STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

September 28, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Keith Alan Lasko, M.D.
2421 West Pratt Boulevard
Suite 525
Chicago, IL 60645

Keith Alan Lasko, M.D.
6900 Van Nuys Boulevard
Suite 8
Van Nuys, CA 91405

Daniel P. Guenzburger, Esq.
Assistant Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001

Effective Date: 10/05/94

RE: In the Matter of Keith Alan Lasko, M.D.

Dear Dr. Lasko and Mr. Guenzburger :

Enclosed please find the Determination and Order (No. 94-203) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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), "(t)he 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 all action 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
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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:mmn

Enclosure

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

IN THE MATTER OF KEITH ALAN LASKO, M.D.	**DETERMINATION AND ORDER**

NO. BPMC-94-203

SAMUEL H. MADELL, M.D., (Chair), **C. FRED PECKHAM, JR, D.O.** and **KENNETH KOWALD** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10)(e) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer.

The Department of Health appeared by **DANIEL P. GUENZBURGER, ESQ.**, Assistant Counsel.

Respondent, **KEITH ALAN LASKO, M.D.**, failed to appear personally at the hearing, was not represented by counsel and failed to submit any answer or response to a Notice of Referral Proceeding and Statement of Charges, both dated July 20, 1994.

A hearing was held on September 8, 1994. Evidence was received and examined. A Transcript of the proceedings was made. After consideration of the record, the Hearing Committee issues this Determination and Order, pursuant to the Public Health Law and the Education Law of the State of New York.

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York. (§230 et seq. of the Public Health Law of the State of New York [hereinafter P.H.L.])

This case, brought pursuant to P.H.L. §230(10)(p), is also referred to as an "expedited hearing". The scope of an expedited hearing is strictly limited to evidence or sworn testimony relating to the nature and severity of the penalty to be imposed on the licensee[1] (Respondent).

KEITH ALAN LASKO, M.D., (hereinafter "Respondent") is charged with professional misconduct within the meaning of §6530(9)(b) of the Education Law of the State of New York (hereinafter N.Y.S. Education Law), to wit: "professional misconduct ... by reason of having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state ..." (Petitioner's Exhibit # 1 and §6530[9][b] of the N.Y.S. Education Law).

In order to find that Respondent committed professional misconduct, the Hearing Committee, pursuant to §6530(9)(b) of the N.Y.S. Education Law, must determine: (1) whether Respondent was found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state and (2) whether Respondent's conduct on which the findings were based would, if committed in New York State, constitute professional misconduct under the laws of New York State.

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[1] P.H.L. §230(10)(p), fifth sentence.

A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Unless otherwise noted, all Findings and Conclusions herein were unanimous.

1. Respondent was authorized to practice medicine in New York State on January 8, 1974 by the issuance of license number 118699 by the New York State Education Department. (Petitioner's Exhibit # 1 & Petitioner's Exhibit # 2)[2]

2. The Respondent is not currently registered with the New York State Education Department to practice medicine. (Petitioner's Exhibit # 1)

3. Jerome Clarkson attempted to personally serve the Notice of Referral Proceeding, the Statement of Charges and exhibits on Respondent on August 2, 1994 at 10:30 A.M., August 5, 1994 at 12:30 P.M. and on August 10, 1994 at 4:30 P.M. and indicated that the "Party was never in" in his declaration of reasonable diligence. (Petitioner's Exhibit # 1)

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[2] refers to exhibits in evidence submitted by the New York State Department of Health (Petitioner's Exhibit)

4. Elyse Williams mailed, by certified mail, on August 19, 1994, the Notice of Referral Proceedings to Respondent, at his last known address. (Petitioner's Exhibit # 1) [T-3][3]

5. The Division of Medical Quality of the Medical Board of California of the State of California (hereinafter "California Board") is a state agency charged with regulating the practice of medicine pursuant to the Laws of the State of California. (Petitioner's Exhibit # 3 and # 4)

6. On July 18, 1991, the California Board charged, by Accusation No. D-4572[4], Respondent with the commission of numerous separate acts, on at least 12 separate patients. The acts performed by Respondent were alleged to constitute negligence, incompetence, excessive use of diagnostic procedures and/or dishonesty and false billing, under the laws of California. (Petitioner's Exhibit # 3)

7. As a result of the July 18, 1991 charges, the California Board adopted Findings of Fact, Determination of issues and Order of the Board in a Default Decision, made on December 23, 1991 and effective January 22, 1992. (Petitioner's Exhibit #4)

8. The Default Decision of the California Board indicates a Finding that the allegations contained in Accusation No. D-4572 are true. (Petitioner's Exhibit # 4)

9. The Hearing Committee accepts the Findings of the California Board and adopts the allegations in Accusation No. D-4572 as its own Findings of Fact. Accusation No. D-4572 is annexed hereto as appendix II and is incorporated herein.

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[3] Numbers in brackets refer to transcript page numbers [T-].

[4] No. D-4572: Before the Medical Board of California, Division of Medical Quality, Department of Consumer Affairs, State of California: In the Matter of the Accusation Against Keith Alan Lasko, M.D., Physician and surgeon Certificate No. A 30165, Respondent. Accusation dated July 18, 1991 and signed by Kenneth J. Wagstaff, Executive Director, Medical Board of California. (Petitioner's Exhibit # 3)

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee.

The Hearing Committee concludes that the following Factual Allegations, from the July 20, 1994 Statement of Charges, are SUSTAINED [5]:

First unnumbered Paragraph on page 2	:	(5 - 9)
Second unnumbered Paragraph on page 2	:	(5 - 9)

The last unnumbered paragraph on page 2 do not consist of factual allegations, but require a conclusion for this Hearing Committee to make, as discussed infra.

The Hearing Committee further concludes, based on the above Factual Conclusion, that the SPECIFICATION on the first page of the Statement of Charges is SUSTAINED

The Hearing Committee concludes that the Department of Health has shown by a preponderance of the evidence that Respondent was found guilty of improper professional practice and of professional misconduct by the State of California and his conduct in California would constitute professional misconduct under the laws of New York State. The Department of Health has met its burden of proof.

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[5] The numbers in parentheses refer to the Findings of Fact previously made herein by the Hearing Committee and support each Factual Allegation.

Service of Charges and of Notice of Hearing.

P.H.S. §230(10)(d) requires that the Charges and Notice of Hearing be served on the licensee personally, at least twenty (20) days before the Hearing. If personal service cannot be made, due diligence must be shown and certified under oath. Thereafter, registered or certified mail to the licensee's last known address must be served, at least fifteen (15) days before the Hearing.

From the affidavit submitted, three attempts at personal service were made as more fully set forth in said affidavits. In determining whether due diligence has been exercised, no rigid rule can properly be prescribed. Each case must be viewed on its own separate facts. Barnes v. City of New York, 51 N.Y.2d 906 (1980).[6]

Pursuant to §6502(5) of the N.Y.S. Education Law, a licensee, such as Respondent, is under a duty to notify the Department of Education of any change of mailing address within thirty (30) days of such change. Matter of Tarter v. Sobol, 189 A.D.2d 916 (Third Dep't. 1993).

As more fully set forth in the Findings of Fact and the Exhibits, and the duty of a licensee to maintain a current address, it is determined that Petitioner has shown due diligence in this case.

Therefore, service of the Notice of Referral Proceeding and the Statement of Charges by Certified Mail to Respondent's last known address, was proper and timely.

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[6] It is noted, however that in Barnes, 4 attempts on 4 different occasions, during normal working hours, on people who were employed was not sufficient to meet due diligence requirements of the New York Civil Practice Law and Rules §308(4).

Professional Misconduct under §6530(9)(b) of the N.Y.S. Education Law.

The California Board of Medicine is a duly authorized professional disciplinary agency. In 1991, said California Board found Respondent guilty of violating California Statutes and said violations warranted disciplinary action by the California Board.

During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum, prepared by Peter J. Millock, General Counsel for the New York State Department of Health, dated February 5, 1992. This document, entitled: Definitions of Professional Misconduct under the New York Education Law, (hereinafter "Misconduct Memo"), sets forth suggested definitions of practicing the profession: (1) fraudulently; (2) with negligence on more than one occasion; (3) with gross negligence; (4) with incompetence on more than one occasion and (5) with gross incompetence.

The definitions from the Misconduct Memo were considered by the Hearing Committee during its deliberations.

Taking all of the allegations of Accusation No. D-4572 as true, the Hearing Committee finds that the record establishes that Respondent performed numerous and excessive testings and procedures, especially on elderly patients. Respondent ordered a wide variety of tests that were not medically indicated, such as, stress tests, extended ophthalmoscopy, nasopharyngoscopy, laryngoscopy, bronchoscopy, esophagoscopy, EKG, Holter monitor, carotid phono angiogram, echocardiography, cardiac wall imaging and ultrasound arteriography[7]. The record further establishes that Respondent fraudulently and falsely billed for diagnostic procedures that were not

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[7] See Petitioner's Exhibit # 3 (Appendix II) for a more comprehensive list.

performed on his patients. Respondent's notes in the patient charts were illegible, disorganized, failed to contain significant patient history information or descriptions of complaints and symptoms. Respondent performed tests without first obtaining consents and without administering proper preoperative medication. Respondent also performed medical tests in an unorthodox manner which endangered the health and safety of numerous patients.

The Hearing Committee finds that Respondent's conduct, if committed in New York State, constitutes professional misconduct, as defined by the Misconduct Memo and under §6530 of the N.Y.S. Education Law as follows:

(2) practicing the profession fraudulently; and

(3) practicing the profession with negligence on more than one occasion; and

(4) practicing the profession with gross negligence on a particular occasion; and

(5) practicing the profession with incompetence on more than one occasion; and

(6) practicing the profession with gross incompetence; and

(21) willfully making or filing a false report; and

(26) performing professional services which have not been duly authorized by the patient; and

(32) failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient; and

(35) ordering of excessive tests or treatment not warranted by the condition of the patient.

Therefore, Respondent has committed professional misconduct pursuant to §6530(9)(b) of the N.Y.S. Education Law.

DETERMINATION

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines that Respondent's license to practice medicine in New York State should be REVOKED.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service and (10) probation.

Since Respondent did not appear at this proceeding, he was not subject to direct or cross-examination nor to questions from the Hearing Committee in this proceeding. Therefore the Committee is bound by the documentary evidence presented

The record establishes that Respondent committed significant violations of California Laws. Respondent's lack of integrity, character and moral fitness is evident in his course of conduct.

The Hearing Committee concludes that if this case had been held in New York, on the facts presented, the pattern of excessive testing, the lack of adequate medical records, the negligent and incompetent performance and the outright billing fraud by Respondent would have resulted in a unanimous vote for revocation of Respondent's license.

The Hearing Committee has noted that the State of California has revoked Respondent's license. The Hearing Committee considers Respondent's misconduct to be very serious. With a concern for the health and welfare of patients in New York State, the Hearing Committee determines that revocation of Respondent's license is the appropriate sanction to impose under the circumstances.

ORDER

Based on the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The Specification of professional misconduct contained within the Statement of Charges (Petitioner's Exhibit # 1) is **SUSTAINED,** and

2. Respondent's license to practice medicine in the State of New York is hereby **REVOKED.**

DATED: **Albany, New York**
September, 26 1994

SAMUEL H. MADELL, M.D., (Chair),

C. FRED PECKHAM, JR, D.O.
KENNETH KOWALD

To: Keith Alan Lasko, M.D.
2421 West Pratt Boulevard
Suite 525
Chicago, IL, 60645

Keith Alan Lasko, M.D.
6900 Van Nuys Boulevard
Suite 8,
Van Nuys, CA, 91405

Daniel P. Guenzburger, Esq.,
Assistant Counsel,
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001

APPENDIX I

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

IN THE MATTER OF KEITH ALAN LASKO, M.D.	STATEMENT OF CHARGES

KEITH ALAN LASKO, M.D., the Respondent, was authorized to practice medicine in New York State on January 8, 1974 by the issuance of license number 118669 by the New York State Education Department. The Respondent is not currently registered with the New York State Education Department to practice medicine in New York State.

SPECIFICATION

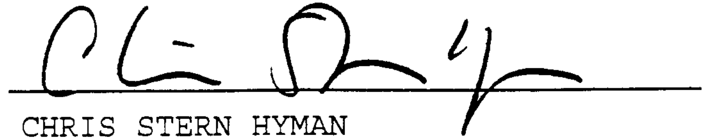
1. Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(9)(b) (McKinney Supp. 1994), in that he has been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct resulting in the disciplinary action would, if committed in New York State, constitute professional misconduct under the law of New York State, specifically:

On or about December 23, 1991, the California Medical Board ("Board"), revoked Respondent's medical license for violating numerous California laws governing professional medical conduct, including: Cal. Bus. and Prof. Code Sections 2234(b) (Gross Negligence), 2234(c) (Repeated negligent acts), 2234(d) (Incompetence), 725 (Excessive prescribing), 810 (Knowingly submitting false insurance claims), 2261 (Signing false certificates), and 2262 (Altering medical records with fraudulent intent).

The Board found that in 1988 Respondent improperly performed "pulmonary stress testing", "stress testing", and/or "stress electrocardiography" by failing to obtain patient consents, improperly administering preoperative medication, and inappropriately performing endoscopies. The Board also found that Respondent ordered excessive diagnostic tests and billed for diagnostic procedures that he did not perform.

The above acts, if committed in New York State, would have constituted professional misconduct under N.Y. Educ. Law Sections 6530(2) ("Practicing the profession fraudulently"), 6530(3) (Practicing the profession with negligence on more than one occasion"), 6530(4) ("Practicing the profession with gross negligence on a particular occasion"), 6530(5) (Practicing the profession with incompetence on more than one occasion"), 6530(6) (Practicing the profession with gross incompetence"), 6530(21) ("Willfully filing a false report"), 6530(26) ("Performing professional services which have not been duly authorized by the patient"), 6530(35) ("Ordering of excessive tests and treatment not warranted by the condition of the patient"), and 6530(32) ("Failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient"). (McKinney Supp. 1994).

DATED: New York, New York
July 20, 1994



CHRIS STERN HYMAN
COUNSEL
Bureau of Professional
Medical Conduct

APPENDIX II

...AL BOARD OF CALIFORNIA
I do hereby certify that
this document is true
and correct copy of the
original on file in this
office.
SIGNED 3/14/94 DATE
analyst TITLE

DANIEL E. LUNGREN, Attorney General
of the State of California
NANCY ANN STONER,
Deputy Attorney General
California Department of Justice
3580 Wilshire Boulevard, Suite 800
Los Angeles, California 90010
Telephone: (213) 736-7795

Attorneys for Complainant

**BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DIVISION OF MEDICAL QUALITY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the Accusation Against:

KEITH ALAN LASKO M.D.
6900 Van Nuys Boulevard, Suite 8
Van Nuys, California 91405

Physician and Surgeon Certificate No. A 30165,

Respondent.

NO. D-4572

A C C U S A T I O N

CASE BPMC
Petitioner EX 3
DATE 9-8-94
ACCU-SCRIBE REPORTING, INC. M.S.B

The Complainant alleges:

PARTIES

1. Complainant, Kenneth J. Wagstaff, is the Executive Director of the Medical Board of California (hereinafter the "Board") and brings this accusation solely in his official capacity.

2. On or about June 10, 1976, Physician and Surgeon Certificate No. A 30165 was issued by the Board to Keith Alan Lasko, M.D. (hereinafter "respondent"). At the times relevant to

1 the charges herein, that license was in full force and effect
2 until July 31, 1989 when the certificate was in a delinquent
3 status due to the respondent's nonpayment of renewal fees.
4
5 JURISDICTION

6 3. This accusation is brought under the authority of
7 the following sections of the California Business and Professions
8 Code (hereinafter "Code"):
9 4. Sections 2003 and 2004 of the Code provide, in
10 pertinent part, that the Division of Medical Quality (hereinafter
11 the "Division") of the Medical Board of California is responsible
12 for the enforcement of the disciplinary provisions of the Medical
13 Practices Act, the administration and hearing of disciplinary
14 actions; carrying out disciplinary actions appropriate to
15 findings made by a medical quality review committee, the division
16 or an administrative law judge, and suspending, revoking or
17 otherwise limiting certificates after the conclusion of
18 disciplinary actions.
19 5. Section 2227 of the Code provides that the Board
20 may revoke, suspend for a period not to exceed one year, or place
21 on probation, the license of any licensee who has been found
22 guilty under the Medical Practice Act.
23 6. Section 118, subdivision (b) of the Code provides,
24 in pertinent part, that the suspension, expiration, or forfeiture
25 by operation of law of a license issued by a board in the
26 department, or its suspension, forfeiture, or cancellation by
27 order of the board or by order of a court of law, or its

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surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.

7. Section 725 of the Code provides, in pertinent part, that repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon.

8. Section 2234 of the Code provides, in pertinent part, that unprofessional conduct includes, but is not limited to, the following:

> "(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts.
>
> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

1 9. Section 810 of the Code provides, in pertinent
2 part, that:
3 "(a) It shall constitute unprofessional conduct and
4 grounds for disciplinary action, including suspension or
5 revocation of a license or certificate, for a health care
6 professional to do any of the following in connection with
7 **his professional activities:**
8 (1) Knowingly present or cause to be presented any false or
9 fraudulent claim for the payment of a loss under a contract
10 of insurance.
11 (2) Knowingly prepare, make, or subscribe any writing, with
12 intent to present or use the same, or to allow it to be
13 presented or used in support of any such claim.
14 10. Section 2261 of the Code provides, in pertinent
15 part, that knowingly making or signing any certificate or other
16 document directly or indirectly related to the practice of
17 medicine or podiatry which falsely represents the existence or
18 nonexistence of a state of facts, constitutes unprofessional
19 conduct.
20 11. Section 2262 of the Code provides, in pertinent
21 part, that altering or modifying the medical record of any
22 person, with fraudulent intent, or creating any false medical
23 record, with fraudulent intent, constitutes unprofessional
24 conduct.
25 /
26 /
27 /

CAUSES OF DISCIPLINARY ACTION

A. EXCESSIVE USE OF DIAGNOSTIC PROCEDURES

12. Respondent Keith Alan Lasko, M.D. is subject to disciplinary action under section 725 of the Code in that he committed repeated acts of clearly excessive use of diagnostic procedures involving several patients, many of whom were elderly and in nursing homes. The circumstances are as follows:

a. On or about May 5, 1988, patient Helen A. was examined in a nursing home by respondent. This 88 year old blind, incontinent female with organic brain syndrome was billed for the following procedures which were not medically indicated: (1) Cerebral functioning assessment; (2) Cognitive testing; (3) Extended ophthalmoscopy, plus eight other procedures.

b. On or about June 8, 1988, patient Helen A. was again examined in a nursing home by respondent and was billed for the following procedures which were not medically indicated: (1) nasopharyngoscopy; (2) laryngoscopy; (3) bronchoscopy; (4) esophagoscopy.

c. On or about June 24, 1988, patient Rosalinda B. was examined in a nursing home by respondent. This 49 year old incontinent, disoriented female with seizure disorders and a nasogastric tube was billed for the following procedures which were not medically indicated: (1) nasopharyngoscopy; (2) laryngoscopy; (3) bronchoscopy; (4) esophagoscopy.

d. On or about April 22, 1988, patient Dorothy

1 A.[1] visited respondent at his office for what she thought
2 was a bad cold. Respondent billed Medicare for the
3 following procedures, in addition to a comprehensive office
4 visit: (1) EKG; (2) Holter Monitor; (3) Carotid Phono
5 Angiogram; (4) Extended ophthalmoscopy; (5) Visual field
6 testing; (6) Echocardiography; (7) Cardiac Wall imaging; (8)
7 Ultrasound arteriography. These procedures were not
8 medically indicated.
9 e. On or about April 20, 1988, patient Ruth B.
10 visited respondent in his office accompanied by her nurse,
11 Michelle R. Respondent billed Medicare for the following
12 procedures, in addition to a comprehensive office visit: (1)
13 EKG; (2) Holter Monitor; (3) Carotid phono angiogram; (4)
14 Extended ophthalmoscopy; (5) Echocardiogram; (6) Cardiac
15 Wall motion imaging; (7) Thyroid scan; (8) Chest echography;
16 (9) Breast scan; and (10) Cognitive testing. These
17 procedures were not medically indicated.
18 f. On or about June 6, 1988, patient Jean V. was
19 examined by respondent, and was billed for the following
20 procedures which were not medically indicated: (1) Upper
21 G.I. endoscopy; (2) Removal of impacted cerumen; (3) Cardiac
22 blood pool imaging; (4) Extended ophthalmoscopy; (5) Nasal
23 function studies; (6) Laryngeal function studies; (7)
24 Cardiovascular stress test; (8) Pulmonary Stress test; (9)
25
26

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27 1. For privacy reasons only the initials of a patient's last name will be used in this pleading. The full name(s) will be provided in discovery upon request by respondent.

Assessment of higher cerebral function; (10) Cognition testing.

g. On or about April 18, 1988, patient Porfiria S. was examined by respondent, and was billed for the following procedures which were not medically indicated: (1) Holter monitor; (2) Carotid phono angiogram; (3) Extended ophthalmoscopy; (4) Echocardiogram; (5) Cardiac wall motion monitoring.

h. On or about July 11, 1988, patient Porfiria S. was again examined by respondent and was billed for the following procedures which were not medically indicated: (1) Extended ophthalmoscopy; (2) Doppler echocardiography.

i. On or about April 27, 1988, patient Elizabeth T. was examined by respondent and was billed for the following procedures which were not medically indicated: (1) EKG; (2) Holter monitor; (3) Carotid phonoangiogram; (4) Extended ophthalmoscopy; (5) Echocardiogram; (6) Cardiac wall motion imaging.

j. On or about June 3, 1988, patient Elizabeth T. was again examined by respondent and was billed for the following procedures which were not medically indicated: (1) Follow-up echocardiography; (2) Ophthalmic contact B scan; (3) Chest echography; (4) Abdominal echography; (5) Retroperitoneal echography.

k. On or about July 1, 1988, patient Elizabeth T. was again examined by respondent and was billed for the following procedures which were not medically indicated:

(1) Doppler echocardiography; (2) Carotid artery ultrasound; (3) Venography; (4) Arteriography.

l. On or about July 20, 1988, patient James F. was examined in his home by respondent and was billed for the following procedures which were not medically indicated: (1) EKG; (2) Holter monitor; (3) Carotid phonoangiogram; (4) Echocardiography; (5) Abdominal echocardiography; (6) Retroperitoneal echography.

B. NEGLIGENCE AND INCOMPETENCE

13. Respondent Keith Alan Lasko, M.D. is subject to disciplinary action under section 2234, subdivision (b) of the Code in that he committed acts of **gross negligence** in his treatment and examinations of several patients, many of whom were elderly and in nursing homes. The circumstances disclosing gross negligence by respondent are as follows:

a. The facts and allegations set forth above in paragraph 12, including subparagraphs a through l, are incorporated here by reference.

b. Respondent's notes in the patient charts for the above-described patients (in paragraph 12, subparagraphs a through l) were illegible, disorganized, failed to contain significant patient history information or descriptions of complaints and symptoms substantiating the procedures billed by respondent, nor did the charts contain a hard copy or record of the results of most of these tests.

c. Respondent performed and billed for

1 performing "pulmonary stress testing," "stress testing,"
2 and/or "stress echocardiography" without first obtaining
3 consent, without administering proper preoperative
4 medication, and in an unorthodox manner through the
5 unannounced insertion of an endoscope which endangered the
6 health and safety of the following elderly patients, among
7 others:

8 (1) Virginia Albrecht at Laurelwood
9 Convalescent Hospital on or about July 17, 1988;
10 (2) Sophie Nicolelti at Laurelwood
11 Convalescent Hospital on or about July 9, 1988;
12 (3) Elizabeth Wendt at Laurelwood
13 Convalescent Hospital on or about July 9, 1988;
14 (4) Alice Gammage at Arteria Convalescent
15 Hospital on or about July 10, 1988;
16 (5) Mary Samuel at Arteria Convalescent
17 Hospital on or about July 10, 1988;
18 (6) Emily Reeling at Arteria Convalescent
19 Hospital on or about July 10, 1991;
20 (7) Eva Sturgeon at Arteria Convalescent
21 Hospital on or about August 7, 1988;
22 (8) Minnie Ziontz at Arteria Convalescent
23 Hospital on or about July 10, 1988;
24 (9) Ella Davidson at Beverly Manor
25 Convalescent Hospital on or about July 23, 1988;
26 (10) David Brushett at Beverly Manor
27 Convalescent Hospital on or about July 23, 1988;

(11) Rhea Emerson at Beverly Manor Convalescent Hospital on or about July 23, 1988;

(12) Ruth Ries at Beverly Manor Convalescent Hospital on or about July 23, 1988.

14. Respondent Keith Alan Lasko, M.D. is subject to disciplinary action under section 2234, subdivision (c) of the Code in that he committed **repeated acts of negligence** in his treatment and examinations of several patients, as is more fully set forth in paragraph 12, subparagraphs a through l, and in paragraph 13, subparagraphs a through c, above, which are incorporated here by reference.

15. Respondent Keith Alan Lasko, M.D. is subject to disciplinary action under section 2234, subdivision (d) of the Code in that he committed **acts of incompetence** in his treatment and examinations of several patients, as is more fully set forth in paragraph 12, subparagraphs a through l, and in paragraph 13, subparagraphs a through c, above, which are incorporated here by reference.

C. DISHONESTY AND FALSE BILLING

16. Respondent Keith Alan Lasko, M.D. is subject to disciplinary action under section 2234, subdivision (e) of the Code in that he committed acts of dishonesty or corruption in relation to his functions and duties as a physician and surgeon in that he falsely and dishonestly billed for diagnostic

procedures that were not performed, that were included in the patient's routine examination, that were less extensive than the procedure for which he billed, and/or that were not medically indicated and for which there is little or no diagnostic value. The circumstances are as follows:

a. The facts and allegations set forth above in paragraph 12, subparagraphs a through l, and paragraph 13, subparagraphs a through c, are incorporated here by reference.

b. The procedures set forth above in paragraph 12, subparagraph d, for patient Dorothy A. were not performed, although a bill for $1,862.00 was submitted by respondent.

c. The procedures set forth above in paragraph 12, subparagraph e, for patient Ruth B. were not performed, although a bill for $2,325.00 was submitted by respondent.

d. Respondent separately billed for an "extended ophthalmoscopy" which consisted of a routine fundus examination that was included in the services already billed for and performed by respondent on the following patients: (1) Helen A. on or about May 5, 1988; (2) Dorothy A. on or about April 22, 1988; (3) Ruth B. on or about April 20, 1988; (4) Jean V. on or about June 6, 1988; (5) Porfiria S. on or about April 18, 1988 and July 11, 1988; and (6) Elizabeth T. on or about April 27, 1988.

e. Respondent separately billed for "cognitive testing" and "assessments of higher cerebral function"

which consisted of asking simple questions that had no diagnostic value to the following patients, among others: (1) Helen A. on or about May 5, 1988; (2) Ruth B. on or about April 20, 1988; (3) Jean V. on or about June 6, 1988.

17. Respondent Keith Alan Lasko, M.D. is subject to disciplinary action under section 810, subdivision (a) of the Code in that he knowingly presented or caused to be presented false or fraudulent claims, and he prepared and subscribed documentation to support such claims for diagnostic tests and treatments that were not performed, that were included in the patient's routine examination, that were less extensive than the procedure for which he billed, and/or that were not medically indicated and for which there is little or no diagnostic value. The facts and circumstances supporting this allegation are set forth above in paragraph 12, subparagraphs a through l, and in paragraph 13, subparagraphs a through c, and in paragraph 16, subparagraphs a through e, which are incorporated here by reference.

18. Respondent Keith Alan Lasko, M.D. is subject to disciplinary action under section 2261 of the Code in that he knowingly made and signed false documents in medical records and in statements that he submitted to billing for diagnostic tests and treatments that were not performed, that were included in the patient's routine examination, that were less extensive than the procedure for which he billed, and/or that were not medically

indicated and for which there is little or no diagnostic value. The facts and circumstances supporting this allegation are set forth above in paragraph 12, subparagraphs a through l, and in paragraph 13, subparagraphs a through c, and in paragraph 16, subparagraphs a through e, which are incorporated here by reference.

19. Respondent Keith Alan Lasko, M.D. is subject to disciplinary action under section 2262 of the Code in that he created false medical records and statements with the intent to defraud patient's and third parties by submitting excessive claims and bills for diagnostic tests and treatments that were not performed, that were included in the patient's routine examination, that were less extensive than the procedure for which he billed, and/or that were not medically indicated and for which there is little or no diagnostic value. The facts and circumstances supporting this allegation are set forth above in paragraph 12, subparagraphs a through l, and in paragraph 13, subparagraphs a through c, and in paragraph 16, subparagraphs a through e, which are incorporated here by reference.

PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following said hearing, the Board issue a decision:

1. Revoking or suspending Physician and Surgeon Certificate Number A 30165, heretofore issued to respondent Keith

1 Alan Lasko M.D.;

2 2. Taking such other and further action as the Board
3 deems proper.

4 DATED: July 18, 1991.

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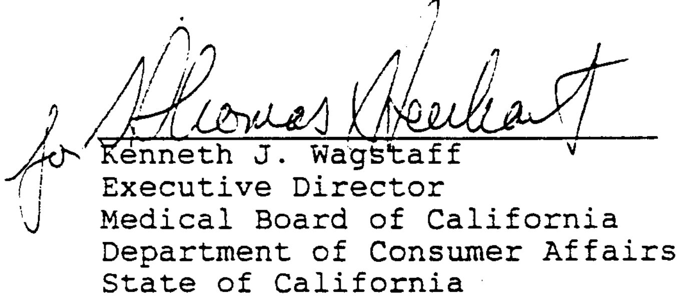

Kenneth J. Wagstaff
8 Executive Director
Medical Board of California
9 Department of Consumer Affairs
State of California
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Complainant
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