DOH STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

May 2, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dianne Abeloff, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001

Robert Goldman, Esq.
Schlam, Stone & Dolan
26 Broadway - 19th Floor
New York, New York 10004

Miles Galin, M.D.
345 East 37th Street
New York, New York 10016

RE: In the Matter of Miles Galin, M.D.

EFFECTIVE DATE AFTER COURT STAY DENIED IS JULY 12,1997

Dear Ms. Abeloff, Mr. Goldman and Dr. Galin:

Enclosed please find the Determination and Order (No. BPMC-97-101) 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.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties **other than suspension or revocation** until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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 Mr. Horan 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,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

COPY

IN THE MATTER

OF

MILES A . GALIN, M.D.

DETERMINATION

AND

ORDER

BPMC-97-101

Sharon Kuritzky, M.D., Chairperson, Donald Cherr, M.D. and Sister Mary Theresa Murphy, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Sections 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **Jane B. Levin, Esq.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	May 31, 1994
Statement of Charges dated:	May 31, 1994
Pre-hearing Conferences:	June 29, 1995 November 9, 1995
Hearing dates:	January 11, 17, 25, 1996 March 14, 21. 1996 April 18, 25, 1996 June 6, 27, 29, 1996 July 11, 1996 August 1, 22, 1996 September 12, 19, 26, 1996 October 17, 21, 1996 November 7, 14, 21, 1996 December 5, 1996 January 20, 23, 1997

Deliberation Dates:	March 13, 1997 April 3, 1997
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Petitioner appeared by:	Hank Greenberg, Esq. General Counsel NYS Department of Health By: Diane Abeloff, Esq. Associate Counsel
Respondent appeared by:	Schlam, Stone & Dolan 26 Broadway New York, New York 10004 By: Robert E. Goldman, Esq. of Counsel

WITNESSES

For the Petitioner:

1) Patient A
2) Patient B
3) Patient C
4) Patient E
5) Patient F
6) Robert Bergen, M.D.
7) Munro Levitsky, M.D.
8) Ricardo Almiron
9) Richard Koplin, M.D.
10) Paul N. Orloff, M.D.
11) Patient D
12) Kenneth R. Barasch, M.D.
13) Stephen Obstbaum. M.D.
14) Patient I
15) Thomas Flynn, M.D.

For the Respondent:

1) Tara Curet
2) Diane Schneiderman
3) Miles Galin, M.D. (Respondent)
4) Harvey Hisrchman, M.D.
5) Herve Byron, M.D.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct in ordering excessive tests or treatments, practicing the profession fraudulently, practicing the profession negligently, and failing to maintain an accurate record.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.[1]

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

GENERAL FINDINGS

1. Respondent was authorized to practice medicine in the State of New York on July 10, 1956 by the issuance of license number 0077998.

2. Respondent has been a licensed, practicing physician in the State of New York for 41 years, specializing in ophthalmology, and currently maintains a medical office at 345 E. 37th Street in New York City.

3. At the time of a patient's initial visit to the Respondent's office, a battery of tests was performed prior to the patient seeing the Respondent. These included testing of the patient's visual acuity, contrast sensitivity, intraocular pressure, and visual field, as well as A and B scans and retinal and iris photographs (T. 1049).

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[1] During the course of the hearings, the following charges were withdrawn by Petitioner: D.5.(a); G.2.(b-d); M(6). In addition, the specifications pertinent to these charges were withdrawn as follows: 17 as to D.5.(a); 36; 40 as to D.5(a); 43 as to G.2.(b-d); 48 as to M.6.; 65 as to G.2.(b).

4. A witness for Respondent, Dr. Hirschman, testified that some of these testes were performed for the Respondent's own intellectual curiosity, and for the benefit of future patients, rather than that of the patient undergoing the test (T. 3844-45).

5. A test for contrast sensitivity is an adjunct tool in evaluating functional vision. To administer this test, a patient looks at a chart which consists of circles or S-shaped lines in different intensities of grays and blacks. The patient is asked to read to a point where s/he cannot make any further distinctions (T. 1291; 1463-1465; 1468-69; 1471; 2007, 2008, 2010). Contrast sensitivity tests are considered part of a general eye exam and not separately reimbursable. They were coded as color vision testing on multiple occasions by Respondent (Pet. Exs. 11, 15).

6. Tonography is a test that measures the dynamic pressure of the fluid of the eye. Clinical practice has shown that the test was not predictive for glaucoma (T. 915; 1407-1409; 1411; 1417; 1587; 2898; 2900; 2685-2689; 2711). The test is performed with the patient in a reclining position with a weight placed on each eye for four minutes. The pulse is recorded. The slope is recorded and calculated from a chart (T. 3321-3322).

7. In a visual field test, the patient looks straight ahead while lights of different intensities are shown centrally and in the periphery, with the patient indicating when he perceives the light. The test graphically demonstrates the patient's visual field (T. 1229).

8. Visual field tests on a patient who has been diagnosed with glaucoma are usually performed once a year if the patient is clinically stable, since changes in visual fields occur relatively slowly (T. 1231).

9. A B-scan is an ultrasound test performed on the closed eye to allow the ophthalmologist to identify gross structures in the eye. It is usually utilized when the physician cannot get a good view of the back of the eye by directly looking into it with an ophthalmoscope. The B-scan is performed by placing a cylindrical probe, which is attached to the ultrasound machine, on the closed eyelid, which usually has been prepared with gel to provide better contact. While moving the probe over the eyelid, the individual administering the test views a

screen to find certain landmarks (T. 1284, 1285).

10. Respondent testified that performing a B-scan with the use of gel produces a better quality sonogram, but that he does not use it because "it is a pain in the neck" and the quality of the B-scans he obtained were adequate for his needs (T. 3347, 3348).

11. Respondent's practice is to obtain a B-scan, usually without the use of gel, on all new patients before they are seen by him (T. 1049; 3097; 3293) and on all patients postoperatively (T. 3335).

12. The Petitioner's expert, Dr. Orloff, stated that there is no purpose to a baseline B-scan when an ophthalmologist can look in the back of the eye through ophthalmoscopy (T. 1286; 1480-1482; 2624). A B-scan is not detailed enough nor accurate enough to show very subtle weaknesses and changes in the retina that can be of concern prior to surgery (T. 1477, 1478).

13. The representative B-scan photographs included in Respondent's records did not show any structures anterior to the equator (T. 1581) and therefore some interpretation would have been necessary as to whether the anterior structures were seen during the examination itself.

14. A fluorescein angiogram is a series of special photographs of the retina taken after fluorescein dye has been administered. It is used primarily in the diagnosis and treatment of retinal diseases, but one can also use it to obtain information about the optic nerve (T. 707, 708; 1376).

15. Fluorescein angiograms are not used in clinical practice as a tool in the work-up or treatment of glaucoma (T. 1378; 1381; 1403; 1547; 1591; 2690; 3909).

16. Ricardo Almiron worked for Respondent from 1979 through 1984 and then from 1986 through February 1992. He was the technician responsible for performing fluorescein angiograms (T, 983; 986; 1015). After he left the office, Diane Schneiderman (who is related to the Respondent) was the primary technician who performed the fluorescein angiograms (T. 3114, 3115).

17. The Respondent used intravenous, oral and topical methods to administer fluorescein (1005; 3068). Ms. Schneiderman testified that she would record information about the dose and method of administration of the fluorescein as well as the flash duration used for each test (T. 3114, 3115). The Respondent would write the dose of fluorescein to be given on a post-it note in the patient's chart (T. 1006; 4402, 4403; 4494; 4498).

18. Topical administration of fluorescein for performance of angiography is not useful, and Respondent's argument that small amounts of the dye enables a physician to better observe small blood vessels is without merit (T. 807-810; 4401, 4402; Pet. Ex. 70).

19. Oral fluorescein angiograms are not useful in the diagnosing and treatment of glaucoma. The only information that can be obtained is about the general anatomy of the eye, which could be discerned from the red free filter photographs, which do not require the ingestion of fluorescein (T. 4416; 4418; 4500).

20. Respondent claimed that he performed oral fluorescein angiograms to avoid overloading the eye's circulatory system. The oral fluorescein enabled him to see the blood flow in the choroidal area. Petitioner's witness, Dr. Flynn, replicated the conditions that Respondent testified that he had used with oral administration of fluorescein. Dr. Flynn performed several studies, both on an empty stomach and with a full stomach, ingesting various strengths of fluorescein diluted in soda, to determine whether the choroidal circulation can be illuminated with oral fluorescein. The angiogram which is Petitioner's Exhibit 70 clearly demonstrates that Respondent's area of concern cannot be studied and evaluated with oral fluorescein, nor can any treatment decisions be based upon an oral fluorescein angiogram (T. 4368; 4410; Pet. Ex 70).

21. Although intravenous injection of fluorescein is the technique accepted by the medical community for performing fluorescein angiograms, Dr. Flynn, testified that he saw the merit of performing oral fluorescein angiogram on his HIV compromised patients and his patients with bad veins, but only for retinal diseases. He testified that the oral administration of fluorescein is useless for visualizing the area Respondent claims is necessary in the diagnosis and treatment of glaucoma (T. 4362; 4368; 4409; 4411).

22. An individual's urine changes color after ingestion of a minute amount of fluorescein (T. 1006; 4402, 4403; 4494; 4498).

23. Diane Schneiderman, Respondent's technician, testified that a B-scan would take 15 to 20 minutes to perform, a visual field test 45-60 minutes, visual acuity 5 minutes, contrast sensitivity 5-10 minutes, fluorescein angiogram 30 minutes, and electrophysiological testing 30 minutes to perform (T, 3124, 3125).

24. Respondent's office sees 65 to 70 patients daily (T. 3168).

25. Respondent testified that his billing personnel reviewed the patient's chart, determined the diagnoses, the procedures performed and how to bill the third party carriers. He further testified that he was completely ignorant of the billing procedures in his office (T. 3319; 3634). A physician must only bill for services actually rendered (T. 2002).

26. Tara Curet, the Respondent's billing clerk, testified that the Respondent writes the diagnosis and the procedures on a post-it note on the patient's chart (T. 3015).

FINDINGS OF FACT AS TO PATIENT A

1. Respondent treated Patient A in his office at 944 Park Avenue in New York City and at the Medical Arts Center Hospital at 57 West 57th Street in New York City from on or about August 17, 1988 through on or about August 28, 1989 (Pet. Exs. 3 and 4).

2. Patient A had complaints of decreased vision resulting from a cataract in her left eye. She specifically sought treatment from Respondent because she had heard that he implanted a lens in the eye during cataract surgery. Patient A testified that Respondent never told her that it would be unnecessary to implant a lens during her surgery, and she remained unaware that she did not in fact have an implant until seen by an optometrist a month or so after her surgery (Pet. Ex. 3, p. 52, 53; T,. 34, 35; 38; 62; 134).

3. Respondent's chart for Patient A documented that she was suffering from a cataract (Pet. Ex. 3).

4. Respondent performed an intracapsular cataract extraction on Patient A's left eye on October 3, 1988. The title of the operative procedure at Medical Arts Center however, was "left intra-capsular cataract extraction with trabeculectomy." (Pet. Ex. 4).

5. Complications such as cystoid macular edema and retinal detachments can occur with either intracapsular or extracapsular extractions and patients operated upon by a surgeon in the learning curve of a new technique are at increased risk (T. 1194).

6. A trabeculectomy is a surgical procedure used in the treatment of glaucoma. Respondent did not perform a trabecultomy on Patient A on 10/3/88, just a left intracapsular cataract extraction. A physician who gonioscopes a patient after a trabeculectomy, even a failed trabeculectomy, would see a cleft, the area created by cutting out the trabecular meshwork. The physician would see signs of where the eye was entered and should see a filtering cleft at the site of where the eye was entered, even if cyclodialysis was performed (T. 1584, 1585). None was seen in Patient A's eye by her subsequent treating physician, Dr. Levitzky, who testified that Patient A did not have a functioning trabeculectomy: there was no elevation of the conjunctiva over a trabeculectomy site, there was no connection between the anterior chamber and the structures underneath the conjunctiva, nor was there any abnormal conjunctival scarring. No fluid went from the anterior chamber out of a hole created under the conjunctiva (T. 858; 910; 911).

7. Respondent's chart for Patient A describes her as a high myope with a left cataract and borderline intraocular pressures, "possibly abnormal" in her left eye (T. 3355; Pet. Ex. 3). The chart also describes an elevated pressure in Patient A's right eye, and an abnormal visual field test performed on August 17, 1988, but the chart does not indicate any treatment for the right eye, nor does it contain a diagnosis of glaucoma (Pet. Ex. 3).

8. The patient testified that she was not told she had abnormal intraocular pressure or glaucoma (T. 35, 36).

9. Glaucoma is usually treated medically before proceeding to surgery. Respondent never treated Patient A's alleged glaucoma of the left eye prior to performing the alleged

trabeculectomy (T. 1256, Pet. Exs. 3, 4).

10. Patient A did not have glaucoma. Neither her prior treating ophthalmologists nor her subsequent treating ophthalmologists saw any evidence of glaucoma; her optic nerve appeared normal; her intraocular pressure has always been in the mid to low teens; nor did she have any optic atrophy (Pet. Exs. 6, 7, 8, 51; T. 36, 37; 855-858).

11. After her intracapsular cataract extraction, Patient A received the proper post-operative care for this procedure, including being fitted with spectacles and a contact lens (Pet. Ex. 3).

12. Several weeks after her cataract surgery, Patient A told Respondent that her eye felt scratchy. Respondent told the patient that he had to remove some sutures with a laser at the Medical Arts Center Hospital (T. 50).

13. The procedure performed on November 10, 1988 at the hospital took thirty minutes. The operative report stated that the patient had a left pars plana vitrectomy, left wound revision and left air injection (Pt. Ex. 4). The procedures billed for included vitrectomy OS, wound repair, air synechotomy and air injection, which exceeded $8,000 (Pet. Ex. 5).

14. Respondent testified that he operated on Patient A and aspirated a pocket of liquid vitreous (T. 3414). This is not the same procedure as a pars plana vitrectomy (T. 3964). A pars plana vitrectomy was not performed, although it was billed (Pet. Ex. 5).

15. Patient A thought that the procedure was suture removal for a foreign body sensation she was having (T. 50-51).

16. When Patient A asked the Respondent why the name of the procedure was different on the consent form that she had signed than what she had been told, Patient A testified that Respondent stated that the word "vitrectomy" was for the insurance company (T. 56).

17. A vitrectomy is a particularly serious procedure, in which the eye is entered behind the limbus. The procedure would take one to three hours to perform, not a few minutes (T. 1272-1274).

18. The anesthesia and nursing records from the surgery appear to have been altered,

increasing the total elapsed time of the surgery (Pet. Ex. 4, p. 11).

19. Respondent's record for Patient A contains the results of two contrast sensitivity tests, performed 11/30/88 and 12/14/88 (Pet. Ex. 3).

20. Patient A's record also contained the tests results of two fluorescein angiograms over a six month period. The tests results from 11/14/88 did not have a name on the photograph. The tests results from 5/11/89 had Patient A's name digitally imprinted on the photograph contained in Pet. Ex. 3, but this test is not contained in Pet. Ex. 52 or 53 (Pet. Exs. 3, 52, 53).

21. Patient A did not have a fluorescein angiogram on either of these two occasions. She testified that she was never injected with any dye, nor did she ingest any dye, and she never noticed any change in the color of her urine. (T. 46; 176; 287; 1009; Pet. Ex. 3).

22. Bills for this procedure were submitted to GHI, Patient A's insurance company (Pet. Ex. 5).

23. Patient A's record contains the results of eight B-scans performed between August 30, 1988 and June 16, 1989. All of these were performed without the use of gel, and the quality of the test results is poor (T. 1581). There is no documentation in the chart to explain repeated B-scans, nor what the tests demonstrated (Pet. Ex. 3).

24. The anterior segment structures of the eye are difficult to envision with a contact B-scan (T. 1580). No anterior segment details were visualized in any of the repeated B-scans of Patient A (T. 1581).

25. The area of vitreous and posterior segments seen on the B-scans could have been visualized through a normal exam (T. 1582). There was no indication in the record that Respondent was unable to visualize the posterior segment (T. 1582).

26. There were two insurance bills submitted to GHI on behalf of Patient A within ten days of each other for comprehensive vitreal retinal exams and B-scans performed on the same day. This is redundant billing, because if the vitreous and retina were fully examined there was no need for a B-scan (Pet. Exs. 3, 5).

27. There are three versions of Patient A's chart in evidence. Pet. Ex. 3 is the chart that

was supplied to OPMC by the Respondent. Pet. Ex. 52 is a copy which was given to Patient A by the Respondent and which she then gave to her subsequent treating physician, and Pet. Ex. 53 is an abridged version of Pet. Ex. 52, which was sent to another physician directly by the Respondent. There are many discrepancies between Pet. Ex. 3 and Pet. Exs. 52 and 53. For example, Pet. Exs. 52 and 53 include copies of what appear to be post-it notes indicating multiple diagnoses for this patient, which are reflected on the bills submitted for Patient A, (Pet. Ex. 5) while these are absent from Pet. Ex. 3. Another example of a difference is that Pet. Ex. 3 contains higher intraocular pressures than does 52 and 53.

CONCLUSIONS OF LAW AS TO PATIENT A

1. The Respondent inappropriately performed excessive B-scans on Patient A which were not medically indicated. The quality of the representative B-scan photos was so poor that an interpretation of the full exam should have been documented. This constituted a deviation from acceptable medical standards.

2. The Respondent practiced fraudulently in that he willfully and intentionally billed for fluorescein angiogram and surgeries he did not perform, and altered patient records to support his fraudulent billing. This deviates from acceptable medical standards.

3. The Respondent was negligent in that he failed to address the issue of the possibly glaucomatous condition of Patient A's right eye and that he knowingly maintained a false record. This deviates from acceptable medical standards.

4. The Respondent failed to maintain an accurate record for Patient A because it failed to interpret B-scans and contained fabricated test results. This deviates from acceptable medical standards.

FINDINGS OF FACT AS TO PATIENT B

1. Respondent treated Patient B in his offices at 944 Park Avenue and 345 East 37th Street, as well as at the Medical Arts Center Hospital from on or about October 5, 1987 through June 1, 1991 (Pet.'s Ex. 9).

2. Respondent found that Patient B had a pale fundus, horizontal nystagmus, strabismus and a residual esotropia. Based upon all these classic findings, Respondent, at the first visit, diagnosed Patient B as an ocular albino. This diagnosis was made prior to any electrophysiological testing of Patient B (Pet. Ex. 9).

3. Respondent performed a muscle operation on Patient B's left eye to straighten out the strabismus on February 26, 1988; however, despite his post-operative note that her left eye looked a little prominent and that he was concerned about a retrobulbar hemorrhage, he failed to record the degree of prominence. He also failed to note the intraocular pressure or the condition of the optic nerve head. Without taking these measurements, he was unable to judge whether there was a problem (Pet. Ex. 9; T. 1629-1632).

4. The chart documents three B-scans performed on Patient B between January 5, 1988 and March 1, 1988. All were performed without the use of gel, and the quality of the test results is poor. There is no documentation in the chart to explain why repeated B-scans were needed, or what these tests demonstrated (Pet. Ex. 9; T. 1633).

5. Patient B's chart contained the test results of 10 fluorescein angiograms performed between January 26, 1988 and June 1, 1991 (Pet. Ex. 9).

6. Patient B did not undergo any fluorescein angiograms at Respondent's office. Patient B testified that she never received an injection in her arm nor did her urine ever change color. She also stated that she never drank any liquid at Respondent's office (T. 325, 326; Pet. Ex. 9, p. 27, 28, 32, 33, 85, 86).

7. The record for Patient B failed to contain any indication for the performance of the 10 fluorescein angiograms (Pet. Ex. 9; T. 1638).

8. Patient B's chart contains the results of 10 visual field tests performed between January 26, 1988 and June 1, 1991 (Pet. Ex. 9).

9. Patient B described taking a visual field test. She stated that she had had one or two visual field tests, perhaps as many as three tests; however, she stated she did not have ten visual field tests (T. 322, 323; 404).

10. There was no indication in the chart to support the need for 10 visual field tests (Pet. Ex. 9; T. 1640).

11. Patient B's chart contains the results for five contrast sensitivity tests performed between November 4, 1989 and January 24, 1991 (Pet. Ex. 9).

12. Neither Respondent nor anyone in his office performed five contrast sensitivity tests on Patient B. She testified that she was never asked to look at a chart with circles of varying shades of black and gray. She remembers seeing such a chart in Respondent's office, but she was never questioned about it (T. 339, 349; 373).

13. Patient B's chart contains the results of five tonograms performed between November 3, 1989 and January 24, 1991 (Pet. Ex. 9). There was no medical indication for the performance of so many tonograms and neither Respondent nor anyone in his office performed these tests. Patient B testified that she never reclined while in Respondent's office nor did she have a weight placed on her eye for a four minute period on each eye (T. 340, 341).

14. Patient B's chart contained results of electrophysiological testing on Patient B. Patient B testified that neither Respondent nor anyone in his office ever placed electrodes on her head or eyes (T. 343; 345).

15. The Respondent testified, and Patient B's chart reflects, that he thought Patient B might have a chiasmal lesion. The patient testified that Respondent never referred her for a CAT scan (T. 344).

16. From on or about November, 1989 through January 1991, Respondent submitted bills to Aetna Insurance Company for Patient B containing the diagnosis of glaucoma. Patient B did not have glaucoma. Her chart does not document any of the three clinical signs of glaucoma:

elevated intraocular pressure, cupping of the optic discs, or visual field defects. Patient B's subsequent treating ophthalmologist never diagnosed Patient B with glaucoma because he did not find any clinical symptom of glaucoma (Pet. Exs. 9, 10, 11; T. 346, 347; 351; 366; 2682; 2684).

17. From on or about November 1989 through January, 1991, Respondent submitted bills to Aetna Insurance Company for Patient B for fluorescein angiogram, tonographies, contrast sensitivity tests and visual field tests which he knew were not performed (Pet. Ex. 11; T. 2690; 2693-2694).

18. Patient B stopped treatment with Respondent when she received the insurance bills which did not reflect the treatment she had received nor her medical condition (T. 348-350).

CONCLUSIONS OF LAW AS TO PATIENT B

1. Respondent's record for Patient B contains the results of a multitude of tests which were allegedly performed. With the exception of the B-scans and, at most, three visual field tests, none of these tests were performed. The performance of three B-scans is excessive and not medically indicated. The quality of the representative B-scans is so poor that an interpretation of the full exam should have been documented. This deviates from acceptable medical standards. Had all of the tests which are documented in the chart actually been performed, they would have also been considered excessive.

2. The Respondent practiced fraudulently in that he willfully and intentionally billed for multiple medical tests that were not performed, and altered patient records to support his fraudulent billing. He also provided diagnoses that he knew were incorrect to the insurance company. This deviates from acceptable medical standards.

3. The Respondent was negligent in that he failed to appropriately follow-up the possibility of a retrobulbar hemorrhage postoperatively, and in that he knowingly maintained a false medical record. This deviates from acceptable medical standards.

4. The Respondent failed to maintain an accurate record for Patient B because it contained fabricated test results. This deviates from acceptable medical standards.

FINDINGS OF FACT AS TO PATIENT C

1. The Respondent treated Patient C at his various medical offices from on or about April 8, 1987 through on or about April 1, 1992 (Pet. Ex. 12).

2. Patient C had recurrent bouts of blepharitis (Pet. Ex. 12, Pet. Exs. 13, 14; T. 1796; 3700).

3. Respondent's record contains the results of a gonioscopy performed on Patient C on April 8, 1987. This was performed because of a finding of an abnormal corneal endothelium, as noted in the chart (T. 3677; Pet. Ex. 12).

4. Patient C's medical record contains the results of an endothelial cell count, external photographs, and a B-scan performed on or about September 9, 1989 (Pet. Ex. 12).

5. There was no medical indication documented in the chart for the performance of any B-scans on this patient, nor was there any interpretation of the results. The patient had normal vision, normal angles and could be dilated. Direct view of the posterior pole could be obtained. No further information could be obtained from the B-scan than could be obtained from direct visualization (Pet. Ex. 12; T. 1800, 1803; 1959; 1961).

6. Patient C visited the Respondent's office on March 21, 1992, complaining of red, irritated eyes. The chart contains a finding that his intraocular pressure was 20-22, and fundus photographs were taken (Pet. Ex. 12; T. 1801, 1802; 1941).

7. During the patients's 1987 visit, there had been no testing (other than direct observation) to evaluate the patient's macula (T. 1941). There were no documented changes in the patient's condition in 1992 to indicate the need for the testing noted in the chart at that time: B-scan, Farnsworth 100 hue test, endothelial cell counts, tonography, visual field test, three angiograms, an electroretinogram, an electrooculogram and a visually evoked potential test (Pet.

Ex. 12; T. 1941).

8. A Farnsworth Color Test determines whether or not a patient is color blind; if s/he is, the test determines the nature of the color blindness. Patient C never complained of having difficulty differentiating colors. There was no indication in the chart as to why the test was performed (Pet. Ex. 12; T. 436; 1803, 1804).

9. Patient C denies having a Farnsworth Color Blindness Test (T. 436).

10. Patient C testified that he never had a tonography. He never reclined and had an instrument placed directly on his cornea and left there for four minutes (T. 439, 440).

11. There was no medical indication documented for the performance of tonography on this patient (Pet. Ex. 12; T. 1805).

12. The record contains the results of two angiogram, one on March 25, 1992 and on April 1, 1992, just one week later (Pet. Ex. 12; T. 1819, 1820).

13. Patient C testified that he never had a fluorescein angiogram performed in the Respondent's office. Patient C was never injected with any fluorescein, or asked to ingest any liquid, nor did his urine change colors after seeing Respondent (T. 436, 437).

14. There was no documentation in Patient C's medical record to indicate the reason for the performance of extensive electrophysiologic testing on Patient C on March 25, 1992 (Pet. Ex. 12; T. 1809, 1810; 1812; 1815-1819).

15. Electrophysiologic testing is done by placing electrodes over the scalp and occipital area. The patient denies having electrodes placed anywhere on his head or face (T. 440, 442; 1818).

16. The record contains the results of a screening visual field test, which was upcoded for billing purposes to an extended visual field test (Pet Ex. 12).

17. Between March 21 and March 31, 1992, the Respondent intentionally submitted bills for these tests to the Traveler's Insurance Company, totalling $3,255, which contained the diagnoses of glaucoma, optic nerve atrophy, pigmentary retinal dystrohy, dacryocystitis or uveitis, and nasolacrimal duct obstruction, acquired. Nothing in the patient's chart supports any

of these diagnoses; the Respondent admitted that the patient did not have pigmentary degeneration or uveitis; and none of Patient C's subsequent treating physicians found evidence of these disorders (Pet. Exs. 12, 13, 14; T. 446, 447; 1820, 1821; 3688).

18. The Respondent submitted a bill to Patient C's insurer for two retrobulbar injections to Patient C. There is no documentation in the record that any retrobulbar injection was either indicated or given to the patient. A lid injection of garamycin was noted (Pet. Ex. 12; T. 1824-1825; 3704, 3708, 3710).

19. Patient C denies that he ever had his eyelids injected or received an injection under his eye while under the care of Respondent. Rather, he stated that he went to Respondent's office several mornings to have his eyes washed with hot compresses for his blepharitis (T. 438; 527, 536).

20. Patient C stopped going to Respondent when he received the explanation of benefits from the insurance company (T. 447, 448).

CONCLUSIONS OF LAW AS TO PATIENT C

1. The Respondent documented and billed an inappropriate and excessive amount of tests on Patient C which were not medically indicated. Most of these tests were never performed, but had they been, they would have been considered excessive. This constituted a deviation from acceptable medical standards.

2. The Respondent practiced fraudulently in that he willfully and intentionally billed for tests and procedures he did not perform, and altered patient records to support his fraudulent billing. This deviates from acceptable medical standards.

3. The Respondent did not practice negligently with respect to the care he rendered Patient C, but he was negligent in that he knowingly maintained a false record. This deviates from acceptable medical standards.

4. The Respondent failed to maintain an accurate record for Patient C because it contained fabricated test results. This deviates from acceptable medical standards.

FINDINGS OF FACT AS TO PATIENT D

1. The Respondent treated Patient D at his Park Avenue office from on or about February 9, 1989 through March 30, 1989 (Pet. Ex. 16).

2. On or about February 9, 1989, Patient D went to Respondent's office for a second opinion concerning cataract surgery (T. 2327, 2328). The patient's chart documents a slightly elevated intraocular pressure and a previous history of eye drops for glaucoma (Pet. Ex. 16).

3. The chart contains the results of fluorescein angiogram for February 9, 14, and 16, 1989. The patient testified that no one ever injected his arm, nor did he ingest any liquid during his visits to Respondent, and his urine never changed colors afterwards (T. 2330-2334).

4. The Respondent submitted bills to Aetna Insurance Company for three angiograms (Pet. Ex. 17).

5. The chart contains documentation of contrast sensitivity testing performed on February 9, 1989. Patient D testified that he never looked at a chart containing circles of various shades of gray or black (T. 2331).

6. Patient D's record documents the performance of argon laser trabeculoplasty (ALT) performed on the patient's right eye on February 14, 1989, upper 180 degrees with 30 spots, and a second right ALT on February 18, 1989, lower 180 degrees with 30 spots; and a left ALT on February 16, 1989, upper 180 degrees with 30 spots (Pet. Ex. 16, p. 15, 17, 21), and bills were submitted to Aetna for these laser surgeries (Pet. Ex. 17).

7. Respondent testified that his technique of treating glaucoma with multiple small diode laser treatments was established on Patient D (T. 3726). However this is not consistent with the documented record of Patient D (Pet. Ex. 16).

8. Patient D stated that the Respondent never discussed performing laser surgery to lower his intraocular pressure. There is a signed consent form in the record. Patient D stated that he signed that after drops had been put in eyes and his eyes were so dilated that he could barely see in front of him, and that anything that he could see was purple. Patient D testified that Respondent put a piece of paper in front of him, and said it was an insurance form that he forgot to sign (T. 2337-2339; 2341, 2342, 2343, 2357).

9. An ALT is performed by first placing a contact lens on the patients's eye (T. 3925) followed by the laser treatment, which the patient perceives as bright flashes of light. It is done for the purpose of lowering intraocular pressure (T. 1993).

10. The usual medical practice is to perform a second ALT, if necessary, at a minimum period of one month after the first. Four days would be too short a time period to determine if a supplemental ALT was needed, especially if there was decrease in the patient's intraocular pressure as this record purports (Pet. Ex. 16; T. 1996; 2057; 2069).

11. The patient testified that he never had any laser treatment (T. 2401).

12. Patient D's record for the period of February 9, 1989 through march 30, 1989 contains the results of the following tests: a visually evoked potential, two B-scans, three visual field tests, an electroretinogram, three fluorescein angiograms, and three tonographies and a subconjunctival injection (Pet. Ex. 16).

13. The patient testified that he underwent two visual field tests and two tonograms while under the care of the Respondent. He denies having B-scans, fluorescein angiograms and a subjuncontival injection (T. 2343-2451).

14. Respondent submitted a bill to the patient's insurer for 25 tests he claimed to have performed on Patient D, totalling $14,190. Of these, few were actually performed (Pet. Exs. 16, 17).

15. There was no medical indication documented for performing B-scans (T. 2028), electrophysiological testing (T. 1997-2000), repeated tonograms or visual field tests or angiograms on this patient (Pet. Ex. 16).

16. Patient D stopped seeing Respondent when he received an explanation of benefits from his insurance company. Patient D realized that these tests and laser surgeries had not been performed upon him. He thought that maybe he had received someone else's bills. Patient D called Respondent's office to inform him of the mix-up. Respondent told Patient D that he did receive the tests and the procedures. Patient D then contacted his insurance company and wrote a letter explaining which tests and procedures had been performed and which had not (T. 2350-2351; Pet. Ex. 17).

CONCLUSIONS OF LAW AS TO PATIENT D

1. The Respondent documented and billed an inappropriate and excessive amount of tests on Patient D which were not medically indicated, with the exception of performing a single visual field test and tonogram. Most of these tests were never performed, but had they been, they would have been considered excessive. This constituted a deviation from acceptable medical standards.

2. The Respondent practiced fraudulently in that he willfully and intentionally billed for tests and procedures he did not perform, and altered patient records to support his fraudulent billing. This deviates from acceptable medical standards.

3. The Respondent did not practice negligently with respect to the care he rendered Patient D, but he was negligent in that he knowingly maintained a false record. This deviates from acceptable medical standards.

4. The Respondent failed to maintain an accurate record for Patient D because it contained fabricated test results. This deviates from acceptable medical standards.

FINDINGS OF FACT AS TO PATIENT E

1. Respondent treated Patient E at his 37th Street office from on or about July, 1990 through April 1992 (Pet. Ex. 20).

2. Patient E testified that she saw the Respondent in 1990 because she had an abnormal visual field and had a history of retinal tears and macular wrinkling (T. 556, 557).

3. Respondent was unable to produce his medical record for this patient. He testified and submitted documentary evidence that a fire in his office on October 12, 1993 had destroyed some of his medical records (Resp. Ex. CC). There was a medical record produced from a subsequent treating physician (Pet. Ex. 19).

4. During the time Patient E was under his care, the Respondent billed Medicare for laser treatment of Patient E's retinal lesion (9/91); for a fistulization of sclera for glaucoma, a vitrectomy and intraocular injection (11/91); laser surgery (3/92); and blood tests (4/92) (Pet. Exs. 20, 21).

5. Patient E testified that the only examination or treatment that Respondent rendered to her was in his office. He first looked into her eyes with a hand-held instrument then took some sort of instrument that looked like a fat fountain pen, not attached to anything else, told Patient E to look down, then applied this instrument to her closed eye for one or two seconds. When Respondent touched Patient E with the "fountain pen" instrument, neither her head or her chin were resting on any instrument or support. Patient E never heard any clicking sounds at Respondent's office. Respondent never told Patient E what he was doing (T. 562-564).

6. Patient E stated that she had had laser treatment prior to her treatment at Respondent's office. At the other physician's office, Patient E had placed her chin on a chin rest, she heard clicking sounds and the treatment took between five and ten minutes, not one or two seconds (T. 565).

7. Blood was drawn from Patient E during the insertion of an IV for a fluorescein angiogram (T. 571; 1034).

8. A vitrectomy, or a fistulization of sclera for glaucoma are major ocular procedures which could only be performed under sterile conditions in an operating room. Patient E testified that she never had surgery performed by Respondent in an operating room, nor did Respondent ever tell Patient E that he was going to perform a vitrectomy on her (T. 571).

9. Patient E stopped going to Respondent when she received the explanation of benefits from Medicare. She stated that she realized that he had been billing for services never rendered (T. 568, 569).

CONCLUSIONS OF LAW AS TO PATIENT E

1. The Respondent practiced fraudulently in that he willfully and intentionally billed for laser surgeries and procedures (the fistulization of sclera and vitrectomy and intraocular injection) that he did not perform, based on the clear testimony of the patient. This deviates from acceptable medical practice.

2. The Respondent was unable to produce a record for this patient, and therefore no conclusion can be reached regarding its accuracy and the charge can not be sustained.

FINDINGS OF FACT AS TO PATIENT F

1. Respondent treated Patient F at his 37th Street office from on or about October 2, 1992 through on or about October 29, 1992 (Pet. Ex. 22).

2. Patient F went to Respondent with complaints regarding her distance vision and burning eyes. The chart contains the result of a B-scan performed on the first visit, but nothing in the record indicated a need for a B-scan, nor did the record contain Respondent's interpretation of the B-scan (Pet. Ex. 22, T. 2076, 2077).

3. Respondent's record contains documentation of tonography performed on Patient F on October 2, 1992 (Pet. Ex. 22).

4. The patient testified that she never had a tonogram. She never reclined in a chair or on a table and had an instrument placed on each of her eyes for a period of four minutes for each eye (T. 621).

5. The record contains the results of fluorescein angiograms dated October 2 and 22, 1992. The patient testified that she never was injected with any dye nor did she ingest dye (T. 622; 666).

6. The record for Patient F failed to document any medical indication for the performance of fluorescein angiograms on Patient F. Medicare was billed for the performance of these tests (Pet. Exs. 22, 23, 24).

7. Patient F's medical record contains the results of two visual field tests, taken just 12 days apart. There was no documented medical indication for the repeat of this test (Pet. Ex. 22; T. 2085).

8. Respondent performed gonioscopy on Patient F twice in 12 days. There is nothing in her medical record to indicate, for example, that the angle structures or patient's history changed, which would necessitate a second test (Pet. Ex. 22; T. 2085).

9. Respondent's record for Patient F failed to sustain the diagnosis of chronic angle closure glaucoma (Pet. Ex. 22; T. 2089-2092).

10. Respondent's record indicated that he performed laser trabeculoplasty, although Respondent testified the procedure was iridoplasty (T. 3798; 3806), on Patient F's left eye on October 22, 1992 and on her right eye on October 29th; however, the record does not document any provision of appropriate post-operative care; the Respondent did not see the patient the day after either of the surgeries or place the patient on steroid drops (Pet. Ex. 22; T. 2088, 2089). The Respondent submitted a bill for trabeculoplasties (Pet. Ex. 23).

11. Patient F testified that the Respondent never performed laser treatment on her. She stated that on two occasions while in Respondent's private office, he came from behind his desk to Patient F and told her to close her eyes. Patient F, at that time, was seated in a regular chair; her chin was not on a chin rest. Respondent then lightly touched Patient F's eyelids. When she

asked what he had just done, Respondent told her that he had just given her a laser treatment to relax her eye muscles. Patient F never saw flashes of lights or heard clicking sounds. The Respondent never explained to Patient F why he was using laser treatment. Respondent asked Patient F to sign a form which she did without reading it (T. 626, 630, 631, 633, 641).

12. Patient F testified that she terminated treatment with Respondent when she saw her insurance forms, and realized that Respondent was billing for services not rendered (Pet. Ex. 24; T. 632).

13. Patient F does not suffer from glaucoma. Her prior treating and subsequent treating physician found that she had normal pressure, normal angles and normal optic nerves (Pet. Ex. 25; T. 2093, 2094).

CONCLUSIONS OF LAW AS TO PATIENT F

1. The Respondent documented and billed an inappropriate and excessive amount of tests on Patient F which were not medically indicated. Many of these tests, including angiography and tonography, were never performed, but had they been, they would have been considered excessive. This constituted a deviation from acceptable medical standards.

2. The Respondent practiced fraudulently in that he willfully and intentionally billed for tests and procedures he did not perform, and altered patient records to support his fraudulent billing. This deviates from acceptable medical standards.

3. The Respondent did not practice negligently with respect to the care he rendered to patient F in not addressing her alleged glaucoma or providing post-operative care, because this patient did not have glaucoma or any laser surgery. However, he was negligent in that he knowingly maintained a false record. This deviates from acceptable medical standards.

4. The Respondent failed to maintain an accurate record for Patient F because it contained fabricated test results and surgeries. This deviates from acceptable medical standards.

FINDINGS OF FACT AS TO PATIENT G

1. Respondent treated Patient G at his 37th Street office from on or about June 11, 1992 through June 22, 1992 (Pet. Ex. 26).

2. Patient G did not testify in these proceedings.

3. The record indicates that the patient visited the Respondent because of a left blood shot eye and blurry vision. The record indicates Respondent's concern over a possible branch vein occlusion (Pet. Ex. 26).

4. The medical record for Patient G contains the results of blood tests dated June 15, 1992 (Pet. Ex. 26).

5. Respondent's record for Patient G contains the results of three fluorescein angiograms performed on June 12, 15 and 22, 1992, just ten days apart, but four tests, dated June 11, 12, 15 an 22, were billed to Medicare (Pet.'s Exs. 26, 27, 28).

6. If the Respondent suspected that Patient G had a branch vein occlusion, one angiogram was indicated (T. 2125) but there was no reason to repeat the test (T. 2126).

7. Patient G did not have a branch vein occlusion (T. 4065). The fluorescein angiogram in the Respondent's record failed to support a finding of an occlusion (Pet. Ex. 26).

8. Patient G reported to the subsequent treating physician that Respondent had performed a laser treatment for subconjunctival hemorrhage. Laser is not the appropriate treatment for subconjunctival hemorrhage (T. 2897).

9. Respondent testified that the laser surgery he performed on Patient G was an iridoplasty, not a trabeculoplasty (T. 4056).

10. Medicare was billed on June 22, 1992 for two laser trabeculoplasties (Pet. Ex. 28).

11. Respondent intentionally submitted the following diagnoses to Medicare for Patient G: diabetic retinopathy, glaucoma nos, optic nerve atrophy nos. The chart does not support these diagnoses (Pet. Ex. 27).

12. Patient G's subsequent treating physician testified that the patient does not suffer

from glaucoma or diabetic retinopathy (T. 2898; 2917-2919; 2130).

CONCLUSIONS OF LAW AS TO PATIENT G

1. The Respondent documented three and billed for four angiogram for Patient G. Since the patient did not testify, the panel was unable to determine if the tests were performed. At most, however, only one test was indicated, and the rest must be considered excessive and therefore a deviation from acceptable medical standards.

2. The Respondent practiced fraudulently in that he willfully and intentionally billed for laser trabeculoplasty he did not perform. This deviates from acceptable medical standards.

3. The Hearing Committee was unable to determine whether the record was accurate.

FINDINGS OF FACT AS TO PATIENT H

1. The Respondent treated Patient H from on or about March 8, 1993 through on or about March 17, 1993 at his 37th Street office (Pet. Exs. 30, 31).

2. The Respondent was unable to provide a record for Patient H; however, Respondent testified that he sent Patient H's nephew, a physician, a copy of the chart which Petitioner obtained during the course of the hearing (T. 4104; Pet. Ex. 68).

3. From a review of Respondent's records for Patient H, the patient's main complaint concerned a foreign body sensation in her right eye. Respondent's records focused on the patient's visual acuity; there were no notes concerning any disease process (Pet. Ex. 68).

4. The Respondent intentionally submitted a bill to Medicare for argon laser trabeculoplasty of Patient H's left eye on or about March 8, 1993 (Pet. Ex. 31). No intraocular pressure was noted in the record for that date, but the pressure taken previously had been low normal. There is no description of the spot size, the length of time or the strength of the laser used. Finally, there is no follow-up at the next visit to indicate that laser surgery had been

performed two days earlier (Pet. Ex. 68).

5. Patient H's subsequent treating ophthalmologist, Dr. Bergen testified that he examined Patient H, an 86 year old woman who was oriented with a decent memory, on April 27, 1993. Dr. Bergen found that she had cataracts, right worse than left, and some macular degeneration. The patient did not have glaucoma or diabetes; therefore, there was no reason to perform the laser trabeculoplasty billed for on March 8, 1993 (Pet. Exs. 30, 31; T. 689-692, 695, 831).

6. The Respondent also submitted a bill to Medicare for pan-retinal photocoagulation on Patient H's right eye on or about March 10, 1993 (Pet. Ex. 31). Respondent testified that he did not perform this procedure (T. 4112).

7. Dr. Bergen testified that it was not performed. This is an extensive laser treatment performed throughout the entire retina, which can easily be visualized upon examination. Dr. Bergen did not observe extensive laser scarring (T. 694-695).

8. The Respondent intentionally submitted a bill to Medicare for stripping Patient H's retinal membrane and repair of Patient H's detached retina on March 17, 1993, procedures which he knew he did not perform (T. 710; Pet.'s Ex. 31).

9. Respondent's testimony concerning his treatment of Patient H's eye was not credible. He testified that the patient had developed a serous detachment of the right macula (T. 4081).

10. Patient H was never in an operating room while under the care of Respondent (T. 701; 4015).

11. Respondent testified that the repair of a retinal detachment requires penetration of the ciliary body (T. 4113). There was no evidence that the ciliary body had been penetrated. There is no operative report in his record for Patient H indicating that he either stripped her retinal membrane or repaired her detached retina. In fact, there was nothing in Respondent's record to indicate that she had any symptoms of a detached retina, nor does the cover letter transmitting her record to her physician nephew mention this serious condition (Pet. Ex. 68).

12. In order to strip the retinal membrane a physician must first perform a vitrectomy, then with special picks and scissors remove the scar tissue from the center of the retina or

macula. This operation must be performed in an operating room under sterile conditions with gowns, masks, caps, and an operating microscope (T. 701).

13. Dr. Bergen testified that Patient H's vitreous was intact. It could not be intact if Respondent stripped the retinal membrane (T. 703, 706, 707, 719, 726, 727; 735).

14. A repair of a detached retina via scleral buckling is done when the retina is detached and instead of being up against the back of the eye is separated from the back of the eye. Most detachments are caused by tears in the retina; therefore, a scleral buckling usually consists of three parts. The first is to put a piece of plastic around the eye to support the retina. The second part is to freeze the retinal tear which forms a scar. The third part is to drain fluid from the retina so it resumes its proper position. Respondent billed for repair of a detached retina via scleral buckling. This procedure was never done (Pet. Exs. 30, 31, 68; T. 704-5).

CONCLUSIONS OF LAW AS TO PATIENT H

1. The Respondent practiced fraudulently in that he willfully and intentionally billed for surgeries he did not perform. This deviates from acceptable medical standards.

2. The Respondent did maintain an accurate record for Patient H.

FINDINGS OF FACT AS TO PATIENT I

1. The Respondent treated Patient I from on or about February 6, 1986 through on or about April 28, 1986 at his Park Avenue office and at the Medical Arts Center Hospital (Pet. Exs. 33, 34).

2. Patient I had had corneal transplants performed in 1965 and 1966 due to Fuch's dystrophy (T. 2155).

3. A patient complaint of progressive vision loss is noted in the history section of Respondent's operative report (T. 2261; Pet. Ex. 34).

4. Dr. Barasch testified that the patient had a cataract prior to 1986 and that he had discussed with her that surgery should wait until she had more visual problems. Thus, the patient was aware of the indications for surgery (T. 2729).

5. The Respondent performed a intracapsular cataract extraction with a posteriorly placed incision and inserted an anterior chamber intraocular lens on Patient I on February 27, 1986. The operative report indicates a pars plana vitrectomy was elected at that time (Pet. Ex. 33).

6. A physician in the "learning curve" of a new procedure has increased complications (T. 2262). Although Dr. Orloff testified that he had never seen a cataract extraction done with capsule forceps (T. 2225), this is an accepted procedure, which in the hands of a skilled surgeon, subjects the patients to less risk than if the same surgeon was in the "learning curve" of a new technique.

7. The Respondent testified that he aspirated liquid vitreous through the pars plana (T. 4151).

8. Patient I sustained a post-operative complication of a giant retinal tear and funnel detachment which could not be repaired (T. 2219).

CONCLUSIONS OF LAW AS TO PATIENT I

None of the charges regarding Patient I were sustained.

FINDINGS OF FACT AS TO PATIENT J

1. The Respondent treated Patient J from on or about June 24, 1986 through on or about June 27, 1988 at his Park Avenue office and at the Medical Arts Center Hospital (Pet. Ex. 36).

2. The Respondent performed a left intracapsular cataract extraction on Patient J on August 4, 1986 (Pet. Ex. 36).

3. Post-operatively, the patient developed cystoid macula edema (T. 1088; Pet. Exs. 36, 37).

4. The Respondent repeatedly performed Goldman visual field tests on Patient J to follow the cystoid macular edema, and the results of these tests were included in the patient's chart (Pet. Ex. 36; T. 4272).

CONCLUSIONS OF LAW AS TO PATIENT J

No charges were sustained as to Patient J.

FINDINGS OF FACT AS TO PATIENT K

1. The Respondent treated Patient K from on or about March 12, 1985 through on or about March 10, 1987 at his Park Avenue office and at the Medical Arts Center Hospital (Pet. Ex. 38).

2. On June 2, 1986 Respondent performed a left intracapsular extraction with an anterior chamber intraocular lens implant and multiple left peripheral iridotomies (Pet. Ex. 38).

3. The patient's chart indicates a drop in the vision of the left eye and the notation "cataract" (T. 4185).

4. The Respondent did not see any reason to test the intraocular pressure at the four post-op visits in the 8 days following the cataract surgery in the left eye (T. 4188).

5. On or about September 15, 1986 the Respondent performed a refractive surgical procedure on Patient K's right eye. The procedure indicated in the operative report was "right wedge resection and relaxing incisions of right cornea" (Pet. Ex. 38; T. 2481).

6. A wedge resection was not performed and a single relaxing incision was done at the flattest meridian (T. 2482).

7. Relaxing incisions to correct astigmatism are performed across the steepest meridian (T. 2440; 3936).

8. During the relaxing procedure, the operative report indicates a vitrectomy was performed. A paracentesis would be the preferred procedure to soften an eye (Pet. Ex. 39; T. 2484).

9. Post-operatively, the patient's chart indicates that the cornea looked "awful" and Decadron drops were prescribed (Pet. Ex. 38).

10. The record for Patient K indicated that seven B-scans were performed over a six month period. There was no indication in the chart to justify the repeated B-scans, but the Respondent testified that they were necessary to check the posterior of the eye since the patient was difficult to examine with indirect ophthalmoscopy (T. 4208). The patient's subsequent treating physician had no difficulty examining the patient this way (T. 2873).

11. There was no indication in the record of any interpretation of the B-scans (Pet. Ex. 38).

12. The diagnosis of a vitreous hemorrhage was used by Respondent for billing purpose on June 28, 1986, although Respondent testified that he had no idea if Patient K had a vitreous hemorrhage (T. 2873; Pet. Ex. 38).

13. The Respondent appropriately removed a cystic bleb from the left eye of Patient K on or about January 5, 1987 (Pet. Ex. 38).

CONCLUSIONS OF LAW AS TO PATIENT K

1. The Respondent documented and billed an inappropriate and excessive amount of B-scans on Patient K which were not medically indicated, nor interpreted in the record. This constituted a deviation from acceptable medical standards.

2. The Respondent practiced fraudulently in that he willfully and intentionally billed for diagnoses that he knew were false. This deviates from acceptable medical standards.

3. The Respondent practiced negligently with respect to the care he rendered to Patient K because the relaxing procedure described by the Respondent was improperly performed. This deviates from acceptable medical standards.

4. The Respondent failed to maintain an accurate record for Patient K because it contained fabricated diagnoses and inaccurate reports of surgery. This deviates from acceptable medical standards.

FINDINGS OF FACT AS TO PATIENT L

1. Respondent treated Patient L from on or about April 8, 1986 through on or about December 17, 1986 at his Park Avenue office and at the medical Arts Center Hospital (Pet. Ex. 42, 43).

2. Patient L went to Respondent in April, 1986, for an opinion regarding the status of his chronic open angle glaucoma. Patient L's left optic nerve had very advanced atrophy and the vision in that eye was very poor. The patient was on maximal medical therapy (T. 2492, 2493).

3. The patient had been followed by Respondent thirty years earlier and had increased pressure in the left eye from an old vascular occlusion (T. 4217, 4218).

4. There was neovascularization of the iris sphincter and angle and treatment was directed at the vessels, not the eye pressure (T. 4229).

5. Respondent's record indicated argon laser trabeculoplasty was performed on Patient L's left eye on or about April 23, 1986 (Pet. Ex. 42).

6. Respondent's record for Patient L contained a B-scan dated June 17, 1986. There was no medical indication in the chart for performing this test, nor any interpretation of the results in the record (Pet. Ex. 42).

7. On or about June 17, 1986, Respondent noted in Patient L's record that his intraocular pressure was 21. The record notes that a cyclocryo procedure was performed on that date (Pet. Ex. 42).

8. Cyclocryo-destructive surgery is a freezing technique to destroy part of the ciliary body and control fluid production (T. 2499). This is not an exact technique or procedure (T. 4225).

9. On or about December 5, 1986, the record indicates that Respondent performed an ultrasonic trabeculectomy with a special ultrasonic transducer on Patient L (Pet. Ex. 43). Ultrasonic treatment for glaucoma was investigational in 1986 (T. 2558) and Respondent had an engineer working for him who built the transducer under an NIH grant (T. 4232).

10. There was no indication in the record that the patient was informed of the investigational nature of this procedure (Pet. Ex. 43).

CONCLUSIONS OF LAW AS TO PATIENT L

1. The Respondent documented and billed for an inappropriate B-scan on Patient L which was not medically indicated or interpreted. This constituted a deviation from acceptable medical standards.

2. The Respondent practiced fraudulently in that he willfully and intentionally billed for an unnecessary B-scan. This constituted a deviation from acceptable medical standards.

3. The Respondent practiced negligently with respect to the care he rendered to Patient L by using an ultrasonic transducer to perform a trabeculectomy. This constituted a deviation from acceptable medical standards.

FINDINGS OF FACT AS TO PATIENT M

1. Respondent treated Patient M from on or about February 17, 1989 through January 18, 1991 at his medical offices and at the Medical Arts Center Hospital (Pet. Exs. 46, 47).

2. Patient M did not testify.

3. Patient M was a frail elderly woman (T. 2565) with aphakia and a macular hole in her

right eye, and elevated intraocular pressures bilaterally (T. 2570).

4. Her medical record contains the following test results:

a) four fluorescein angiograms within five months;

b) six tonographies performed over 23 months;

c) four contrast sensitivity tests performed over 23 months;

d) five fundus photographs taken at a separate time from the fluorescein angiogram; and

e) two B-scans (Pet. Ex. 46, 48).

5. There are no medical indications in the record for the performance of this amount of testing. In fact, on March 25, 1989 the record documents the performance of a B-scan and a fluorescein angiogram on the same day. This is contradictory, because if an angiogram can be performed, then the retina can be visualized without a B-scan (Pet. Ex. 46; T. 2576, 2577; 2622).

6. The Respondent testified that the repeated tonograms and angiograms were indicated to see the effects of medication changes (T. 4244, 4250).

7. However, there was no change in the patient's condition on August 11, 1989 or January 18, 1991 to warrant repeated contrast sensitivity tests, angiograms or tonography (T. 2578, 2580).

8. There was no medical indication in the record for the performance of five sets of fundus photographs taken at a different time than the four fluorescein angiograms (Pet. Ex. 46; T. 2575, 2576).

9. Respondent himself described Patient M as elderly and feeble. It is not credible that the tremendous amount of testing billed at each visit, according to Respondent's record, could have been done at that one sitting (Pet. Ex. 46; T. 2578-2580; 4264).

CONCLUSIONS OF LAW AS TO PATIENT M

1. The Respondent documented and billed an inappropriate and excessive amount of testing on Patient M which was not medically indicated, nor interpreted where indicated. There was considerable testimony about whether the Respondent owned angiogram equipment during the time period in question, or had loaner or demo machines in his office. However, in the absence of any patient testimony concerning the ingestion of dye, the panel is unable to conclude that angiograms were not performed. Nonetheless, the number of tests documented in the record is excessive and constituted a deviation from acceptable medical standards.

2. The Respondent practiced fraudulently in that he willfully and intentionally billed Medicare for an excessive amount of testing which he knew was not performed and fabricated results which he knew were false. This deviates from acceptable medical standards.

3. The Respondent practiced negligently with respect to the care he rendered to Patient M. This deviates from acceptable medical standards.

4. The Respondent failed to maintain an accurate record for Patient M because it contained fabricated test results. This deviates from acceptable medical standards.

CONCLUSIONS AS WITNESS CREDIBILITY

The Hearing Committee feels it is important to comment on the credibility and potential biases of the key witnesses in this proceeding which were helpful in reaching this decision.

Patient A was an articulate and credible witness, but we were aware of the possible bias in her testimony because of her own civil lawsuit against the Respondent. The record substantiated her testimony, and the version of her medical record which she provided (Pet. Ex. 52) is reflected in the bills which Respondent submitted to her insurer, whereas his own record (Pet. Ex. 3) does not document the reasons for his billing.

Patient B was a young professional woman whose testimony was completely believable, and which remained consistent even under vigorous cross-examination. She was knowledgeable about her care, accurately describing those procedures which were performed.

Although Patient C was at times belligerent and short tempered, his testimony was highly credible. Given his temperament, he surely would have remembered the lengthy time that would have been required to perform all the tests claimed to have been done by the Respondent. In particular, based upon the testimony of Dr. Flynn, a male patient would be expected to notice changes in the color of his urine after a fluorescein angiogram, which this patient denied.

Patient D was an elderly gentleman, who although he did not recognize the Respondent upon entering the hearing room, had written a contemporaneous letter to his insurance company at the time of treatment. For this reason, we felt his testimony to be reliable.

Patient E was an elderly lady with poor vision. She was able to describe procedures she had had in other physician's offices. We felt her to be credible, and unlikely to not be able to recall the procedures claimed to have been done by Respondent.

Patient F maintained a detailed contemporaneous calendar of her visits to the Respondent, and her testimony was thus highly credible.

Patient I sued the Respondent for malpractice and the Hearing Committee was aware of that bias.

Dr. Orloff, an ophthalmologist with a sub-specialty in glaucoma, was the State's expert witness. We found him to be credible and generally knowledgeable about clinical practice. He was frank in admitting that there were some areas in which he was not knowledgeable. The Committee felt that where he was unable to interpret a patient's chart, whether because of the Respondent's handwriting or unfamiliar abbreviations, he should have declined to form conclusions. When challenged on this issue, he did admit his errors.

The Committee found that Drs. Barasch and Obstbaum, former partners of the Respondent, were biased in their personal opinions about the Respondent, and therefore we placed little weight on their testimony. However in those instances where there were subsequent

treating physicians of particular patients, their medical records were regarded as reliable sources.

The Petitioner's rebuttal witness, Dr. Flynn, was a highly credible, objective and valuable witness. His testimony concerning fluorescein angiogram was thorough, informative and knowledgeable.

The Respondent's witness, Dr. Hirschman, is an ophthalmologist who has been closely associated with the Respondent for many years. The Committee felt that the credibility of his testimony altered after a break in the hearing, during which he had a meeting with Respondent's attorney.

The Respondent's witness Dr. Byron gave credible testimony but had not reviewed any of the patient's records.

The testimony of Dianne Schneiderman, the Respondent's office technician, and a relative, was totally inconsistent and not credible. On the other hand, Respondent's billing clerk, Tara Curet was much more credible.

The Hearing Committee found much of the Respondent's testimony to be obfuscatory, not credible and even self-contradictory. He claimed repeatedly that he had no understanding of billing and codes and left same to his office staff, but the Committee felt that was not credible and was contradictory to the testimony of Ms. Curet.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous)

FIRST THROUGH THIRTY-FIFTH SPECIFICATIONS:
(Ordering excessive tests or treatment)

SUSTAINED as to Paragraphs A, A.2, A.3, A.3(a), A.3.(c), A.,4, A.4(a); B, B.2, B.2(a), B.3, B.3(a), B.4, B.4(a), only as to repeated testing after three, B.5, B.6, B.6(a), only as to repeated testing after the first; C, C.1, C.2, C.4, C.4(a), C.5, C.5(a), C.6; D.1, D.2, D.2(a), D.4, D.4(a), D.5, D.6, D.6(a), D.7, D.7(a) as to that part of the allegation pertaining to the performance of a visually evoked potential, B-scans, and an electroretinogram; F, F.1, F.1(a), F.3, F.3(a), F.7; G, G.1, G.1(a), as to the second test, G.2; I; J, J.2; K, K.4, K.4(a); L, L.2, L.2(a); M, M.1, M.2(a),

M.3, M.4, M.4(a), M.5, M.5(a).

NOT SUSTAINED as to Paragraphs A.2(a); B.5(a); C.1(a), C.2(a), C.2(b), C.6(a); D.1(a), D.7(a) as to that part of the allegation pertaining to one tonograpm and one angiogram; G.2(a); I.1; J.2(a); M.3(a).

THIRTY-SEVENTH THROUGH FORTY-SEVENTH SPECIFICATIONS:
(Practicing fraudulently)

SUSTAINED as to Paragraphs A, A.2, A.3, A.3(a), A.4, A.4(a), A.4(b), A.5, A.6; B.2, B.2(b), B.3, B.3(a), B.3(c), B.4, B.4(c), B.6, B.6(a), with the exception of the first test, B.6(c), B.7, B.8, B.9; C, C.2, C.2(c), C.4(a) with the exception of an endothelial cell count, C.4(c) with the exception of an endothelial cell count, C.5(a), C.5(c), C.6(c), C.7, C.8, C.9; D, D.1(c), D.1(d); D.2(a), D.2(c), D.2(d), D.3(a), D.3(b), D.4(a), D.4(c), D.4(d), D.5(b), D.6(a-c), D.7(a) with the exception of one tonogram and one angiogram, D.7(b) as to B-scans only , D.7(c) with the exception of the visually evoked potential, the electroretinogram and the B-scans, D.7(d), D.8; E, E.1, E.2, E.3, E.4, E.5; F, F.7; G, G.1, G.1(a), after the first test, G.2; H, H.1, H.2, H.3; I; J, J.2; K.4, K.4(a); L; L.2, L.2(a); M, M.1, M.1(a), with the exception of the first test, M.2, M.3, M.4, M.4(a), M.5, M.5(a).

NOT SUSTAINED as to Paragraphs A.2(a-c), A.3(b), A.4(c); B.2(c), B.3(b), B.4(b), B.5(a-c), B.6(b); C.2(a), C.2(c), C.4(a), C.4(b), C.5(b), C.6(a), C.6(b); D.1(b), D.2(b), D.4(b), D.7(a) as to that part of the allegation pertaining to a tonogram, and an angiogram, D.7(c) as to that part of the allegation pertaining to a visually evoked potential, electroretinogram and B-scans; G.2(a); I.1-4; J.2(a); M.2(a), M.3(a).

FORTY-NINTH THROUGH FIFTY-EIGHTH SPECIFICATIONS:
(Practicing negligently)

SUSTAINED as to Paragraphs A, A.1(b), A.1(d), A.6; B, B.1, B.9, C, C.9, D, D.6(a), D.8; F; J; K, K.1, K.2, K.7; L, L.4.

NOT SUSTAINED as to Paragraphs A.1 (a, c, g, h); C.3; F.4, F.6; I, I.1-4; J.1; K.1(a-c), K.3(a), K.5, K.6; L.1, L.3(a), L.3(b).

FIFTY-NINTH THROUGH SIXTY-EIGHTH SPECIFICATIONS:
(Failing to maintain an accurate record)

SUSTAINED as to Paragraphs A, A.4(b), A.5; B, B.2(b), B.9; C, C.5(b), C.9; D, D.8; E, E.6; F, F.1(b); G; H; K, K.4(b), K.7; M, M.5(b).

NOT SUSTAINED as to Paragraphs A.2(b), A.3(b); B.3(b), B.4(b), B.5(b), B.6(b); C.2(b), C.4(b); C.5(b); C.6(b); D.1(b), D.2(b); D.4(b); D.7(b), with the exception of B-scans; F.3(b); G.1(b); G.4, G.5; H.4; K.1(a); K.3(a); M.1(b), M.2(b), M.3(b).

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee unanimously votes to revoke the Respondent's license to practice medicine, and to impose a monetary penalty of $55,000 ($5,000 for each of the eleven sustained specifications of practicing fraudulently). This decision was reached during lengthy deliberations after the Committee had an opportunity through 24 hearing dates and the review of more than 4,700 pages of transcript to evaluate the testimony of the Respondent, expert witnesses, patients, and their subsequent treating physicians.

The Respondent was described as a research oriented physician, an educator and former department chairman. With very limited exceptions, at no times during the proceedings was his ability as a surgeon in question. Because of this, the Hearing Committee found negligence charges regarding the increased risk to the patients because of his choice of basic technique (intracapsular v., extracapsular cataract extraction) not sustained by the evidence and testimony.

The Hearing Committee wishes to comment especially that it agrees with the Respondent that glaucoma may primarily be a vascular disease. However it does not believe the purpose of the frequent angiograms allegedly performed on these patients was for anything else but reimbursement. The panel bases this conclusion on the testimony of patients; of Dr. Flynn who found structures around the optic nerve visualized with red-free photos, without dye; the testimony of Dr. Barasch, who said the Respondent was not evaluating glaucoma patients with fluorescein angiography while he was partnered with him; and the testimony of Dr. Hirschman, who was under the impression that oral fluorescein was a new procedure (T. 3905). Lastly, the patient records did not indicate the mode of administration of dye or dosages and in fact, often only pictured one eye on each visit , which would have made any alleged attention to comparative studies impossible.

The Committee was struck by the similarity of patient after patient's testimony regarding exorbitant fees for tests and procedures which they denied having. In some cases, there was billing for tests which were not even documented in the charts.

There were multiple inconsistencies between the patient records and the bills submitted in listing diagnoses, tests and procedures. The Hearing Committee finds that the Respondent failed to maintain accurate patient records because it believes that the Respondent altered patient records by fabricating test results on numerous occasions to justify insurance billing. To cite one particular example, it is totally incredible that the Respondent would have billed for serious surgery on Patient H and not documented the procedures in the patient's record nor mentioned the results in a letter he wrote afterwards to the patient's nephew, who was also a physician. The only conclusion the panel could draw based on the chart, the letter, and the patient's testimony, corroborated by Dr. Bergen, is that these procedures were not done, although they were fraudulently billed.

The gross use of upcoding of procedures was repeated over and over again: Patient A's simple suture removal was upcoded to justify submission of a bill for $8100, and the supposed vitreous aspiration in Patients A, E, and K were upcoded to pars plana vitrectomy, a far more expensive procedure.

The Hearing Committee finds the evidence too overwhelming to draw any other conclusion but that the Respondent engaged in systematic fraud: he intentionally made misrepresentations of material facts to the insurance companies, knowing that the information he provided was false, but intending to deceive the insurers, who, relying on his fabricated records, paid out substantial sums to him.

The Hearing Committee rejects the Respondent's defense to the charge of excessive testing that he performed multiple tests as a means of furthering his knowledge about the patients, and his contention that in the future his multiple test approach will be verified. The Respondent himself negates this argument that all possible tests need to be done to defend against possible malpractice claims, since he states that he is not motivated by "malpractice phobia" (T. 3202).

Given the extended practice of an egregious level of fraud by the Respondent, the Committee finds that the appropriate penalty is to revoke the Respondent's license and impose a

monetary penalty of $55,000.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT**

1. The Respondents license to practice medicine in the State of New York is hereby revoked.

2. A fine in the amount of Fifty Five Thousand ($55,000) Dollars is imposed upon the Respondent. Payment of the fine shall be made within thirty (30) days of the effective date of this **ORDER** to the New York State Department of Health, Bureau of Accounts Management, Revenue and Cash Unit, Corning Tower Building, Room 1245, Empire State Plaza, Albany, New York 12237.

3. This **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: New York, New York
April 30, 1997

SHARON KURITZKY, M.D.
Chairperson

DONALD CHERR, M.D.
SISTER MARY THERESSA MURPHY

Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes but is not limited to the imposition of interest, referral to the New York State Department of Taxation and Finance for collection and non renewal of permits or licenses (tax law 171(27); state finance law 18; CPLR 5001; executive law 32).

TO: Dianne Abeloff, Esq.
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STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
MILES A. GALIN, M.D.	:	CHARGES

----------X

MILES A. GALIN, M.D., the Respondent, was authorized to practice medicine in New York State on July 10, 1956 by the issuance of license number 077998 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from 345 East 37th Street, N.Y., N.Y. 10016.

FACTUAL ALLEGATIONS

PATIENT A

A. Intermittently from on or about August 17, 1988 through on or about August 28, 1989, Respondent treated Patient A (the identity of Patient A and the other patients' identities are contained in the attached appendix), at his 944 Park Avenue, N.Y. office and at Medical Arts Center Hospital, 57 West 57th Street, N.Y., N.Y.

1. On or about October 3, 1988, Respondent performed a combined cataract extraction with a glaucoma filtering procedure on Patient A's left eye.

   a. Respondent failed to establish and document in his record for Patient A that a cataract was the cause of her visual problem.

   b. Respondent failed to establish and document in his record for Patient A that she suffered from chronic open angle glaucoma.

   c. Respondent failed to manage the patient's alleged glaucoma medically or with laser treatment prior to proceeding directly to intraocular surgery.

   d. On or about August 3, 1988, Patient A had elevated pressure in her right eye and an had abnormal results on her visual field test on August 17, 1988,

Respondent failed to treat these abnormal findings.

e. Respondent during the course of the 10/3/88 cataract operation utilized an intracapsular cataract extraction, subjecting the patient to unnecessary ocular risks.

f. Subsequent to the 10/3/88 intracapsular extraction surgery, Respondent failed to describe in the record the anterior chamber depth or the presence or absence of a conjunctival bleb to evaluate the status of the eye one day following a filtering procedure.

g. Respondent, just eleven days post surgery, despite the risk of infection at an early post operative time prior to complete wound healing, ordered a new contact lens for Patient A and fitted her three weeks post operatively.

h. Nine days subsequent to Patient A's major intraocular procedure, Respondent in an untimely manner terminated all eye drops for Patient A.

2. Patient A's record contained the test results of contrast sensitivity tests dated 11/30/88 and 12/14/88.

a. There was no medical indication for these tests.

b. Respondent failed to document in Patient A's chart his interpretation of these tests.

c. Respondent knowingly submitted bills to GHI for these tests when he knew that he had not performed either of these tests.

3. Patient A's record contained the test results of two fluorescein angiograms over a six month period from on or about November 14, 1988 through on or about May 11, 1989.

a. There was no medical indication for the test in Patient A's record.

b. Respondent failed to document in Patient A's record his interpretation of that test.

c. Respondent did not perform any fluorescein angiograms on Patient A.

d. Respondent knowingly submitted bills to GHI for these tests when he knew that he had not performed any of the procedures.

4. Patient A's record contained the test results of B-scans or entries for B-scans on eight occasions over a 10 month period from on or about August 30, 1988 through on or about June 16, 1989.

a. There was no medical indication for these tests in Patient A's record.

b. Respondent failed to document in Patient A's record his interpretation of the tests.

c. Respondent did not perform any B-scan on Patient A.

d. Respondent knowingly submitted bills to GHI for these tests when he knew that he had not performed these tests on Patient A.

5. Respondent knowingly submitted bills to GHI for a vitrectomy os, wound repair, air synechotomy and air injection on 11/~~18~~21/88 when Respondent knew that he had not performed any of these procedures. 4/18/96 JBL

6. Respondent intentionally maintained his record for Patient A knowing that it was false.

PATIENT B

B. Intermittently, from on or about October 5, 1987, through on or about June 1, 1991, Respondent treated Patient B at each of his offices, 944 Park Avenue and 345 East 37th Street, and at the Medical Arts Center Hospital.

1. On or about February 26, 1988, Respondent performed a left medial rectus muscle ~~recision~~ recession 8/1/96 JBL on Patient B. Post-operatively Respondent was

concerned that a retrobulbar hemorrhage had occurred. Respondent failed to: measure the degree of prominence (proptosis), the intra-ocular pressure, and to describe the status of the fundus and optic nerve.

2. From on or about January 5, 1988 through on or about March 1, 1988, Patient B's chart contained the results of three B-scans.

   a. There were no medical indications in the chart for the performance of these tests.

   b. Respondent failed to record in Patient B's chart his interpretation of these B-scans.

   c. None of the B-scans were ever performed on Patient B.

3. Patient B's chart contained the test results of 10 fluorescein angiograms over a 30 month period, from on or about January 26, 1988 through on or about June 1, 1991.

a. There were no medical indications for the performance of these tests.

b. Respondent failed to record in Patient B's chart interpretations of the 10 fluorescein angiograms.

c. None of these 10 fluorescein angiograms were performed on Patient B.

4. Patient B's chart contained the tests results of 10 visual field tests for a 30-month period, from on or about January 26, 1988 through on or about June 1, 1991.

a. There were no medical indications for the performance of these tests.

b. Respondent failed to record in Patient B's chart interpretations of the 10 visual field tests.

c. These visual field tests were not performed.

5. Patient B's chart contained the test results for five contrast sensitivity tests from on or about November 4, 1989 through January 24, 1991.

   a. There were no medical indications for the performance of these contrast sensitivity tests.

   b. Respondent failed to record in Patient B's chart his interpretation for these five tests.

   c. The five contrast sensitivity tests were not performed.

6. Patient B's chart contained the test results for five tonographies from on or about November 3, 1989 through January 24, 1991.

   a. There were no medical indications for the performance of these tonographies.

   b. Respondent failed to record in Patient B's chart his interpretation of these five tests.

   c. These tonographies were not performed.

7. From in or about November 1989 through in or about January 1991, Respondent intentionally submitted bills to Aetna Insurance Company for Patient B that contained the diagnosis of glaucoma. Respondent knew or should have known that Patient B did not have glaucoma.

8. From in or about November 1989 through in or about January 1991, Respondent intentionally submitted bills to Aetna Insurance Co. for Patient B for fluorescein angiograms, tonographies, contrast sensitivity tests, and visual field test, which Respondent knew were never performed.

9. Respondent maintained a record for Patient B knowing that it contained false information.

PATIENT C

C. Intermittently from on or about April 8, 1987 through on or about April 1, 1992, Respondent treated Patient C at each of his offices.

1. On or about April 8, 1987, Respondent gonioscoped Patient C.

   a. This test was done without medical indication.

2. On or about September 9, 1989, Respondent performed a B-scan ultrasound on Patient C.

   a. There was no medical indication for this test.

   b. The test was never performed.

   c. Respondent failed to document in Patient C's record his interpretation of the test.

3. On or about March 21, 1992, Patient C presented at Respondent's office with red, irritated eyes. His vision was 20/20, intraocular pressures were borderline (20-22). Despite these clinical signs, Respondent failed to describe Patient C's optic nerves.

4. Patient C's chart for March 21, 1992 contained results of a B-Scan ultrasound, a Farnsworth

color-blindness test, an endothelial cell count, tonography, external photographs, and visual field test.

a. There were no medical indications in the chart for these tests.

b. Respondent failed to record in Patient C's chart any interpretation of the tests performed on or about March 21, 1992.

c. Respondent did not perform these tests.

5. Patient C's chart for on or about March 25, 1992, contained results of a fluorescein angiogram, an electroretinogram, an electrooculogram and a visually evoked potential.

a. There were no medical indications in the chart for these tests.

b. Respondent failed to record in Patient C's chart any interpretation of the

tests performed on or about March 25, 1992.

c. Respondent did not perform these tests on or about March 25, 1992.

6. Patient C's chart for April 1, 1992, contained results of a fluorescein angiogram.

a. There was no medical indication in the chart for this test.

b. Respondent failed to record in Patient C's chart any interpretation of this fluorescein angiogram.

c. Respondent did not perform these tests.

7. On or about 3/31/92, Respondent intentionally submitted bills to Traveler's Insurance Company for Patient C that contained the diagnoses of glaucoma, optic nerve atrophy, pigmentary retinal dystrophy, dacryocystitis, and nasolacrimal duct, acquired, knowing that Patient C did not suffer from these diseases.

8. Respondent intentionally submitted bills to Traveler's Insurance Co. for among other tests, but not limited to the following: a fluorescein angiogram on March 21, 25, 1992 and retrobulbar injections on 3/27/92 and 3/31/92. He knew that these tests were not performed.

9. Respondent maintained his record for Patient C knowing that it contained false information.

PATIENT D

D. Intermittently from on or about February 9, 1989 through on or about March 30, 1989, Respondent treated Patient D at his Park Avenue office.

1. Patient D's chart for February 9, 1989, contained results of a fluorescein angiogram and contrast sensitivity testing.

   a. There were no medical indications in the chart for these tests.

   b. Respondent failed to record in Patient D's chart any interpretation of these tests.

c. The fluorescein angiogram and contrast sensitivity testing dated February 9, 1989 were never performed.

d. Respondent submitted bills to the Aetna Insurance Co. for the fluorescein angiogram dated February 9, 1989 which he knew was not performed.

2. Patient D's chart for February 14, 1989, contained results of a fluorescein angiogram.

a. There was no medical indication in the chart for this test.

b. Respondent failed to record in Patient D's chart any interpretation of this test.

c. The fluorescein angiogram dated February 14, 1989, was not performed.

d. Respondent intentionally submitted a bill to Aetna Insurance Co. for the February 14, 1989 angiogram which he knew was not performed.

3. Patient D's chart for February 14, 1989, contained an entry that argon laser trabeculoplasty (ALT) was performed on Patient D's right eye.

   a. An ALT was not performed on Patient D's right eye on or about February 14, 1989.

   b. Respondent intentionally submitted a bill to Aetna Insurance Company for this surgery which he knew was not performed.

4. Patient D's chart for February 16, 1989, contained results of a fluorescein angiogram.

   a. There was no medical indication for this test.

   b. Respondent failed to record in Patient D's chart any interpretation of the fluorescein angiogram dated February 16, 1989.

c. A fluorescein angiogram was not performed on or about February 16, 1989.

d. Respondent intentionally submitted a bill Aetna Insurance Co. for this angiogram dated February 25, 1989 which he knew was not performed.

5. Patient D's chart for February 16, 1989, contained an entry that ALT was performed on Patient D's left eye.

~~a. This ALT was not medically indicated.~~ Withdrawn 6/27/96 JBL

b. This ALT was never performed.

6. Patient D's chart for February 18, 1989, contained an entry that ALT was again performed on Patient D's right eye.

a. An ALT just four days after a prior ALT laser was contraindicated.

b. The ALT recorded in Patient D's chart for February 18, 1989 was never performed.

c. Respondent intentionally submitted a bill to Aetna for this February 18, 1989 ALT which he knew was not performed.

7. Patient D's record for March 1, 1989 through March 30, 1989, contained results of a visually evoked potential, two B-scans, an electroretinogram, fluorescein angiogram, tonography, and subconjunctival ~~fluorescein.~~ injection 6/27/96 JBL

a. These tests and the injection were not medically indicated.

b. Respondent failed to record the interpretation of any of these tests in Patient D's record.

c. The tests, and the injection, recorded from on or about March 1, 1989, through March 30, 1989, were not performed on Patient D.

d. Respondent knowingly submitted a bill to Aetna for the fluorescein angiograms, two B scans; three visual

field tests; the electroretinogram and the subconjunctival injection. Respondent knew these tests were never administered to Patient D.

8. Respondent maintained a record for Patient D which Respondent knew contained false information.

PATIENT E

E. Intermittently from in or about July 1990 through April 1992, Respondent treated Patient E at his 37th Street office.

1. Respondent intentionally billed Medicare for a September 26, 1991, laser treatment of Patient E's retinal lesion knowing that Patient E did not have a retinal lesion nor did Respondent perform laser surgery on Patient E.

2. Respondent intentionally billed Medicare for a fistulization of sclera for glaucoma, a vitrectomy and an intraocular injection purportedly performed on Patient E on November 1, 1991, knowing that he did not

perform any surgery on Patient E on November 1, 1991.

3. Respondent intentionally billed Medicare for a March 3, 1992 laser surgery on Patient E's eye, knowing that he did not perform laser surgery on Patient E on or about March 3, 1992.

4. Respondent intentionally billed Medicare for a March 9, 1992 laser surgery on Patient E, knowing that he did not perform laser surgery on Patient E on March 9, 1992.

5. Respondent intentionally billed Medicare for drawing blood and performing four different types of blood tests on April 30, 1992, on Patient E, knowing that neither Respondent nor anyone in his office ever drew blood from Patient E.

6. Respondent does not have his medical record for Patient E.

PATIENT F

F. Intermittently from on or about October 2, 1992, through on or about October 29, 1992, Respondent treated Patient F at his 37th Street office.

1. Patient F's chart for October 2, 1992 contained results of a B-scan.

   a. This test was not medically indicated.

   b. Respondent failed to record in Patient F's record his interpretation of the October 2, 1992 B-scan.

   c. The October 2, 1992 B-scan was never performed on Patient F.

2. Respondent performed tonography upon Patient F.

   a. Respondent failed to record the interpretations of that test in the record.

3. The record contained results of a fluorescein angiogram dated October 2, 1992.

a. There was no medical indication for this test.

b. Respondent failed to record in Patient F's chart his interpretation of this test.

c. Respondent never performed this October 2, 1992 fluorescein angiogram on Patient F.

d. Respondent intentionally billed Medicare for the October 2 test, knowing that the test had not been performed.

4. Despite the clinical evidence in Patient F's chart that she suffered from chronic glaucoma, i.e., an elevated intraocular pressure, a paracentral scotomata to visual field test and optic nerve cupping, Respondent failed to prescribe any medications for Patient F's elevated intraocular pressure.

5. Respondent diagnosed Patient F as suffering from chronic angle closure glaucoma without pupillary block; however, the clinical information did not support this diagnosis.

6. Respondent failed to treat Patient F's alleged glaucoma medically prior to performing laser surgery on each of her eyes.

7. On or about October 14, 1992, 12 days after the initial gonioscopy, Respondent repeated the gonioscopy on Patient F. There was no medical indication to repeat the gonioscopy just 12 days after the previous gonioscopy.

8. On or about October 14, 1992, just 12 days after the first visual field test, the record contained results of another visual field test.

   a. This test was repeated without any medical indication.

9. On October 22, 1992, the record of Patient F contained results of visual field tests, fluorescein angiogram, and more external photographs.

   a. There was no medical indication for any of these three tests and photographs.

b. Respondent failed to document in the record his interpretations of these tests dated October 22, 1992.

c. The tests on October 22, 1992 were not performed.

d. Respondent intentionally billed Medicare for the October 2 and 22 tests, knowing that these tests had not been performed.

10. Patient F's record indicated that laser surgery was performed on Patient F's left eye on October 22, 1992.

a. Respondent did not provide timely post-operative follow up care to Patient F.

b. Respondent did not,in fact, perform laser surgery on Patient F on October 22, 1992.

c. Respondent intentionally billed Medicare for laser surgery allegedly performed on or about October 22, 1992,

when he knew that he had not performed laser surgery on that date.

11. Patient F's record indicated that laser surgery was performed on Patient F's right eye on October 29, 1992.

    a. Respondent did not provide timely post-operative follow up care to Patient F.

    b. Respondent did not, in fact, perform laser surgery on Patient F on October 29, 1992.

    c. Respondent intentionally billed Medicare for this laser surgery allegedly performed on October 29, 1992, when, as Respondent knew, he never performed this surgery upon Patient F.

12. Respondent intentionally maintained a record for Patient F knowing that it was false.

PATIENT G

G. Intermittently from on or about June 11, 1992 through on or about June 22, 1992. Respondent treated Patient G at his 37th Street office.

1. Respondent's record for Patient G contained results of a fluorescein angiogram dated June 12 and 22, 1992.

   a. There were no medical indications for the fluorescein angiograms.

   b. Respondent failed to document in the record for Patient G his interpretation of the angiogram.

   c. Respondent did not perform a fluorescein angiogram on June 12 or 22, 1992 on Patient G.

   d. Respondent intentionally billed Medicare for a fluorescein angiogram and evaluation performed on Patient G on June 12 and 22, 1992 which he knew were not performed.

2. Respondent's record for Patient G contained blood results dated June 15, 1992.

a. There was no medical indication for the blood work.

~~b. Respondent failed to document in his record for Patient G his interpretation of the blood tests.~~

Withdrawn

~~c. Respondent did not take any blood from Patient G on June 15, 1992 or any other day.~~

Withdrawn

~~d. Respondent intentionally billed Medicare for four different types of blood tests on Patient G on June 11, 1992 which he knew were not performed.~~

Withdrawn 6/27/96 JBL

3. Respondent's record for Patient G indicate that laser surgery was performed on June 22, 1992.

a. Respondent never performed laser surgery on Patient G on June 22, 1992 or any other day.

b. Respondent intentionally billed Medicare for laser surgery performed on June 22, 1992 on Patient G.

4. Respondent intentionally submitted the following diagnoses to Medicare for Patient G; diabetic retinopathy, glaucoma nos, and optic nerve atrophy nos, which were not supported by the record. Respondent knew or should have known that Patient G did not suffer from these conditions.

5. Respondent maintained a record for Patient G which he knew contained false information.

PATIENT H

H. Intermittently, from on or about March 8, 1993, through on or about March 17, 1993, Patient H was treated by Respondent at his 37th Street office.

1. Respondent intentionally submitted a bill to Medicare for laser treatment of Patient H's eye on or about March 8, 1993, knowing that he did not perform any laser treatment to Patient H's eye on or about March 8, 1993.

2. Respondent intentionally submitted a bill to Medicare for treatment of retinal lesions on Patinet H's eye on or about March 10, 1993,

knowing that he did not treat any retinal lesions on Patient H's eye.

3. Respondent intentionally submitted a bill to Medicare for stripping Patient H's retinal membrane and repair of Patient H's detached retina on or about March 17, 1993, knowing that he did not strip Patient H's retinal membrane, and that he did not repair a detached retina.

4. Respondent failed to maintain a medical record for Patient H.

PATIENT I

I. Intermittently from on or about February 6, 1986, through on or about April 28, 1986, Respondent treated Patient I at his Park Avenue office, and at Medical Arts Center Hospital.

1. On or about April 18, 1986, Respondent performed a cataract extraction on Patient I's left eye with lens implant and a pars plana vitrectomy without medical indication.

2. On or about April 18, 1986, Respondent performed an intracapsular cataract surgery which exposed Patient I to unnecessary risks.

3. On or about April 18, 1986, Respondent implanted an anterior chamber lens which exposed Patient I to unnecessary risks.

4. On or about April 18, 1986, Respondent performed a pars plana vitrectomy on Patient I without her knowledge and/or prior consent.

PATIENT J

J. Intermittently from on or about June 24, 1986 through on or about June 27, 1988, Respondent treated Patient J at his Park Avenue office and Medical Arts Center Hospital.

1. On or about August 4, 1986, Respondent performed intracapsular cataract extraction thereby exposing Patient J to unnecessary risks.

2. The record contained the results of ~~three~~ four visual field tests for each dated 6/25/86; 4/12/88 and 5/10/88.

a. There were no medical indications for these tests.

b. Respondent failed to record his interpretation of the visual field tests in Patient J's chart.

PATIENT K

K. Intermittently from on or about March 12, 1985, through on or about March 10, 1987, Respondent treated Patient K at his Park Avenue office and at Medical Arts Center Hospital.

1. On or about June 2, 1986, Respondent performed an intracapsular cataract extraction with an anterior chamber intraocular lens implant and multiple peripheral iridotomies on Patient K at Medical Arts Center Hospital.

a. Respondent failed to document in Patient K's chart any evidence of the cataract.

b. Respondent inappropriately performed an intracapsular cataract extraction, thereby exposing Patient K's only seeing eye to unnecessary risks.

c. After the June 2nd surgery, Respondent failed to record in Patient K's chart the intraocular pressure despite the fact that Patient K was in Respondent's office four times in eight days.

2. Respondent had planned to perform a relaxing procedure at 90 degrees according to his note of August 7, 1986; however, at the time of operation, he performed an incision at 180 degrees without any explanation, in the operative report or office record, for the change.

3. On or about September 15, 1986, Respondent at ~~his office~~, performed a pars plana vitrectomy on Patient K. The pars plana vitrectomy performed on September 15, 1986, was not the appropriate method to "soften an eye."

a. On or about September 18, 1986, Patient K's first post-operative visit, Respondent failed to record either Patient K's intraocular pressure or his visual acuity.

4. From on or about September 18, through March 10, 1987, a period of 6 months, Respondent had seven entries for B scans in his record for Patient K.

   a. There were no medical indications for these tests.

   b. Respondent failed to document sufficient interpretation of his tests in Patient K's record.

5. Respondent, despite noting in Patient K's record for September 27, 1986, that the cornea was "awful", failed to prescribe any topical steroid ointment and antibiotic drops.

6. On or about January 5, 1987, Respondent, at Medical Arts, did a repair of a cystic bleb of the left eye. Respondent failed to manage the patient's problem with medication prior to operating.

7. Respondent failed to maintain a record which accurately reflected his care and treatment of Patient K.

PATIENT L

L. Intermittently from on or about April 8, 1986, through on or about December 17, 1986 Respondent treated Patient L at his Park Avenue office and at Medical Arts Hospital.

1. On or about April 23, 1986, Patient L's chart indicated that Respondent, in his office, performed an argon laser trabeculoplasty on Patient L's left eye for open angle glaucoma. Respondent failed to prescribe and/or order steroid drops after the laser surgery. He also inappropriately told Patient L to discontinue the pilocarpine drops he had been taking.

2. The record for Patient L 8/1/96 JBV for on or about June 17, 1986, contained the entry "B-scan LE."

   a. There was no medical indication for a B-scan at that time.

   b. Respondent failed to document his interpretation of the B-scan in Patient L's medical chart.

3. On or about June 17, 1986, Respondent noted in Patient L's chart that Patient L's intraocular pressure was 23. Respondent performed a cyclocryo destructive procedure.

a. Respondent failed to perform a trabeculectomy prior to performing a cyclocryo destructive procedure.

b. In performing a cyclocryo destructive procedure on or about ~~June 17, 1986~~ July 14, 1986 8/1/96 JB, Respondent's technique deviated from accepted medical standards, in that Respondent placed the freezing probe incorrectly and he left the probe for an an inadequate amount of time in each of the freeze positions.

4. On or about December 5, 1986, at Medical Arts Center Hospital, Respondent performed an ultrasonic trabeculectomy with special ultrasonic transducer. This procedure deviated from accepted medical standards in that it was an experimental and unproven procedure.

PATIENT M

M. Intermittently from on or about February 17, 1989 through on or about January 18, 1991, Respondent treated Patient M in both of his offices and at Medical Arts Center Hospital.

1. Respondent's record for Patient M contained the results of 4 fluorescein angiograms performed over a five month period.

   a. There were no medical indications in the record for these angiograms.

   b. Respondent failed to document in the record his interpretations of these angiograms.

2. Respondent's record for Patient M contained the results of six tonographies over a 23-month period.

   a. There were no medical indications in the record for these six tonographies.

   b. Respondent failed to document in Patient M's record his interpretation of these tests.

3. Respondent's record for Patient M contained the results of four contrast sensitivity tests over a 23 month period.

   a. There were no medical indications in the record for these tests.

   b. Respondent failed to document in the record his interpretation of these tests.

4. Respondent's record for Patient M contained five fundus photographs taken at a separate time than the four fluorescein angiograms.

   a. There were no medical indications for these photographs.

5. Respondent's record for Patient M contained the results of two B-scans.

   a. There were no medical indications in the record for these tests.

   b. Respondent failed to document in the record his interpretations of these tests.

~~6. Respondent's records for Patient M indicate that in just 23 months, he performed three unnecessary surgical, two unnecessary cycloeryo treatments and five unnecessary laser procedures on Patient M, an elderly and feeble woman.~~

Withdrawn 8/1/96 JBL

SPECIFICATIONS OF CHARGES

FIRST THROUGH THIRTY-SIXTH SPECIFICATIONS

ORDERING EXCESSIVE TESTS OR TREATMENTS

Respondent is charged with professional misconduct by reason of ordering excessive tests and treatment not warranted by the patient within the meaning of N.Y. Educ. Law Section 6530(35) (McKinney Supp. 1994), Petitioner charges:

1. The facts in paragraphs A, A(2), A (2)(a).

2. The facts in paragraphs A, A(3), A (3)(a).

3. The facts in paragraphs A, A(4), A (4)(a).

4. The facts in paragraphs B, B(2), B (2)(a).

5. The facts in paragraphs B, B(3), B (3)(a).

6. The facts in paragraphs B, B(4), B (4)(a).

7. The facts in paragraphs B, B(5), B (5)(a).

8. The facts in paragraphs B, B(6), B (6)(a).

9. The facts in paragraphs C, C(1), C (1)(a).

10. The facts in paragraphs C, C(2), C (2)(a).

11. The facts in paragraphs C, C(4), C (4)(a).

12. The facts in paragraphs C, C(5), C (5)(a).

13. The facts in paragraphs C, C(6), C (6)(a).

14. The facts in paragraphs D, D(1), D (1)(a).

15. The facts in paragraphs D, D(2), D (2)(a).

16. The facts in paragraphs D, D(4), D (4)(a).

17. The facts in paragraphs D, D(5), ~~D (5)(a).~~ withdrawn 12/5/96

18. The facts in paragraphs D, D(6), D (6)(a).

19. The facts in paragraphs D, D(7), D (7)(a).

20. The facts in paragraphs F, F(1), F (1)(a).

21. The facts in paragraphs F, F(3), F (3)(a).

22. The facts in paragraphs F, F(7).

23. The facts in paragraphs F, F(8), F(8)(a).

24. The facts in paragraphs F, F(9), F (9)(a).

25. The facts in paragraphs G, G(1), G (1)(a).

26. The facts in paragraphs G, G(2), G (2)(a).

27. The facts in paragraphs I, I(1).

28. The facts in paragraphs J, J(2), J (2)(a).

29. The facts in paragraphs K, K(4), K (4)(a).

30. The facts in paragraphs L, L(2), L (2)(a).

31. The facts in paragraphs M, M(1), M (1)(a).

32. The facts in paragraphs M, M(2), M (2)(a).

33. The facts in paragraphs M, M(3), M (3)(a).

34. The facts in paragraphs M, M(4), M (4)(a).

35. The facts in paragraphs M, M(5), M (5)(a).

~~36. The facts in paragraphs M, M(6).~~ withdrawn 8/1/96 JBL

THIRTY-SEVENTH THROUGH FORTY-EIGHTH SPECIFICATIONS

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with professional misconduct by reason of practicing the profession of medicine fraudulently within the meaning of N.Y. Educ. Law Section 6530(2) (McKinney Supp. 1994), in that Petitioner charges:

37. The facts in paragraphs A, A (2)(a)-(c), A (3) (a)-(c), A (4)(a)-(c), A(5), A(6).

38. The facts in paragraphs B, B (2)(a)(b)(c), B (3)(a)-(c), B(4)(b)(c), B 5(a)-(c), B 6(a)-(c), B(7), B(8),B(9).

39. The facts in paragraphs C, C (2)(a)-(c), C (4)(a)-(c), C (5)(a)-(c), C 6(a)-(c), C (7), C (8), C (9).

40. The facts in paragraphs D, D (1)(a)-(d), D (2)(a)-(d), D (3)(a),(b), D (4)(a)-(d), D (5)~~(a)~~ b -(c), D 6 (a)-(c), D (7)(a)-(d), D (8).

41. The facts in paragraphs E, E (1), E (2), E (3), E (4), E (5).

42. The facts in paragraphs F, F (1)(a)-(c), F (2)(a), F (3)(a)-(d), F (5), F (7), F (8)(a), F (9)(a)-(d), F (10)(a)(b), F (11), F (12).

43. The facts in paragraphs G, G (1)(a)-(d), G (2)(a)~~-(d)~~, G (3)(a)-(b), G (4), G (5).

44. The facts in paragraphs H, H (1), H (2), H (3).

45. The facts in paragraphs J, J (2)(a),(b).

46. The facts in paragraphs K, K (4)(a),(b), K (7).

47. The facts in paragraphs L, L (2)(a),(b).

~~48. The facts in paragraphs M, M (1)(a)-(b), M (2)(a)-(b), M (3)(a)-(b), M (3)(a)-(b), M (4)(a)-(b), M 5 (a)-(b), M (6).~~ withdrawn 8/1/96 JBL

K ONLY M withdrawn 12/3/96

FORTY-NINTH THROUGH FIFTY-EIGHTH SPECIFIACTIONS

PRACTICING THE PROFESSION NEGLIGENTLY

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530(30) (McKinney Supp. 1994), in that Petitioner charges that Respondent committed two or more of the following:

49. The facts in paragraphs A, A(1)(a)-(h), A(6)

50. The facts in paragraphs B, B(1), B(9).

51. The facts in paragraphs C, C(3), C(9).

52. The facts in paragraphs D, D(6)(a), D(8).

53. The facts in paragraphs F, F(4), F(6), F (10)(a), F(12).

54. The facts in paragraphs I, I(1)- I(4).

55. The facts in paragraphs J, J(1).

56. The facts in paragraphs K, K(1)(a)-(c), K (2), K (3)(a), K (5), K (6), K (7).

57. The facts in paragraphs L, L (1), L(3)(a)-(b), L (4).

~~58. The facts in paragraphs M, M (1)(a)-(b), M (2)(a)-(b), M (3)(a)-(b), M (5)(a)-(b), M (6).~~ withdrawn 8/1/96 JBL

M ... 1-15-96

FIFTY-NINTH THROUGH SIXTY-EIGHTH SPECIFICATIONS

FAILING TO MAINTAIN AN ACCURATE RECORD

Respondent is charged with professional misconduct by reason of failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient within the meaning of N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1994), in that Petitioner charges:

59. The facts in paragraphs A, A (2)(b), A (3)(b), A (4)(b), A (5).

60. The facts in paragraphs B, B (2)(b), B (3)(b), B (4)(b), B (5)(b), B (6) (b), B(9).

61. The facts in paragraphs C, C (2)(b), C (4)(b), C (5)(b), C (6)(b), C (9).

62. The facts in paragraphs D, D (1)(b), D (2)(b), D (4)(b), D (7)(b), D (8).

63. The facts in paragraphs E, E (6).

64. The facts in paragraphs F, F (1)(b), F (2)(b), F(3)(b), F (9)(b), F (12).

65. The facts in paragraphs G, G (1)(b), ~~G (2)(b)~~, G(4), G(5).

66. The facts in paragraphs H, H (4).

67. The facts in paragraphs K, K (1)(a), K (3)(a), K(4)(b), K(7).

68. The facts in paragraphs M, M (1)(b), M (2)(b), M(3)(b), M(5)(b).

DATED: New York, New York
May 31, 1994

Chris Stern Hyman
Counsel
Bureau of Professional Medical Conduct