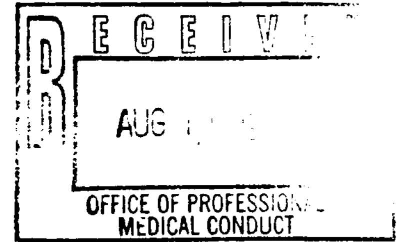
# STATE OF NEW YORK
# DEPARTMENT OF HEALTH

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*

August 9, 1993




**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Richard Adler, M.D.
Red Hutters Farm
Patterson, New York 12563

Neal H. Rosenberg, Esq.
9 Murray Street
New York, New York 10007

Terrence Sheehan, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001-1810

**RE: In the Matter of Richard Adler, M.D.**

Dear Dr. Adler, Mr. Rosenberg and Mr. Sheehan:

Enclosed please find the Determination and Order (No. BPMC-93-105) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:

New York State Department of Health
Office of Professional Medical Conduct
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 than 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
Corning Tower -Room 2503
Empire State Plaza
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.

Very truly yours,

Tyrone T. Butler/nam

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nam
Enclosure

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

| | |
|---|---|
| **IN THE MATTER** | : **HEARING COMMITTEE** |
| **OF** | : **DETERMINATION** |
| **RICHARD ADLER, M.D.** | : **AND ORDER** |
| | **NO. BPMC-93-** 105 |

**Thea Graves Pellman**, Chairperson, **John P. Frazer M.D.**, and **Richard N. Pierson, M.D.**, 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(10)(e) and 230(12) of the Public Health Law. **Stephen Bermas, 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

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| Notice of Hearing dated: | June 24, 1992 |
| Statement of Charges dated: | June 26, 1992 |
| Hearing Dates: | Sept. 11, Nov. 20, Dec. 4, Dec. 11, 1992; Jan. 4, Jan. 5, Jan. 11, Feb. 17, Feb. 25, April 21, May 7, May 10, June 4, 1993 |
| Deliberation Dates: | June 24, June 28, 1993 |

| | |
|---|---|
| Place of Hearing: | NYS Department of Health<br>5 Penn Plaza<br>New York, New York |
| Petitioner Appeared By: | Peter J. Millock, Esq.<br>General Counsel<br>NYS Department of Health<br>BY: Terrence Sheehan, Esq. |
| Respondent Appeared By: | Neal Rosenberg, Esq. |

## STATEMENT OF CHARGES

The Statement of Charges has been marked as Petitioner's Exhibit 1 and hereto attached as Appendix A.

## FINDINGS OF FACT

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

1. **Richard Adler, M.D.**, Respondent, was authorized to practice medicine in New York State on August 1, 1972 by the issuance of license number 113264 by the New York State Education Department. Respondent was registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992. (Ex. 1)

2. **Murray Dworetzky, M.D.**, was the State's expert witness. Dr. Dworetzky is board certified in internal medicine and in allergy and immunology. He obtained his training, among other places, at State University of New York at Downstate and at the Mayo Clinic in Rochester Minnesota. He has been affiliated with the New York Hospital, Cornell University Medical Center for a number of years. He has been a clinical professor of medicine at The New York Hospital and was director of the training program in allergy and immunology in the Department of Medicine and was also a physician in charge of the allergy clinic for a number of years. Dr. Dworetzky has had a private practice in New York City since 1951. While, originally, his practice also included internal medicine, it has been limited to allergy and immunology for approximately the last 20 years. Dr. Dworetzky has also had considerable experience in peer review activities. For about sixteen years, he was a member of the Peer Review committee of the New York County Medical Society. We find him to be a highly credible witness. (T. 30-2)

3. When dealing with allergies, the most important part of arriving at a diagnosis is taking a good history. Most of the time with a patient should be spent taking a thorough history. (T. 42)

**PATIENT A**

4. Between on or about September 17, 1987, and on or about March 17, 1988, Respondent treated Patient A for nasal congestion at Respondent's office at 10 Mitchell Place, White Plains, N.Y. (Ex. 2)

5. Patient A's mother testified as witness for Petitioner. She has been a registered nurse for 29 years. Respondent never took a history from Patient A's mother concerning the patient's nasal congestion. Respondent did not perform a physical examination of Patient A. The rhinoscopy performed by Respondent consisted of inserting the tube about a 1/4 inch into each nostril. It took a total of about 5 seconds. (T. 509-14, Ex. 2)

6. No one explained to Patient A's mother what tests were going to be done and why. She was merely ushered into an office occupied by a nurse and a number of tests were done. (T. 512-514)

7. Patient A at one point during this treatment by Respondent was prescribed Dicloxacillin. He was to take that for ten days. However, nowhere in the patient's chart is there any mention of this medication. (T. 515-6, Ex. 2)

8. Patient A was never told to wait in the office after receiving his immunotherapy injections. (T. 517-8, Ex. 5)

9. On all occasions that Patient A and his mother returned to Respondent's office to receive shots, they never saw nor were examined by Respondent. (T. 519)

10. Patient A's mother decided to go to another allergist. She contacted her union and they recommended a Dr. Barry Josephson in Yonkers. Dr. Josephson took a history. In comparison to the history and curscry examination performed by Respondent, Dr. Josephson's was extensive and professional. He spent approximately 1 1/2 hours taking an extensive history and doing a complete physical examination. (T. 520-24, Ex. 3)

11. Patient's mother told Dr. Josephson that Dr. Adler had informed her that the results of the RAST tests were very high. After repeating the RAST tests, Dr. Josephson informed the mother that the tests were all negative. Dr. Josephson put Patient A on a food elimination program to see whether he was allergic to a particular food. It was determined that his nasal congestion was caused by peanut butter, rye products and chocolate. As a result, the patient no longer ate those items and his allergy problems completely cleared up. Dr. Josephson determined that Patient A did not need allergy shots. (T. 522-3, Ex. 3)

12. Patient A's mother made a co-payment for the charges associated with her first visit with her child to Respondent's office. However, after that visit Respondent's office did not require her to make any co-payments. (T. 543-4)

13. Patient A complained of constant nasal congestion. An adequate history of such a complaint should include information as to how long this condition has been present, the nature, if any, of a discharge and whether the discharge is watery or purulent, in order to determine whether or not there is an infection. There should also be information as to whether or not itching or sneezing is also present. The relative constancy of the condition should be elucidated. One would need to know whether it varies in intensity and whether there are associated symptoms such as itching and tearing of the eyes. The presence at any time of chest symptoms such as wheezing or a cough should be determined. Whether the patient ever had eczema, a rash or hives should also be made clear. The patient should also be questioned about possible triggers of the condition and any exposures such as foods that make the condition worse. It should also be determined whether the severity of the symptoms are related to seasons, locations indoors or outdoors, or the presence of domestic pets. After a complete picture of the condition is obtained, questions concerning the patient's family history should be posed. The allergist must also take an environmental history of the

patient's home. He must get information concerning the nature of the patient's bedding, whether carpeting is present in his bedroom or in the house and the nature of the heating that is used. Based upon the answers given to these questions, additional lines of questioning would have to be pursued in order to track down the cause of the patient's condition. Although time-consuming, this type of extensive history taking is crucial to the patient receiving appropriate allergy care. (T. 43-5, Ex. 2)

14. The history taken by Respondent as found in the patient's chart does not constitute an acceptable patient history. (T. 45, Ex. 2)

15. The standards of proper medical care required a physical examination of this patient by Respondent. Aside from the sketchy results of a rhinoscopy, it is apparent from this record that no physical examination was performed by Respondent. (T. 45-7, Ex. 2)

16. This patient was seen by another physician after he stopped seeing Respondent. An example of a more adequate history and physical is contained in the medical record maintained by that subsequent treating physician. (T. 47-8, Ex. 3)

17. The PRIST is a test which measures the total immunoglobulin E, which is an indirect indication of the likelihood of a patient being allergic. The RAST is a test for the presence of specific antibodies in the blood. The antibodies would be produced by specific substances such as foods, pollens, and dust mites. (T. 48-9) Respondent ordered the performance of both PRIST and RAST tests for this patient. Based on this patient's medical record, there was no indication for performance of these tests. (T. 40, Ex. 2)

18. The Respondent ordered a hypersensitivity pneumonitis panel for this patient. This test is used when rare allergic conditions are suspected. However, there was no reason to order this test in the treatment of this patient. (T. 51-2, Ex. 2)

19. Complement studies were also ordered by Respondent. These studies are indicated when treating certain conditions such as hereditary angioedema, nephritis and rheumatoid arthritis. They were unnecessary in the treatment of this patient, however. (T. 52-4, Ex. 2)

20. A pulmonary function test was ordered and billed for this patient. There is no support for doing that test in this patient's chart. (T. 55-6, 512-514, Ex. 2)

21. Chest films were ordered for this patient. There is no positive finding concerning an examination of this patient's chest. Therefore, there is no reason to have performed or ordered an X-ray of the chest. (T. 57, Ex. 2)

22. A fiberoptic examination was performed on Patient A. The chart does not provide any substantiation of the need for this test on this patient on the first date he was seen by Respondent. (T. 58-9, Ex. 2)

23. According to Respondent's bill there were three parts of the fiberoptic examination: a rhinoscopy, a pharyngoscopy and a laryngoscopy. In fact, according to the chart, a laryngoscopy was not performed. (T. 59-60, Ex. 2)

24. The generally accepted manner of treating allergic diseases is set forth in a publication by the National Institute of Allergy and Infectious Diseases of the National Institutes of Health. The expert consensus as reflected in this publication is that the first line of defense in the treatment of allergies is to remove or reduce the offending allergens. The second line of treatment consists of medical treatment. There are medications available for the treatment of allergies. Only when those two modes of therapy prove unavailing should immunotherapy be considered. Inasmuch as these two lines of treatment were not attempted by Respondent

and his record does not constitute a valid basis upon which to conclude that this patient had an allergy problem, the immunotherapy he ordered for this patient was not medically indicated. (T. 66-71, Ex. 5)

25. The evaluation and management of this patient by Respondent does not meet accepted standards of medical practice. (T. 72)

26. The medical record maintained by Respondent for this patient does not meet the accepted standards of medical record-keeping in this specialty. (T. 71-2)

27. The chart does not contain, as it should, any report relative to the X-rays which were ordered for this patient. (Ex. 2)

**PATIENT B**

28. On or about September 18, 1985 Respondent treated Patient B for an ear infection and allergies at Respondent's office at 37 Main Street, Fishkill, N.Y. (Ex. 6)

29. Patient B's mother took her child to Respondent's office in response to a brochure that was sent to her in the mail by Respondent. She first took her child to Respondent's office in September, 1985. Respondent did not perform any physical examination of Patient B, aside from looking in the patient's

nose. (T. 545-9, Ex. 6)

30. Patient B's mother was told on at least two occasions that the bill for the visit would be $600. However, she received a bill for $1,592. The patient's mother contacted her insurance company and informed them that there was something definitely wrong with Respondent's office practice and that they should investigate before paying anything to him. (T. 550-52, Ex. 6)

31. A physical examination was medically indicated but was not performed on this patient. (T. 95-6, Ex. 6)

32. Respondent performed a PRIST test for this patient. That test was unnecessary since the Respondent also did a RAST test. The PRIST test produces a gross measurement which is valueless if one has already decided to do RAST tests which give more specific measurements. (T. 96-7, Ex. 6)

33. Chest and sinus X-rays were ordered for this patient. However, chest X-rays were unnecessary in the treatment of this 13 year-old patient. In addition, the chart does not contain any report concerning these X-rays. (T. 98-100, 1127, Ex. 6)

34. The report in the chart of the rhinoscopy performed on Patient B is inadequate and incomplete. (T. 100-101, Ex. 6)

35. The chart does not mention any chest symptoms concerning this patient. Therefore, the pulmonary function that was ordered was not medically justified. (T. 101-2, Ex. 6.)

36. Respondent diagnosed Patient B as having perennial allergic rhinitis, sinusitis and conjunctivitis. These diagnoses were not medically supported by Respondent's chart or laboratory tests. The history taken from this patient is much too meager to constitute any type of support for these diagnoses. The lab tests, specifically the RAST and PRIST tests, do not substantiate the diagnoses but refute it. The PRIST test result was 16, which is perfectly normal for a 13 year old. (T. 113-4, Ex. 6)

37. The charge to the patient for this first visit was $1,554. (T. 116, Ex. 6, p. 6) Respondent's fees for this patient were outrageously excessive. (T. 121)

38. Given this patient's history of serious ear problems, Respondent should have either referred this patient to an ear, nose and throat specialist or at least had an audiogram or tympanogram performed. Respondent failed to do so. (T. 126-7, Ex. 6)

39. In the presence of these ear problems, Respondent should have explored with the patient's mother any problems with learning,

speech development, or school work. He failed to do so. (T. 126-7, Ex. 6)

PATIENT C

40. Between on or about May 10, 1989, and on or about June 21, 1989, Respondent treated Patient C for hives at Respondent's Fishkill office. (Ex. 7)

41. According to Respondent Patient C had hives. There is no indication in Respondent's chart that he considered a possibility that this was a dermatological condition, as he should have, or that he considered the possibility of referring this patient to a dermatologist. (T. 131-2, Ex. 7)

42. Patient's other complaint was a stuffed nose. The history of this complaint is inadequate. For example, there is no mention of seasonality, nature of the nasal discharge or the presence of triggers, e.g., events or foods, that cause the reaction. In the absence of a thorough discussion of these issues as well as other issues, there is nothing in the record that points to an allergic cause for this condition. The history as given is extremely meager and does not begin to provide an adequate picture of this patient's condition upon presentation to Respondent. (T. 132-3, Ex. 7)

43. The absence of an adequate history makes the ordering of sophisticated allergy tests such as PRIST and RAST premature. The PRIST might be indicated. However, since the result of the PRIST was an extremely low score, that result obviated the need for the performance of RAST tests. There is no need to subject a patient to an expensive secondary test for specific allergy conditions. (T. 135-6, Ex. 7)

44. Respondent ordered quantitative immunoglobulins. There is no reason to perform these tests. It would be expected that they would be normal and in fact they were normal. (T. 136-7, Ex. 7)

45. At some point during the treatment of their patients, legitimate allergists will write a comprehensive note or an analytic note describing what they think the patient has, how they propose to deal with it, and what test results are or are not consistent with their tentative diagnosis. Nowhere in the chart of this patient is there any such note by Respondent. (T. 144, Ex. 7)

46. This patient was placed on a weekly program of immunotherapy. The chart, including laboratory test results, provides no legitimate basis for starting this patient on immunotherapy. (T. 145-7, Ex. 7)

47. In addition to giving the patient immunotherapy and inhalants, Respondent gave him injections of various types of food antigens. This is unjustified and contraindicated. Had the patient been highly allergic to these substances, the administration of food injections in an immunotherapy program would be dangerous. It could cause anaphylactic shock. (T. 147-50, Ex. 7)

48. The evaluation and management of this patient by Respondent does not meet the acceptable standards of medical practice. The medical record does not constitute an acceptable record. (T. 150-1, Ex. 7)

**PATIENT D**

49. Between on or about October 17, 1985, and on or about November 4, 1985, Respondent treated Patient D for wheezing at Respondent's office at 74 West Street, Danbury, Connecticut. (Ex. 13)

50. Patient D is an 11 year-old who complained of breathing difficulty, coughing and a stuffed nose. (T. 236, Ex. 13)

51. Aside from a rhinoscopy, no physical examination is contained in this patient's chart. Given this patient's age and

complaints, a physical examination was indicated. (T. 236-7, Ex. 13)

52. This chart contains a 3-part bill for a fiberoptic examination. One of the parts of this examination that was billed for was a laryngoscopy. The report of the examination reveals that the laryngoscopy was not in fact performed. Respondent billed for a procedure he did not perform. (T. 238, Ex. 13, p. 1 and 11)

53. On the first date Respondent saw this patient, he ordered chest and sinus X-rays. There are no X-ray reports or notations. The chart discloses that these X-rays were billed to the patient. (T. 239-40, Ex. 13, p. 1 and 13)

**PATIENT E**

54. Between on or about May 8, 1986, and on or about April 3, 1990, Respondent treated Patient E for sinusitis at Respondent's office at 226 North Main Street, New City, N.Y. (Ex. 8)

55. This patient had nasal symptoms and he had had surgery for a deviated septum in 1981. (T. 158-9, Ex. 8)

56. Respondent made a diagnosis of perennial allergic rhinitis and chronic infectious sinusitis. There is not adequate historical information recorded in this chart to justify those diagnoses. There is in fact inadequate information to make any diagnosis, but what little information is present does not suggest any type of allergic condition. (T. 160, 162, Ex. 8)

57. Respondent performed PRIST, RAST and an extensive battery of prick skin tests. Since the history taken of this patient was in no way suggestive of any allergic condition there was no reason to pursue this extensive series of different types of allergy tests. If one was determined to do some sort of testing, a simple set of pilot skin tests would have been sufficient. It is especially egregious that Respondent ordered both RAST and extensive skin tests for this patient. These tests are merely two ways of doing the same thing, and it is rarely defensible to do both of them on the same patient. (T. 160-2, Ex. 8)

58. A pulmonary function test was ordered for this patient. This test was medically unnecessary since there is no record of any kind of chest symptoms that would warrant this type of study. (T. 162, Ex. 8)

59. Quantitative immunoglobulins are done when one suspects some sort of immune deficiency with hipo gamma globulinemia. There

is no indication in this record that Respondent performed this test with that diagnosis in mind. There is no justification in this chart for performing that test. (T. 164-5, Ex. 8)

60. Chest films were ordered for this patient, but there is not any support for them in the chart inasmuch as there are no chest symptoms noted. (T. 166, Ex. 8)

61. Because of this patient's nasal problem, sinus films could be indicated in this case. The medical record is inadequate on this subject since sinus films are checked on a list of diagnostic procedures, but nowhere in the chart or in any of the subsequent visits is there any reference to them having been done or what the results of the tests were. (T. 166, Ex. 8)

62. This patient was placed on a program of immunotherapy, which continued for an extensive period of time. This therapy was unnecessary. There was no evidence the patient had any allergic condition. It was much more likely that he had some type of infectious process which should have been referred to an ear, nose and throat specialist. (T. 163, Ex. 8)

63. The evaluation and management of this patient does not meet acceptable standards of medical practice. The medical record maintained by respondent does not constitute an acceptable

medical record. (T. 167, Ex. 8)

64. Although Respondent was billed for laryngoscopy, one was not performed. (T. 176, Ex. 8)

**PATIENT F**

65. Between on or about July 29, 1985, and on or about January 23, 1986, Respondent treated Patient F for asthma and allergies at Respondent's Danbury office. (Ex. 9)

66. Patient F testified that she went to the Respondent's office in response to a radio ad which stated that if individuals were having trouble breathing, Respondent could help them. The patient told Respondent that she had been diagnosed as having asthma and that currently she could not breathe, her chest was very tight and that she constantly coughed up mucus. (T. 306-7, Ex. 9)

67. The only examination Respondent performed was to look down the patient's throat, into her ears and to place a lighted tube into each nostril approximately 1/2 of an inch. The tube remained in each nostril for a few seconds. (T. 307-9, Ex. 9)

68. The chart for this patient lists salicylate allergy as one of this patient's diagnoses. However, this patient regularly was

taking aspirin and did not discuss with Dr. Adler any type of allergy or problem she had with aspirin. (T. 310-11, Ex. 9)

69. Respondent wanted to have chest X-rays done on this patient. The patient informed Respondent that she had recently had such X-rays done, but Respondent insisted that she drive for 40 minutes to his other office to have additional chest films taken. (T. 311-312, Ex. 9)

70. The patient received weekly allergy injections from the beginning of August 1985 until January 1986. Respondent never was the person who administered the injections. During that period Respondent never examined the patient or talked to her about her progress. (T. 314-16, Ex. 9) The chart for this patient includes charges for three office visits as well as three injections during 8/8/85 and 9/5/85. (Ex. 9, p. 12)

71. After receiving her weekly injection the patient would immediately leave Respondent's office. She was never informed by anyone at Respondent's office that it would be advisable to stay around the office for a period of time after receiving the injection in order to observe any adverse reaction. (T. 316, Ex. 9)

72. This patient's insurance had a 20% co-pay component. Aside from the first visit, Patient F never had to pay the 20% co-

pay for the weekly visits she made to Respondent's office between August 1985 and January 1986. (T. 317-8)

73. Respondent informed this patient that he was going to have five vials of blood drawn in order to have RAST tests done. He was also going to do skin tests. She was subsequently informed that she was allergic to weeds, grass, dust, mites and mold. (T. 313) The patient stopped going for injections in January 1986 because her condition was not improving. (T. 316-317)

74. After stopping treatment with Respondent, patient contacted Danbury Hospital and requested a referral. She was referred to a Dr. Jeffrey Miller, a Board-certified allergist. Dr. Miller's chart for this patient was accepted into evidence. (Ex. 15)

75. The patient's initial visit with Dr. Miller lasted 1 hour. Subsequent visits averaged 20 to 30 minutes. (T. 352, Ex. 15)

76. Dr. Miller informed the patient that he had to rerun all the allergy tests performed by Respondent to see what readings he found. The tests run by Dr. Miller show that Patient F had no allergies. All the results were negative. The patient's mucous problem was treated by Dr. Miller with large doses of Theophylline, Ventolin Inhaler, and other drugs to loosen up

the patient's mucus. The treatment was successful and the patient presently does not take any medication at all. (T. 325, Ex. 15)

77. Although Respondent swore to this panel that his initial visit with patients was quite extensive and time consuming, Patient F stated that her initial visit with Respondent lasted five minutes. (T. 352, 1343)

78. Patient F complained of tightness in the chest, sore throat and swollen neck glands. (T. 177-8, Ex. 9) Respondent's history consists of three lines. Although this patient represented a complex problem, Respondent made an inadequate attempt to gather relevant information about this problem. (T. 178-9, Ex. 9)

79. Other than the rhinoscopy Respondent performed, no relevant physical examination of this patient was done. The absence of a space for physical findings on Respondent's form is a reflection of Respondent's lack of appreciation of the importance of such examinations. (T. 179-80, Ex. 9)

80. The combination of PRIST, RAST, intradermal and quantitative immunoglobulins allergy tests was unnecessary. (T. 180, 182, 185, Ex. 9)

81. With respect to both the chest and sinus films, the medical record is deficient in that it fails to note the results of either of these X-rays. (T-185-7, Ex. 9)

82. There was no reasons to perform a rhinoscopy on this patient. (T. 187, Ex. 9)

83. Respondent billed Patient F $85 for a laryngoscopy. There is no evidence in the chart that this portion of the fiberoptic examination was in fact performed. The patient was billed improperly for this component of the fiberoptic examination. (T. 187-8, Ex. 9)

84. This patient was also placed on a weekly program of immunotherapy, which was not medically justifiable. (T.188-9, Ex. 9)

85. Respondent sent to the Office of Professional Medial Conduct a letter enclosing a copy of a PRIST and RAST test result sheet dated 7/29/1985, which conflicts with another PRIST and RAST test result already in evidence dated 8/5/1985. The test results are totally different. (T. 192-5, Ex. 9, p. 2, Ex. 10, p. 3)

86. The evaluation and management of this patient by Respondent does not meet with accepted standards of medical practice and

the medical record is inadequate. (T. 197, Ex. 9)

## PATIENT G

87. Between on or about June 30, 1982, and on or about March 25, 1983, Respondent treated Patient G for a rash at Respondent's Fishkill office. (Ex. 12)

88. Patient G testified that he went to Respondent in July 1982 because of a rash which consisted of small white itchy blisters. (T. 225, 361-2)

89. The patients initial visit with Respondent lasted approximately 15 minutes. (T. 390) The Respondent examined the rash on the patient's arm. He did not perform any other type of physical examination. Respondent performed a RAST test. The patient was put on an immunotherapy program consisting of two different injections, two times a week, from approximately September 1982 through March 1983. (T. 362-5)

90. Respondent's history of this patient's complaints is inadequate. With respect to hay-fever there is no discussion of the typical information that an allergist must obtain. With respect to the rash complaint, there is no elucidation. (T. 226)

91. The physical examination of this patient is inadequate. Respondent only noted a follicular-type rash. Respondent ordered 30 RAST tests, 30 prick-skin tests and 35 intradermal skin tests between June 30, 1982 and September 24, 1982. These tests were unnecessary. There is no evidence that the rash was due to an allergy. (T. 230, Ex. 12)

92. After the completion of those tests the patient was given allergy injections and food antigens until March 25, 1983. This treatment was not medically required and the treatment with the food antigens was potentially harmful. (T. 230)

93. During this period of testing and immunotherapy, Respondent made no progress notes or recorded any type of examination in the patient's chart. This is unacceptable medical practice. (T. 230)

94. As an employee of IBM, Patient G was required to pay 20% of his covered medical costs. Patient G was advised by Respondent's nurse that Respondent would accept the IBM payment in full. After it was determined by IBM that Patient G did not make the co-payment to Dr. Adler, Patient G agreed to repay to IBM 20% of the figure actually paid to Respondent by IBM. He decided to do this in order not to jeopardize his job. (T. 369-70)

95. Respondent billed the patient's employer, IBM, for an office visit as well as for allergy serums, whenever the patient received injections. Inasmuch as the Respondent did not provide the injection and in the overwhelming majority of cases on these follow-up visits the Respondent did not examine the patient in any way, it was improper for Respondent to bill for an office visit. (T. 230-2)

96. The evaluation and management accorded this patient does not satisfy the standards of medical practice and the medical record does not constitute an acceptable record. (T. 231-2, Ex. 12)

97. Although much of the care in this case took place in the early 1980's, by the standards of treatment and recordkeeeping during that period Respondent's practices would not be acceptable. The treatment rendered to this patient is found to be inadequate. (T. 234-5)

**PATIENT H**

98. Between on or about April 10, 1985, and on or about August 19, 1985, Respondent treated Patient H for hives at Respondent's Fishkill office. (Ex. 11A, 11B)

99. The Patient complained of hives. The history taken by Respondent was inadequate. (T. 215-217, Ex 11A) A complete systems review is mandated in an individual with chronic hives. Chronic hives in an adult can be the herald of some very serious problems. Respondent improperly failed to perform such a systems review. (T. 217, Ex 11A)

100. A physical examination was indicated in evaluating this patient. Respondent failed to perform one. (T. 217, Ex. 11A)

101. Respondent placed Patient H on a weekly program of immunotherapy. Respondent never determined what caused the patient's hives. Since no offending allergen was considered the cause of hives, there was no basis upon which to subject the patient to a course of immunotherapy. (T. 218-9, Ex. 11A)

102. An alpha anti-trypsin test is indicated when emphysema is suspected. The history and physical examination revealed no reason to suspect this condition in this patient and therefore, the anti-trypsin test was unwarranted. (T. 219-20 Ex. 11A)

103. A hypersensitivity pneumonitis test was not indicated when there were no chest symptoms in this patient and this test was unwarranted. (T. 220, Ex. 11A)

104. Among the antigens employed by Respondent in his immunotherapy for this patient, were food antigens. There is potential danger of anaphylactic shock and we find this practice to have been contraindicated. (T. 221, Ex. 11A)

105. The evaluation and management of this patient by Respondent does not meet acceptable standards of medical practice and the medical record maintained by Respondent does not constitute an acceptable medical record. (T. 221, Ex. 11 A)

**INSURANCE MATTERS**

106. Metropolitan Life Insurance Company (Metropolitan) issues the Empire Plan. The Empire Plan covers employees of the State of New York and participating agencies and their covered dependents. For the years 1983 through 1985 the Empire Plan was called the State-Wide Plan. (T. 403-6)

107. Respondent billed Metropolitan under this insurance program a total of $837,708 for the years 1983 through 1985. Of that total amount, Metropolitan paid out to Respondent $703,675. (T. 405-6) All or a portion of that time, Respondent submitted bills out of different offices located in Fishkill, New City, White Plains and Brewster in New York, and Danbury, Connecticut. (T. 406-7)

108. For the years 1983 through 1985, if a patient went to a physician's office for allergy injections and was not seen by the physician, it violated the generally accepted standards of medical practice for the physician to bill the patient for an office visit in addition to billing the patient for the injection itself. If the physician was not involved in any way during that visit to his office, it was fraudulent to bill the patient or the patient's insurance company for an office visit. (T. 189-91)

109. Respondent engaged in fraudulent billing practices with respect to Metropolitan. In submitting bills to Metropolitan, Respondent employed the Current Procedural Terminology (CPT). This is a document containing codes for various services and procedures performed by physicians. It is used by all physicians and insurance companies. Respondent's bills to Metropolitan for office visits used certain codes of the CPT which, according to the definitions contained in the CPT, involved actual personal involvement of a physician in a patient's care. (T. 422-430, Ex. 17)

110. Although the CPT code book in evidence is dated 1985, the relevant entries are applicable to previous years inasmuch as there is no indication of any change, as would normally be done. (T. 484-5, Ex. 17)

111. Respondent admitted during his testimony that he feels it was perfectly proper to bill for office visits for allergy patients when Respondent was not present at the office during the visit. (T. 1054) He also admitted it would be appropriate to bill for such a visit even if he were on vacation in Spain. (T. 1063-5) Respondent billed Metropolitan for office visits for time periods when Respondent was out of the country. (T. 432-3, Ex. 18 and 19)

112. Respondent was rarely in the office at the time of office visits billed to Metropolitan. The injections were actually given by a nurse. The fact that Dr. Adler did not personally attend to these patients during these office visits was established by the testimony of patients, by the statements of Dr. Adler and by interviews of witnesses by Metropolitan. This conclusion is also supported by the fact that Dr. Adler had five offices that were all open at the same time on many occasions, while he was the only doctor. (T. 430-33)

113. Between 1983 and 1985 approximately $197,028 in improper office visit charges were made by Respondent to Metropolitan. (T. 435)

114. In Respondent's advertising, he informed patients that "in many cases, your insurance will be accepted as payment in full". (Ex. 14)

115. Although on occasion Respondent did collect the 20% co-payment from some of his patients, T. 531, Respondent's wide-spread practice of waiving the 20% co-payment is indicated both by his advertisements (Ex. 14) and by testimony (T. 438).

116. Due to this wide-spread practice of waiving the co-payment, Respondent's claim forms routinely contained overstatements of his actual charges which perpetrated a fraud upon Metropolitan. (T. 438-41)

117. As a result of Respondent's fraudulent practices in this area, Respondent improperly received an additional $100,000 in payments from Metropolitan for the years in question. (T. 441)

118. After an audit of Respondent's bills, Metropolitan and another insurance company, Aetna, sued Respondent for fraud. The actual damages Metropolitan sought in the lawsuit were approximately $300,000, plus punitive damages. (T. 410-11, 417)

119. There was testimony concerning a settlement agreement between Respondent and Metropolitan and Aetna Insurance Companies dated May 1, 1989, under which Respondent in July, 1989, paid $144,000 and in September, 1989, paid the remaining $336,000 for a total of $480,000. (T-490-1) Because of the nature of settlements, the panel members did not use this as evidence of any wrongdoing by Respondent and based their findings on other

credible evidence in this proceeding.

## DANBURY HOSPITAL

120. On or about April 23, 1976, Respondent submitted an application for an appointment to the staff of Danbury Hospital in Danbury, Connecticut. In the application, Respondent falsely stated that he had received a BA degree from Princeton University in 1957. (Ex. 20; T. 1044-7)

## CONCLUSIONS

I. Respondent is found to have engaged in professional misconduct by reason of practicing medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530(3) (McKinney Suppl. 1992) in that:

a. Respondent failed to obtain an adequate patient history for Patient A.

b. Respondent failed to perform an adequate physical examination of Patient A.

c. In the course of his treatment of Patient A, Respondent ordered the following tests or procedures which were not medically indicated:

(1) Quantitative immunoglobulins IgG, IgA and IgM

(2) Chest X-rays

(3) Fiberoptic pharyngoscopy and laryngoscopy

(4) Serum complement levels C3

(5) Serum complement levels C4

(6) Total complement level CH50

(7) Hypersensitivity pneumonitis panel

(8) Nasal cultures

d. Respondent placed Patient A on a weekly program of immunotherapy. This treatment was not medically indicated.

e. Respondent failed to obtain an adequate patient history for Patient B.

f. Respondent failed to perform an adequate physical examination of Patient B.

g. In the course of his treatment of Patient B, Respondent ordered the following tests or procedures which were not medically indicated:

(1) Quantitative immunoglobulins IgG, IgA and IgM

(2) Chest X-rays

(3) Pulmonary function test

(4) Fiberoptic laryngoscopy.

h. Respondent failed to obtain an adequate patient history for Patient C.

i. Respondent failed to perform an adequate physical examination of Patient C.

j. In the course of his treatment of Patient C, Respondent ordered the following tests or procedures which were not medically indicated:

(1) PRIST and RAST allergy tests

(2) Quantitative immunoglobulins IgG, IgA and IgM

k. Respondent placed Patient C on a weekly program of immunotherapy. This treatment was not medically indicated.

l. Among the antigens employed by Respondent in his immunotherapy program were food antigens. The injection of food antigens was contraindicated.

m. Respondent failed to obtain an adequate patient history for Patient D.

n. Respondent failed to perform an adequate physical examination of Patient D.

o. In the course of his treatment of Patient D, Respondent ordered the following tests or procedures which were not medically indicated:

(1) Quantitative immunoglobulins IgG, IgA and IgM

(2) Fiberoptic pharynoscopy and laryngoscopy

p. Respondent recommended that Patient D be placed on a weekly program of immunotherapy. This treatment was not medically indicated.

q. Respondent failed to maintain a medical record for Patient D which accurately reflected the patient's history, examination, rationales for tests and treatment, test results, evaluation of test results, report of fiberoptic examination and progress notes.

r. Respondent failed to obtain an adequate patient history for Patient E.

s. Respondent failed to perform an adequate physical examination of Patient E.

t. In the course of his treatment of Patient E, Respondent ordered the following tests or procedures which were not medically indicated:

(1) PRIST, RAST and extensive batteries of prick skin tests

(2) Quantitative immunoglobulins IgG, IgA and IgM

(3) Chest X-rays

(4) Fiberoptic pharyngoscopy and laryngoscopy

u. Respondent placed Patient E on a weekly program of immunotherapy. This treatment was not medically indicated.

v. Respondent failed to obtain an adequate patient history for Patient F.

w. Respondent failed to perform an adequate physical examination of Patient F.

x. In the course of his treatment of Patient F, Respondent ordered the following tests or procedures which were not medically indicated:

(1) PRIST, RAST and intradermal allergy tests

(2) Quantitative immunoglobulins IgG, IgA and IgM

(3) Fiberoptic laryngoscopy

y. Respondent placed Patient F on a weekly program of immunotherapy. This treatment was not medically indicated.

z. Respondent failed to obtain an adequate patient history of Patient G.

aa. Respondent failed to perform an adequate physical examination of Patient G.

bb. In the course of his treatment of Patient G, Respondent ordered RAST, prick and intradermal allergy tests or procedures which were not medically indicated.

cc. Respondent placed Patient G on a weekly program of immunotherapy. This treatment was not medically indicated.

dd. Among the antigens employed by Respondent in this immunotherapy program were food antigens. The injection of food antigens was contraindicated.

II. Respondent is found to have engaged in professional misconduct by reason of practicing medicine with incompetence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530(5) (McKinney Suppl. 1992) in that:

a. Respondent failed to obtain an adequate patient history for Patient A.

b. Respondent failed to perform an adequate physical examination of Patient A.

c. In the course of his treatment of Patient A, Respondent ordered the following tests or procedures which were not medically indicated:

(1) Quantitative immunoglobulins IgG, IgA and IgM
(2) Chest X-rays
(3) Fiberoptic pharyngoscopy and laryngoscopy
(4) Serum complement levels C3
(5) Serum complement levels C4
(6) Total complement level CH50
(7) Hypersensitivity pneumonitis panel
(8) Nasal cultures

d. Respondent placed Patient A on a weekly program of immunotherapy. This treatment was not medically indicated.

e. Respondent failed to obtain an adequate patient history for Patient B.

f. Respondent failed to perform an adequate physical examination of Patient B.

g. In the course of his treatment of Patient B, Respondent ordered the following tests or procedures which were not medically indicated:

(1) Quantitative immunoglobulins IgG, IgA and IgM
(2) Chest X-rays
(3) Pulmonary function test
(4) Fiberoptic laryngoscopy.

h. Respondent failed to obtain an adequate patient history for Patient C.

i. Respondent failed to perform an adequate physical examination of Patient C.

j. In the course of his treatment of Patient C, Respondent ordered the following tests or procedures which were not medically indicated:

(1) PRIST and RAST allergy tests
(2) Quantitative immunoglobulins IgG, IgA and IgM

k. Respondent placed Patient C on a weekly program of immunotherapy. This treatment was not medically indicated.

l. Among the antigens employed by Respondent in his

immunotherapy program were food antigens. The injection of food antigens was contraindicated.

m. Respondent failed to obtain an adequate patient history for Patient D.

n. Respondent failed to perform an adequate physical examination of Patient D.

o. In the course of his treatment of Patient D, Respondent ordered the following tests or procedures which were not medically indicated:

(1) Quantitative immunoglobulins IgG, IgA and IgM

(2) Fiberoptic pharynoscopy and laryngoscopy

p. Respondent recommended that Patient D be placed on a weekly program of immunotherapy. This treatment was not medically indicated.

q. Respondent failed to maintain a medical record for Patient D which accurately reflected the patient's history, examination, rationales for tests and treatment, test results, evaluation of test results, report of fiberoptic examination and progress notes.

r. Respondent failed to obtain an adequate patient history

for Patient E.

s. Respondent failed to perform an adequate physical examination of Patient E.

t. In the course of his treatment of Patient E, Respondent ordered the following tests or procedures which were not medically indicated:

(1) PRIST, RAST and extensive batteries of prick skin tests

(2) Quantitative immunoglobulins IgG, IgA and IgM

(3) Chest X-rays

(4) Fiberoptic pharyngoscopy and laryngoscopy

u. Respondent placed Patient E on a weekly program of immunotherapy. This treatment was not medically indicated.

v. Respondent failed to obtain an adequate patient history for Patient F.

w. Respondent failed to perform an adequate physical examination of Patient F.

x. In the course of his treatment of Patient F, Respondent

ordered the following tests or procedures which were not medically indicated:

(1) PRIST, RAST and intradermal allergy tests
(2) Quantitative immunoglobulins IgG, IgA and IgM
(3) Fiberoptic laryngoscopy

y. Respondent placed Patient F on a weekly program of immunotherapy. This treatment was not medically indicated.

z. Respondent failed to obtain an adequate patient history of Patient G.

aa. Respondent failed to perform an adequate physical examination of Patient G.

bb. In the course of his treatment of Patient G, Respondent ordered RAST, prick and intradermal allergy tests or procedures which were not medically indicated.

cc. Respondent placed Patient G on a weekly program of immunotherapy. This treatment was not medically indicated.

dd. Among the antigens employed by Respondent in this immunotherapy program were food antigens. The injection

of food antigens was contraindicated.

III. Respondent is found to have engaged in professional misconduct by reasons of practicing medicine fraudulently within the meaning of N.Y. Educ. Law Section 6530(2) (McKinney Suppl. 1992) in that:

a. In the course of his treatment of Patient A, Respondent ordered the following tests or procedures which were not medically indicated:

(1) Quantitative immunoglobulins IgG, IgA and IgM
(2) Chest X-rays
(3) Fiberoptic pharyngoscopy and laryngoscopy
(4) Serum complement levels C3
(5) Serum complement levels C4
(6) Total complement level CH50
(7) Hypersensitivity pneumonitis panel
(8) Nasal cultures

b. Respondent billed Patient A for a laryngoscopy which was not performed.

c. Respondent placed Patient A on a weekly program of immunotherapy. This treatment was not medically indicated.

d. In the course of his treatment of Patient B, Respondent ordered the following tests or procedures which were not medically indicated:

(1) Quantitative immunoglobulins IgG, IgA and IgM
(2) Chest X-rays
(3) Pulmonary function test
(4) Fiberoptic laryngoscopy

e. Respondent ordered and billed Patient B for a laryngoscopy, which was not performed.

f. In the course of his treatment of Patient C, Respondent ordered the following tests or procedures which were not medically indicated:

(1) PRIST and RAST allergy tests
(2) Quantitative immunoglobulins IgG, IgA and IgM

g. Respondent placed Patient C on a weekly program of immunotherapy. This treatment was not medically indicated.

h. In the course of this treatment of Patient D, Respondent ordered the following tests or procedures which were not medically indicated:

(1) Quantitative immunoglobulins IgG, IgA and IgM

(2) Fiberoptic pharyngoscopy and laryngoscopy

i. Respondent billed Patient D for a laryngoscopy, which was not performed.

j. Respondent recommended that Patient D be placed on a weekly program of immunotherapy. This treatment was not medically indicated.

k. In the course of his treatment of Patient E, Respondent ordered the following tests or procedures which were not medically indicated:

(1) PRIST, RAST and extensive batteries of prick skin tests

(2) Quantitative immunoglobulins IgG, IgA and IgM

(3) Chest X-rays

(4) Fiberoptic pharyngoscopy and laryngoscopy

l. Respondent billed Patient E for a laryngoscopy, which was not performed.

m. Respondent placed Patient E on a weekly program of immunotherapy. This treatment was not medically indicated.

n. In the course of his treatment of Patient F, Respondent

ordered the following tests or procedures which were not medically indicated:

(1) PRIST, RAST and intradermal allergy tests
(2) Quantitative immunoglobulins IgG, IgA and IgM
(3) Fiberoptic laryngoscopy

o. Respondent billed Patient F for a laryngoscopy, which was not performed.

p. Respondent placed Patient F on a weekly program of immunotherapy. This treatment was not medically indicated.

q. On or about August 8, 1985, August 15, 1985 and September 5, 1985, Patient F received immunotherapy injections at Respondent's office. The injections were administered by a nurse. Patient F was not seen or examined by Respondent. Yet on each occasion Respondent improperly billed the Patient for an office visit as well as for each injection.

r. In the course of his treatment of Patient G, Respondent ordered RAST, prick and intradermal allergy tests or procedures which were not medically indicated.

s. Respondent placed Patient G on a weekly program of

immunotherapy. This treatment was not medically indicated.

t. Between on or about October 1, 1982 and on or about March 25, 1983, Patient G received twenty (20) immunotherapy injections at Respondent's office. The injections were administered by a nurse. Patient G was not seen or examined by Respondent. Yet on each occasion Respondent improperly billed the Patient and/or the Patient's insurer for an office visit as well as for the allergy serum contained in each injection.

u. In the course of his treatment of Patient H, Respondent ordered the following tests or procedures which were not medically indicated:

(1) Chest X-ray

(2) Alpha Anti-Trypsin test

(3) Hypersensitivity Pneumonitis test

v. Respondent placed Patient H on a weekly program of immunotherapy. This treatment was not medically indicated.

w. Between on or about May 24, 1985, and on or about August 17, 1985, Patient H received sixteen (16) immunotherapy

injections at Respondent's office. The injections were administered by a nurse. Patient H was not seen or examined by Respondent. Yet on each occasion Respondent improperly billed the Patient and/or her insurer for an office visit as well as for each injection.

x. Between on or about January 1983 and on about January 1987, Respondent routinely submitted to Metropolitan Life Insurance Company (Metropolitan) claims for payment which contained false information.

(1) At each of the various offices operated by Respondent, nurses employed by Respondent administered periodic allergy injections to patients, usually on a weekly basis. During these visits the patients were not seen or examined by Respondent. Yet Respondent on such occasions routinely billed Metropolitan $40 for an "office visit", "allergy visit" or "office evaluation", in addition to a charge for the administration of each allergy injection.

(2) Respondent also entered or caused to be entered certain CPT codes on claim forms which falsely represented that a physician had evaluated or treated the patient on such occasions.

(3) As a result of the Respondent's false representations, Metropolitan paid in excess of $150,000 to Respondent for non-existent office visits, allergy visits and office evaluations.

y. Under Metropolitan's New York Statewide policy, insured patients are generally required to pay 20% of the fees charged by their physician, with Metropolitan paying the remaining 80%. Part of the rationale for requiring the patient to make a 20% "co-payment" is to limit the amount of unnecessary medical treatment. Respondent defeated this cost-cutting mechanism by failing to charge patients the 20% co-payment.

z. As a result of Respondent's misrepresentations, Metropolitan was caused to make inflated payments to Respondent. During the time period in question Metropolitan paid $703,675 to Respondent. Approximately $100,000 of this amount is attributable to Respondent's systematic practice of deliberately misrepresenting his actual charges for medical services.

aa. In on or about 1989, Respondent paid to Metropolitan and Aetna Life Insurance Company approximately $480,000 in settlement of lawsuits Metropolitan and Aetna had brought against Respondent under the federal Racketeer Influenced

and Corrupt Organizations Act. The lawsuits alleged that Respondent had engaged in a systematic scheme to defraud Metropolitan and Aetna between 1983 and 1987 by means of certain fraudulent practices.

bb. On or about March 26, 1976, Respondent applied to the Connecticut Medical Examining Board for a license to practice medicine in Connecticut. As part of the application Respondent swore before a notary public that all statements contained in the application were true. Respondent stated in the application that he received an undergraduate degree from Princeton University in 1958. This statement was knowingly false. Respondent never received any degree from Princeton University.

cc. On or about April 23, 1976, Respondent submitted an application for appointment to the staff of Danbury Hospital in Danbury, Connecticut. In the application Respondent falsely stated that he had received an undergraduate degree from Princeton University in 1957.

IV. Respondent is found to have engaged in professional misconduct by reason of willfully making or filing false reports within the meaning of N.Y. Educ. Law Section 6530(21) (McKinney Suppl. 1992) in that:

a. On or about August 8, 1985, August 15, 1985 and September 5, 1985, Patient F received immunotherapy injections at Respondent's office. The injections were administered by a nurse. Patient F was not seen or examined by Respondent. Yet on each occasion Respondent improperly billed the Patient for an office visit as well as for each injection.

b. Between on or about May 24, 1985, and on or about August 17, 1985, Patient H received sixteen immunotherapy injections at Respondent's office. The injections were not administered by a nurse. Patient H was not seen or examined by Respondent. Yet on each occasion Respondent improperly billed the Patient and/or her insurer for an office visit as well as for each injection.

c. Between on or about January 1983 and on about January 1987, Respondent routinely submitted to Metropolitan Life Insurance Company (Metropolitan) claims for payment which contained information Respondent knew to be false.

(1) At each of the various offices operated by Respondent, nurses employed by Respondent administered periodic allergy injections to patients, usually on a weekly basis. During these visits the patients were not seen or examined by

Respondent. Yet Respondent on such occasions routinely billed Metropolitan $40 for an "office visit", "allergy visit" or "office evaluation", in addition to a charge for the administration of each allergy injection.

(2) Respondent also entered or caused to be entered certain CPT codes on claim forms which falsely represented that a physician had evaluated or treated the patient on such occasions.

(3) As result of Respondent's false representations, Metropolitan paid in excess of $150,000 to Respondent for non-existent office visits, allergy visits and office evaluations

d. Under Metropolitan's New York Statewide policy, insured patients are generally required to pay 20% of the fees charged by their physician, with Metropolitan paying the remaining 80%. Part of the rationale for requiring the patient to make a 20% "co-payment" is to limit the amount of unnecessary medical treatment. Respondent defeated this cost-cutting mechanism by failing to charge patients the 20% co-payment.

e. As a result of Respondent's misrepresentations,

Metropolitan was caused to make inflated payments to Respondent. During the time period in question Metropolitan paid $703,675 to Respondent. Approximately $100,000 of this amount is attributable to Respondent's systematic practice of deliberately misrepresenting his actual charges for medical services.

f. In on or about 1989, Respondent paid to Metropolitan and Aetna Life Insurance Company approximately $480,000 in settlement of lawsuits Metropolitan and Aetna had brought against Respondent under the federal Racketeer Influenced and Corrupt Organizations Act. The lawsuits alleged that Respondent had engaged in a systematic scheme to defraud Metropolitan and Aetna between 1983 and 197 by means of certain fraudulent practices.

g. On or about March 26, 1976, Respondent applied to the Connecticut Medical Examining Board for a license to practice medicine in Connecticut. As part of the application Respondent swore before a notary public that all statements contained in the application were true. Respondent stated in the application that he received an undergraduate degree from Princeton University in 1958. This statement was knowingly false. Respondent never received any degree from Princeton University.

h. On or about April 23, 1976, Respondent submitted an application for appointment to the staff of Danbury Hospital in Danbury, Connecticut. In the application Respondent falsely stated that he had received an undergraduate degree from Princeton University in 1957.

V. Respondent is found to have engaged in professional misconduct by reason of ordering excessive tests and treatment within the meaning of N.Y. Educ. Law Section 6530(35) (McKinney Suppl. 1992) in that:

a. In the course of his treatment of Patient A, Respondent ordered the following tests or procedures which were not medically indicated:

(1) Quantitative immunoglobulins IgG, IgA and IgM
(2) Chest X-rays
(3) Fiberoptic pharyngoscopy and laryngoscopy
(4) Serum complement levels C3
(5) Serum complement levels C4
(6) Total complement level CH50
(7) Hypersensitivity pneumonitis panel
(8) Nasal cultures

b. Respondent placed Patient A on a weekly program of immunotherapy. This treatment was not medically indicated.

c. In the course of his treatment of Patient B, Respondent ordered the following tests or procedures which were not medically indicated:

(1) Quantitative immunoglobulins IgG, IgA and IgM
(2) Chest X-rays
(3) Pulmonary function test
(4) Fiberoptic laryngoscopy

d. In the course of his treatment of Patient C, Respondent ordered the following tests or procedures which were not medically indicated:

(1) PRIST and RAST allergy tests
(2) Quantitative immunoglobulins IgG, IgA and IgM

e. Respondent placed Patient C on a weekly program of immunotherapy. This treatment was not medically indicated.

f. In the course of his treatment of Patient D, Respondent ordered the following tests or procedures which were not medically indicated:

(1) Quantitative immunoglobulins IgG, IgA and IgM
(2) Fiberopticpharyngoscopy and laryngoscopy

g. Respondent recommended that Patient D be placed on a weekly program of immunotherapy. This treatment was not medically indicated.

h. In the course of his treatment of Patient E, Respondent ordered the following tests or procedures which were not medically indicated:

(1) PRIST, RAST and extensive batteries of prick skin tests

(2) Quantitative immunoglobulins IgG, IgA and IgM

(3) Chest X-rays

(4) Fiberoptic pharyngoscopy and laryngoscopy

i. Respondent placed Patient E on a weekly program of immunotherapy. This treatment was not medically indicated.

j. In the course of his treatment of Patient F, Respondent ordered the following tests or procedures which were not medically indicated:

(1) PRIST, RAST and intradermal allergy tests

(2) Quantitative immunoglobulins IgG, IgA and IgM

(3) Fiberoptic laryngoscopy

k. Respondent placed Patient F on a weekly program of immunotherapy. This treatment was not medically

indicated.

l. In the course of his treatment of Patient G, Respondent ordered RAST, prick and intradermal allergy tests or procedures which were not medically indicated.

m. Respondent placed Patient G on a weekly program of immunotherapy. This treatment was not medically indicated.

n. In the course of his treatment of Patient H, Respondent ordered the following tests or procedures which were not medically indicated:

(1) Chest X-ray

(2) Alpha Anti-Trypsin test

(3) Hypersensitivity Pneumonitis test

o. Respondent placed Patient H on a weekly program of immunotherapy. This treatment was not medically indicated.

VI. Respondent is found to have engaged in professional misconduct within the meaning of N.Y. Educ. Law Section 6530(32) (McKinney Suppl. 1950) by reason of failing to maintain a record for each patient which accurately reflected respondent's evaluation and treatment of the patient, in that:

a. Respondent failed to maintain a medical record for Patient A which accurately reflects the patient history, examination, rationales for tests and treatment, test results, evaluation of test results, report of the fiberoptic examination and progress notes.

b. Respondent failed to maintain a medical record for Patient B which accurately reflects the patient history, examination, rationales fcr tests and treatment, tests results, evaluation of tests results and report of the fiberoptic examination.

c. Respondent failed to maintain a medical record for Patient C which accurately reflects the patient history, examination, rationales for tests and treatment, test results, evaluation of test results, report of the fiberoptic examination and progress notes.

d. Respondent failed to maintain a medical record for Patient D which accurately reflects the patient history, examination, rationales for tests and treatment, test results, evaluation of test results, report of fiberoptic examination and progress notes.

e. Respondent failed to maintain a medical record for Patient E which accurately reflects the patient history,

examination, rationales for tests and treatment, test results, report of fiberoptic examination and progress notes.

f. Respondent failed to maintain a medical record for Patient F which accurately reflects the patient history, examination, rationales for tests and treatment, test results, evaluation of test results, report of the fiberoptic examination and progress notes.

g. Respondent failed to maintain a medical record for Patient G which accurately reflects the patient history, examination, rationales for tests and treatment, test results, evaluation of test results, report of the fiberoptic examination and progress notes.

h. Respondent failed to maintain a medical record for Patient H which accurately reflects the patient history, examination, rationales for tests and treatment, test results, evaluation of test results, report of the fiberoptic examination and progress notes.

VII. Respondent is found to have engaged in conduct in the practice of medicine which evidences his moral unfitness to practice medicine within the meaning of N.Y. Educ. Law Section 6530(20) McKinney Suppl. 1932) in that:

a. Respondent billed Patient A for a laryngoscopy, which was not performed.

b. Respondent ordered and billed Patient B for a laryngoscopy, which was not performed.

c. Respondent ordered and billed Patient D for a laryngoscopy, which was not performed.

d. Respondent ordered and billed Patient E for a laryngoscopy, which was not performed.

e. Respondent ordered and billed Patient F for a laryngoscopy, which was not performed.

f. On or about August 8, 1985, August 15, 1985 and September 5, 1985, Patient F received immunotherapy injections at Respondent's office. The injections were administered by a nurse. Patient F was not seen or examined by Respondent. Yet on each occasion Respondent improperly billed the Patient for an office visit as well as for each injection.

g. Between on or about October 1, 1982 and on or about March 25, 1983, Patient G received twenty (20) immunotherapy injections at Respondent's office. The injections were

administered by a nurse. Patient G was not seen or examined by Respondent. Yet on each occasion Respondent improperly billed the Patient and/or the Patient's insurer for an office visit as well as for the allergy serum contained in each injection.

h. Between on or about May 24, 1985, and on or about August 17, 1985, Patient H received sixteen (16) immunotherapy injections at Respondent's office. The injections were administered by a nurse. Patient H was not seen or examined by Respondent. Yet on each occasion Respondent improperly billed the Patient and/or her insurer for an office visit as well as for each injection.

i. Between on or about January 1983 and on about January 1987, Respondent routinely submitted to Metropolitan Lie Insurance Company (Metropolitan) claims for payment which contained information Respondent knew to be false.

(1) At each of the various offices operated by Respondent, nurses employed by Respondent administered periodic allergy injections to patients, usually on a weekly basis. During these visits the patients were not seen or examined by Respondent. Yet Respondent on such occasions routinely billed Metropolitan $40 for an "office

visit", "allergy visit" or "office evaluation", in addition to a charge for the administration of each allergy injection.

(2) Respondent also entered or caused to be entered certain CPT codes on claim forms which falsely represented that a physician had evaluated or treated the patient on such occasions.

(3) As a result of Respondent's false representations, Metropolitan paid in excess of $150,000 to Respondent for non-existent office visits, allergy and office evaluations.

j. Under Metropolitan's New York Statewide policy, insured patients are generally required to pay 20% of the fees charged by their physician, with Metropolitan paying the remaining 80%. Part of the rationale for requiring the patient to make a 20% "co-payment" is to limit the amount of unnecessary medical treatment. Respondent defeated this cost-cutting mechanism by failing to charge patients that 20% co-payment.

k. As a result of Respondent's misrepresentations, Metropolitan was caused to make inflated payments to Respondent. During the time period in question

Metropolitan paid $703,675 to Respondent. Approximately $100,000 of this amount is attributable to Respondent's systematic practice of deliberately misrepresenting his actual charges for medical services.

l. In on or about 1989, Respondent paid to Metropolitan and Aetna Life Insurance Company approximately $480,000 in settlement of lawsuits Metropolitan and Aetna had brought against Respondent under the federal Racketeer Influenced and Corrupt Organizations Act. The lawsuits alleged that Respondent had engaged in a systematic scheme to defraud Metropolitan and Aetna between 1983 and 1987 by means of certain fraudulent practices.

m. On or about March 26, 1976, Respondent applied to the Connecticut Medical Examining Board for a license to practice medicine in Connecticut. As part of the application Respondent swore before a notary public that all statements contained in the application were true. Respondent stated in the application that he received an undergraduate degree from Princeton University in 1958. This statement was knowingly false. Respondent never received any degree from Princeton University.

n. On or about April 23, 1976, Respondent submitted an application for appointment to the staff of Danbury

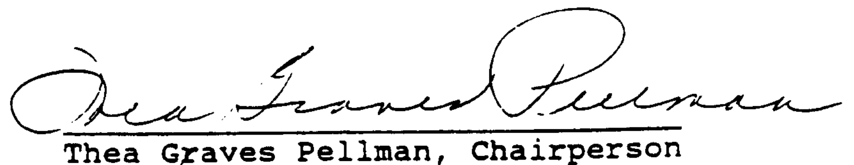
Hospital in Danbury, Connecticut. In the application Respondent falsely stated that he had received an undergraduate degree from Princeton University in 1957.

## ORDER

On those specifications that the Committee found were sustained by the evidence before them and that resulted in direct unwarranted financial gain to Respondent, the Committee has imposed a financial penalty in addition to revocation of Respondent's license to practice medicine. On all other specifications sustained by the record before the Committee, it was determined that revocation of Respondent's license is the appropriate penalty.

Accordingly, the Committee of the Board of Professional Medical Conduct determines and orders that the Respondent's license to practice medicine be revoked. The Committee further orders and determines that Respondent shall pay a fine of $10,000 each for Specifications numbered 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 17, 18, 21, 22, 23, 24, 25, 26, 27 and 28 for a total fine of $200,000.

Dated: New York, N.Y.
July 31, 1993



Thea Graves Pellman, Chairperson

John P. Frazer, M.D.
Richard N. Pierson, Jr., M.

# APPENDIX A

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

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| IN THE MATTER | CASE BPMC Adler<br>EXHIBIT 1<br>FOR I.D. M.S.S.<br>INV EVID. 9/11/92 M.S.S. | NOTICE |
| OF | | OF |
| RICHARD ADLER, M.D. | | HEARING |

TO: RICHARD ADLER, M.D.
Red Hutters Farm
Patterson, NY 12563

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1992) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1992). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 11th day of September, 1992 at 10:00 in the forenoon of that day at and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have

subpoenas issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1992), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a

qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A RECOMMENDATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW Section 230-a (McKinney Supp. 1992). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
June 24, 1992

CHRIS STERN HYMAN,
Counsel

Inquiries should be directed to: Terrence Sheehan
Associate Counsel
5 Penn Plaza - 6th fl.
New York, New York

Telephone No.: (212) 613-2601

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

-------------------------------------------X

| IN THE MATTER OF RICHARD ADLER, M.D. | : | STATEMENT OF CHARGES |
|---|---|---|

-------------------------------------------X

RICHARD ADLER, M.D., the Respondent, was authorized to practice medicine in New York State on August 1, 1972 by the issuance of license number 113264 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992.

## FACTUAL ALLEGATIONS

A. Between on or about September 17, 1987, and on or about March 17, 1988, Respondent treated Patient A for nasal congestion at Respondent's office at 10 Mitchell Place, White Plains, N.Y.

   1. Respondent failed to obtain an adequate patient history.

2. Respondent failed to perform an adequate physical examination.

3. In the course of his treatment of Patient A Respondent ordered the following tests or procedures which were not medically indicated:

   a. Prist and Rast allergy tests;

   b. Quantitative immunoglobulins IgG, IgA and IgM

   c. Chest x-rays

   d. Sinus x-rays

   e. Fiberoptic rhinoscopy, pharyngoscopy and laryngoscopy

   f. Serum complement levels C3

   g. Serum complement levels C4

   h. Total complement level CH50

   i. Hypersensitivity pneumonitis panel

j. Nasal cultures.

4. Respondent billed Patient A for a laryngoscopy which was not performed.

5. Respondent placed Patient A on a weekly program of immunotherapy. This treatment was not medically indicated.

6. Respondent knew that the tests he ordered and the treatment he prescribed for Patient A, as described in Paragraphs A.3 and A.5, were not medically warranted.

7. Respondent failed to maintain a medical record for Patient A which accurately reflects the patient history, examination, rationales for tests and treatment, test results, evaluation of test results, report of the fiberoptic examination and progress notes.

B. On or about September 18, 1985 Respondent treated Patient B for an ear infection and allergies at Respondent's office at 37 Main Street, Fishkill, N.Y. (Fishkill office).

1. Respondent failed to obtain an adequate patient history.

2. Respondent failed to perform an adequate physical examination.

3. In the course of his treatment of Patient B Respondent ordered the following tests or procedures which were not medically indicated:

   a. 31 Rast tests

   b. Quantitative immunoglobulins IgG, IgA and IgM

   c. Chest x-rays

   d. Sinus x-rays

   e. Pulmonary function test

   f. Fiberoptic rhinoscopy, pharyngoscopy and laryngoscopy.

4. Respondent ordered and billed Patient B for a laryngoscopy, which was not performed.

5. Respondent knew that the tests he ordered for Patient B as described in paragraph B.3, were not medically warranted. The tests and treatment were done for Respondent's financial benefit and not for Patient B's welfare.

6. Respondent failed to maintain a medical record for Patient B which accurately reflects the patient history, examination, rationales for tests and treatment, test results, evaluation of test results, and report of the fiberoptic examination.

7. On or about March 13, 1986, Respondent wrote a letter to Patient B's mother. In this letter Respondent falsely accused Patient B's mother of slander, harassment and vicious actions in connection with her communications with the State Department of Health concerning Respondent. In the letter, Respondent also threatened and intimidated Patient B's mother.

C. Between on or about May 10, 1989, and on or about June 21, 1989, Respondent treated Patient C for hives at Respondent's Fishkill office.

1. Respondent failed to obtain an adequate patient history.

2. Respondent failed to perform an adequate physical examination.

3. In the course of his treatment of Patient C Respondent ordered the following tests or procedures which were not medically indicated:

   a. Prist and Rast allergy tests

   b. Quantitative immunoglobulins IgG, IgA and IgM

   c. Fiberoptic rhinoscopy.

4. Respondent diagnosis of chronic urticaria was incorrect and without medical justification.

5. Respondent placed Patient C on a weekly program of immunotherapy. This treatment was not medically indicated.

6. Among the antigens employed by Respondent in his immunotherapy program were food antigens.

The injection of food antigens is contraindicated.

7. Respondent knew that the tests he ordered and the treatment he prescribed for Patient C as described in paragraphs C.3 and C.5, were not medically warranted. The tests and treatment were done for Respondent's financial benefit and not for Patient C's welfare.

8. Respondent failed to maintain a medical record for Patient C which accurately reflects the patient history, examination, rationales for tests and treatment, test results, evaluation of test results, report of the fiberoptic examination and progress notes.

D. Between on or about October 17, 1985, and on or about November 4, 1985, Respondent treated Patient D for wheezing at Respondent's office at 74 West Street, Danbury Connecticut (Danbury office).

1. Respondent failed to obtain an adequate patient history.

2. Respondent failed to perform an adequate physical examination.

3. In the course of his treatment of Patient D Respondent ordered the following tests or procedures which were not medically indicated:

   a. A Prist test and a battery of food Rast tests

   b. Quantitative immunoglobulins IgG, IgA and IgM

   c. Chest x-ray

   d. Sinus x-ray

   e. Fiberoptic rhinoscopy, pharyngoscopy and laryngoscopy

   f. Nasal culture.

4. Respondent billed Patient D for a laryngoscopy, which was not performed.

5. Respondent recommended that Patient D be placed on a weekly program of immunotherapy. This treatment was not medically indicated.

6. Respondent knew that the tests he ordered and the treatment he prescribed for Patient D as described in paragraphs D.3 and D.5, were not medically warranted. The tests were done and treatment recommendation made for Respondent's financial benefit and not for Patient D's welfare.

7. Respondent failed to maintain a medical record for Patient D which accurately reflects the patient history, examination, rationales for tests and treatment, test results, evaluation of test results, report of fiberoptic examination and progress notes.

E. Between on or about May 8, 1986, and on or about April 3, 1990, Respondent treated Patient E for sinusitis at Respondent's office at 226 North Main Street, New City, N.Y.

1. Respondent failed to obtain an adequate patient history.

2. Respondent failed to perform an adequate physical examination.

3. In the course of his treatment of Patient E Respondent ordered the following tests or procedures which were not medically indicated:

   a. Prist, Rast and extensive batteries of prick skin tests

   b. Quantitative immunoglobulins IgG, IgA and IgM

   c. Chest x-ray

   d. Sinus x-ray

   e. Fiberoptic rhinoscopy, pharyngoscopy and laryngoscopy

   f. Nasal culture.

4. Respondent billed Patient E for a laryngoscopy, which was not performed.

5. Respondent placed Patient E on a weekly program of immunotherapy. This treatment was not medically indicated.

6. Respondent knew that the tests he ordered and the treatment he prescribed for Patient E as described in paragraphs E and E.5, were not medically warranted. The tests and treatment were done for Respondent's financial benefit and not for Patient E's welfare.

7. Respondent failed to maintain a medical record for Patient E which accurately reflects the patient history, examination, rationales for tests and treatment, test results, report of the fiberoptic examination and progress notes.

F. Between on or about July 29, 1985, and on or about January 23, 1986, Respondent treated Patient F for asthma and allergies at Respondent's Danbury office.

1. Respondent failed to obtain an adequate patient history.

2. Respondent failed to perform an adequate physical examination.

3. In the course of his treatment of Patient F Respondent ordered the following tests or procedures which were not medically indicated:

   a. Prist, Rast and intradermal allergy tests

   b. Quantitative immunoglobulins IgG, IgA and IgM

   c. Chest x-ray

   d. Sinus x-ray

   e. Fiberoptic rhinoscopy, pharyngoscopy and laryngoscopy.

4. Respondent billed Patient F for a laryngoscopy, which was not performed.

5. Respondent placed Patient F on a weekly program of immunotherapy. This treatment was not medically indicated.

6. Respondent knew that the tests he ordered and the treatment he prescribed for Patient F as

described in paragraphs F.3 and F.6, were not medically warranted. The tests and treatment were done for Respondent's financial benefit and not for Patient F's welfare.

7. On or about August 8, 1985, August 15, 1985 and September 5, 1985, Patient F received immunotherapy injections at Respondent's office. The injections were administered by a nurse. Patient F was not seen or examined by Respondent. Yet on each occasion Respondent improperly billed the Patient for an office visit as well as for each injection.

8. Respondent failed to maintain a medical record for Patient F which accurately reflects the patient history, examination, rationales for tests and treatment, test results, evaluation of test results, report of the fiberoptic examination and progress notes.

G. Between on or about June 30, 1982, and on or about March 25, 1983, Respondent treated Patient G for a rash at Respondent's Fishkill office.

1. Respondent failed to obtain an adequate patient history.

2. Respondent failed to perform an adequate physical examination.

3. In the course of his treatment of Patient G Respondent ordered the following tests or procedures which were not medically indicated:

   a. Rast, prick and intradermal allergy tests.

4. Respondent placed Patient G on a weekly program of immunotherapy. This treatment was not medically indicated.

5. Among the antigens employed by Respondent in this immunotherapy program were food antigens. The injection of food antigens is contraindicated.

6. Respondent knew that the tests he ordered and the treatment he prescribed for Patient G as described in paragraphs G.3 and G.4, were not medically warranted. The tests and treatment

were done for Respondent's financial benefit and not for Patient G's welfare.

7. Between on or about October 1, 1982 and on or about March 25, 1983, Patient G received twenty (20) immunotherapy injections at Respondent's office. The injections were administered by a nurse. Patient G was not seen or examined by Respondent. Yet on each occasion Respondent improperly billed the Patient and/or the Patient's insurer for an office visit as well as for the allergy serum contained in each injection.

8. Respondent failed to maintain a medical record for Patient G which accurately reflects the patient history, examination, rationales for tests and treatment, test results, evaluation of test results, and progress notes.

H. Between on or about April 10, 1985, and on about August 19, 1985, Respondent treated Patient H for hives at Respondent's Fishkill office.

1. Respondent failed to obtain an adequate patient history.

2. Respondent failed to perform an adequate physical examination.

3. In the course of his treatment of Patient H Respondent ordered the following tests or procedures which were not medically indicated:

   a. Intradermal skin tests for foods, inhalants and mold

   b. Quantitative immunoglobulins IgG, IgA and IgM

   c. Chest x-ray

   d. Alpha Anti-Trypsin test

   e. Hypersensitivity Pneumonitis test.

4. Respondent placed Patient H on a weekly program of immunotherapy. This treatment was not medically indicated.

5. Among the antigens employed by Respondent in this immunotherapy program were food antigens.

The injection of food antigens is contraindicated.

6. Respondent knew that the tests he ordered and the treatment he prescribed for Patient H as described in paragraphs H.3 and H.4, were not medically warranted. The tests and treatment were done for Respondent's financial benefit and not for the Patient's welfare.

7. Between on or about May 24, 1985, and on or about August 17, 1985, Patient H received sixteen immunotherapy injections at Respondent's office. The injections were administered by a nurse. Patient H was not seen or examined by Respondent. Yet on each occasion Respondent improperly billed the Patient and/or her insurer for an office visit as well as for each injection.

8. Respondent failed to maintain a medical record for Patient H which accurately reflects the patient history, examination, rationales for tests and treatment, test results, evaluation of test results, and progress notes.

I. Between on or about January 1983 and on about January 1987, Respondent routinely submitted to Metropolitan Life Insurance (Metropolitan) claims for payment which contained information Respondent knew to be false.

1. At each of the various offices operated by Respondent, nurses employed by Respondent administered periodic allergy injections to patients, usually on a weekly basis. During these visits the patients were not seen or examined by Respondent. Yet Respondent on such occasions routinely billed Metropolitan $40 for an "office visit", "allergy visit" or "office evaluation", in addition to a charge for the administration of each allergy injection.

2. Respondent also entered or caused to be entered certain cpt codes on claim forms which falsely represented that a physician had evaluated or treated the patient on such occasions.

3. As a result of Respondent's false representations, Metropolitan paid in excess of $150,000 to Respondent for non-existent office visits, allergy visits and office evaluations.

J. Under Metropolitan's New York Statewide policy, insured patients are generally required to pay 20% of the fees charged by their physician, with Metropolitan paying the remaining 80%. Part of the rationale for requiring the patient to make a 20% "co-payment" is to limit the amount of unnecessary medical treatment. Respondent intentionally defeated this cost-cutting mechanism by routinely failing to charge patients the 20% co-payment.

1. As a result of this practice, all claims for payment submitted by Respondent to Metropolitan between January 1983 and January 1987, contained false information. On each claim form Respondent misrepresented the actual fees charged each patient. While Respondent represented that the listed fees accurately reflected his charges for each service, in fact, the listed charges were inflated by 20% by virtue of Respondent's standard policy of waiving all co-payments.

2. As a result of Respondent's misrepresentations, Metropolitan was caused to make inflated payments to Respondent. During the time period in question Metropolitan paid $703,675 to Respondent. Approximately $100,000 of this

amount is attributable to Respondent's systematic practice of deliberately misrepresenting his actual charges for medical services.

K. In on or about 1989, Respondent paid to Metropolitan and Aetna Life Insurance Company approximately $480,000 in settlement of lawsuits Metropolitan and Aetna had brought against Respondent under the federal Racketeer Influenced and Corrupt Organizations Act. The lawsuits alleged that Respondent had engaged in a systematic scheme to defraud Metropolitan and Aetna between 1983 and 1987 by means of the fraudulent practices outlined in paragraphs I and J, herein.

L. On or about March 26, 1976, Respondent applied to the Connecticut Medical Examining Board for a license to practice medicine in Connecticut. As part of the application Respondent swore before a notary public that all statements contained in the application were true. Respondent stated in the application that he received an undergraduate degree from Princeton University in 1958. This statement was knowingly false. Respondent never received any degree from Princeton University.

M. On or about April 23, 1976, Respondent submitted an application for appointment to the staff of Danbury Hospital in Danbury, Connecticut. In the application Respondent falsely stated that he had received an undergraduate degree from Princeton University in 1957.

## SPECIFICATION OF CHARGES

### FIRST SPECIFICATION

### PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3)(McKinney Supp. 1992) in that Petitioner charges that Respondent committed at least two of the following:

1. The facts in paragraphs A and A.1-A.3, A.5, B and B.1-B.3, C and C.1-C.6, D and D.1-D.3, D.5, D.7, E and E.1-E.3, E.5, F and F.1-F.3, F.5 and/or G and G.1-G.5.

### SECOND SPECIFICATION

### PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1992), in that Petitioner charges:

2. The facts in paragraphs A and A.1-A.3, A.5, B and B.1-B.3, C and C.1-C.6, D and D.1-D.3, D.5, D.7, E and E.1-E.3, E.5, F and F.1-F.3, F.5 and/or G and G.1-G.5.

THIRD THROUGH FOURTEENTH SPECIFICATION

PRACTICING FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently under N.Y. Educ. Law Section 6530(2)(McKinney Supp. 1992) in that Petitioner charges:

3. The facts in paragraphs A and A.3, A.4, A.5, A.6.

4. The facts in paragraphs B and B.3, B.4, B.5.

5. The facts in paragraphs C and C.3, C.5, C.7.

6. The facts in paragraphs D and D.3, D.4, D.5, D.6.

7. The facts in paragraphs E and E.3, E.4, E.5, E.6.

8. The facts in paragraphs F and F.3, F.4, F.5, F.6, F.7.

9. The facts in paragraphs G and G.3, G.4, G.6, G.7.

10. The facts in paragraphs H and H.3, H.4, H.6, H.7.

11. The facts in paragraphs I and I.1-I.3 and K.

12. The facts in paragraphs J and J.1, J.2 and K.

13. The facts in paragraph L.

14. The facts in paragraph M.

## FIFTEENTH THROUGH TWENTIETH SPECIFICATION

### MAKING FALSE REPORTS

Respondent is charged with willfully making or filing false reports under N.Y. Educ. Law Section 6530(21)(McKinney Supp. 1992) in that Petitioner charges:

15. The facts in paragraphs F and F.7.

16. The facts in paragraphs H and H.7.

17. The facts in paragraphs I and I.1-I.3, K.

18. The facts in paragraphs J and J.1, J.2, K.

19. The facts in paragraph L.

20. The facts in paragraph M.

## TWENTY-FIRST THROUGH TWENTY-EIGHTH SPECIFICATION

### ORDERING EXCESSIVE TESTS AND TREATMENT

Respondent is charged with ordering excessive tests and treatment under N.Y. Educ. Law Section 6530(35)(McKinney Supp. 1992) in that Petitioner charges:

21. The facts in paragraphs A and A.3, A.5.

22. The facts in paragraphs B and B.3.

23. The facts in paragraphs C and C.3, C.5.

24. The facts in paragraphs D and D.3, D.5.

25. The facts in paragraphs E and E.3, E.5.

26. The facts in paragraphs F and F.3, F.5.

27. The facts in paragraphs G and G.3, G.4.

28. The facts in paragraphs H and H.3, H.4.

## TWENTY-NINTH THROUGH THIRTY-SIXTH SPECIFICATION

## FAILURE TO MAINTAIN ACCURATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(32)(McKinney Supp. 1992) in that he failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient, specifically, Petitioner charges:

29. The facts in paragraphs A and A.7.

30. The facts in paragraphs B and B.6

31. The facts in paragraphs C and C.8.

32. The facts in paragraphs D and D.7.

33. The facts in paragraphs E and E.7.

34. The facts in paragraphs F and F.8.

35. The facts in paragraphs G and G.8.

36. The facts in paragraphs H and H.8.

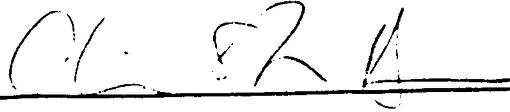
## THIRTY-SEVENTH SPECIFICATION

### MORAL UNFITNESS

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine under N.Y. Educ. Law Section 6530(20)(McKinney Supp. 1992) in that Petitioner charges:

37. The facts in paragraphs A and A.4, A.6, B and B.4, B.5, B.7, C and C.7, D and D.4, D.6, E and E.4, E.6, F and F.4, F.6, F.7, G and G.6, G.7, H and H.6, H.7, I and I.1-I.3, J and J.1, J.2, K, L, and/or M.

DATED: New York, New York
June 26, 1992



CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct