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

OF

JIGNYASA DESAI, D.O.

STATEMENT

OF

CHARGES

JIGNYASA DESAI, D.O., the Respondent, was authorized to practice medicine in New York State on or about August 19, 2011, by the issuance of license number 262711 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about June 11, 2015, through on or about May 12, 2016, Respondent, a Physical Medicine and Rehabilitation (PM&R) physician (also known as a physiatrist) evaluated Patient A, who at his initial visit was a 23-year-old male, at her office at 38 West 32nd Street, New York, New York. Patient A was a passenger in a car involved in a motor vehicle accident 10 months before on August 15, 2014. Patient A was evaluated at a nearby Emergency Department immediately after the accident from which he was discharged home. Respondent deviated from the standard of care by:

1. Failing to obtain and/or document pertinent information regarding Patient A's evaluation and treatment from other physicians and/or medical professionals for the 10-month period after his accident, including but not limited to Patient A's use of prescribed Opioids, prior to Respondent providing care to Patient A.

2. Failing to obtain and/or document compliance checks, including but not limited to urine drug testing, pill counts and iStop inquiry before continuing to prescribe Opioids for Patient A.
3. Failing to have Patient A sign an Opioid contract.
4. Failing to advise Patient A of the risks of continued and prolonged Opioid use, especially those controlled substance drugs that are short-acting.
5. Failing to assess Patient A's risk for Opioid abuse with any standardized measured assessment tool.
6. Failing to identify a clinical justification for her treatment of Patient A's pain consistent with the type, dosage and combination of Opioid substances she prescribed to him.
7. Inappropriately combining prescriptions for various short acting Opioids, Benzodiazepines and Soma, a muscle relaxant, in varying doses, for Patient A.
8. Performing numerous interventional procedures too frequently, including but not limited to, facet injections, branch blocks and trigger point injections, without sufficient medical justification.
9. Failing to follow-up in on Patient A's hospital treatment at Mount Sinai St. Luke's after being contacted by Patient A's primary team there on February 29, 2016 to verify her prescriptions for him.
10. Failing to adequately evaluate Patient A after his St. Luke's hospital stay which record documented the presence of track marks on Patient A's arms.
11. Continuing to prescribe increasing doses of multiple controlled substances for Patient A's complained of pain, including but not limited to doubling his Dilaudid prescription, after his March 1, 2016 discharge from St. Luke's Hospital, which put Patient A and those around him at serious risk.
12. Failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient A.

B. On or about October 10, 2013, through at least on or about March 4, 2021, Respondent evaluated Patient B, a female who at her initial visit was soon to be 37-

years old, at her office at 38 West 32nd Street, New York, New York. At the initial visit, Patient B reported that two years previously she injured her lower back pushing a heavy wheel barrel, the pain from which became worse seven months prior. Patient B was taking Percocet 10/325mg six times daily as prescribed by another physician who died suddenly in a motor vehicle accident. At the initial visit with Respondent, Patient B complained of severe lower back and tingling shooting pain bilaterally to her legs. She was seeking continuation of her pain medication. Respondent deviated from the standard of care by:

1. Failing to obtain and/or document pertinent information regarding Patient B's evaluation and treatment from another physician, including but not limited to Patient B's use of prescribed Opioids, prior to Respondent providing continued such care to Patient B.
2. Failing to obtain and/or document compliance checks before continuing to prescribe Opioids for Patient A until June 23, 2016, which was 2 years and 8 months after Patient B initially presented to Respondent.
3. Failing to have Patient B sign an Opioid contract and/or failing to advise her of the risks of continued and prolonged Opioid use until June 11, 2015, which was 1 year and 8 months after Patient B initially presented to Respondent.
4. Documenting numerous urine tests that she purportedly performed on Patient B, yet no such reports appear in Patient B's record.
5. Continuing to prescribe 10mg Percocet 4 times daily along with 25mcg Fentanyl over the course of at least 4 years with little indication as to their efficacy or any attempt to change the regimen to avoid Patient B developing a tolerance to these addictive medications.
6. Exposing Patient B to risk by performing many interventional procedures too close in time where steroid was used.
7. Prescribing Tamiflu for Patient B on more than one occasion when she complained of flu-like symptoms yet administered interventional injections with

steroids on the very days Patient B was fighting an infection, exposing Patient B to risk.

8. Performing numerous interventional procedures too frequently, including but not limited to repeated facet injections, branch blocks and trigger point injections, without sufficient medical justification, with limited efficacy.
9. Failing to seek and/or refer Patient B to appropriate specialists to adequately address the underlying cause or causes of Patient B's pain.
10. Failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient B.

C. On or about January 31, 2013, through at least on or about August 29, 2018, Respondent evaluated Patient C, who at his initial visit was 54-year-old male, at her office at 38 West 32nd Street, New York, New York. At the initial visit, Patient C reported acute lower back pain, neck pain and numbness and tingling in his right leg. The back pain worsened after a fall the past November. Patient C since had three months of physical therapy and four sets of Transforaminal Epidural Steroid injections with minimal relief. Respondent deviated from the standard of care by:

1. Failing to seek, obtain and/or document a proper diagnosis for Patient C's initial symptoms, yet started Patient C on short acting Opioids which continued over the entire at least five-year course of her treatment of him.
2. Failing to obtain and/or document compliance checks before prescribing Opioids for Patient C.
3. Inappropriately combining prescriptions for short acting Percocet, Xanax and Soma, a muscle relaxant, in varying doses, for Patient C.
4. Performing interventional procedures at almost every visit which occurred several times monthly, despite failing to arrive at proper diagnoses for Patient C's complained of pain, including but limited to Lumbar Transforaminal Epidural Injections, SI Joint Injections, Right Knee Steroid Injections, Right Trochanteric Bursa Injections, Gluteus Medius Tendon Injections, Hamstring Tendon Insertion Injections, Right Lateral Epicondyle Injections, Thoracic Trigger Point

Injections, Lumbar Trigger Point Injections, Lumbar Facet Injections, Right Intercostal Rib Blocks, Tibialis Tendon Injections, Right Hip Platelet Rich Plasma (PRP) Injections, Right Hip Joint Injections and Right Medical Branch Blocks, without sufficient medical justification exposing Patient C to risk while failing to effectively control his pain.

5. Obtaining an x-ray on Patient C's right hip on March 21, 2013, less than two months after Patient C's initial visit, that demonstrated severe osteoarthritis, from which pain Patient C complained of regularly throughout 2015 and 2016. Respondent, nonetheless continued interventional procedures and Opioid prescribing over the course of her treatment of Patient C, instead of referring him to an Orthopedist for consideration of a possible hip replacement to rectify the cause of the Patient C's right hip and right hip related pain.
6. On December 15, 2016, performing a Right Hip Joint Injection, Right L4/5 and Left L5/SI Transforaminal Epidural Injections, and a Right Medical Branch Block Procedure, all on the same day using steroids, without sufficient medical justification exposing Patient C to risk.
7. On September 29, 2017, performing a Right Hip Injection and Right Shoulder Injection under fluoroscopy as well as a Lateral Epicondyle injection with ultrasound, all on the same day using steroids, without sufficient medical justification exposing Patient C to risk.
8. Failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient C.

D. From on or about November 12, 2015 through on or about March 21, 2016, Respondent evaluated and treated Patient D, who at his initial visit was a 32-year-old male and the son of Patients E and F. He was referred by Binod Sinha, M.D. from New Jersey and came to Respondent seeking refills for his Oxycodone 30mg every 6 hours prescription complaining of neck, low back and right shoulder pain of unspecified etiology. Respondent deviated from the standard of care by:

1. Failing to identify any mechanism of injury for Patient D to inform his treatment protocol.
2. Failing to perform and/or document compliance checks on Patient D through the course of his treatment with her ending on March 21, 2016 during which time Respondent continued to prescribe short acting Opioids.
3. Documenting that she performed a right shoulder injection on Patient D but failing to document when it was performed and the nature of the injection.
4. Failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient D.

E. From on or about November 19, 2015 through on or about March 14, 2016, Respondent evaluated and treated Patient E, who at his initial visit was a 61-year-old man and Patient D's father. He came to Respondent 1 week after his son's initial visit. Patient E was also referred by Binod Sinha, M.D. from New Jersey and came to Respondent seeking refills for his Oxycodone 30mg every 6 hours prescription complaining of neck, low back and bilateral shoulder pain from a motor vehicle accident 11 years earlier. Respondent deviated from the standard of care by:

1. Failing to perform and/or document compliance checks on Patient E throughout the course of her treatment of him ending on March 14, 2016, when Respondent discharged Patient E telling him to find a physician for chronic pain medication management as her practice is for acute interventional pain management, yet during Patient E's treatment, Respondent continued to prescribe short acting Opioids.
2. Prescribing two new medications (a muscle relaxant and a neuropathic pain medication) for Patient E the day she discharged him from her practice leaving him without any follow-up for such treatment change, exposing Patient E to risk.
3. Failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient E.

F. On or about December 7, 2015 and on or about February 4, 2016, Respondent evaluated and treated Patient F, who at her initial visit was a 57-year-old woman, Patient D's mother and Patient E's wife. She came to Respondent complaining of severe neck, lower back and bilateral knee pain of unspecified etiology. Patient F admitted to taking oxycodone 30mg from her husband to alleviate her pain. Respondent deviated from the standard of care by:

1. Failing to document Patient F's age and identify any mechanism of injury to inform her treatment protocol.
2. Failing to perform and/or document compliance checks on Patient F at either visit yet continued to prescribe the same dose and frequency of short acting Opioids.
3. Failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient F.

SPECIFICATION OF CHARGES
FIRST THROUGH THIRD 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 any and/or all of its subparagraphs, except A (12).
2. Paragraph B and any and/or all of its subparagraphs, except B (10).
3. Paragraph C and any and/or all each of its subparagraphs, except C (8).

FOURTH THROUGH NINTH 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:

4. Paragraph A and each of its subparagraphs.

5. Paragraph B and each of its subparagraphs.

6. Paragraph C and each of its subparagraphs.

7. Paragraph D and each of its subparagraphs.

8. Paragraph E and each of its subparagraphs.

9. Paragraph F and each of its subparagraphs.

TENTH THROUGH TWELFTH 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:

10. Paragraph A, A (6), A (7), A (8) and/or A (11).

11. Paragraph B, B (5), B (6) and/or B (8).

12. Paragraph C, C (3), C (4), C (5), C (6) and/or C (7).

THIRTEENTH THROUGH EIGHTEENTH 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:

13. Paragraph A and A (12).

14. Paragraph B and B (10).

15. Paragraph C and C (8).

16. Paragraph D and D (4).

17. Paragraph E and E (3).

18. Paragraph F and F (3).

DATE: December 8 , 2022
New York, New York

[redacted]

HENRY WEINTRAUB
Chief Counsel
Bureau of Professional Medical Conduct