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

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

| IN THE MATTER<br><br>OF<br><br>LORELEI DAVIDSON, M.D. | STATEMENT<br><br>OF<br><br>CHARGES |
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LORELEI DAVIDSON, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 18, 1997 by the issuance of license number 206144 by the New York State Education Department.

## FACTUAL ALLEGATIONS

A. On or about sometime in February of 2012 through on or about sometime in December of 2017, Respondent, a Physical Medicine and Rehabilitation (PM&R) physician (also known as a physiatrist) evaluated Patient A, a male patient born on March 6, 1988. Respondent deviated from the standard of care by:
   1. Documenting a visit as an "Initial Examination" but failing to document and/or obtain a detailed history and an appropriate and complete physical examination for Patient A.
   2. Failing to identify or describe an adequate diagnosis or diagnoses for Patient A that would medically justify the treatment prescribed.
   3. Failing to obtain and/or document an adequate pain history on any visit for Patient A.
   4. Failing to prescribe appropriate physical therapy to Patient A for his reported lower back pain.
   5. Inappropriately and with no medical justification prescribing varying types, doses and combinations of addictive substances, including but not limited to

Opioids, to Patient A for unsupported diagnoses that do not warrant such medications, which put him at risk.

6. Providing addictive medications to Patient A who reported a history of substance abuse.
7. Inappropriately prescribing varying types, doses and combinations of addictive substances, including but not limited to Opioids, to Patient A repeatedly on dates when no medical visit(s) and/or documented interactions between doctor and patient occurred.
8. Prescribing Methadone to Patient A without appropriate pre-screening.
9. Failing to appropriately document and/or obtain appropriate follow-up information and physical examinations for Patient A.
10. Failing to adequately follow-up on the treatments prescribed for Patient A.
11. Failing to consistently check and/or document the New York State database for Patient A's prescribed controlled substance medications.
12. Failing to consistently perform appropriate compliance checks on Patient A.
13. Failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient A.

**B.** On or about sometime in January of 2012 through on or about sometime in March of 2018, Respondent evaluated Patient B, a male patient and Patient A's older brother, who was born on February 15, 1985. Respondent deviated from the standard of care by:

1. Failing to perform and/or document an initial office visit for Patient B and further failing to ever obtain and/or document a detailed history and an appropriate and complete physical examination for him, documenting only apparent re-visits.
2. Failing to identify or describe an adequate diagnosis or diagnoses for Patient B that would medically justify the treatment prescribed.
3. Failing to obtain and/or document an adequate pain history on any visit for Patient B.

4. Failing to prescribe appropriate physical therapy to Patient B for his reported lower back pain.
5. Inappropriately and with no medical justification prescribing varying types, doses and combinations of addictive substances, including but not limited to Opioids, to Patient B for unsupported diagnoses that do not warrant such medications, which put him at risk.
6. Providing addictive medications to Patient B who reported a history of substance abuse.
7. Failing to appropriately document and/or obtain appropriate follow-up information and physical examinations for Patient B.
8. Failing to adequately follow-up on the treatments prescribed for Patient B.
9. Failing to consistently check and/or document the New York State database for Patient B's prescribed controlled substance medications.
10. Failing to consistently perform appropriate compliance checks on Patient B.
11. Failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient B.

**C.** On or about April 30, 2012 through on or about June 26, 2018, Respondent evaluated Patient C, a male patient and Patient A and Patient B's father, who was born on May 28, 1953. Respondent deviated from the standard of care by:

1. Failing to perform and/or document an initial office visit for Patient C and further failing to ever obtain and/or document a detailed history and an appropriate and complete physical examination for him, documenting only apparent re-visits.
2. Failing to identify or describe an adequate diagnosis or diagnoses for Patient C that would medically justify the treatment prescribed.
3. Failing to obtain and/or document an adequate pain history on any visit for Patient C.
4. Failing to prescribe appropriate physical therapy to Patient C for his reported lower back pain.

5. Inappropriately and with no medical justification prescribing varying types, doses and combinations of addictive substances, including but not limited to Opioids, to Patient C for unsupported diagnoses that do not warrant such medications, which put him at risk.
6. Inappropriately prescribing varying types, doses and combinations of addictive substances, including but not limited to Opioids, to Patient C repeatedly on dates when no medical visit(s) and/or interactions between doctor and patient occurred.
7. Providing addictive medications to Patient C who reported a history of substance abuse.
8. Prescribing Methadone to Patient C without appropriate pre-screening.
9. Failing to appropriately document and/or obtain appropriate follow-up information and physical examinations for Patient C.
10. Failing to adequately follow-up on the treatments prescribed for Patient C.
11. Failing to consistently check and/or document the New York State database for Patient C's prescribed controlled substance medications.
12. Failing to consistently perform appropriate compliance checks on Patient C.
13. Failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient C.

**D.** On or about January 24, 2012 through on or about December 31, 2015, Respondent evaluated Patient D, a male patient born on April 1. 1977. Respondent deviated from the standard of care by:

1. Failing to perform and/or document an initial office visit for Patient D and further failing to ever obtain and/or document a detailed history and an appropriate and complete physical examination for him, documenting only apparent re-visits.
2. Failing to identify or describe an adequate diagnosis or diagnoses for Patient D that would medically justify the treatment prescribed.

3. Failing to obtain and/or document an adequate pain history on any visit for Patient D.
4. Failing to prescribe appropriate physical therapy to Patient D for his reported lower back pain.
5. Inappropriately and with no medical justification prescribing varying types, doses and combinations of addictive substances, including but not limited to Opioids, to Patient D for unsupported diagnoses that do not warrant such medications, which put him at risk.
6. Prescribing Methadone to Patient D without appropriate pre-screening.
7. Failing to appropriately document and/or obtain appropriate follow-up information and physical examinations for Patient D.
8. Failing to adequately follow-up on the treatments prescribed for Patient D.
9. Failing to consistently check and/or document the New York State database for Patient D's prescribed controlled substance medications.
10. Failing to consistently perform appropriate compliance checks on Patient D.
11. Failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient D.

**SPECIFICATION OF CHARGES**

**FIRST THROUGH FOURTH SPECIFICATIONS**

**GROSS NEGLIGENCE**

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

1. Paragraph A and/or each of its subparagraphs, except A (13).

2. Paragraph B and/or each of its subparagraphs, except B (11).

3. Paragraph C and/or each of its subparagraphs, except C (13).

4. Paragraph D and/or each of its subparagraphs, except D (11).

**FIFTH THROUGH EIGHTH 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:

5. Paragraph A and each of its subparagraphs.

6. Paragraph B and each of its subparagraphs.

7. Paragraph C and each of its subparagraphs.

8. Paragraph D and each of its subparagraphs.

**NINTH THROUGH TWELFTH SPECIFICATIONS**

**GROSS INCOMPETENCE**

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

9. Paragraph A and/or each of its subparagraphs, except A (13).

10. Paragraph B and/or each of its subparagraphs, except B (11).

11. Paragraph C and/or each of its subparagraphs, except C (13).

12. Paragraph D and/or each of its subparagraphs, except D (11).

**THIRTEENTH THROUGH SIXTEENTH 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:

13. Paragraph A and each of its subparagraphs.

14. Paragraph B and each of its subparagraphs.

15. Paragraph C and each of its subparagraphs.

16. Paragraph D and each of its subparagraph.

**SEVENTEENTH THROUGH 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:

17. Paragraph A and A (13).

18. Paragraph B and B (11).

19. Paragraph C and C (13).

20. Paragraph D and D (11).

DATE: May 23, 2023
New York, New York

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