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

August 1, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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

Robert Larkins, D.O.
94-38 59th Avenue
Rego Park, New York 11373

Harold Solomon, Esq.
430 Sunrise Highway
Rockville Centre, New York 11570

Charles Kutner, Esq.
Pulvers, Pulvers, Thompson & Kutner
110 East 59th Street
New York, New York 10026

RE: In the Matter of Robert Larkins, D.O.

Dear Parties:

Enclosed please find the Determination and Order (No. 97-189) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

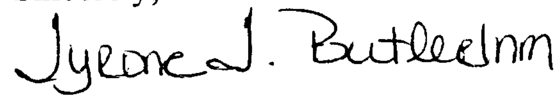
The notice of review served on the Administrative Review Board should be forwarded to:

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:nm
Enclosure

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

COPY

IN THE MATTER OF ROBERT LARKINS, D.O.	DETERMINATION AND ORDER

BPMC-97-189

JERRY WAISMAN, M.D., RALPH LEVY, D.O. and **REV. EDWARD HAYES** 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 Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **MICHAEL P. MCDERMOTT, ESQ.,** Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges:	March 14, 1997
Pre-Hearing Conference:	April 2, 1997
Hearing Dates:	April 11, 1997 May 27, 1997 June 5, 1997 July 2, 1997
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Dates of Deliberations:	July 2, 1997 July 15, 1997

Petitioner appeared by: Henry M. Greenberg, Esq.
General Counsel
NYS Department of Health
By: Dianne Abeloff, Esq.
Associate Counsel

Respondent appeared by: Harold Solomon, Esq.
430 Sunrise Highway
Rockville Centre, NY 11570
(on 4/11/97, 5/27/97, 6/5/97 and 7/2/97)
and Charles Kutner, Esq.
Pulvers, Pulvers, Thompson & Kutner
110 East 59th Street
New York, New York 10026
(on 4/11/97 only)

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with Fraudulent Practice; Ordering Excessive Tests and Treatment; Negligence on More Than One Occasion; Incompetence on More Than One Occasion; and Failure to Maintain Records.

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

WITNESSES

For the Petitioner: Jerome S. Greenholz, D.O.

For the Respondent: Freda Lozanoff, D.O.
James S. Kaufman, D.C.

FINDINGS OF FACT

Numbers in parenthesis 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 or the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS AS TO THE RESPONDENT

1. The Respondent is a physician duly licensed to practice medicine in the State of New York under license number 116624 issued by the State Education Department on July 2, 1973 (Pet's. Ex. 1)

GENERAL FINDINGS AS TO THE TESTING EMPLOYED BY THE RESPONDENT

2. **CYBEX TESTING** - Testing used to determine range of motion (Tr. 34-36, 430-431).

3. **TYMPANOGRAM TESTING** - A test used to determine damage or disease to the tympanic membrane and the middle ear (Tr. 38-39).

4. **THERMOGRAPHY** - An outdated, non specific test for measuring injury to soft tissue (Tr. 42-45).

5. **MAGNETIC RESONANCE IMAGING (MRI)** - A highly sensitive, highly specific test for defining inner structures of the body. MRI testing is very expensive (Tr. 45, 129, 331, 343-345, 399-401, 433-434, 684, 708).

6. **<u>ARTERIAL-VENOUS DOPPLER TESTING</u>** - Testing used to assess the quantity and quality of blood flow through arteries and veins (Tr. 39-40, 372-373, 454-456).

7. **<u>SONOGRAPHY</u>** - Imaging procedure using soundwaves (Tr. 48).

8. a) The Cybex testing and the Tympanogram testing were performed by the Respondent in the Respondent's office (Tr. 521).

b) The Sonography testing was performed in the Respondent's office. The testing was done by a technician working for a radiologist who rented space in the Respondent's office (Tr. 573-574, 643).

c) The Thermography testing was performed by Modern Thermographic Testing Company, Inc., a firm in which the Respondent had been a paid employee (Associate Medical Director) until he resigned on January 10, 1994 (Tr. 530-536).

d) The Magnetic Resonance Imaging (MRI) testing was performed by Magnetic Resonance Imaging of Queens, P.C., a firm in which the Respondent had no apparent financial interest (Tr. 535-539).

e) The Arterial-Venous Doppler testing was performed in the Respondent's office under his direction (Tr. 603-604, 651-653).

FINDINGS AS TO PATIENT A

9. Patient A was in an automobile accident on July 6, 1991. Immediately after the accident he went to St. Francis Hospital. X-rays were taken of the pelvis, lumbo-sacral spine, chest and cervical spine. The X-rays were said to be normal. Patient A was sent home from the hospital with a soft cervical collar, a prescription for Naprosyn and a referral to Dr. Enrico, an orthopedic surgeon (Pet's. Ex. 5; Tr. 30).

10. Patient A was seen by the Respondent on 31 occasions during the period July 9, 1991 to December 13, 1991 (Pet's. Ex. 5).

11. On the initial visit, July 9, 1991, Patient A complained of vertigo; neck, shoulder and back pain; and pain in the upper extremity and thorax (Pet's. Ex. 5; Tr. 28).

12. Based upon the Respondent's examination of Patient A on July 9, 1991, and also based on the history given by the patient, no further testing was indicated at that time (Pet's. Ex. 5, pp. 2, 118; Tr. 40).

13. The Respondent's billing records for Patient A, which are a part of Patient A's medical records, indicate that the Respondent performed Cybex testing on Patient A on July 9, 1991. There is no note of Cybex testing or the results of the Cybex testing anywhere in the Respondent's progress notes or as a separate report (Pet's. Ex. 5, p. 66; Tr. 34-36, 436, 647).

14. Cybex testing was not medically indicated on July 9, 1991, unless it was intended to be part of a serial testing to determine response to treatment. There were no further Cybex tests performed on Patient A after the initial test of July 9, 1991 to determine residual disability after treatment (Pet's. Ex. 5).

15. The Respondent's billing records for Patient A also indicate that the Respondent performed a Tympanogram test on Patient A on July 9, 1991. There is no note of the Tympanogram test or the results of the Tympanogram test anywhere in the Respondent's progress notes (Pet's. Ex. 5, p. 66).

16. A Tympanogram is not useful in diagnosing the etiology of a patient's complaints referable to headaches and dizziness unless there are signs and symptoms of damage to the tympanic membrane and middle ear (Tr. 72-73, 154).

17. There was nothing in the patient's medical record to show that Tympanogram testing was medically indicated on July 9, 1991 (Pet's. Ex. 5).

18. A Queens Hospital record on Patient A, indicates that Patient A was epileptic and was taking Dilantin and Inderal. These drugs can cause vertigo as a side effect, but the Respondent never ascertained if they were the cause of Patient A's dizziness (Pet's. Ex. 5, p. 53; Tr. 106).

19. Arterial-Venous Doppler studies were performed on Patient A on July 31, 1991 pursuant to the Respondent's order. The Respondent submitted bills for these studies to the insurance carrier on August 23, 1991.

    There is nothing in Patient A's medical record to show that such studies were medically indicated at that time (Pet's. Ex. 5, pp. 2, 44-45; Tr. 456-457).

20. Thermography testing was performed on Patient A on September 9, 1991.

There is nothing in Patient A's medial record to show that such testing was medically indicated. Also, there is no record of the Respondent's ordering the testing; the results of the testing; or how the results may have effected his treatment of Patient A (Pet's. Ex. 5, pp. 8-9, 82, 84, 86, 88-89; Tr. 43-45, 127).

21. MRI testing was performed on Patient A as follows:

7/12/91 - lumbar spine; 7/13/91 - cervical spine; 7/15/91 - right shoulder;

7/18/91 - right knee

There is nothing in Patient A's medical record to show that such testing was medically indicated at these times (Pet's. Ex. 5, pp. 14-18; Tr. 46-47, 127).

22. Sonogram testing was performed on Patient A on July 17, 1991.

There is nothing in Patient A's medical record to show that a sonogram of Patient A's pelvis, prostate gland or abdomen was medically indicated at that time (Pet's. Ex. 5, pp. 3-4, 124; Tr. 49, 121-122).

23. The Respondent ordered a drug screen on Patient A. The specimen was collected on September 5, 1991 and a report, dated September 10, 1991, indicated that Patient A had tested positive for Methadone.

The Respondent had previously referred Patient A to Dr. Andrew Schildhaus, a psychologist, for counselling. However, there is no record indicating the communication of the results of the drug screen to Dr. Schildhaus, nor is there a report from Dr. Schildhaus in the Respondent's records (Pet's. Ex. 5, pp. 8, 19; Tr. 564-565).

CONCLUSIONS AS TO PATIENT A

The Hearing Committee concludes that the Cybex, Tympanogram, Thermography, MRI, Sonogram and Arterial-Venous testing on Patient A were either not medically indicated or not performed in a timely manner.

There is no indication that any of these tests influenced the Respondent's care and treatment of Patient A.

The record indicates that Patient A was seen by the Respondent on 31 occasions during the period July 9, 1991 to December 13, 1991.

The Patient showed no signs of improvement; the Respondent did not re-evaluate the patient or make any changes in therapy; and there was no consultation with a specialist in injuries to the back.

Under the circumstances of the case, the Hearing Committee concludes that the Respondent's continued treatment of Patient A was excessive.

FINDINGS AS TO PATIENT B

24. On July 6, 1991, Patient B was in the same automobile accident as Patient A. Immediately after the accident she went to St. Francis Hospital where X-rays were taken. All of the X-rays were normal and Patient B was discharged from the hospital with a cervical collar (Pet's. Ex. 6).

25. Patient B was seen by the Respondent on 32 occasions during the period July 9, 1991 to December 13, 1991 (Pet's. Ex. 6).

26. On the initial visit, July 9, 1991, Patient B complained of headache, dizziness, pain in the neck and shoulders, difficulty turning in any direction, pain in the back radiating down the groin to both legs and swelling of both knees (Pet's. Ex. 6; Tr. 171).

27. The Respondent's billing records for Patient B, which are a part of Patient B's medical records, indicate that the Respondent performed Cybex testing on Patient B on July 9, 1991. There is no note of Cybex testing or the results of the Cybex testing anywhere in the Respondent's progress notes (Pet's. Ex. 6, p. 62; Tr. 175).

28. Cybex testing was not medically indicated on July 9, 1991, unless it was intended to be part of a serial testing to determine response to treatment. There were no further Cybex tests performed on Patient B after the initial test of July 9, 1991 to determine residual deisability after treatment (Pet's. Ex. 6, p. 62; Tr. 175).

29. The Respondent's billing records for Patient B also indicate that the Respondent performed a Tympanogram test on Patient B on July 9, 1991. There is no note of the Tympanogram test or the results of the Tympanogram test anywhere in the Respondent's progress notes (Pet's. Ex. 6, p. 62).

30. There was nothing in the patient's medical record to show that Tympanogram testing was medically indicated on July 9, 1991 (Pet's. Ex. 6; Finding of Fact 13).

31. Thermography testing was performed on Patient B on July 9, 1991.
There is nothing in Patient B's medical record to show that such testing was medically indicated. Also, there is no record of the Respondent's ordering the testing; the result of the testing; or how the results may have effected his treatment of Patient B (Pet's. Ex. 6, pp. 57-60; Tr. 177).

32. The Respondent referred Patient B to a Dr. Bajaj, who performed a range of motion studies on the patient on July 12, 1991. Patient B showed marked improvement in the neck, shoulder and low back (Pet's. Ex. 6; Tr. 174).

33. Arterial-Venous Doppler studies were performed on Patient B on July 24, 1991.
There is nothing in Patient B's medical record to show that such studies were medically indicated at that time (Pet's. Ex. 6, pp. 3, 18-25; Tr. 177-178).

34. MRI testing was performed on Patient B as follows:
7/12/91 - lumbar spine; 7/13/91 - cervical spine; 7/15/91 - right shoulder; 7/18/91 - left shoulder; 7/19/91 - right knee; 7/22/91 - left knee
The Respondent noted that the MRI for the lumbar spine and the cervical spine were normal. He made no notations concerning the shoulders or the knees.
There is nothing in Patient B's medical record to show that such testing was indicated at these times. (Pet's. Ex. 6, pp. 7, 27-34; Tr. 178-180).

35. A pelvic sonogram was performed on Patient B on July 17, 1991.
A sonogram of the abdomen was also performed on July 17, 1991.
There is nothing in the medical record to show that either the pelvic sonogram or the sonogram of the abdomen was medically indicated (Pet's. Ex. 6, pp. 3, 6-8, 26; Tr. 180-181, 196).

CONCLUSIONS AS TO PATIENT B

The Hearing Committee concludes that the Cybex, Tympanogram, Thermography, Arterial-Venous, MRI and Sonogram testing on Patient B were either not medically indicated or were not performed in a timely manner.

There is no indication that any of these tests influenced the Respondent's care and treatment of Patient B.

Two other physicians examined Patient B, and with the exception of guarding in the neck and low back area, they found her condition to be much improved within a month after the accident.

The record indicates that Patient B was seen by the Respondent on 32 occasions during the period July 9, 1991 to December 13, 1991.

Under the circumstances of this case the Hearing Committee concludes that the Respondent's continued treatment of Patient B was excessive.

FINDINGS AS TO PATIENT C

36. Patient C was in an automobile accident on April 16, 1992. He was taken to Parkway Hospital, treated and released (Pet's. Ex. 7).

37. Patient C was seen by the Respondent on 32 occasions during the period April 17, 1991 to October 2, 1991 (Pet's. Ex. 7).

38. On the initial visit, April 17, 1991, Patient C complained of severe shoulder pain, low back pain, dizziness and cephalgia (Pet's. Ex. 7; Tr. 226).

39. The Respondent performed Tympanogram testing on Patient C on April 17, 1992, but failed to document the results of the testing.

    There is nothing in Patient C's medical record to show that Tympanogram testing was medically indicated. In fact, the Respondent's examination of Patient C's ear indicated that it was within normal limits (Pet's. Ex. 7, p. 43; Tr. 227, 605).

40. MRI testing was performed on Patient C as follows:

8/11/92 - head; 8/14/92 - cervical spine; 8/25/92 - lumbar spine; 8/27/92 - right hand

The Respondent documented the results of the MRI testing in a note dated August 31, 1992 (Pet's. Ex. 7, pp. 11, 37-40).

41. A neurology consultant had recommended an MRI of the lumbar and cervical spine and an orthopedic consultant had recommended an MRI of the lumbar spine (Pet's. Ex. 7, p. 19).

42. There is nothing in Patient C's medical record to show that MRIs of the head and right hand were medically indicated (Pet's. Ex. 7).

CONCLUSIONS AS TO PATIENT C

The Hearing Committee concludes that the Tympanogram testing and the MRIs of Patient C's head and right hand were not medically indicated.

There is no indication that any of these tests influenced the Respondent's care and treatment of Patient C.

The record indicates that Patient C was seen by the Respondent on 32 occasions during the period April 17, 1992 to October 2, 1992.

Patient C did not improve; his symptoms and stated physical findings remained the same.

Under the circumstances of this case, the Hearing Committee concludes that the Respondent's continued treatment of Patient C was excessive.

FINDINGS AS TO PATIENT D

43. Patient D was in an automobile accident on April 18, 1992 (Pet's. Ex. 8).

44. Patient D was seen by the Respondent on 20 occasions during the period April 24, 1992 to January 23, 1993 (Pet's. Ex. 8).

45. On the initial visit, April 18, 1992, Patient D complained of traumatic flexion and extensor injuries. The Respondent also noted that Patient D had a painful jaw, a stiff neck and decreased sensation to her upper shoulder levels bilaterally (Pet's. Ex. 8; Tr. 249).

46. The Respondent failed to note any diagnosis for Patient D in his initial and subsequent progress notes. However, his subsequent consultation requests and billing records contained numerous diagnoses.

    The physical examination of April 21, 1992 does not substantiate a diagnosis of compression of the abdomen and pelvis, nor did the examination substantiate a diagnosis of post concussion syndrome. Also, a finding of painful jaw was not sufficient to substantiate a diagnosis of Tempomandibular Derangement (Pet's. Ex. 8, pp. 4, 15, 16, 20-21, 29; Tr. 250-255).

CONCLUSIONS AS TO PATIENT D

The record indicates that Patient D was seen by the Respondent on 20 occasions during the period April 24, 1992 to January 23, 1993. However, it should be noted that 19 of these visits occurred between April 24, 1992 to June 23, 1992, and that the last visit was on January 23, 1993, seven months later.

Under the circumstances of this case, the Hearing Committee concludes that the Respondent's treatment of Patient D was not excessive.

VOTE OF THE HEARING COMMITTEE

(All Votes Were Unanimous Unless Otherwise Indicated)

FIRST THROUGH FOURTH SPECIFICATIONS: (Fraudulent Practice)

A(1)(a)	SUSTAINED
A(1)(b)	SUSTAINED
A(1)(c)	SUSTAINED
A(1)(d)	SUSTAINED
A(3)(a)	NOT SUSTAINED
A(3)(b)	NOT SUSTAINED
A(3)(c)	NOT SUSTAINED
a(3)(d)	NOT SUSTAINED
A(3)(e)	NOT SUSTAINED
A(3)(f)	NOT SUSTAINED
A(5)	NOT SUSTAINED (2-1)
B(1)(a)	SUSTAINED
B(1)(b)	SUSTAINED
B(1)(c)	SUSTAINED
B(3)	SUSTAINED
B(4)(a)	NOT SUSTAINED
B(4)(b)	NOT SUSTAINED
B(4)(c)	NOT SUSTAINED
B(4)(d)	NOT SUSTAINED
B(4)(e)	NOT SUSTAINED
B(4)(f)	NOT SUSTAINED
B(4)(g)	NOT SUSTAINED
B(4)(h)	NOT SUSTAINED
B(5)	NOT SUSTAINED (2-1)
C(1)	SUSTAINED
C(3)(a)	NOT SUSTAINED
C(3)(b)	NOT SUSTAINED
C(3)(c)	NOT SUSTAINED
C(3)(d)	NOT SUSTAINED
C(4)	NOT SUSTAINED (2-1)
D(1)	NOT SUSTAINED
D(2)	NOT SUSTAINED

FIFTH THROUGH EIGHTH SPECIFICATIONS:

(Ordering Excessive Tests and Treatment)

A(1)(a)	SUSTAINED
A(1)(b)	SUSTAINED
A(1)(c)	SUSTAINED
A(1)(d)	SUSTAINED
A(3)(a)	SUSTAINED
A(3)(b)	SUSTAINED
A(3)(c)	SUSTAINED
A(3)(d)	SUSTAINED
A(3)(e)	SUSTAINED
A(3)(f)	SUSTAINED
A(5)	SUSTAINED

B(1)(a)	SUSTAINED
B(1)(b)	SUSTAINED
B(1)(c)	SUSTAINED
B(3)	SUSTAINED
B(4)(a)	SUSTAINED
B(4)(b)	SUSTAINED
B(4)(c)	SUSTAINED
B(4)(d)	SUSTAINED
B(4)(e)	SUSTAINED
B(4)(f)	SUSTAINED
B(4)(g)	SUSTAINED
B(4)(h)	SUSTAINED
B(5)	SUSTAINED

C(1)	SUSTAINED
C(3)(a)	SUSTAINED
C(3)(b)	NOT SUSTAINED
C(3)(c)	NOT SUSTAINED
C(3)(d)	SUSTAINED
C(4)	SUSTAINED

D(1)	NOT SUSTAINED
D(2)	NOT SUSTAINED

NINTH SPECIFICATION: **(Negligence on More Than One Occasion)**

A(1)(a)	NOT SUSTAINED
A(1)(b)	NOT SUSTAINED
A(1)(c)	NOT SUSTAINED
A(1)(d)	NOT SUSTAINED
A(2)	NOT SUSTAINED
A(3)(a)	NOT SUSTAINED
A(3)(b)	NOT SUSTAINED
A(3)(c)	NOT SUSTAINED
A(3)(d)	NOT SUSTAINED
A(3)(e)	NOT SUSTAINED
A(3)(f)	NOT SUSTAINED
A(4)	SUSTAINED
A(5)	NOT SUSTAINED
B(1)(a)	NOT SUSTAINED
B(1)(b)	NOT SUSTAINED
B(1)(c)	NOT SUSTAINED
B(2)	NOT SUSTAINED
B(3)	NOT SUSTAINED
B(4)(a)	NOT SUSTAINED
B(4)(b)	NOT SUSTAINED
B(4)(c)	NOT SUSTAINED
B(4)(d)	NOT SUSTAINED
B(4)(e)	NOT SUSTAINED
B(4)(f)	NOT SUSTAINED
B(4)(g)	NOT SUSTAINED
B(4)(h)	NOT SUSTAINED
B(5)	NOT SUSTAINED
C(1)	NOT SUSTAINED
C(2)	NOT SUSTAINED
C(3)(a)	NOT SUSTAINED
C(3)(b)	NOT SUSTAINED
C(3)(c)	NOT SUSTAINED
C(3)(d)	NOT SUSTAINED
C(4)	NOT SUSTAINED
D(1)	NOT SUSTAINED
D(2)	NOT SUSTAINED

TENTH SPECIFICATION: **(Incompetence on More Than One Occasion)**

A(1)(a)	NOT SUSTAINED
A(1)(b)	NOT SUSTAINED
A(1)(c)	NOT SUSTAINED
A(1)(d)	NOT SUSTAINED
A(2)	NOT SUSTAINED
A(3)(a)	NOT SUSTAINED
A(3)(b)	NOT SUSTAINED
A(3)(c)	NOT SUSTAINED
A(3)(d)	NOT SUSTAINED
A(3)(e)	NOT SUSTAINED
A(3)(f)	NOT SUSTAINED
A(4)	NOT SUSTAINED
A(5)	NOT SUSTAINED
B(1)(a)	NOT SUSTAINED
B(1)(b)	NOT SUSTAINED
B(1)(c)	NOT SUSTAINED
B(2)	NOT SUSTAINED
B(3)	NOT SUSTAINED
B(4)(a)	NOT SUSTAINED
B(4)(b)	NOT SUSTAINED
B(4)(c)	NOT SUSTAINED
B(4)(d)	NOT SUSTAINED
B(4)(e)	NOT SUSTAINED
B(4)(f)	NOT SUSTAINED
B(4)(g)	NOT SUSTAINED
B(4)(h)	NOT SUSTAINED
B(5)	NOT SUSTAINED
C(1)	NOT SUSTAINED
C(2)	NOT SUSTAINED
C(3)(a)	NOT SUSTAINED
C(3)(b)	NOT SUSTAINED
C(3)(c)	NOT SUSTAINED
C(3)(d)	NOT SUSTAINED
C(4)	NOT SUSTAINED
D(1)	NOT SUSTAINED
D(2)	NOT SUSTAINED

ELEVENTH THROUGH FOURTEENTH SPECIFICATIONS: (Failure to Maintain Records)

A(2) SUSTAINED

A(4) NOT SUSTAINED

B(2) SUSTAINED

C(2) SUSTAINED

D(1) NOT SUSTAINED

HEARING COMMITTEE DETERMINATIONS

The Hearing Committee has reviewed the entire record in this matter and makes the following determinations:

1. ON THE ISSUE OF FRAUDULENT PRACTICE

It is quite obvious that in his treatment of Patients A, B and C, the Respondent ordered numerous tests which he knew were either not medically indicated or were not medically indicated at the times they were performed. Indeed, there is a pattern of excessive and inappropriate testing of patients, often with a direct financial benefit to the Respondent.

The record indicates that the Respondent never evaluated the test results or incorporated the information into his treatment plans. In some instances he never even recorded the results of the testing and his billing records serve as the only documentation for the testing.

Based on the foregoing, the Hearing Committee determines that the Respondent knowingly and intentionally ordered excessive and inappropriate tests for the purpose of reaping financial gain. He was motivated by a greed that led him to commit egregious violations of professional trust which constitute fraud in the practice of medicine.

2. ON THE ISSUE OF ORDERING EXCESSIVE TESTS AND TREATMENT

PATIENT A: The Respondent saw Patient A on 31 occasions during the period July 19, 1991 to December 13, 1991.

During the course of his treatment of Patient A, the Respondent ordered Cybex, Tympanogram, Thermography, MRI and Arterial-Venous testing for the patient, and the Hearing Committee has concluded that these tests were either not medically indicated or not medically indicated at the times they were performed.

Patient A's medical record indicates that the patient showed no signs of improvement during the course of treatment; that the Respondent did not re-evaluate the patient or make any changes in therapy; and there was no consultation with a specialist in injuries to the back.

PATIENT B: The Respondent saw Patient B on 32 occasions during the period July 19, 1991 to December 13, 1991.

During the course of his treatment of Patient B, the Respondent ordered Cybex, Tympanogram, Arterial-Venous, MRI and Sonogram testing for the patient and the Hearing Committee has concluded that these tests were not medically indicated or not medically indicated at the time they were performed.

Patient B's medical record indicates that two other physicians examined her, and with the exception of guarding in the neck and low back area, they found that her condition to be much improved within a month after her accident.

PATIENT C: The Respondent saw Patient C on 32 occasions during the period April 17, 1992 to October 2, 1992.

During the course of his treatment of Patient C, the Respondent ordered Tympanogram testing, and MRIs of the patient's head and right hand and the Hearing Committee has concluded that these tests were not medically indicated.

Patient C's medical record indicates that the patient did not improve during the course of treatment, his symptoms and stated findings remains the same.

Based on the foregoing, the Hearing Committee determines that the Respondent ordered excessive tests and treatment for Patients A, B and C.

PATIENT D: Under the circumstances of this case, the Hearing Committee concluded that the Respondent's treatment of Patient D was not excessive.

3. ON THE ISSUES OF NEGLIGENCE ON MORE THAN ONE OCCASION AND INCOMPETENCE ON MORE THAN ONE OCCASION

The Hearing Committee has voted unanimously (3-0) to **NOT SUSTAIN** either of these Specifications.

4. ON THE ISSUE OF FAILING TO MAINTAIN RECORDS

The Respondent has a very busy medical office but his office practices and procedures indicate a lack of willingness to maintain the office in a way that reflects modern procedures and requirements.

The Respondent did not document his rationale for the various testings he ordered; he infrequently noted the results of the testing; and he did not note how the testing may have influenced his treatment and management of the patient. In some instances, the only note regarding testing is the billing record.

Also, the Respondent noted that he prescribed relaxant and analgesic drugs, but failed to specifically identifying the drug or the dosage prescribed.

The Hearing Committee determines that the Respondent's records do not accurately reflect the treatment and care of his patients.

5. ON THE ISSUE OF PENALTY

The Hearing Committee has determined that the Respondent has committed egregious violations of professional trust which constitute fraud in the practice of medicine.

The Respondent is 73 years old and it is questionable that any courses in morality and ethical conduct could rehabilitate him at this late date. These are lessons which he should have learned many years ago.

The Hearing Committee determines that the only appropriate penalty in this case is **REVOCATION.**

ORDER

It is hereby **ORDERED** that:

1. The Respondent's license to practice medicine in New York State is hereby **REVOKED.**

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

DATED: New York, New York
July, 29 1997

JERRY WAISMAN, M.D.
Chairperson

RALPH LEVY, D.O.
REV. EDWARD HAYES

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

IN THE MATTER OF ROBERT LARKINS, D.O.	STATEMENT OF CHARGES

Robert Larkins, D.O., the Respondent, was authorized to practice medicine in New York State on or about July 2, 1973, by the issuance of license number 116624, by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, then age 30, at his office, which was located at 94-38 59th Avenue, Rego Park, New York, from approximately July 9, 1991 to December 13, 1991. (The identities of Patient A and the other patients are disclosed in the attached Appendix.) Patient A sought Respondent's services following a motor vehicle accident which occurred on or about July 6, 1991.

1. Respondent inappropriately ordered/performed a series of tests, including the following tests which were not warranted for this patient at these times.

   a. Muscle Testing (Cybex Machine), on or about July 9, 1991.

   b. Tympanogram, on or about July 9, 1991.

   c. Arterial and venous testing, on or about July 31, 1991.

   d. Thermograms, which Patient A received at Modern Thermographic Testing, Inc., on or about

September 9, 1991.

2. Respondent failed to note in the chart that on or about July 9, 1991 he had performed Muscle Testing (Cybex Machine) and Tympanogram upon this patient.

3. On or about July 9, 1991, Respondent inappropriately referred Patient A for a series of tests, including the following tests which were not warranted for this patient at this time.

   a. MRI of the lumbar spine, which Patient A received at Magnetic Resonance Imaging of Queens, P.C. on or about July 12, 1991.

   b. MRI of the cervical spine, which Patient A received at Magnetic Resonance Imaging of Queens, P.C. on or about July 13, 1991.

   c. MRI of the right shoulder, which Patient A received at Magnetic Resonance Imaging of Queens, P.C. on or about July 15, 1991.

   d. MRI of the right knee, which Patient A received at Magnetic Resonance Imaging of Queens, P.C. on or about July 18, 1991.

   e. Sonography of the prostate, which Patient A received at Ultrasonic Diagnostics Inc. on or about July 17, 1991.

   f. Sonography of the abdomen, which Patient A received at Ultrasonic Diagnostics Inc. on or about July 17, 1991.

4. Despite Respondent's notation in the chart on or about September 10, 1991, that Patient A was evaluated for drug

abuse in July 1991, and Respondent's next notation that said results were positive for methadone, Respondent inappropriately failed to follow up on this significant finding or to note in the chart that he had followed up.

5. Respondent inappropriately continued to treat Patient A with osteopathic manipulation and physiotherapy, and analgesic and muscle relaxant medications until approximately December 1991; said continued treatments were not warranted by the patient's condition.

B. Respondent treated Patient B, then age 25, at his office, which was located at 94-38 59th Avenue, Rego Park, New York, from approximately July 9, 1991 to December 13, 1991. Patient B sought Respondent's services following a motor vehicle accident which occurred on or about July 6, 1991.

1. Respondent inappropriately ordered/performed a series of tests, including the following tests which were not warranted for this patient at these times.

    a. Muscle Testing (Cybex Machine), on or about July 9, 1991.

    b. Tympanogram, on or about July 9, 1991.

    c. Thermography, which Patient B received at Modern Thermographic Testing, Inc., on or about September 9, 1991.

2. Respondent failed to note in the chart that on or about July 9, 1991 he had performed Muscle Testing (Cybex Machine) and Tympanogram upon this patient.

3. On or about July 24, 1991, Respondent inappropriately ordered/performed arterial and venous doppler studies of

Patient B's arms, which were not warranted for this patient at this time.

4. On or about July 9, 1991, Respondent inappropriately referred Patient B for a series of tests, including the following tests which were not warranted for this patient at this time.

   a. MRI of the lumbar spine, which Patient B received at Magnetic Resonance Imaging of Queens, P.C. on or about July 12, 1991.

   b. MRI of the cervical spine, which Patient B received at Magnetic Resonance Imaging of Queens, P.C. on or about July 13, 1991.

   c. MRI of the right shoulder, which Patient B received at Magnetic Resonance Imaging of Queens, P.C. on or about July 15, 1991.

   d. MRI of the left shoulder, which Patient B received at Magnetic Resonance Imaging of Queens, P.C. on or about July 18, 1991.

   e. MRI of the right knee, which Patient B received at Magnetic Resonance Imaging of Queens, P.C. on or about July 19, 1991.

   f. MRI of the left knee, which Patient B received at Magnetic Resonance Imaging of Queens, P.C. on or about July 22, 1991.

   g. Sonography of the pelvis, which Patient B received at Ultrasonic Diagnostics Inc. on or about July 17, 1991.

   h. Sonography of the abdomen, which Patient B

received at Ultrasonic Diagnostics Inc. on or about July 17, 1991.

5. Respondent inappropriately continued to treat Patient B with osteopathic manipulation and physiotherapy until approximately December 1991; said continued treatments were not warranted by the patient's condition.

C. Respondent treated Patient C, then age 32, at his office, which was located at 94-38 59th Avenue, Rego Park, New York, from approximately April 17, 1992 to October 2, 1992. Patient C sought Respondent's services following a motor vehicle accident which occurred on or about April 16, 1992.

1. On or about April 17, 1992, Respondent inappropriately ordered/performed a Tympanogram, which was not warranted for this patient at this time.

2. On or about April 17, 1992, Respondent failed to note in the chart that a Tympanogram was performed.

3. On or about April 17, 1992, Respondent inappropriately referred Patient C for a series of tests, including the following tests which were not warranted for this patient at this time.

   a. MRI of the head, which Patient C received at the offices of Steven W. Prufer, M.D. on or about August 11, 1992.

   b. MRI of the cervical spine, which Patient C received at the offices of Steven W. Prufer, M.D. on or about August 14, 1992.

   c. MRI of the lumbar spine, which Patient C received at the offices of Steven W. Prufer, M.D. on or about August 25, 1992.

d. MRI of the right hand emphasizing the 5th finger, which Patient C received at the offices of Steven W. Prufer, M.D. on or about August 27, 1992.

4. Respondent inappropriately continued to treat Patient C with osteopathic manipulation and physiotherapeutic modalities, and prescription of analgesic and muscle relaxant medications until approximately October 1992; said continued treatments were not warranted by the patient's condition.

D. Respondent treated Patient D, then age 44, at his office, which was located at 94-38 59th Avenue, Rego Park, New York, from approximately April 21, 1992 to January 26, 1993. Patient D sought Respondent's services following a motor vehicle accident which occurred on or about April 18, 1992.

1. Respondent failed to note in the chart Patient D's diagnoses which accurately reflect his care and treatment of Patient D on or about April 21, 1992.

2. Respondent inappropriately continued to treat Patient D with osteopathic manipulation and physiotherapy until approximately January 1993; said continued treatments were not warranted by the patient's condition.

SPECIFICATION OF CHARGES

FIRST THROUGH FOURTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1997) by practicing the profession of

medicine fraudulently as alleged in the facts of the following:

1. A and A1 and A1a-d, and/or A3 and A3a-f, and/or A5,

2. B and B1 and B1a-c, and/or B3, and/or B4 and B4a-h, and/or B5,

3. C and C1, and/or C3 and C3a-d, and/or C4,

4. D and D2,

in that Petitioner further alleges that Respondent ordered/performed said unwarranted tests and treatment intentionally, knowing that they were not for a *bona fide* medical purpose.

FIFTH THROUGH EIGHTH SPECIFICATIONS

ORDERING EXCESSIVE TESTS AND TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 1997) by ordering excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

5. A and A1 and A1a-d, and/or A3 and A3a-f, and/or A5.

6. B and B1 and B1a-c, and/or B3, and/or B4 and B4a-h, and/or B5.

7. C and C1, and/or C3 and C3a-d, and/or C4.

8. D and D2.

NINTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1997) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

9. A and A1 and A1a-d, and/or A2, and/or A3 and A3a-f, and/or A4, and/or A5, and/or B and B1 and B1a-c, and/or B2, and/or B3, and/or B4 and B4a-h, and/or B5, and/or C and C1, and/or C2, and/or C3 and C3a-d, and/or C4, and/or D and D1, and/or D2.

TENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1997) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

10. A and A1 and A1a-d, and/or A2, and/or A3 and A3a-f, and/or A4, and/or A5, and/or B and B1 and B1a-c, and/or B2, and/or B3, and/or B4 and B4a-h, and/or B5, and/or C and C1, and/or C2, and/or C3 and C3a-d, and/or C4, and/or D and D1, and/or D2.

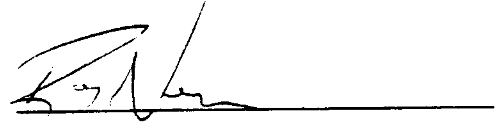
ELEVENTH THROUGH FOURTEENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §(32)(McKinney Supp. 1997) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

11. A and A2, and/or A4.
12. B and B2.
13. C and C2.
14. D and D1.

DATED: March 14, 1997
New York, New York



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct