# Department of Health

KATHY HOCHUL
Governor

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

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

February 1, 2024

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Christine M. Radman, Esq.
NYS Department of Health
90 Church Street
New York, New York 10007

Jeffrey Randolph, Esq.
Law Office of Jeffrey Randolph, LLC
139 Harristown Road, Suite 205
Glen Rock, New Jersey 07452

**RE: In the Matter of Jignyasa Desai, D.O.**

Dear Parties:

Enclosed please find the Determination and Order (No. 24-032) 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:

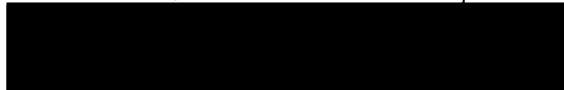
Jean T. Carney, Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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,



Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB:nm
Enclosure

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

COPY

| IN THE MATTER OF JIGNYASA DESAI, D.O. | DETERMINATION AND ORDER |
|---|---|
| | BPMC-24-032 |

Pursuant to New York State Public Health Law (PHL) § 230(10)(d)(i), the New York State Department of Health, Bureau of Professional Medical Conduct (Department) served Jignyasa Desai, D.O. (Respondent) with a Notice of Hearing and Statement of Charges. The hearing was held via videoconference. **ANDREW J. MERRITT, M.D.**, Chairperson, **JAGDISH M. TRIVEDI, M.D.**, and **PAUL J. LAMBIASE**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to PHL § 230(10)(e). **TINA M. CHAMPION**, Administrative Law Judge, served as the Administrative Officer.

The Department appeared by Christine M. Radman, Esq. The Respondent appeared by Jeffrey Randolph, Esq. Evidence was received, witnesses were sworn or affirmed, and a transcript of the proceeding was made.

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

## PROCEDURAL HISTORY

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|---|---|
| Notice of Hearing and Statement of Charges: | December 8, 2022 |
| Pre-Hearing Conference: | January 4, 2023 |
| Hearing Dates: | January 10, 2023<br>January 11, 2023<br>February 22, 2023<br>March 7, 2023<br>March 28, 2023<br>April 28, 2023<br>May 24, 2023<br>May 31, 2023 |
| Witnesses for Department: | Denny Battista, D.O.<br>[redacted] |
| Department Exhibits: | 1-3, 3A, 3B, 3C, 4-13, 14A, 14B |
| Witnesses for Respondent: | Patient B<br>Patient C<br>Jignyasa Desai, D.O.<br>Jeffrey Gudin, M.D. |
| Respondent Exhibits: | A-F |
| Written Submissions Received: | July 11, 2023 |
| Deliberations Held: | August 2, 2023 |

## STATEMENT OF CASE

The Department charged the Respondent with eighteen specifications of professional misconduct under NY Educ. Law § 6530 involving the Respondent's care of six patients.

The Department has stated that the Respondent should "forfeit her privilege to practice medicine" and recommends that a "significant penalty" be imposed on the Respondent. (Tr. 13; Department's post-hearing brief.) The Respondent requests that if the Hearing Committee sustains any of the charges against her then a penalty less than suspension or revocation be imposed, noting the availability of a monetary penalty, censure and reprimand, continuing education, skills assessment. (Tr. 43; Respondent's post-hearing brief.)

## FINDINGS OF FACT

The following findings are the unanimous determinations of the Hearing Committee after consideration of the entire record in this matter. Numbers in parentheses refer to exhibits (Ex.) or transcript page numbers (Tr.).

1. The Respondent was licensed to practice medicine in New York State on August 19, 2011, by issuance of license number 262711. (Dept. Ex. 2 at p. 2.)

2. The Respondent is also licensed to practice medicine in New Jersey. (Tr. 682.)

3. The Respondent is board certified in Physical Medicine and Rehabilitation (PM&R), also referred to as physiatry, and in Pain Management. (Tr. 679-681, 828.)

4. Physiatrists treat a wide variety of neuromuscular problems in patients who are experiencing pain. Treatment provided can include physical therapy, topical pain medication, oral pain medication, and interventional pain management (injections). (Tr. 46, 64-67.)

5. Upon seeing a PM&R and pain management patient for the first time, a reasonably prudent physician takes a detailed history to garner information about the patient's pain, including medications and therapies already tried, medical and surgical history, allergies, current medications, social history, and job/hobbies. A review of systems, physical examination

typically focused on the complained-about body part, and neuromuscular examination should also be included. A reasonably prudent physician then engages in an assessment and develops a treatment plan. (Tr. 62-65.)

6. The standard of care for a reasonably prudent physiatrist includes an assessment for addictive behaviors prior to prescribing opioids for chronic pain. (Tr. 51-52.)

7. The standard of care for a reasonably prudent physiatrist with a patient who reports being prescribed opioids and/or other controlled substances from another practitioner includes seeking the patient's records from the other practitioner. (Tr. 65.)

8. A reasonably prudent physiatrist routinely performs urine drug screens of patients for whom the physiatrist has prescribed controlled substances on a long-term basis.

9. The Respondent's care of six patients (Patients A – F) was reviewed in this proceeding. All patients were treated by the Respondent through her private practice, iHeal Pain Center, with office locations in New York and New Jersey. (Dept. Exs. 1, 3, 3A, 3B, 3C, 4-11, 13, 14A, 14B.)

10. The Respondent currently practices medicine at four locations in New York. At three of the locations, she conducts neurologic testing and at the fourth she is the "everything" doctor and does medical management. The Respondent also practices in New Jersey providing pain management care as an interventionalist. (Tr. 689-695.)

11. The Respondent currently prescribes narcotics in New York at the one office where she handles medical management, and when a patient is post-procedure or having acute pain due to a procedure. Those prescriptions are short-acting and short-term (2 weeks), and are not for chronic pain management. (Tr. 695-696.)

**Patient A**

12. Patient A was first treated by the Respondent on June 11, 2015. He presented with complaints of neck, low back, knee, and jaw pain secondary to a motor vehicle accident that occurred in 2014. (Dept. Ex. 3 at pp. 28-30.)

13. Patient A's post motor vehicle accident MRIs of his cervical, thoracic and lumbar spines showed no significant pathology. (Dept. Ex. 3 at pp. 11-14; Tr. 71-76, 587-588.)

14. When he began treatment with the Respondent, Patient A had prescriptions for multiple medications from other providers, including oxycodone 10 mg, Cymbalta 60 mg and Wellbutrin 300 mg. (Dept. Ex. 3 at pp. 28-30.)

15. The Respondent attempted, unsuccessfully, to obtain the medical records from Patient A's psychiatrist, Dr. Stacey Dee, who had prescribed Patient A's antidepressant medications. (Dept. Ex. 3 at pp. 28-30.)

16. The Respondent produced an opioid contract with Patient A, dated June 11, 2015, that contained an electronic signature, and that was absent from the certified "complete" medical record provided to the Department. The document was provided to the Department's Office of Professional Medical Conduct in 2017. (Dept. Ex. 3; Resp. Ex. E.)

17. Patient A's medical record does not contain an opioid risk tool assessment of Patient A's addiction behavior. (Dept. Ex. 3; Rêsp. Ex. E; Tr. 79, 86.)

18. There is no indication that the Respondent performed compliance checks for Patient A through I-STOP/New York State Prescription Monitoring Program (PMP) or performed a urine drug screen prior to prescribing Percocet 5/325mg at his first appointment. (Dept. Ex. 3; Tr. 59-62, 79, 81-83.)

19. The Respondent did not document physical examination methods to adequately rule out whether Patient A was being truthful about his reports of pain prior to diagnosing him with non-specific cervical and lumbar disc displacements at his first appointment. (Dept. Ex. 3; Tr. 84-86.)

20. The Respondent ordered physical therapy for Patient A at his first appointment, yet she failed to document any assessment as to compliance with and/or the effect of any physical therapy in Patient A's medical record for subsequent appointments. (Dept. Ex. 3.)

21. The Respondent treated Patient A for just under year. (Dept. Ex. 3.)

22. During the course of her treatment, the Respondent prescribed multiple medications in varying dosages to Patient A, including Percocet, Soma, Tramadol, Opana ER, oxycodone, Dilaudid, and Fentanyl. (Dept. Ex. 3, 3A, 3B, 3C, 14A, 14B.)

23. Some changes in previously prescribed medications were made as a result of Patient A's complaints of negative side effects and an inability to tolerate NSAIDS and other medications. (Dept. Ex. 3.)

24. The Respondent did not perform urine drug screens of Patient A sufficient to comport with the standard of care of a reasonably prudent physician prior to and throughout the Respondent's course of prescribing controlled substances to Patient A. (Dept. Ex. 3.)

25. A Department PMP printout for the Respondent from January 1, 2015 through January 1, 2017 reflects that the Respondent ran six PMP checks on Patient A between June 18, 2015 and September 30, 2016. (Dept. Ex. 13.)

26. During the course of her treatment, the Respondent performed multiple trigger point injections (TPI) on Patient A. The Respondent's records contain multiple entries documenting the administration of Depo-Medrol, a steroid, being utilized during TPIs. (Dept. Ex. 3.)

27. The Respondent disputed the accuracy of her own records, testifying that she never used Depo-Medrol in conjunction with TPIs, and that the entries stating such are a documentation error. (Tr. 717-719.)

28. During the course of her treatment, the Respondent performed multiple facet/joint injections and medial branch blocks on Patient A. (Dept. Ex. 3.)

29. The Respondent repeatedly failed to adequately document an assessment/clinical findings prior to and subsequent to the numerous interventions she performed on Patient A. (Dept. Ex. 3.)

30. On February 24, 2016, Patient A presented to the Emergency Department at St. Luke's Roosevelt in Manhattan with the tip of a broken needle stuck in his arm, along with fever, chills, reported night sweats, and reported weight loss. Patient A was admitted to the hospital and his medical records reflect Systemic Inflammatory Response Syndrome (SIRS) with cellulitis and possible endocarditis. He was discharged on March 1, 2016. Patient A's hospital admission record notes findings of track marks on his arms after physical examination. (Dept. Ex. 4.)

31. St. Luke's Roosevelt contacted the Respondent to obtain a list of his medications. The Respondent inquired as to the circumstances of the Respondent's admission but was told that Patient A expressly directed that his information not be disclosed to the Respondent. (Dept. Ex. 4; Tr. 760-762.)

32. On March 17, 2016, Patient A saw the Respondent, who documented that Patient A reported hospitalization due to fevers. The Respondent did not request Patient A authorize her to obtain the hospital records. The Respondent documented performing a physical exam on Patient A and performing TPIs, but made no note of track marks on his arms. The Respondent increased Patient A's prescription for Dilaudid, without performing a urine drug screen or checking I-STOP, based on Patient A reporting that he had been undertreated for his pain at the hospital. (Dept Ex. 3 at pp. 77-79.)

33. Patient A's medical records are replete with physical examination and medication entries clearly being carried over from appointment to appointment rather than updated to reflect the current information at the time of his visits and consistency with the documented care plan. (Dept. Ex. 3.)

34. On May 18, 2016, Patient A was taken by ambulance to Northwell Health-Lenox Health Greenwich Village (Northwell-Lenox) Emergency Department with an apparent drug

overdose after injecting himself with synthetic fentanyl from China that he ordered online. The attending physician reported that Patient A had a severe opioid addiction and required long term rehabilitation. (Dept. Ex. 5 at pp. 7-17, 24-26.)

35. A hospital social worker notified the Respondent of Patient A's status and requested a letter be sent to rehabilitation facilities regarding his need for pain management. The hospital record reflects that the Respondent refused to write the letter and refused to write Patient A any additional prescriptions as he was an "addict." (Dept. Ex. 5 at p. 72.)

36. The Respondent's medical records contain a note on Patient A's Northwell-Lenox hospital admission classifying his admission as voluntary for a medication interaction episode and stating that she was contacted by the hospital to verify his medications. (Dept. Ex. 3 at p. 9.)

37. Patient A passed away from a drug overdose in 2019, after multiple failed rehabilitation attempts and approximately three years after he last treated with the Respondent. (Tr. 609-619.)

38. The Respondent deviated from the standard of care by failing to obtain and document pertinent information regarding Patient A's evaluation and treatment from other physicians or medical professionals for the period of time between Patient A's 2014 accident and his initial visit with the Respondent, including information on Patient A's use of prescribed opioids.

39. The Respondent deviated from the standard of care by failing to obtain and document compliance checks before continuing to prescribe opioids to Patient A.

40. The Respondent deviated from the standard of care by failing to follow-up on Patient A's hospital treatment at St. Luke's after being contacted by the hospital to verify her prescriptions for Patient A. The Respondent, when faced with a refusal for release of the information, should have been alerted to a potential issue and should have taken steps to secure a release for the information when Patient A next presented to the Respondent for a refill of his prescriptions.

41. The Respondent deviated from the standard of care by failing to adequately evaluate Patient A after his St. Luke's hospital admission. The Respondent should have completed a full examination of Patient A, particularly in light of her inability to obtain the hospital records.

42. The Respondent deviated from the standard of care by prescribing increased doses of multiple controlled substances for Patient A's complaints of pain after his St. Luke's hospital admission without first securing a release from Patient A for his records, obtaining his hospital records, and adequately evaluating him.

43. The Respondent deviated from the standard of care by failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient A.

**Patient B**

44. Patient B was first treated by the Respondent on October 10, 2013, at the age of 37. At the time she worked at a bank in a finance position and had to sit at a desk all day. (Dept. Ex. 6 at pp. 684-688.)

45. Patient B presented to the Respondent with complaints of lower back pain that started in 2011 and became acute in March 2013. Patient B reported the pain to be severe and to shoot into both of her legs, and that she had cramping during the night and a severe tingling sensation in her legs. (Dept. Ex. 6 at pp. 684-688.)

46. Patient B was prescribed Percocet 10/325 mg by her previous doctor, who passed away suddenly, and Patient B presented to the Respondent seeking continuation of her pain medication as well as possible injection therapy. She reported never taking any other pain medication and having minimal short-term relief from therapy in the past. (Dept. Ex. 6 at pp. 684-688.)

47. The Respondent failed to document Patient B's date of birth at the initial visit. (Dept. Ex. 6 at pp. 684-688.)

48. The Respondent noted Patient B's current prescription for Percocet in the History of Present Illness (HPI) and Plan section of Patient B's medical record but failed to note it in the Current Medications section of the record. (Dept. Ex. 6 at pp. 684-688.)

49. The Respondent continued Patient B's prescription for Percocet and added Zanaflax, a muscle relaxer. (Dept. Ex. 6 at pp. 684-688.)

50. The Respondent performed bilateral lumbar trigger point injections with lidocaine and Traumeel at the initial visit. The specific muscles injected were not documented in the medical record. (Dept. Ex. 6 at pp. 684-688.)

51. Patient B continued treating with the Respondent for nearly a decade, stopping treatment only when the patient moved out of state in 2022. (Tr. 903.)

52. The Respondent made several adjustments to Patient B's medications in the first few months of treating Patient B, ultimately stabilizing Patient B and decreasing her Percocet by adding other medications, including long-acting medication, with the last significant change occurring in December 2013. (Dept. Ex. 6 at pp. 635-688; Tr. 902-903.)

53. The Respondent repeatedly failed to accurately reflect Patient B's current medications in the Current Medication portion of the record, with reference to medications appearing in other sections. (Dept. Ex. 6.)

54. The Respondent repeatedly failed to accurately reflect Patient B's current information in the medical record, instead carrying information over time and again from prior visits. (Dept. Ex. 6.)

55. The Respondent performed multiple trigger point injections on Patient B over the course of her treatment. The Respondent repeatedly referenced use of Depo-Medrol, the overuse of which could have negative effects for a patient, yet maintains that those references were a charting error and that she only used lidocaine in those procedures. (Dept. Ex. 6; Tr. 893, 905.)

56. The Respondent performed other injections with steroids on Patient B, which injections occurred in multiple regions of the body and were stretched over several years of treatment. (Dept. Ex. 6 [with procedure summaries and percentage of pain relief achieved noted at p. 3].)

57. Patient B's medical record contains an opioid contract signed by Patient B on June 11, 2015, approximately one year and eight months after treatment commenced, which coincided with the Respondent changing to an electronic record format. (Dept. Ex. 6 at p. 469.)

58. Patient B's medical record contains an opioid risk tool, patient agreement, and D.I.R.E. (tool for patient compliance with opioid treatment) score sheet from 2016. (Dept. Ex. 6 at pp. 307-310.)

59. The Respondent began noting urine drug screens in the Procedures section of Patient B's medical record starting in 2016. (Dept. Ex. 6 at pp. 9, 17, 36, 52.)

60. The Respondent credibly testified that there is no urine "report" because the urine screen was done by a dipstick check viewed by the Respondent after Patient B was accompanied to the bathroom, and that Patient B signed a form indicating consistent results. The forms are present in Patient B's medical record. (Dept. Ex. 6 at pp. 98, 203, 306; Tr. 908-910.)

61. A Department PMP printout for the Respondent from January 1, 2015 through January 1, 2017 reflects that the Respondent ran one check on Patient B, dated March 3, 2016. (Dept. Ex. 13.)

62. The Respondent deviated from the standard of care by failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient B.

**Patient C**

63. Patient C was first treated by the Respondent on January 31, 2013, at the age of 54. (Dept. Ex. 7 at pp. 487-498.)

64. Patient C presented with complaints of acute lower back pain and reported increased pain in his lower back since a fall several months prior, when he developed severe right leg pain, buttock pain, and sacroiliac joint (SIJ) pain. Patient C also reported decreased range of motion (ROM). (Dept. Ex. 7 at p. 487.)

65. Prior to his initial visit with the Respondent, Patient B reportedly had three months of physical therapy with no relief of his symptoms. He also reported having four sets of transforaminal epidural steroid injections (TFESI) from another physician, with minimal relief. (Dept. Ex. 7 at p. 487.)

66. Patient C received other treatments throughout his period of treatment with the Respondent. He received acupuncture, chiropractic care, cupping, physical therapy, and massage, all from providers at the Manhattan Spine Clinic. (Tr. 649-652.)

67. Patient C's date of birth is not noted on the medical record from his initial visit. (Dept. Ex. 7 at pp. 487-498.)

68. On February 7, 2013, the Respondent first noted that Patient C's pain and dysfunction interferes with quality of life and multiple daily household, occupational, recreational and social activities. On May 30, 2013, the Respondent first noted that Patient C works in the music industry as a sound engineer for musicians. (Dept. Ex. 7 at pp. 438, 483.)

69. The Respondent's records subsequent to May 30, 2013, four months after Patient C commenced treatment with the Respondent, contain periodic notations of the physically demanding nature of Patient C's job. (Dept. Ex. 7.)

70. Patient C testified that his prior job as an audio engineer doing sound mix for major artists and touring all over the world, as well as his household chores such as cutting trees down and lawn work on his property in the country, were physically demanding. (Tr. 649, 654.) The specificity of this relevant social history, although seemingly known to the Respondent from her testimony, is largely absent from her medical record for Patient C. (Dept. Ex. 7; Tr. 918-1080.)

71. At his initial visit, the Respondent had Patient C complete an opioid agreement, a D.I.R.E assessment, and an Opioid Risk assessment. (Dept. Ex. 7 at pp. 487-497.)

72. The Respondent noted having checked the PMP for Patient C at his initial visit. (Dept. Ex. 7 at p. 490.)

73. Patient C's medical record reflects multiple urine screens having been performed from 2016 forward, in accordance with the same method of tracking utilized with Patient B. (Dept. Ex. 7 at pp. 40, 104, 201.)

74. The Respondent repeatedly failed to accurately reflect Patient C's current medications in the Current Medication portion of the record, with reference to medications appearing in other sections. (Dept. Ex. 7.)

75. The Respondent failed to consistently perform a physical examination or record physical examination findings, as evidenced by unchanged findings being unlikely subsequent to Patient C undergoing intervention procedures and/or medication changes. (Dept Ex. 7 at pp. 471-482.)

76. The Respondent failed to appropriately note pertinent information of the dates associated with Patient C's surgical history, which included a cervical fusion, left knee surgeries, and left shoulder surgery. (Dept. Ex. 7 at p. 487.)

77. The Respondent performed multiple trigger point injections on Patient C over the course of her treatment. The Respondent repeatedly referenced use of Depo-Medrol, yet maintains that it was a charting error and that she only used lidocaine in those procedures. (Dept. Ex. 7; Tr. 958-959.)

78. The Respondent performed other injections with steroids on Patient C in multiple regions of the body over several years of treatment. (Dept. Ex. 7, [with procedure summaries and percentage of pain relief achieved noted at p. 4].)

79. The Respondent deviated from the standard of care by failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient C.

**Patients D-F**

80. Patients D, E and F are related. Patient D is the adult son of Patient E (father) and Patient F (mother). Patients E and F are married. All three patients live in the same household. (Dept. Exs. 8-10; Tr. 1100.)

81. Patients D and E were referred to the Respondent by their previous physician in New Jersey, Dr. Binod Sinha. (Dept. Exs. 8 & 9; Tr. 1082.)

82. Patients D and E were treated by the Respondent in New Jersey from November 2015 through March 2016. (Dept. Exs. 8 & 9; Tr. 1085.)

83. Patient F was treated by the Respondent in New Jersey from December 2015 through February 2016. (Dept. Ex. 10.)

84. The Respondent wrote prescriptions for Patients D, E and F with her New York State prescribing privileges and the patients filled prescriptions in Brooklyn, New York. (Dept. Ex. 11.)

85. Patient D presented to the Respondent seeking refills of an existing oxycodone prescription and complaining of right shoulder, neck and lower back pain. (Dept. Ex. 8 at p. 5.)

86. The Respondent continued Patient D's prescription for oxycodone at the same dosage. (Dept. Ex. 8 at p. 6.)

87. Patient D signed an opioid contract with the Respondent, dated November 12, 2015. (Dept. Ex. 8 at p. 4.)

88. The Respondent did not document performing any urine drug screens on Patient D. (Dept. Ex. 8.)

89. A Department PMP printout for the Respondent from January 1, 2015 through January 1, 2017 reflects that the Respondent ran one PMP check on Patient D on March 3, 2016. (Dept. Ex. 13.)

90. The Respondent did not document identifying any mechanism of injury for Patient D. (Dept. Ex. 8.)

91. The Respondent documented a right shoulder injection on Patient D but did not note when it was performed or the nature of the injection. At the hearing, the Respondent was unsure if she performed the injection. (Dept. Ex. 8 at p. 12; Tr. 1088, 1094.)

92. The Respondent discharged Patient D immediately following an incident wherein Patient D became belligerent seeking drugs and the police were called due to safety concerns. (Tr. 1090-1091.)

93. The Respondent deviated from the standard of care in her treatment of Patient D by failing to perform and document compliance checks during the course of treatment while continuing to prescribe short-acting opioids.

94. The Respondent deviated from the standard of care in her treatment of Patient D by not performing and documenting urine screens.

95. The Respondent deviated from the standard of care in her treatment of Patient D by documenting that she performed a right shoulder injection but failing to document when it was performed and the nature of the injection. (Dept. Ex. 8 at p. 12.)

96. The Respondent deviated from the standard of care in her treatment of Patient D by failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient D based on the Respondent not documenting compliance checks, urine screens, and pertinent information relating to the shoulder injection.

97. Patient E first presented to the Respondent a week after Patient D's first visit, seeking refills of an existing oxycodone prescription and complaining of bilateral shoulder, lower back and neck pain from a motor vehicle accident approximately eleven years prior. (Dept. Ex. 9 at pp. 5-6.)

98. The Respondent continued Patient E's prescription for oxycodone at the same dosage. (Dept. Ex. 9 at pp. 5-6.)

99. Patient E signed an opioid contract with the Respondent, dated November 19, 2015. (Dept. Ex. 9 at p. 4.)

100. The Respondent did not document performing any urine drug screens on Patient E. (Dept. Ex. 9.)

101. A Department PMP printout for the Respondent from January 1, 2015 through January 1, 2017 reflects that the Respondent ran two PMP checks on Patient E, both occurring on February 18, 2016 and occurring less than a minute apart. (Dept. Ex. 13.)

102. The Respondent discharged Patient E on March 14, 2016, and instructed him to find a physician for chronic pain medication as her practice was for acute interventional pain management. (Dept. Ex. 9 at p. 14; Tr. 1106.)

103. The Respondent deviated from the standard of care in her treatment of Patient E by failing to perform and document compliance checks during the course of treatment while continuing to prescribe short-acting opioids.

104. The Respondent deviated from the standard of care in her treatment of Patient E by not performing and documenting urine screens.

105. The Respondent deviated from the standard of care in her treatment of Patient E by failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient E based on the Respondent not documenting compliance checks and urine screens.

106. Patient F presented to the Respondent complaining of severe neck, lower back and bilateral knee pain. (Dept. Ex. 10 at p. 3.)

107. Patient F admitted to the Respondent that she had taken Patient E's oxycodone prescription. (Dept. Ex. 10 at p. 3.)

108. The Respondent did not document identifying any mechanism of injury for Patient F. (Dept. Ex. 10 at pp. 3-11.)

109. The Respondent prescribed short-acting opioids for Patient F. (Dept. Ex. 10 at pp. 3-11.)

110. Patient F's medical record does not contain an opioid contract. (Dept. Ex. 10.)

111. The Respondent did not document performing any urine drug screens on Patient F. (Dept. Ex. 10.)

112. Patient F refused a TPI for her pain, and sought medication from the Respondent. (Dept. Ex. 10 at p. 8.)

113. Patient F was not officially discharged by the Respondent, but Patient F did not return to see the Respondent after a visit in February 2016. (Dept. Ex. 10; Tr. 1115.)

114. The Respondent deviated from the standard of care in her treatment of Patient F by not performing and documenting urine screens.

115. The Respondent deviated from the standard of care in her treatment of Patient F by failing to maintain a record that accurately and adequately reflects the evaluation and treatment of Patient F based on the Respondent not documenting urine screens and Patient F's age.

## CONCLUSIONS OF LAW

As required by PHL § 230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Statement of Charges were more probable than not. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department. (See Prince, Richardson on Evidence § 3-206.) Having considered the complete record in this matter, the Hearing Committee concludes that the Department has established the Fourth through Seventh Specifications and the Thirteenth through Sixteenth Specifications, as contained in the Statement of Charges. The sustained specifications include negligence on more than one occasion [NY Educ. Law § 6530(3)] and failing to maintain a record which accurately reflects the evaluation and treatment of the patient [NY Educ. Law § 6530(32)]. The Hearing Committee made these conclusions of law pursuant to the factual findings listed above. The conclusions resulted from a 2-1 vote on the specifications of negligence and a unanimous vote on the specifications of failing to maintain a record. The

Hearing Committee unanimously voted to not sustain all other specifications in the Statement of Charges.

DEPARTMENT'S EXPERT

The Department's expert witness was Denny Battista, D.O. Dr. Battista is licensed to practice medicine in New York. He is board certified in PM&R and in Pain Management. He is the owner of and a practicing physician at CNY Spine and Pain Medicine, with offices in Liverpool and Utica, New York, where he provides "out-patient PM&R/EMG services [w]ith a focus on Pain Management." (Dept. Ex. 12.)

Dr. Battista reviewed the Respondent's medical records for each of the six patients involved in this case. The Hearing Committee found his testimony to be credible but limited due to problems with the Respondent's recordkeeping and the resulting inaccuracy of the information that he was presented to review. The Hearing Committee found Dr. Battista's commentary on medications to be reasonable, but found that he drew conclusions on the types of injections administered by the Respondent without adequate consideration of the Respondent's type of practice, patients, and the time frame during which treatment was rendered, and applied standards that may not have applied during the time frame at issue.

RESPONDENT'S EXPERT

The Respondent's witness was Jeffrey Gudin, M.D. Dr. Gudin is board certified in Anesthesiology, Pain Management, Addiction Medicine, and Hospice and Palliative Medicine. Dr. Gudin was the Director of Pain Management and Palliative Care at the Englewood Hospital and Medical Center in New Jersey until recently, and he is currently a professor in the Department of Anesthesiology at the University of Miami Miller School of Medicine. Due to scheduling conflicts and at the Department's suggestion, Dr. Gudin provided his direct testimony in this matter via an Affirmation and appeared virtually for cross-examination. (Resp. Ex. F; Tr. 1140-1145.)

Dr. Gudin reviewed the Respondent's medical records and the testimony of Dr. Battista. The majority of the Hearing Committee found Dr. Gudin to be credible, knowledgeable on the

subject matter, and credited him with asserting opinions about the Respondent's recordkeeping that, although they may not be preferable to hear, are an accurate depiction of the reality of recordkeeping. The majority of the Hearing Committee also found that Dr. Gudin was familiar with the type of practice and patients the Respondent treated, and was therefore familiar with the pitfalls associated therewith. The dissenting Hearing Committee member found Dr. Gudin to be biased and felt he answered questions in an effort to portray the Respondent in a positive light rather than responding factually. The dissenting member of the Hearing Committee also found that Dr. Gudin was not familiar with the Respondent's medical records at the time he provided testimony on cross-examination and, therefore, found he lacked knowledge as to the care the Respondent provided despite his being knowledgeable in the relevant area of medicine.

[REDACTED] TESTIMONY

The Department presented [REDACTED] Patient A's mother, as a witness. Ms. [REDACTED] testimony was heartfelt, emotional and tragic, as she detailed her son's substance addiction and untimely death. Her testimony, however, offered no probative value as to the charges against the Respondent. It was largely void of specifics of treatment rendered by the Respondent and centered on his fatal overdose, which occurred more than two years after he was discharged from the Respondent's care.

PATIENT B'S & PATIENT C'S TESTIMONY

The Respondent presented Patients B and C. Patient B testified that the Respondent took over her medical care in 2013 when her previous doctor passed away, and that she only stopped treating with the Respondent in 2022 because she moved to Texas. Patient B testified that the pain medication prescriptions and injections she received from the Respondent had been "saving [her] life" and that she can "live a normal life" because of them. Patient B elaborated that the treatments from the Respondent significantly reduced her pain and allowed her to function normally at her job as well as take care of her child and chores at home. Patient B unequivocally testified that the Respondent's treatment benefited her and did not harm her. She also testified

that she was on prescription opioids when she was transferred to the Respondent's care and that her current doctor is "pretty much continuing the same treatment" she received from the Respondent. (Tr. 628-646.)

Patient C testified that he started seeing the Respondent after his previously treating physician moved to Utah, and that he was already treating with a physical therapist in the same office as the Respondent and wanted to have all his care in one place. He testified that he co-treated with other providers throughout his course of care with the Respondent. Patient C received pain medication prescriptions and injections from the Respondent, and he testified that the Respondent's treatment brought him comfort and helped him perform his job and physical work at home such as chopping down trees. Patient C further testified that he was very satisfied with the care he received from the Respondent, that he has benefited from the medications and injections, and that he has not been harmed in any way by her care. He also testified that he has not seen her recently because she is working out of New Jersey and that he receives treatment in New York. (Tr. 648-673.)

The Hearing Committee found Patients B and C to be honest, forthright and candid in discussing the care they received from the Respondent.

RESPONDENT'S TESTIMONY

The Respondent was present on each hearing date except for March 7, 2023, during the testimony of [redacted]. The Respondent provided testimony on March 28 and April 28, 2023. The Hearing Committee found the Respondent to be qualified and knowledgeable in the area of PM&R and Pain Management. The Hearing Committee specifically notes that although all physicians may not agree with her approach to treatment, that does not negate her knowledge and competency. The Hearing Committee found the Respondent to display numerous and repetitive shortcomings in her recordkeeping, and noted the Respondent's reluctance to readily admit those shortcomings and acknowledge their importance. Despite her resistance to owning up to her recordkeeping errors and their potential negative consequences, the Hearing Committee

overall found the Respondent to be truthful in her testimony. The Hearing Committee also acknowledges the high level of familiarity the Respondent had with all six patients and her treatment, which spanned multiple years.

FIRST – THIRD SPECIFICATIONS

The Department's First through Third Specifications charge the Respondent with professional misconduct for practicing medicine with gross negligence in her care of Patients A through C in violation of New York Education Law § 6530(4). Gross negligence is defined as negligence which involves a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequences. Post v. State of New York Department of Health, 245 A.D.2d 985 (3d Dept. 1997). There is no need to prove that the medical provider was conscious of the impending dangerous consequences of his conduct. Minielly v. Commissioner of Health, 222 A.D.2d 750 (3d Dept. 1995).

The Hearing Committee is not persuaded that the Respondent committed professional misconduct as charged in these specifications. It declines to find that any of the deviations from the standard of care, as enumerated in the Findings of Fact above, constitute gross negligence. The Hearing Committee finds that any deviations by the Respondent did not rise to the level of serious or significant such that they created the risk of potentially grave consequences to Patients A though C. Patients B and C credibly testified to benefitting from, and not being harmed by, the treatment they received from the Respondent. Their testimony is uncontradicted by their medical records and the credible testimony of Dr. Gudin. Patient A's mother testified contrarily, indicating that her son was harmed by the treatment he received from the Respondent. However, as discussed above, that testimony was heartfelt and following a tragedy but was largely void of specifics of the treatment that was rendered by the Respondent and not probative. Patient A was one of the most difficult and complicated patients a physiatrist can encounter.

Accordingly, Specifications First through Third are not sustained.

FOURTH – NINTH SPECIFICATIONS

The Department's Fourth through Ninth Specifications charge the Respondent with professional misconduct for practicing medicine with negligence on more than one occasion in her care of Patients A through F, in violation of New York Education Law § 6530(3). Negligence is defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances and involves a deviation from acceptable medical standards in the treatment of patients. Bogdan v. State Board for Professional Medical Conduct, 195 A.D.2d 86 (3d Dept. 1993).

The Hearing Committee finds, by a vote of 2-1, that the Respondent was negligent in her care of Patients A – D based upon the seriousness, significance, and repetitiveness (with respect to Patients A – C) of her failure to maintain a record which accurately and adequately reflected the evaluation and treatment of those patients. The Hearing Committee declines, by a vote of 2-1, to conclude that the Respondent otherwise was negligent in her care and treatment of Patient A, and it unanimously declines to conclude that the Respondent was otherwise negligent in her care and treatment of Patients B – D. Accordingly, the Hearing Committee sustains the Fourth through Seventh Specifications to the extent indicated.

The Hearing Committee unanimously finds that the Respondent was not negligent as charged in the Eighth and Ninth Specifications (Patients E and F). While the Hearing Committee makes certain findings of deviations from the standard of care, it is not persuaded that those findings are sufficient to constitute negligence given the totality of circumstances. Accordingly, the Eighth and Ninth Specifications are not sustained.

TENTH – TWELFTH SPECIFICATIONS

The Department's Tenth through Twelfth Specifications charge the Respondent with professional misconduct for ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient in her care of Patients A through C, in violation of New York Education Law § 6530(35). The Hearing Committee thoroughly considered the

Department's argument that the Respondent over-prescribed opioids and over-utilized interventional procedures with Patients A though C. It undertook a detailed review of the medical records for Patients A though C, and considered the testimony of the Respondent, Dr. Battista and Dr. Gudin.

The Hearing Committee is not persuaded that the Respondent committed professional misconduct as alleged. The Hearing Committee acknowledges the large quantity and combination of medications prescribed to Patient A, but finds that it is significantly tempered by Patient A's deceitfulness, drug-seeking behaviors, and high tolerance to medications due to his addiction. The Hearing Committee also finds that the prescribing practices with respect to Patients B and C did not constitute professional misconduct. With respect to interventional procedures, the Hearing Committee credits the Respondent's testimony that she did not use steroids with the trigger point injections she administered, believing that the notations for Depo-Medrol with the injections are a charting error as described by the Respondent. In voting to not sustain these specifications, the Hearing Committee acknowledges that varying opinions may exist between the experts and practitioners, and gives deference to the Respondent for her medical decision-making when determining the number, type and frequency of interventional procedures for Patients A through C. The Hearing Committee also largely credits the testimony of Patients B and C and their satisfaction with the Respondent's treatment, coupled with the lack of any indication that either patient was directing their own care or was abusing their prescribed medications.

Accordingly, these specifications are not sustained.

THIRTEENTH – EIGHTEENTH SPECIFICATIONS

The Department's Thirteenth through Eighteenth Specifications charge the Respondent with professional misconduct for failing to maintain a record for Patients A through F which accurately reflects the evaluation and treatment of the patients, in violation of Education Law § 6530(32). A medical record needs to convey objectively meaningful medical information

concerning a patient treated to other physicians. Maglione v. New York State Dept. of Health, 9 A.D.2d 522 (3d Dept. 2004).

By her own admission, the Respondent's medical records contain multiple errors and lack certain information. The Respondent's recordkeeping for Patient A's treatment is most egregious, with major areas of concern being the Respondent's failure to obtain or include relevant portions of the patient's prior history, failure to keep an accurate and updated plan of treatment and medication list, notes reflecting the carrying over of examination information between visits, failure to obtain or include hospitalization records, inaccurate information for medications used during interventional procedures, and lack of documentation of compliance checks. As described in the Findings of Fact above, some of these concerns also relate to Patients B and C. With respect to Patient D, the Respondent failed to perform or document having performed compliance checks despite continuing to prescribe opioids and had insufficient documentation regarding a shoulder injection. Accordingly, Specifications Thirteen through Sixteen are sustained.

The Hearing Committee declines to sustain Specifications Seventeen and Eighteen, noting the circumstances under which Patients E and F came to treat with the Respondent, the difficulty of the situation, and short duration of time that they were patients.

**DETERMINATION AS TO PENALTY**

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

The Hearing Committee declines to revoke the Respondent's license to practice medicine as suggested by the Department. The Hearing Committee found no overwhelming concerns with Respondent's qualifications, knowledge, or competency in the area of PM&R and Pain Management, noting that approaches to managing pain may differ among physicians.

The Hearing Committee unanimously finds that censure and reprimand, along with a fine and continuing medical education is an appropriate penalty. The Hearing Committee finds that a

fine in the amount of $10,000 is appropriate given the lack of remorse displayed by the Respondent for her shortcomings with recordkeeping, her lackadaisical attitude toward making a complete and accurate record, and her failure to appreciate the importance of accurate records and the effect poor records may have. The Hearing Committee additionally finds appropriate that the Respondent be required to complete three hours of continuing medical education courses on the topic of recordkeeping.

**ORDER**

Based upon the foregoing, IT IS HEREBY ORDERED THAT:

1. The Fourth, Fifth, Sixth, Seventh, Thirteenth, Fourteenth, Fifteenth, and Sixteenth Specifications of professional misconduct, as set forth in the Statement of Charges, are sustained;

2. The First, Second, Third, Eighth, Ninth, Tenth, Eleventh, Twelfth, Seventeenth, and Eighteenth Specifications of professional misconduct, as set forth in the Statement of Charges, are not sustained;

3. The Respondent is subject to censure and reprimand pursuant to PHL § 230-a(1);

4. A fine in the amount of $10,000 is imposed upon the Respondent pursuant to PHL § 230-a(7), with payment due thirty (30) days from issuance of this Order;

5. The Respondent is required to complete three hours of continuing medical education courses on the topic of recordkeeping as approved by the Director of the Office of Professional Medical Conduct, within thirty (30) days from issuance of this Order, and submit proof of completion of the same to the Director within thirty (30) days of completing the courses; and

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

DATED: Albany, New York
January 30, 2024

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

| IN THE MATTER<br>OF<br>JIGNYASA DESAI, D.O. | STATEMENT<br>OF<br>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

HENRY WEINTRAUB
Chief Counsel
Bureau of Professional Medical Conduct