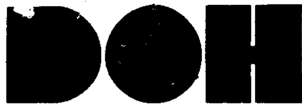


STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

April 23, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Masao Mitsui, M.D.
9 Briarwood Road
Jersey City, New Jersey 07305

Daniel Guenzburger, Esq.
NYS Department of Health
Metropolitan Regional Office
5 Penn Plaza – 6th Floor
New York, New York 10001

RE: In the Matter of Masao Mitsui, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.99-82) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

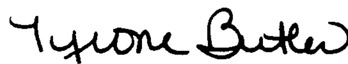
The notice of review served on the Administrative Review Board should be forwarded to:

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

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mla
Enclosure

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

COPY

IN THE MATTER

OF
Masao Mitsui, M.D. A/K/A George Wang, A/K/A Cheng Wang

DETERMINATION

AND

ORDER

ORDER #99-82

REV. DANIEL W. MORRISSEY, O.P., CHAIRMAN, STEVEN M. LAPIDUS, M.D. and DAVID W. HARRIS, 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 Section 230(10)(p) and (12) of the Public Health Law. **MICHAEL P. MCDERMOTT, ESQ.,** Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Commissioner's Summary Order	December 9, 1998
Notice of Hearing and Statement of Charges:	January 20, 1999

Pre-Hearing Conference:	February 19, 1999 February 23, 1999
Hearing Dates:	March 4, 1999
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Date of Deliberations:	March 25, 1999
Petitioner appeared by:	Henry M. Greenberg, Esq. General Counsel NYS Department of Health by: Daniel Guenzburger, Esq. of Counsel
Respondent appeared by:	The Respondent appeared in person on his own behalf.

WITNESSES

For the Respondent	1) Patient B 2) Robert Shimm M.D.
For the Petitioner	1) Yoeklan Young 2) Jimmy Liu 3) Louis Pace 4) Stuart Liu

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with Criminal Conviction (Federal); having been found guilty in a Department of Social Services hearing; fraudulent practice; making or filing false reports; negligence on more than one occasion; failing to maintain records and non-compliance with record requests.

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

FINDINGS OF FACT

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

GENERAL FINDINGS

1. Masao Mitsui, M.D. the Respondent, was authorized to practice medicine in New York Stare on January 23, 1973 by the issuance license number 115663 by the New York State Education Department (Pet's. Exs. 1 and 3).

2. On June 20, 1995, the Respondent was found guilty in an adjudicaory proceeding before the Department of Social Services of having engaged in a pattern of unacceptable Medicaid services, including but not limited to unacceptable record keeping, ordering of excessive services and the

submission of false claims, in violation of Title 8 NYCRR Sections 515.2(b)(1) and 515.2(b)(11).

The Respondent was excluded from the Medicaid Program and ordered to make restitution to the Department of Social Services in the amount of $729,881.00

To date, the Respondent has not made any payments in restitution as ordered by the Department of Social Services (Pet's. Ex. 8; Tr. 55).

3. The Administrative Law Judge in the Department of Social Services case determined, among other things:

- "The evidence at the hearing was consistent and overwhelming that these charts, and the corresponding prescriptions retrieved from the pharmacies that filled them, depict a practice which consisted, in essence, of little more than the routine and frequent dispensing of multiple medications at Medicaid Program expense without ascertaining and documenting genuine medical need."
- "Every prescription is designated "dispense as written" for the several brand names of medications prescribed, never for less expensive generic equivalents. Virtually every prescription provides for numerous, usually five, refills of these medications. The refill dates routinely overlap with return office visits: For example, the patient in chart 104 was prescribed Zantac, Lotrisone, Seldane and Duricef on November 6, 1988. A ten day supply, with five refills, was prescribed for the Zantac, Seldane and Duricef (20 doses twice each day). This is 60 days worth of medications, which presumably should last until early January 1989. Yet the patient visited the Appellant nine or more times in the next 60 days, and each

time, according to the chart, was given other medications as well. This pattern occurs over and over in these charts."

- "The visits are frequent, every few days in many cases."
- The variety of serious conditions these patients are reported to have, one at a time, one after the other on successive visits, is astonishing. For example, the patient in Sample 21 is recorded to have upper respiratory infection, then arthritis, then peptic ulcer, then muscle pain, and finally asthma, on five consecutive office visits all in the month of March 1988. The patient also has a rash, vertigo, abdominal pain, allergy, migraine headache, anxiety, nausea and vomiting, one at a time, on later visits. These various conditions are rotated through the chart entries numerous times, always one per office visit. There is little documentation of any ongoing evaluation or monitoring of these complaints or conditions as they come and go. They simply appear and reappear in turn" (Pet's. Ex. 8).

4. On September 23, 1997, the Respondent plead guilty in the United States District Court, Southern District of New York, to having violated Title 21 of the United States Code §843(a)(3), ("Aiding and abetting acquisition of controlled substance"), a Class E felony, in that he illegally issued multiple prescriptions for controlled substances to Patient A.

   The Respondent was put on probation for three (3) years under terms which included the surrender of his DEA certificate and his New York State triplicate prescription books. He was also fined $1,000.00 (Pet's. Ex. 4).

5. The criminal prosecution was the culmination of an investigation of the Respondent and Patient A by the Federal Drug Enforcement Agency, ("DEA").

   The DEA commenced its investigation in July 1995 when a pharmacist from a drug store in Valley Stream, New York reported that one individual, later identified as Patient A, had presented multiple triplicate prescriptions for Percocet written by the Respondent for several different individuals (Tr.63).

6. Percodan and Percocet are narcotic drugs that are indicated in cases of severe pain and where a patient has not responded to simpler analgesics, such as Aspirin, Ibuprofen or Aceaminophen. They are schedule II controlled substances which can only be prescribed on a triplicate prescription form.

   Percocet is highly addictive and is frequently diverted for illicit purposes. It is commonly used by heroin addicts experiencing pain from withdrawal symptoms (Tr. 63-65, 128-129).

7. The DEA investigative plan had two components. One component was an undercover operation in which a DEA Special Agent, Patient B, would introduce himself to the Respondent as a friend of Patient A and attempt to buy prescriptions for Percocet and Percodan. The second component was to locate the individuals whose names appeared on the prescriptions presented by Patient A to the Valley Stream Pharmacy and to determine from those individuals whether they were legitimate patients who had appropriate medical indications requiring prescriptions for Percocet.

Patient A was employed at Belmont Race Track and began cooperating with the DEA investigation after his arrest on January 4, 1996 (Tr. 65, 75-76).

8. On October 11, 1995, Patient B, (the Special Agent), using the fictitious name "Tim Landry", presented at the Respondent's office at 2 Mott Street, New York, New York.

   Patient B told the Respondent that he worked at Belmont Race Track and that he knew Patient A. He said that he wanted a prescription for Percodan because he was experiencing pain from an injury caused by a fall from a horse approximately ten days prior.

   Patient B declined the Respondent's request that he disrobe for an examination alleging that he felt uncomfortable in doing so. (The real reason was that he wanted to conceal an electronic recording device that he was wearing) (Tr. 68-69).

9. Patient B indicated that he was experiencing pain the lower back area. The Respondent gently touched the area through Patient B's clothing and then performed what the Respondent was referred to as the bi-digital O-ring test. Patient B observed the Respondent, with the help of an assistant, Ms. Yong, wave a thin metal rod behind his back. After the Respondent completed the bi-digital O ring test, he informed Patient B that he had a herniated disc (Tr. 70).

10. The Respondent then wrote a prescription for 100 Percodan and told Patient B that the charge was $200.00 dollars. However, in response to a request

from Patient B, the Respondent agreed to accept $150.00 dollars for the prescription (Pet's. Exs. 21and 22; Tr. 70).

11. The Respondent failed to perform an adequate physical examination on Patient B. A physical examination in response to a complaint of lower back pain following a fall from a horse would concentrate on range of motion and neurological findings, including reflexes and changes to strength of the lower extremities (Tr. 126).

12. The Respondent inappropriately diagnosed Patient A as having a herniated disc. The bi-digital O-ring test that Respondent claims to have performed is not a medically accepted procedure for making such a diagnosis.

    The Respondent made the diagnosis without having physical findings that would support a presumptive diagnoses of herniated disc. A definitive diagnosis of this condition can be made with an MRI or some other type of imaging study (Tr. 127-128).

13. The Respondent prescribed Percodan for Patient B without adequate medical indications (TR.129, 137-139).

14. On March 6, 1996, Patient B returned to the Respondent's office for a second time. On this occasion Patient B was accompanied by Patient A (Tr. 75-76).

15. On the March 6, 1996 visit, Patient A purchased two prescriptions, each for 100 Percocet, from the Respondent who wrote the prescriptions in the names of other individuals. Patient A paid $200.00 for each of the prescriptions.

On this visit, Patient B also purchased a prescription for 100 Percocet from the Respondent who wrote the prescription in the name "Tim Landry". Patient B paid $160.00 for his prescription.

The Respondent did not physically examine either Patient A or Patient B on the occasion of the March 6, 1996 visit (Pet's. Ex. 23, 24 and 25; Tr 75-80).

16. On April 4, 1996, Patient B visited the Respondent's office for a third time and was again accompanied by Patient A.

On this occasion Patient A again purchased two prescriptions, each for 100 Percocet, from the Respondent who wrote the prescriptions in the names of other individuals. Patient A paid $400.00 for the two prescriptions.

Patient B also purchased a prescription for 100 Percocet from the Respondent who wrote the prescription in the name "Tim Landry". Patient B paid $200.00 for his prescription (Pet's. Ex. 26, 27 and 28; Tr. 82-87).

17. In written statements obtained by the DEA, Patients C, D, E and F each stated that they had accompanied Patient A to the Respondent's office on one occasion only. Patients C, D, E and F were all Belmont Race Track employees and associates of Patient A (Pet's. Ex. 11,14,17 and 20).

18. During the period, March 23,1995 through April 2,1996, the Respondent issued 8 prescriptions, each for 100 Percoct, in the name of Patient C.

During the period, January 29,1995 through August 21,1995 the Respondent issued 8 prescriptions, each for 100 Percoct, in the name of Patient D.

During the period, July 19,1994 through July 21,1995, the Respondent issued 8 prescriptions, each for 100 Percoct, in the name of Patient E.

During the period, February 19,1995 through August 11,1995, the Respondent issued 6 prescriptions, each for 100 Percocet, in the name of Patient F.

The Respondent has admitted that he gave Patient A prescriptions issued in the names of other Belmont Race Track employees even though those individuals were not even present at the time the prescriptions were written (Pet's. Exs. 10, 11, 13, 14, 16, 17, 19, 20; Tr. 196).

19. Based on Finding of Fact No 17, and after reviewing the Respondent's medical records for Patient C, D, E and F, the Hearing Committee finds that those medical records were fabricated by the Respondent for the purpose of covering up his illegal prescribing practices (Pet's. Ex. 9, 12, 15 and 18).

20. The Percocet prescriptions issued by the Respondent in the names of Patient C, D, E and F were not medical indicated (Pet's. Ex. 10, 11, 13, 14, 16, 17, 19, 20; Tr. 78-87, 195).

21. In a letter to the Administrative Law Judge, dated March 23,1999, the Petitioner withdrew the charges specified in paragraphs G(1) and H(1) of the Statement of Charges.

22. There is not sufficient evidence in the record for the Hearing Committee to sustain any of the charges specified in paragraphs G(2), G(3), H(2) and H(3) of the Statement of Charges.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise specified)

FIRST SPECIFICATION:(CRIMINAL CONVICTION(FEDERAL))

SUSTAINED as to the charge specified in paragraph A of the Statement of Charges.

SECOND SPECIFICATION:(HAVING BEEN FOUND GUILTY IN A DSS HEARING)

SUSTAINED as to the charge specified in paragraph I of the Statement of Charges.

THIRD THROUGH NINTH SPECIFICATIONS:(FRAUDULENT PRACTICE)

SUSTAINED as to all those charges specified in paragraphs B(4), C(2), D(2), E(2) and F(2) of the Statement of Charges. (The Petitioner withdrew charges G1 and H1).

TENTH THROUGH SIXTEENTH SPECIFICATIONS:(FALSE REPORTS)

SUSTAINED as to those charges specified in paragraphs B(4), C(2), D(2), E(2) and F(2) of the Statement of Charges. (The Petitioner withdrew charges G1 and H1).

SEVENTEENTH SPECIFICATIONS: (NEGLIGENCE ON MORE THAN ONE OCCASION)

SUSTAINED as to those charges specified in paragraphs B(1), B(2),B(3),C(1),D(1), E(1) and F(1) of the Statement of charges.

NOT SUSTAINED as to those charges specified in paragraphs G(2) and H(2) of the Statement of Charges.

EIGHTEENTH SPECIFICATION: (INCOMPETENCE ON MORE THAN ONE OCCASION)

SUSTAINED as to those charges specified in paragraphs B(1), B(2), C(1), D(1), and F(1) of the Statement of Charges

NOT SUSTAINED as to those charges specified in paragraphs G(2) and H(2) of the Statement of Charges.

NINETEENTH THROUGH TWENTIETH SPECIFICATIONS: (RECORD-KEEPING)

NOT SUSTAINED as to any of the charges alleging record keeping failures

TWENTY-FIRST THROUGH TWENTY-SECOND SPECIFICATIONS: (NON-COMPLIANCE WITH RECORD REQUEST)

NOT SUSTAINED as to any of the charges alleging non-compliance with record requests.

AFTER THE HEARING COMMITTEE VOTED ON THE CHARGES IN THIS INSTANT CASE, THE ADMINISTRATIVE OFFICER SUBMITTED COPIES OF THE DETERMINATION AND ORDER BPMC-96-302 TO THE HEARING COMMITTEE FOR FURTHER CONSIDERATION IN DETERMINING THE NATURE AND SEVERITY OF THE PENALTY TO BE IMPOSED ON THE RESPONDENT

THE ADMINISTRATIVE OFFICER DID NOT SUBMIT COPIES OF THE PETITIONER'S POST-HEARING "STATEMENT WITH RESPECT TO PRIOR DISCIPLINE TAKEN BY THE BOARD" FOR THE HEARING COMMITTEE CONSIDERATION.

a) DETERMINATION AND ORDER BPMC-96-302 SPEAKS FOR ITSELF
b) THE RESPONDENT DID NOT HAVE AN OPPORTUNITY TO RESPOND TO PETITIONER'S POST-HEARING STATEMENT.

HEARING COMMITTEE DETERMINATIONS AS TO THE CREDIBILITY OF WITNESSES:

For The Petitioner:

1. Patient B, a federal D.E.A. agent, testified in a very straightforward, professional manner and produced documentation to support his testimony. He was a very credible witness.
2. Robert Shimm, M.D., the Petitioner's medical expert, was a credible and knowledgeable witness whose testimony was uncontroverted.

For The Respondent:

1. Yoeklan Young, the Respondent's receptionist who is also one of his patients testified on his behalf. The nature of her testimony was strictly to deny any allegations against the Respondent without any further elaboration when answering questions. She was not a credible witness.
2. Jimmy Liu, Louis Pace and Stuart Liu, are either themselves patients or have family members who are the Respondent's patients. They were character witness and each of them spoke very highly regarding the Respondent's reputation. They were very credible witnesses. However, none of them was in a position to address any of the factual issues in this case.
3. The Respondent: The Hearing Committee had the opportunity to observe the Respondent, listen to his testimony and to ask him questions. He was not a credible witness. He was manipulative and not forthcoming in his testimony and displayed a defiant attitude as though he had a right to commit the violations for which he was charged.

He never directly addressed the charges against him. His defense consisted of repeating statements about his good moral character, and at the same time, attacking the moral character of those supporting the charges against him.

AS TO PENALTY:

The action taken by the Department of Social Services in 1995 should have served as a wake-up call to the Respondent. It did not. He has not made a single payment in restitution to the Medicaid Program as ordered by the Department of Social Services.

In the very same year that he was excluded from participating in the Medicaid Program, the Respondent began issuing the Percocet prescriptions which are the subject of this case. This illegal prescribing continued until he was arrested by the DEA in May 1996.

It should also be noted that the Respondent was a subject of a prior case involving the improper dispensing of controlled substances during the period January 1,1991 through April 21,1994, culminated in the issuance's of ORDERS CS-94-64 and BPMC 96-302. This was another wake-up call ignored by the Respondent.

The Hearing Committee has read all of the post-hearing correspondence submitted by the Respondent attesting to his good reputation in the community.

The Hearing Committee is also aware that the Federal judge in the Respondent's case, the Honorable Thomas P. Greisa, has recommended against

suspending or revoking the Respondent's license to practice medicine (Resp's. Ex A, P15). The Hearing Committee respectfully disagrees.

The record in this case clearly indicates that the Respondent profited from the enormous quantities of controlled substances that he illegally prescribed. This was truly an egregious abuse of his prescribing privileges and evidences a consistent pattern of illegal prescribing for personal financial gain.

The Hearing Committee is also concerned about the Respondent's lack of insight regarding his wrongdoing and his total lack of remorse. His complete denial of any wrongdoing, in the face of overwhelming evidence to the contrary, demonstrates his total unrepentence for his egregious behavior.

Based on the entire record in this case the Hearing Committee determines that the Respondents license to practice medicine in the State of New York should be **REVOKED.**

The Hearing Committee also determines that a monetary fine is appropriate in this case where the Respondent has profited financially from his wrongdoing.

The Hearing Committee determines that the monetary penalty should be assessed as follows:

$10,000- Criminal Conviction

$10,000- Sanctioned by the NYS Department of Social Services.

$10,000- Fraudulent and Negligent treatment of Patient B

$10,000- Fraudulent and Negligent treatment of Patient C

$10,000- Fraudulent and Negligent treatment of Patient D

$10,000- Fraudulent and Negligent treatment of Patient E

$10,000- Fraudulent and Negligent treatment of Patient F

for a total monetary penalty of Seventy Thousand Dollars ($70,000.00).

ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondent's license to practice medicine in New York State is **REVOKED.**
2. A civil penalty in the amount of Seventy Thousand Dollars ($70,000) is assessed against the Respondent. Payment of the civil penalty shall be due within 90 days of the effective date of this Order.

   Payment shall be made to the New York State Department of Health, Bureau of Accounts Management, Corning Tower Building, Room 1258, Empire State Plaza, Albany, New York 12237.

   Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating debt collections by New York State. This includes but is not limited to imposition of interest, late payment charges and collection fees; referral to New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law Section 171 (27)]; State Finance Law section 18: CPLR section 5001: Executive Law section 32}.
3. The Hearing Committee strongly recommends that the licensing authority not consider any application by the Respondent for the restoration of his medical license unless he has paid the Seventy Thousand Dollars ($70,000) monetary fine assessed by this Order and has also made full restitution of the $729,881.00 as Ordered by the Department of Social Services.

4. This Order shall be effective upon service on the Respondent or his attorney by personal service or certified or registered mail.

DATED: New York, New York
April 20, **1999**

Rev. Daniel W. Morrissey, O.P.

REV. DANIEL W. MORRISSEY, O.P.,
CHAIRMAN

STEVEN M. LAPIDUS, M.D.
DAVID W. HARRIS, M.D.

APPENDIX ONE

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

IN THE MATTER OF MASAO MITSUI, a/k/aGEORGE WANG,a/k/a CHENG WANG, M.D.	STATEMENT OF CHARGES

MASAO MITSUI, M.D., the Respondent, was authorized to practice medicine in New York State on or about January 22, 1973 , by the issuance of license number 115663 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about September 23, 1997 the Respondent plead guilty in the United States District Court, Southern District of New York, to having violated Title 21 of the United States Code §843(a)(3), ("Aiding and abetting the acquisition of a controlled substance"). A violation of the aforementioned section is a Class E felony. Respondent plead guilty to illegally issuing multiple prescriptions of controlled substances to Patient A. (The identity of Patient A and the other patients in the Statement of Charges are identified in the annexed appendix.)

B. On or about October 11, 1995, Patient B, an undercover agent for the federal Drug Enforcement Administration ("DEA") introduced himself to Respondent as an associate of Patient A at Respondent's office located at 2 Mott Street, New York, New York. The undercover agent complained of pain in the lower back after having fallen off a horse at the Belmont Race Track. At the visit, and at two subsequent visits dated March 7, 1996 and April 4, 1996, the undercover agent tendered cash to obtain a triplicate prescription of Percocet, 100 (d.u.). Respondent:

1. Failed to perform an adequate physical examination.

2. Inappropriately diagnosed that Patient A had a herniated disk.

3. Prescribed Percocet without adequate medical indication.

4. Knowingly intended to create the false belief that he had issued the prescriptions of Percocet for a legitimate medical purpose when, in fact, he knew that he lacked adequate medical justification for issuing the prescriptions.

C. Patient A introduced Patient C to Respondent. Respondent:

1. Inappropriately issued 5 prescriptions of Percocet to Patient C.

2. Knowingly intended to create the false belief that he had issued the prescriptions of Percocet for a legitimate medical purpose when, in fact, he knew that he lacked adequate medical justification for issuing the prescriptions.

D. Patient A introduced Patient D to Respondent. Respondent:

1. Inappropriately issued 8 prescriptions of Percocet (100 d.u.) to Patient D.

2. Knowingly intended to create a false belief that he had issued the

prescriptions of Percocet for a legitimate medical purpose when, in fact, he knew that he lacked adequate medical justification for issuing the prescriptions.

E. Patient A introduced Patient E to Respondent. Respondent:

1. Inappropriately issued 10 prescriptions of Percocet (100 d.u.) to Patient E.

2. Knowingly intended to create a false belief that he had issued the prescriptions of Percocet for a legitimate medical purpose when, in fact, he knew that he lacked adequate medical justification for issuing the prescriptions.

F. Patient A introduced Patient F to Respondent. Respondent:

1. Inappropriately issued 6 prescriptions of Percocet (100 d.u.) to Patient F.

2. Knowingly intended to create a false belief that he had issued the prescriptions of Percocet for a legitimate medical purpose when, in fact, he knew that he lacked adequate medical justification for issuing the prescriptions.

G. On or about August 28, 1996, the Respondent completed a medical referral form for Patient G for the Woman Infant and Child Program of the Bureau of Supplemental Food Programs of the New York State Department of Health

("WIC"). Respondent:

1. Knowingly and falsely represented on the form that Patient G had a hemoglobin test taken on August 28, 1996 when, in fact, he knew that the Patient had not had such a laboratory test.

2. Respondent failed to maintain a medical record that accurately reflects the evaluation and treatment of Patient G.

3. Failed to respond to a written request from the Department of Health to produce a medical record for Patient G. The written request was dated October 13, 1998.

H. On or about April 14, 1997, the Respondent completed a WIC medical referral form for Patient H. Respondent:

1. Knowingly and falsely represented on the form that Patient H had a hemoglobin test taken on April 14, 1997 when, in fact, he knew that the patient had not had such a laboratory test.

2. Respondent failed to maintain a medical record that accurately reflects the evaluation and treatment of Patient H.

3. Failed to respond to a written request from the Department of Health to produce a medical record for Patient H. The written request was dated October 13, 1998.

I. On or about June 20, 1995 the Respondent was found guilty in an adjudicatory proceeding before the Department of Social Services of having engaged in a pattern of unacceptable Medicaid services, including but not limited to unacceptable recordkeeping, ordering of excessive services and the submission of false claims. Said conduct violated Title 8 NYCRR Sections 515.2(b)(1), 515.2(b)(6) and 515.2(b)(11). Respondent was excluded from the Medicaid Program and ordered to make restitution to the Department of Social Services in the amount of $729.881,00.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

CRIMINAL CONVICTION (Federal)

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(9)(a)(ii)(McKinney Supp. 1999) by having been convicted of committing an act constituting a crime under federal law as alleged in the facts of the following:

1. Paragraph A.

SECOND SPECIFICATION

HAVING BEEN FOUND GUILTY IN A DSS HEARING

Respondent is charged with committing professional misconduct as defined in

N.Y. Educ. Law §6530(9)(c)(McKinney Supp. 1999) by having been found guilty in an adjudicatory proceeding of violating a state statute and state regulation, pursuant to a final decision, and when no appeal is pending, and when the violation would constitute professional misconduct pursuant to Education Law §6530(32) and (35), as alleged in the facts of:

2. Paragraph I.

THIRD THROUGH NINTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1999) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. Paragraphs B and B4.
4. Paragraphs C and C2.
5. Paragraphs D and D2.
6. Paragraphs E and E2.
7. Paragraphs F and F2.
8. Paragraphs G and G1.
9. Paragraphs H and H1.

TENTH THROUGH SIXTEENTH SPECIFICATIONS

FALSE REPORTS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21)(McKinney Supp. 1999) by willfully making or filing a false

report, as alleged in the facts of:

10. Paragraphs B and B4.

11. Paragraphs C and C2.

12. Paragraphs D and D2.

13. Paragraphs E and E2.

14. Paragraphs F and F2.

15. Paragraphs G and G1.

16. Paragraphs H and H1.

SEVENTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1999) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

17. Paragraphs B, B1, B2, B3, C, C1, D, D1, E, E1, F, F1, G2, and/or H and H2.

EIGHTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1999) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

18. Paragraphs B, B1, B2, B3, C, C1, D, D1, E, E1, F, F1, G2, and/or

H and H2.

NINETEENTH THROUGH TWENTIETH SPECIFICATIONS

RECORD-KEEPING

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1999) , by failing to maintain a record which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

19. Paragraphs G and G2.
20. Paragraphs H and H2.

TWENTY-FIRST THROUGH TWENTY-SECOND SPECIFICATIONS

NON-COMPLIANCE WITH RECORD REQUEST

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(28)(McKinney Supp. 1999) by failing to respond within thirty days to a written communication of the Department of Health to make available relevant medical records, as alleged in the facts:

21. Paragraphs G and G3.
22. Paragraphs H and H3. .

DATED: January 20, 1999
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct