STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Dennis P. Whalen
Executive Deputy Commissioner

January 12, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrence Sheehan, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza – Suite 601
New York, NY 10001

William L. Wood, Jr. Esq.
Wood & Scher
14 Harwood Court
Scarsdale, NY 10583

RE: In the Matter of Olga Benitez

Dear Parties:

Enclosed please find the Determination and Order (No. 99-6) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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,

-REDACTED

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mla
Enclosure

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

IN THE MATTER

OF

OLGA BENITEZ, M.D.

COPY

DETERMINATION

AND

ORDER
BPMC #99-6

NORTON SPRITZ, M.D., Chairperson, **RALPH LEVY, D.O.** and **JAMES J. DUCEY**, 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 Sections 230(1)(e) and 230(12) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.**, served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **HENRY M. GREENBERG, General Counsel, TERRENCE SHEEHAN, ESQ.**, Associate Counsel, of Counsel. The Respondent appeared in person and was represented by **WOOD & SCHER, WILLIAM L. WOOD, Jr., ESQ.** of Counsel. Evidence was received, witnesses sworn and heard, and transcripts of these proceedings were made.

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

STATEMENT OF CHARGES

The accompanying Amended Statementof of Charges allege thirty-three (33) specifications of professional misconduct, including allegations of negligence on more than one occasion, incompetence on more than one occasion, fraudulent practice, false report, unnecessary tests or treatment, fee splitting, failure to maintain records and moral unfitness. The charges are more

specifically set forth in the Amended Statement of Charges, a copy of which is attached hereto and made a part of this Determination and Order in Appendix I .

WITNESSES

For the Petitioner: Elliot Howard, M.D.

For the Respondent: Olga Benitez, M.D.

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Petitioner's Exhibits are designated by numbers. Respondent's exhibits are designated with letters.

GENERAL FINDINGS

1. Respondent is licensed to practice medicine in the State of New York and is currently registered with the New York State Education Department. (Ex. 1)

2. Respondent was licensed to practice medicine in New York State in 1982 after graduating f rom the University of Pennsylvania School of Medicine in 1981. (Ex. F, T. 299)

3. Her post graduate training was done at Montefiore Hospital from 1981 through 1985. (Exs. F, G and H.)

4. After working at St. Mary's Hospital and Elmhurst Hospital, she entered the private practice of medicine in 1986 and has maintained that practice to date. Her practice consists of primary and general care. (T. 300)

PATIENT A

5. Patient A was a 14 year old female who was seen by Respondent on November 25, 1992 at the Women's Total Health of New York clinic at 37-51 91st Street, (Ex. 8, pp. 2, 4)

6. The patient history is inadequate for an initial visit. Respondent merely recorded the patient's chief complaint without the customary exploration of the history of the patient's illness. Specifically, the patient's chart lacks information on the length of time of the complaint and whether the patient had been examined or diagnosed for this complaint before. (T. 82-83, 90-91)

7. Respondent's physical examination of Patient A lacks thoroughness for an initial exam. (T. 83)

8. Respondent knowingly billed Patient A's insurance carrier for the interpretation of tests, which included echocardiograms and chest x-rays , when if fact the interpretations were done by another physician, Bruce Herzog, M.D. (Ex. 8,p.2; T. 84-85, 250-256, 419-423)

9. Respondent failed to appropriately follow-up Patient A's complaint of chest pain and palpitation, as well as the heart murmur noted in Respondent's physical exam. (T. 88, 263)

10. Respondent's medical records for Patient A did not meet the generally accepted standard for medical record keeping.(T. 90-91)

PATIENT B

11. Respondent saw Patient B, a 17 year old female, for complaints of frequency, dysuria, hematuria for one and-a-half weeks, suprapubic pain, nausea, vomiting, fever, chills, abdominal pain, heartburn, occasional diarrhea and dysfunctional uterine bleeding. (Pet. Ex., p.4; T. 121-120, 125-126)

12. Respondent failed to obtain and note adequate histories and failed to perform and note adequate physical examinations for Patient B. (T. 135)

13. Although, the pelvic and breast sonograms were justified, Respondent inappropriately ordered an echocardiogram without a physical finding of a heart murmur. (T. 136-137,143-144,133)

14. It was also unnecessary for Respondent to order the retroperitoneal sonogram until she first received the results of the pelvic sonogram. (T. 137)

15. "Unbundling" means to separate parts of a test that could be billed individually, when in fact only one test was done and included all those individual things. (T. 231)

16. Respondent engaged in "unbundling" with respect to her billing of sonograms for Patient B. There are only 2 reports from the radiologist for all these abdominal scans, but there are 5 separate billings, hence the billing is inappropriate. (T. Ex. 9, p.2; 129-130.)

17. Respondent knowingly billed Patient B's insurance carrier for the interpretation of numerous, sonograms, when in fact the interpretations were done by another physician, Bruce Herzog, M.D. (Ex. 9, pp. 2,6-10; T. 136, 410-411)

18. Respondent failed to follow up the nodule she found in Patient B's right breast. Despite the finding of generalized fibrocystic disease and the negative mammogram, the existence of a specific nodule located on physical examination warranted a referral to an expert for further evaluation. (T. 144-147) Respondent also failed to follow-up by providing Patient B with the negative results of the numerous sonograms performed. (T. 134, 324, 328)

19. Respondent's records for Patient B fail to meet the generally acepted statndards of medical record keeping. (T. 135)

PATIENT C

20. Respondent saw, Patient C, a 63 year old male with hypertension on February 28, 1992. (Ex.4, p.2)

21. Respondent failed to obtain and note an adequate history. (T. 251-252) There should have been an extensive history of the nature of the hypertension. (T.245) There is no indication that the patient was taking medications on Respondent's initial visit, yet the patient subsequently advises the cardiologist that he is taking Vasotec. (T. 246)

22. Respondent's physical examination of Patient C did not meet the acceptable standard of care. (T. 252)

23. Respondent knowingly billed Patient C's insurance carrier for the interpretation of echocardiograms and chest x-rays, when in fact, the interpretations were not performed by Respondent. (Ex. 10; T. 244, 248-249, 258)

24. Respondent's record for Patient C, taken as a whole, does not meet the minimally acceptable standards of medical record keeping. (T. 251-252)

PATIENT D

25. From October 1990 through October 1991, Respondent treated this 52 year old female at her clinic. (Ex. 5)

26. The history for Patient D is inadequate because there is no definition of detail in the patient's chief complaint of blood in the urine and pain in the right upper quadrant. (T. 158-160)

27. Respondent failed to perform an adequate physical examination of Patient D because she failed to take all significant vital signs and failed to adequately exam the abdominal area after specific complaints of pain were made by the patient. (T. 160-161)

28. Respondent knowingly engaged in "unbundling" because only the abdominal sonogram was performed, but Respondent billed for separate tests of the heptac, gallbladder and renal areas. (T. 168, 191)

29. Respondent again knowingly billed Patient D's insurance company for the interpretations of numerous sonograms when the interpretations were performed by another physician, Dr. Herzog.(Ex. 11; T. 191-192)

30. Respondent failed to appropriately follow up with respect to the patient's complaint of tenderness of the abdomen. (T. 171, 175)

31. Respondent's medical records for Patient D did not meet the minimum standards for adequate record keeping. (T. 159, 171-172)

PATIENT E

32. In or about August and September, 1992, Respondent treated Patient E, a 13 year old female twin at Respondent's clinic. (Ex.6, 12, p.23)

33. Respondent failed to obtain and note adequate histories, particularly noting that family history was negative without any mention that Respondent had a twin sister. (T. 197-198, 200-201)

34. Respondent failed to obtain and note an adequate physical examination for Patient E. (T. 200-201)

35. Respondent ordered a pelvic sonogram and a chest x-ray that was medically unwarranted. (T. 200-201). The echocardiogram may, however, have been justified. (T. 206-207)

36. Respondent knowingly billed Patient E's insurance company for the interpretation of the pelvic sonogram and the chest x-ray, when the interpretations were done by Dr. Herzog. (Ex. 12; T.200-201)

37. Respondent's medical records for Patient E did not meet the minimum standards for adequate record keeping. (T.199-201, 203)

PATIENT F

38. Between January 1991 and April 1992, Respondent treated Patient F, a 63 year old female at her clinic. (Ex. 13; T. 214-215)

39. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations. (T. 228) More particularly, Respondent failed to check the patient's blood pressure, pulse rate and respiration during what was billed as a comprehensive physical exam. (T. 230-231, 235)

40. Respondent ordered a pelvic sonogram for Patient F without sufficient medical justification. (T. 226, 227-228, 232, 239)

41. Respondent engaged in "unbundling" by billing Patient F's insurance company for separate tests of the liver, pancreas, spleen and kidney, when in fact only an abdominal sonogram was performed. (Ex. 13; T. 231-232)

42. Respondent knowingly billed Patient F's insurance carrier for the interpretation of echocardiograms, x-rays, and sonograms when in fact the interpretations were done by Dr. Bruce Herzog. (Ex. 13, T. 228)

43. On the visit of March 27, 1992, Respondent failed to follow up on Patient F's cystitis, by ordering a urinalysis and then carefully evaluating it .(T. 222-223)

44. Respondent's medical records for Patient F did not meet the minimum standards for adequate record keeping. (T. 228, 230)

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parenthesis refer to the Findings of Fact which support each Factual Allegation:

Paragraph A:	(5)
Paragraph A.1:	(6,7)
Paragraph A.3:	Withdrawn
Paragraph A.4:	(8)
Paragraph A.6:	(9)
Paragraph A.7:	(10)
Paragraph B:	(11)
Paragraph B.1:	(12)
Paragraph B.2:	(13,14)
Paragraph B.3:	(15,16)
Paragraph B.4:	(17)
Paragraph B.6:	(18)
Paragraph B.7:	(19)
Paragraph C:	(20)
Paragraph C.1:	(21,22)
Paragraph C.2:	Withdrawn
Paragraph C.3:	(23)
Paragraph C.6:	(24)
Paragraph D:	(25)
Paragraph D.1	(26,27)
Paragraph D.3	(28)
Paragraph D.4:	(29)
Paragraph D.6	(30)
Paragraph D.7	(31)
Paragraph E:	(32)
Paragraph E.1:	(33,34)
Paragraph E.2(a)	(35)except with respect to echocardiogram
Paragraph E.2(b)	(35)
Paragraph E.3:	(36)
Paragraph E. 5	Withdrawn
Paragraph E.6:	(37)
Paragraph F.	(38)
Paragraph F.1	(39)
Paragraph F.2(d):	(40)

Paragraph F.3: (41)
Paragraph F.4: (42)except with respect to electrocardiogram
Paragraph F.6: (43)
Paragraph F.7: (44)

The Hearing Committee further concluded that the following Factual Allegations **should not be sustained:**

Paragraph A.2
Paragraph A.5

Paragraph B.5

Paragraph C.4
Paragraph C.5

Paragraph D.2 (a) and (b)
Paragraph D.5

Paragraph E.4

Paragraph F.2 (a), (b) and (c)

Paragraph F.5

The Hearing Committee further concluded that the following Specifications **should be sustained**. The citations in parenthesis refer to the Factual Allegations which support each specification:

NEGLIGENCE ON MORE THAN ONE OCCASION

First Specification: (Paragraph A and A.1, A.6 and A.7)
(Paragraph B and B.1,B.2, B.6 and B.7)
(Paragraph C and C.1, and C.6)
(Paragraph D and D.1, D and D.7)

(Paragraph E and E.1,E.2 and E.6)

(Paragraph F and F.1, F.2, F.6 and F.7)

FRAUDULENT PRACTICE

Third Specification:	(Paragraphs A and A.4)
Fourth Specification:	(Paragraphs B and B.3 and B.4)
Fifth Specification:	(Paragraphs C and C.3)
Sixth Specification:	(Paragraphs D and D.3 and D.4)
Seventh Specification:	(Paragraphs E and E.3)
Eighth Specification:	(Paragraphs F and F.3 and F.4)

FALSE REPORT

Ninth Specification:	(Paragraphs A and A.1 and A.4)
Tenth Specification:	(Paragraphs B and B.3 and B.4)
Eleventh Specification:	(Paragraphs C and C.3)
Twelfth Specification:	(Paragraphs D and D.3 and D.4)
Thirteenth Specification:	(Paragraphs E and E.3)
Fourteenth Specification:	(Paragraphs F and F.3 and F.4)

UNNECESSARY TESTS OR TREATMENT

Sixteenth Specification:	(Paragraphs B and B.2)
Nineteenth Specification:	(Paragraphs E and E.2)
Twentieth Specification:	(Paragraphs F and F.2)

FAILURE TO MAINTAIN RECORDS

Twenty-Seventh Specification:	(Paragraphs A and A.7)
Twenty-Eighth Specification:	(Paragraphs B and B.7)
Twenty-Ninth Specification:	(Paragraphs C and C.6)
Thirtieth Specification:	(Paragraphs D and D.7)
Thirty-First Specification:	(Paragraphs E and E.6)
Thirty-Second Specification:	(Paragraphs F and F.7)

MORAL UNFITNESS

Thirty-Third Specification:	(Paragraphs A and A.4; Band B.3 and B.4; C and C.3; D and D.3 and D.4; E and E.3 and F and F.3 and F.4)

The Hearing Committee further concluded that the following Specifications should not be sustained:

Second Specification (Negligence on More than One Occasion)

Fifteenth Specification (Unnecessary Tests or Treatment)

Seventeenth Specification (Unnecessary Tests or Treatment)

Eighteenth Specification (Unnecessary Tests or Treatment)

Twenty-First through Twenty-Sixth Specifications (Fee Splitting)

DISCUSSION

Respondent is charged with thirty-three (33) specifications alleging professional misconduct within the meaning of Education Law Section 6530. This statute sets forth numerous forms of

conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence and fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Fraudulent practice is the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that twenty-three (23) of the thirty-three (33) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, The Hearing Committee made a determination as to the credibility of the witnesses presented by the parties. Petitioner's sole witness was Elliot Howard, M.D. Dr. Howard is a cardiologist and as well as a board certified internist who has been in private practice in New York City since 1960. (T. 81) The Hearing Committee found Dr. Howard to be a well trained and experienced physician. Dr. Howard testified in a straightforward manner. He readily acknowledged areas where he had no specific expertise, such as OB-GYN issues and also acknowledged that in some instances Respondent met the minimum standard of care.

Overall, the Hearing Committee finds Dr. Howard to be a credible witness and they gave his testimony great weight.

With respect to Respondent, the Hearing Committee finds her testimony to be evasive and self-serving. The Hearing Committee finds Respondent's pattern of memory loss as an excuse for poor documentation to be unpersuasive. Most incredible, was Respondent's testimony that follow-up appointments had been made for these patients yet there is not documentation in the record or other proof of follow-up treatment. (T. 258-263) As a result, the Hearing Committee gave Respondent's testimony little weight.

NEGLIGENCE ON MORE THAN ONE OCCASION

The Hearing Committee concurs with Dr. Howard that for Patients A through F, Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations. (T.6,7,12,21,22,26,27,33-34,39) Even Respondent admits that her patient histories are not always complete. (T. 320-321, 405, 412-413) The Hearing Committee further finds that Respondent failed to provide follow-up treatment in the case of Patient A's heart murmur (T. 88), Patient B's breast nodule (T.144-147), Patient D's tenderness of the abdomen (T. 171-175 and Patient F's cystitis (T. 222-223) It should be noted however that Respondent did refer Patient C to a cardiologist for follow up treatment. (T. 258-259) Finally, the Hearing Committee concurs with Dr. Howard's assessment that all patient records fell below the minimum standard of medical record keeping. (T. 90-91, 135,251-252, 159, 171-172, 199-201,203,228,230) Therefore, the Hearing Committee concludes that the First Specification is sustained.

INCOMPETENCE ON MORE THAN ONE OCCASION

The Hearing Committee finds that Respondent appeared to be a well trained and knowledgeable physician. Petitioner provided no proof of her lack of medical skill, therefore the

Hearing Committee does not sustain the Second Specification.

FRAUDULENT PRACTICE

Respondent is charged with fraudulent practice for engaging in the practice of "unbundling" in the cases of Patients B, D and F. "Unbundling" occurs when only one test is actually performed but the separate parts of the test are billed individually, resulting in an increased charge to the insurance company. Respondent acknowledged this improper billing practice at the hearing (T. 385), but she claims that she had relied upon the advice of Dr. Herzog, her radiologist. (T. 386) Respondent testified that Dr. Herzog told her that an abdominal sonogram is interpreted by reading the gallbladder, then reading the hepatic system and then the abdominal sonogram and that it is appropriate to bill for the reading of each separate organ. (T. 388-389) In 1993, after Respondent learned this billing system was wrong, she changed her billing practice. (T. 389)

The Hearing Committee finds that evidence clearly shows that Respondent's billing procedure was fraudulent. In the case of Patient B, Ex. 9, p. 2 shows individual sonograms that include specific organ designations for organs not involved in Patient B's illness. The Hearing Committee also believes that even if Dr. Herzog advised her, Respondent was the one responsible for filling in and signing the insurance form. The Hearing Committee concludes from the facts presented, that Respondent knowingly, with intent to deceive, misrepresented that separate tests were needed and performed when only one songoram was necessary. Thus, the insurance company was grossly overcharged. The Hearing Committee further notes a repeated pattern of unbundling for Patients D and F. The Hearing Committee finds this to constitute fraudulent practice.

The Hearing Committee also finds fraud in Respondent's practice of billing the patient's insurance company for test interpretations that were not performed by her. Respondent acknowledged that she paid Dr. Herzog to read and interpret the x-rays and sonograms that she sent over to him. (T. 328-329, 448) The Hearing Committee further notes that all of the patient's files

were replete with written interpretations by Dr. Herzog. At the hearing, Respondent testified tha she had no idea of what the billing codes were when she signed the forms. (T. 326-327, 331-332 The Hearing Committee finds Respondent's excuse of her lack of knowledge of the billing codes t be totally incredulous. They note that she made no attempt to modify or indicate on her bills tha another physician was interpreting the results for her. From these circumstances, the Hearing Committee concludes that Respondent intended to deceive the insurance carriers for Patients A through F. As a result, the Hearing Committee sustains the Third through Eighth Specifications.

FALSE REPORT

The Hearing Committee finds that for the reasons discussed in the aforementioned section, Respondent's practice of repeated unbundling and billing the insurance carrier for the interpretation of tests which she did not perform resulted in the filing of false reports with the insurance carriers. Therefore, the Hearing Committee sustains the Ninth through Fourteenth Specifications.

UNNECESSARY TESTS OR TREATMENT

For Patient A, the Hearing Committee does not sustain the Fifteenth Specification. Since Respondent's notes state that she heard a heart murmur, the Hearing Committee finds that there was no way to prove that she didn't hear one. Thus, the echocardiogram could have been justified. (T. 89, 91, 104, 110-111) Respondent testified that she ordered the chest x-ray based on complaints of palpitations and near syncope. (T. 314-315) Dr. Howard testified if the echocardiogram was normal, the chest x-ray could have been deferred. (T. 103) The Hearing Committee was not persuaded by Dr. Howard's testimony in this instance. Petitioner withdrew the charges relating to the electrocardiogram and the sonogram.

For Patient B, the Hearing Committee concurs with Dr. Howard that the pelvic and breast sonograms were deemed appropriate (T. 143, 144), but that the echocardiogram and the retroperitoneal were not appropriate. (T. 133, 137) Therefore, the Hearing Committee sustains the Sixteenth Specification in part.

For Patient C, all charges in support the Seventeenth Specification were withdrawn by the Department .

For Patient D, Respondent testified that she ordered pelvic and retroperitoneal sonograms because the patient presented with hematuria and pelvic pain.(T. 468-469) Dr. Howard even testified that the sonograms might have been justified based on the subsequent findings of a gastroenterologist who saw the patient 2 months later. (T. 180-181) It was not proven that the CAT scan was ordered by Respondent. Even Dr. Howard believed it was subsequently ordered by a urologist. (T. 163, 176) Therefore, the Hearing Committee does not sustain the Eighteenth Specification.

For Patient E, the Hearing Committee concurs with Dr. Howard that the pelvic sonogram and the chest x-ray were not warranted for this patient. (T. 200) but that the echocardiogram may have been justified. (T. 206-207) Therefore, the Hearing Committee sustains the Nineteenth Specification.

For Patient F, the Hearing Committee finds that there was no complaint of pelvic pain to justify the pelvic sonogram and that a colonoscopy, or barium tests were more appropriate . (T. 226-228, 232-233, 239) They, however find that the echocardiograms, the electrocardiograms and the x-rays were warranted due to the patient's enlarged heart and high blood pressure.(T. 233-235) Therefore, the Hearing Committee sustains the Twentieth Specification in part.

FEE SPLITTING

The Hearing Committee was suspicious of the disparity between Dr. Herzog's nominal fee for his interpretations of the tests and Respondent's reimbursement from the insurance carrier, which

suggested an illicit agreement between them. (T. 305, 448-453) The Hearing Committee however, believes that the Department failed to prove the crucial element of payment of money or other benefits by Dr. Herzog to the Respondent. As a result, the Hearing Committee concludes that there is insufficient evidence to sustain the Twenty-First through Twenty Sixth Specifications.

FAILURE TO MAINTAIN RECORDS

The Hearing Committee concurs with Dr. Howard's on going criticism that Respondent's records for Patients A through F did not meet the minimum standard for adequate medical record keeping. (T. 90-91, 135,251-252, 159, 171-172, 199-201,203,228,230) Therefore, the Hearing Committee sustains the Twenty Seventh through Thirty Second Specifications.

MORAL UNFITNESS

The Hearing Committee finds that Respondent's pattern of excessive billing, falsifying insurance records and failure to follow up treatment for Patient's A, B, D and F constitutes moral unfitness by a physician in the practice of medicine. The Hearing Committee is most concerned with Patient A's heart murmur and Patient B's breast nodule. Either these conditions were manufactured by Respondent for excessive billing or if real, Respondent's lack of follow up care represents a flagrant lack of concern for the well being of these patients.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice medicine in New York State should be suspended for four (4) years following the effective date of this Determination and Order. The suspension shall be stayed for three(3) years and nine(9) months and Respondent shall

be placed on probation that includes monitoring for adequate record keeping and billing practices. In addition, Respondent shall be required to perform 150 hours of community service which shall be completed in the first year of probation. Respondent shall also be fined a civil penalty of Ten Thousand Dollars ($10,000). The complete terms of probation are attached to this Determination and Order in Appendix II. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to stature, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Hearing Committee believes that the prescribed penalty is sufficiently severe and that revocation is not warranted in this instance. The charges in this case date back to 1990 through 1992. The Department offered no evidence that Respondent's misconduct continues today. Respondent testified that she changed her billing practices in 1993, once she became aware that they were inappropriate. (T.389) The Hearing Committee is satisfied that Respondent has learned from these mistakes and will not repeat them.

The Hearing Committee further notes that during the time of these incidents Respondent was experiencing enormous stress from the break up of her marriage that included harassment and threats by her husband to Respondent and other persons in the building where her clinic was situated. (Ex. B, T. 307-308) Finally, the Hearing Committee notes that no proof of incompetence was established by the Department. They believe that Respondent, a graduate of the University of Pennsylvania is a well trained physician who demonstrated thorough medical knowledge at the hearing. The Hearing Committee truly believes that a three (3) month actual suspension followed by forty-five (45) months of monitored probation, 150 hours of community service and a civil penalty of $10.000 truly punishes Respondent for her past professional misconduct and is the appropriate sanction in this instance.

ORDER

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

1. The First, Third through Fourteenth, Sixteenth, Nineteenth, Twentieth and Twenty-Seventh through Thirty Third Specifications of professional misconduct contained within the Statement of Charges (Pet. Ex. 1) are **SUSTAINED.**

2. The Second Fifteenth, Seventeenth, Eighteenth and Twenty-First through Twenty-Sixth Specifications are **NOT SUSTAINED**

3. Respondent's license to practice medicine in New York State is **SUSPENDED** for a period of four (4) years, said suspension to be **STAYED for a period of three(3) years and nine months (9);**

4. Respondent's license shall be placed on **PROBATION** during the period of suspension, and he shall comply with all Terms of Probation as set forth in Appendix II, attached hereto and made a part of this Order.

5. Respondent shall complete **150 hours of COMMUNITY SERVICE** within the **first** year of probation;

6. A civil penalty in the amount of **TEN THOUSAND DOLLARS ($10,000.00)** be and hereby is assessed against Respondent. Payment of the aforesaid sum shall be made to the Bureau of Accounts Management, New York State Department of Health, Erastus Corning Tower Building, Room 2230, Empire State Plaza, Albany, New York 12237 within thirty (30) days of the effective date of this Order;

7. 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, late payment charges and collection fees, 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);

8. This Order shall be effective upon service on the Respondent or Respondent's attorney by personal service or by certified or registered mail.

DATED: New York , New York
1/8 **1999**

REDACTED

NORTON SPRITZ, M.D.
(Chair)

RALPH LEVY, D.O.
JAMES J. DUCEY

TO: Terrence Sheehan, Esq.
Associate Attorney
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Jackson Heights, NY 11372

APPENDIX ONE

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

IN THE MATTER

OLGA BENITEZ, M.D.

STATEMENT
OF
CHARGES

OLGA BENITEZ, M.D., the Respondent, was authorized to practice medicine in New York State by the issuance of license number by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about November 25, 1992, Respondent treated Patient A, a 14 year old female at the Respondent's facility named Women's Total Health of New York at 37-51 91st Street, Jackson Heights, New York ("the Clinic"). (The names of the patients are contained in the attached Appendix.)

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondent inappropriately and without legitimate medical purpose ordered one or more:

   a. Echocardiograms
   b. Electrocardiograms
   c. Chest x-rays
   d. Sonograms

withdrawn

Petitioner's Ex 1-A
In Ev
10-20-95

3. Respondent, with intent to deceive, billed Patient A's insurance carrier for several sonograms of different organ groups, when in fact, only one sonogram was performed, a practice called "unbundling".

4. Respondent, with intent to deceive, billed Patient A's insurance carrier for the interpretation of numerous echocardiograms, electrocardiograms, x-rays and sonograms, when in fact, the interpretations were done by another physician, Bruce Herzoz, M.D.

5. Respondent inappropriately shared professional fees with Bruce Herzoz, M.D., for services Respondent did not perform.

6. Patient A complained of chest pain and palpitation. On physical examination a heart murmur was noted. Respondent failed to appropriately follow-up these complaints and finding.

7. Respondent failed to maintain a record for Patient A which accurately reflects the evaluation and treatment she provided, including patient complaints, history, physical examinations, diagnoses, treatment plans, insurance bills and analysis of lab test result.

B. In or about January, 1991, Respondent treated Patient B, a 17 year old female at the Respondent's Clinic.

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondent inappropriately and without legitimate medical purpose ordered numerous:

   a. Sonograms

3. On numerous occasions, Respondent, with intent to deceive, billed Patient B's insurance carrier for several sonograms of different organ groups, when in fact, only one sonogram was performed, a practice called "unbundling".

4. Respondent, with intent to deceive, billed Patient B's insurance carrier for the interpretation of numerous sonograms, when in fact, the interpretations were done by another physician, Bruce Herzoz, M.D.

5. Respondent inappropriately shared professional fees with Bruce Herzoz, M.D., for services Respondent did not perform.

6. Patient B complained of hematuria and dysuria. Respondent failed to properly follow-up these complaints

7. Respondent failed to maintain a record for Patient B which accurately reflects the evaluation and treatment she provided, including patient complaints, history, physical examinations,

diagnoses, treatment plans, rationales for testing, insurance bills and analysis of lab test result.

C. Between or and about February, 1992, and on or about March, 1992, Respondent treated Patient C, a 63 year old male at the Clinic.

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondent inappropriately and without legitimate medical purpose ordered an:

   a. Echocardiogram
   b. Electrocardiogram
   c. Chest x-ray

3. Respondent, with intent to deceive, billed Patient A's insurance carrier for the interpretation of echocardiograms, electrocardiograms, chest x-rays, when in fact, the interpretations were done by another physician, Bruce Herzog, M.D.

4. Respondent inappropriately shared professional fees with Bruce Herzog, M.D., for services Respondent did not perform.

5. Patient C had a blood pressure of 190/110 while at Respondent's facility. Respondent improperly failed to take a repeat blood pressure or to further evaluator this condition.

6. Respondent failed to maintain a record for Patient C which accurately reflects the evaluation and treatment she provided, including patient complaints, history, physical examinations, diagnoses, treatment plan, rationales for testing, insurance bills and analysis of lab test results.

D. On or about October, 1990, and on or about October, 1991, Respondent treated Patient D, a 52 year old female at the Respondent's Clinic.

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondent inappropriately and without legitimate medical purpose ordered:

   a. Sonograms
   b. Cat Scans

3. Respondent, with intent to deceive, billed Patient D's insurance carrier for several sonograms of different organ groups, when in fact, only one sonogram was performed, a practice called "unbundling".

4. Respondent, with intent to deceive, billed Patient D's insurance carrier for the interpretation of numerous sonograms and Cat Scans, when in fact, the interpretations were done by another physician, Bruce Herzoz, M.D.

5. Respondent inappropriately shared professional fees with Bruce Herzoz, M.D., for services Respondent did not perform.

6. Patient D complained of abdominal pain. Respondent failed to properly follow-up this complaint.

7. Respondent failed to maintain a record for Patient D which accurately reflects the evaluation and treatment she provided, including patient complaints, history, physical examinations, diagnoses, treatment plans, rationales for testing, insurance bills and analysis of lab test result.

E. In or about August and September, 1992, Respondent treated Patient E, a 13 year old female at the Respondent's Clinic.

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondent inappropriately and without legitimate medical purpose ordered:

   a. A pelvic sonogram and echocardiograms
   b. Chest x-rays

3. Respondent, with intent to deceive, billed Patient E's insurance carrier for the interpretation of numerous sonograms, when in fact, the interpretations were done by another physician, Bruce

Herzoz, M.D.

4. Respondent inappropriately shared professional fees with Bruce Herzoz, M.D., for services Respondent did not perform.

5. Laboratory tests showed abnormal results in the alkaline phosphatase and transaminase. Respondent failed to follow-up these findings.

6. Respondent failed to maintain a record for Patient E which accurately reflects the evaluation and treatment she provided, including patient complaints, history, physical examinations, diagnoses, treatment plans, rationales for testing, insurance bills and analysis of lab test result.

F. Between on or about January, 1991, and on or about April, 1992, Responden treated Patient F, a 63 year old female at the Respondent's Clinic.

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondent inappropriately and without legitimate medical purpose ordered:

   a. Echocardiograms
   b. Electrocardiograms
   c. X-rays

d. Sonograms

3. On numerous occasions, Respondent, with intent to deceive, billed Patient F's insurance carrier for several sonograms of different organ groups, when in fact, only one sonogram was performed, a practice called "unbundling".

4. Respondent, with intent to deceive, billed Patient F's insurance carrier for the interpretation of numerous echocardiograms, electrocardiograms, x-rays and sonograms, when in fact, the interpretations were done by another physician, Bruce Herzoz, M.D.

5. Respondent inappropriately shared professional fees with Bruce Herzoz, M.D., for services Respondent did not perform.

6. Patient F complaint of cystitis. Respondent failed to order a urinalysis or follow-up and test this condition.

7. Respondent failed to maintain a record for Patient F which accurately reflects the evaluation and treatment she provided, including patient complaints, history, physical examinations, diagnoses, treatment plans, rationales for testing, insurance bills and analysis of lab test result.

SPECIFICATION OF CHARGES

FIRST 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. 1998) 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:

1. Paragraphs A and A1, A2, A6 and A7; B and 1, B2, B6, and B7; C and C1, C2, C5 and C6; D and D1, D2, D6, and D7; E and E1, E2, E5, E6 and/or F and F1, F2, F6 and F7.

SECOND 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. 1998) 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:

2. Paragraphs A and A1, A2, A6 and A7; B and 1, B2, B6, and B7; C and C1, C2, C5 and C6; D and D1, D2, D6, and D7; E and E1, E2, E5, E6 and/or F and F1, F2, F6 and F7.

THIRD THROUGH EIGHTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined b N.Y. Educ. Law §6530(2)(McKinney Supp. 1998) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. Paragraphs A and A3, and A4.
4. Paragraphs B and B3 and B4.
5. Paragraphs C and C3.
6. Paragraphs D and D3 and D4.
7. Paragraphs E and E3
8. Paragraphs F and F3 and F4.

NINTH THROUGH FOURTEENTH SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21)(McKinney Supp. 1998) by wilfully making or filing a false report, or failing to file a report required by law or by the Department of Health or the Education Department as alleged in the facts of:

9. Paragraphs A and A1, and A4.
10. Paragraphs B and B3 and B4.
11. Paragraphs C and C3.
12. Paragraphs D and D3 and D4.

13. Paragraphs E and E3

14. Paragraphs F and F3 and F4.

FIFTEENTH THROUGH TWENTIETH SPECIFICATIONS

UNNECESSARY TESTS OR TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 1998) by ordering excessive tests or treatment as alleged in the facts of:

15. Paragraphs A and A2.

16. Paragraphs B and B2.

17. Paragraphs C and C2.

18. Paragraphs D and D2.

19. Paragraphs E and E2.

20. Paragraphs F and F2

TWENTY-ONE THROUGH TWENTY-SIX SPECIFICATIONS

FEE SPLITTING

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(19)(McKinney Supp. 1998) by permitting any person to share in the fees for professional services as alleged in the facts of:

21. Paragraphs A and A5.

22. Paragraphs B and B5.

23. Paragraphs C and C4.

24. Paragraphs D and D5.

25. Paragraphs E and E4.

26. Paragraphs F and F5.

TWENTY-SEVEN THROUGH THIRTY-TWO SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined i N.Y. Educ. Law §6530(32)(McKinney Supp. 1998) by failing to maintain a record fo each pateint which accurately reflects the care and treatment of the patient as alleged in the facts of:

27. Paragraphs A and A7.

28. Paragraphs B and B7.

29. Paragraphs C and C6.

30. Paragraphs D and D7.

31. Paragraphs E and E6.

32. Paragraphs F and F7.

THIRTY-THIRD SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined i N.Y. Educ. Law §6530(20)(McKinney Supp. 1998) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

33. Paragraphs A, A3 and A4; B and B3, and B4; C and C3; D and D3 and D4; E and E3 and/or F and F3 and F4.

DATED: October , 1998
New York, New York

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

APPENDIX II

TERMS AND CONDITIONS OF PROBATION

1. Respondent shall conduct herself in all ways in a manner befitting her professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession.

2. Respondent shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Respondent shall submit written notification to the Board, addressed to the Director, Office of Professional Medical Conduct ("OPMC"), Hedley Park Place, 433 River Street, 5th Floor, Troy, NY 12180, regarding any change in employment, practice, address, (residence or professional) telephone numbers, and facility affiliations within or without New York State, within 30 days of such change.

4. Respondent shall submit written notification to OPMC of any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within 30 days of each charge or action.

5. Respondent shall submit written proof to the Director of the OPMC at the address indicated above that she has paid all registration fees due and is currently registered to practice medicine as a physician with the New York State Education Department.

6. Respondent's practice of medicine shall be monitored by a physician monitor, who specializes in primary and general care, ("practice monitor") approved in advance, in writing, by the Director of the Office of Professional Medical Conduct. Respondent may not practice medicine until an approved practice monitor and monitoring program is in place. Any practice of medicine prior to the submission and approval of the proposed practice monitor will be determined to be a violation of probation.

(a) The practice monitor shall report in writing to the Director of the Office of Professional Medical Conduct or his/her designee, on a schedule to be determined by the office. The practice monitor shall visit Respondent's hospital, medical practice at each and every location, on a random basis and shall examine a random selection of records maintained by Respondent, including patient histories, prescribing information and billing records. Respondent will make available to the monitor any and all hospital records or access to the practice requested by the monitor, including on-site observation. The review will determine whether the Respondent's hospital medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall immediately be reported to the Office of Professional Medical Conduct by the monitor.

(b) Any change in practice monitor must be approved in writing, in advance, by the Office of Professional Medical Conduct.

(c) It is the responsibility of the Respondent to ensure that the reports of the practice monitor are submitted in a timely manner. A failure of the practice monitor to submit required reports on a timely basis will be considered a possible violation of the terms of probation.

7. Respondent will maintain legible and complete hospital medical records which accurately reflect evaluation and treatment of patients. All hospital records will contain a comprehensive history, physical examination findings, chief complaint, present illness, diagnosis and treatment. In cases of prescribing, dispensing, or administering of controlled substances, the medical record will contain all information required by state rules and regulations regarding controlled substances.

8. All expenses, including but not limited to those of complying with these terms of probation and the Determination and Order, shall be the sole responsibility of the Respondent.

9. Respondent must maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230 (18) (b) of the Public Health Law. Proof of coverage shall be submitted to the Director or designee prior or the placement of a practice monitor.

10. Respondent shall perform 150 hours of community service. The service must be medical in nature, and delivered in a facility or with an organization equipped to provide medical services and serving a needy or medically underserved population. A written proposal for community service must be submitted in advance, for written approval by the Director of the Office of Professional Medical Conduct or designee. Community service performed prior to the effective date of this Order cannot be credited for compliance with

this term.

11. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the Order of the Board. A violation of any of these terms of probation shall be considered professional misconduct. On receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against the Respondent pursuant to New York Public Health Law §230(19) or any other applicable laws.