph E and its subparagraphs.

ELEVENTH-FIFTEENTH 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:

11. Paragraph A and A2 and its subparagraphs.

12. Paragraph B and B2 and its subparagraphs.

13. Paragraph C and C2 and its subparagraphs.

14. Paragraph D and D2 and its subparagraphs.

15. Paragraph E and E2 and its subparagraphs.

SIXTEENTH-TWENTIETH 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:

16. Paragraph A(1)(g).

17. Paragraph B(1)(j).

18. Paragraph C(1)(h).

19. Paragraph D(1)(g).

20. Paragraph E(1)(b).

DATE: September 8, 2022
New York, New York

[redacted]

HENRY WEINTRAUB
Chief Counsel
Bureau of Professional Medical Conduct