STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

Public

November 16, 2005

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Heron Rattray, M.D.
137-04 Guy R. Brewer Boulevard
Jamaica, New York 11434

Heron Rattray, M.D.
229 Lower Rocky Point Road
Sound Beach, New York 11789

Daniel Guenzburger, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

J. Stewart Moore, Esq.
38 New Street
Huntington, New York 11743

RE: In the Matter of Heron Rattray, M.D. & Rochdale Medical, P.C.

Dear Parties:

Enclosed please find the Determination and Order (No. 05-265) 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 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,

Sean D. O'Brien

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah

Enclosure

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

IN THE MATTER OF HERON RATTRAY, M.D. & ROCHDALE MEDICAL, P.C.	DETERMINATION AND ORDER BPMC #05-265

COPY

A Notice of Hearing, dated March 15, 2005, and a Statement of Charges, dated March 16, 2005, were duly served upon the Respondents, **HERON RATTRAY, M.D.** and **ROCHDALE MEDICAL, P.C.** **FRANK E. IAQUINTA, M.D.**, Chairperson, **ELEANOR KANE, M.D.** and **WILLIAM McCAFFERTY,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee ("the Committee") in this matter pursuant to Section 230(10)(e) of the Public Health Law. **FREDERICK ZIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer.

The **NEW YORK STATE DEPARTMENT OF HEALTH** ("the Department" or "the Petitioner") appeared by **DONALD P. BERENS, JR., ESQ.**, General Counsel, by **DANIEL GUENZBURGER, ESQ.**, of Counsel. Respondents appeared by **J. STEWART MOORE, ESQ.**

Evidence was received and witnesses sworn and heard, and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Answer Filed	May 11, 2005
Pre-Hearing Conference	May 3, 2005
Witnesses for Petitioner	Ellen Czajka, M.D., Joseph Cain, R.N., Henry Spector, M.D.
Witnesses for Respondent	Heron Rattray, M.D.
Hearing Dates	May 11, June 7 and July 22, 2005
Deliberation Date(s)	September 16, 2005

STATEMENT OF CASE

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

This case was brought by the Petitioner, New York State Department of Health, Office of Professional Medical Conduct, pursuant to §230 of the P.H.L. Respondent, Heron Rattray, M.D. is charged with twenty eight specifications of professional misconduct, as defined in §6350 of the Education Law of the State of New York ("Education Law"). Specifically, Dr. Rattray is charged with eleven specifications of fraudulent practice, eleven specifications of willfully filing false reports or failing to file a required report, one specification of practicing the profession with negligence on more than one occasion, one specification of practicing the profession with incompetence on more than one occasion, one specification of failing to maintain records, one specification of failing to respond within thirty days to written Department of Health communications and failing to make available relevant records to the Department concerning alleged misconduct, one specification of filing a false report with a hospital in violation of Public

Health Law § 2805-k and one specification of willfully or grossly negligently failing to comply with substantive provisions of federal law governing the practice of medicine. Rochdale Medical, P.C. ("Rochdale") is charged with eight specifications of practicing the profession fraudulently and with eight specifications of willfully filing false reports or failing to file a required report.

These charges concern, among other things, allegations that Respondents submitted fraudulent insurance claims concerning Patients A through G, and that Dr. Rattray knowingly made false claims on various hospital and professional licensure applications. A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

Respondent, in his Answer, denied having knowledge or information, sufficient to form a belief, as to the allegations contained in the Statement of Charges.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Committee in arriving at a particular finding.

Having heard testimony and considered documentary evidence presented by the Department and Respondent, respectively, the Committee hereby makes the following Findings of Fact:

1. **HERON RATTRAY, M.D.**, Respondent, ("Dr. Rattray") was authorized to practice medicine in New York State on October 18, 1993 by the issuance of license number 193948 by the New York State Education Department (Pet's Ex. 2).
2. Respondent, **ROCHDALE MEDICAL, P.C.** ("Rochdale") was authorized to operate as a

professional service corporation in April 1997 and is located at 137-04 Guy R. Brewer Boulevard, Jamaica, New York 11434. Dr. Rattray is the sole officer, director and shareholder of Rochdale which was the legal entity through which Dr. Rattray submitted insurance and Medicare claims (Pet's Ex. 10 and 33; Rattray, T. 363, 367-368).

3. During September 2000, Rochdale entered into an agreement whereby Synergy, Inc. ("Synergy") performed Rochdale's medical billing which agreement continued through July of 2003. Rochdale provided the necessary information for the preparation of insurance claims to Synergy on a pre-printed form referred to as a "superbill". A "superbill" is a document prepared by the physician, or the physician's staff, for the purpose of conveying to a third party the information that would be necessary to submit a Medicare or insurance claim. Synergy relied on the information contained in the "superbills" provided by Respondents to prepare claims (Pet's Ex. 10, Mona Mullen Affidavit; Rattray, T. 405, 492).

4. In October 2002, the Office of Professional Medical Conduct ("OPMC") assigned Medical Conduct Investigator Joseph Cain, R.N., to a complaint alleging that Respondent had improperly billed for care, treatment and medical tests which were not performed (Cain, T. 135-139).

5. By a December 10, 2002 letter, OPMC Investigator Cain requested certified copies of the complete medical records for, among other patients, Patients A through G, including the originals of any and all x-ray films, diagnostic studies, laboratory tests, correspondence, billing records and all other documents in the patient's file He provided Dr. Rattray with thirty days, as required by Education Law § 6530(28), to respond to the written request. After Dr. Rattray failed to provide OPMC with the requested material, Mr. Cain called Dr. Rattray to determine if he intended to comply, and arranged to view the records at Dr. Rattray's office on January 23,

2003 (Pet's Ex. 25; Cain, T. 140-142).

6. During the January 23, 2003 record review, Mr. Cain observed Respondents' superbills, which indicated billing for certain procedures, but he could not always find a corresponding medical record to support the billing (Cain, T. 199-203).

7. Mr. Cain photo scanned portions of various records which he reviewed during his January 23, 2003 visit to Dr. Rattray's office (Cain, T. 143-176).

8. When Mr. Cain concluded his inspection of records, he told Dr. Rattray that he would have to submit copies of records for the various patients, A, B, C, D, E, F and G. On February 6, 2003, Respondent signed the following certification on each medical record for the above patients which he submitted to OPMC ;

> "I Heron Rattray certify that these are complete, true and exact copies/original of the Rochdale Medical Center record of (patient name) kept on file during the regular course of business and were made at the time of such events as recorded or written." (Cain, T. 141, 203-204; Dept's Ex. 3-9).

9. OPMC obtained copies of Respondents' "superbills" from Synergy for patients, A, B, C, D, E, F and G (Pet's Ex. 3C, 4C, 5C, 6C, 7,C, 8C, 9C, and 10).

10. Dual views of the chest reimburse at a higher rate than strictly anterior/posterior views (Chajka, T.80).

11. Changing the label or name on an x-ray copy may be accomplished by blacking out the label containing the x-ray identifying information, and then substituting information on it (Czajka, T. 87).

12. Under New York State law, x-ray films are required to be maintained for a period of six years (Czajka, T. 21; Spector, T. 280).

13. An EKG or ECG is an abbreviation for an electrocardiogram, a test which measures the

electrical activity of the heart. The EKG would be manifested in a patient's medical record through EKG tracings and a report on the tracings. Physicians are required to keep ECG tracings for 6 years. Maintaining the paper tracings serves the critical medical purpose of establishing a baseline EKG (Spector, T. 277-279).

PATIENT A

14. Dr. Rattray, individually and in his capacity as officer/shareholder of Rochdale, treated Patient A, a 61 year old female, beginning on November 13, 1999 and continuing through at least January 25, 2003, for hypertension, breast cancer and depression (Pet's Ex. 3; Spector, T. 275-276).

15. Patient A's medical record contains progress notes indicating that chest x-rays were performed on October 20, 2001, June 25 or 28, 2002 and August 5 and October 1, 2002 (Pet's Ex. 3; Spector, T. 279-280).

16. Dr. Rattray caused claims to be submitted to Oxford Health, Inc. for dual views of Patient A's chest, billed under CPT code 71020, purportedly taken and interpreted on June 7, 2002 and August 5, 2002 (Pet's Ex. 3, 3A, 3B and 10).

17. Dr. Rattray provided four x-rays to the Department for Patient A. The x-rays were purportedly dated October 20, 2001 and July 5, August 5 and October 1, 2002 and depicted four purported frontal views of Patient A's chest (Czajka, T. 26-27; Pet's Ex. 3C).

18. Dr. Rattray falsely represented the date of the x-rays which he provided to OPMC for Patient A. All four films of Patient A are exact duplicate copies of each other even though the dates on the x-ray identification markers are different. The degree of similarity between all of the films, including the positioning of the patient, the location of artifacts and the location of various anatomy, is scientifically and medically impossible (Czajka, T. 26-34).

19. Patient A's medical record contains progress notes indicating that on, among other dates, EKGs were performed on March 27 and October 20, 2001 and on March 21, June 25 or 28, August 5 and October 1, 2002 (Pet's Ex. 3; Spector, T. 279).

20. No EKG tracings were present in Patient A's medical record (Pet's Ex. 3).

21. Dr. Rattray caused claims to be submitted to Oxford Health, Inc. for EKGs (code # 93000) of Patient A which were purportedly performed upon Patient A and interpreted on June 7 and August 5, 2002 (Pet's Ex. 3A, 3B and 10).

22. The certified medical record for Patient A submitted by Dr. Rattray contains a progress note, dated March 21, 2002, on which Respondent added EKG, a history and a more detailed diagnostic impression. This information was not contained in the copy of the March 21, 2002 progress note which was scanned by Mr. Cain during the January 23, 2003 record review (Pet's Ex. 3, pgs. 74-75, and Ex. 31; Cain, T. 173-176).

23. Dr. Rattray acknowledged making additional entries to the medical records which he provided to OPMC. The alterations to the records were made after Mr. Cain scanned them on January 23, 2003 (Rattray, T. 487-489).

24. A January 20, 2000 laboratory report noted that Patient A had a cholesterol value of 335 which is significantly abnormal and an HDL of 75 and an LDL of 223 all of which were distinctly high results. These results indicated that Patient A was at significant risk of developing coronary artery disease and arteriosclerosis in other organs. Patient A returned to Dr. Rattray's office on February 7, 2000. The copy of the February 7, 2004 progress note offered by the Department as part of Patient A's record is missing the bottom of the progress note (Spector, T. 280-284; Pet's Ex. 3, pg. 4 and 1st pag. 103).

25. A December 28, 2000 laboratory report showed that Patient A had an elevated Platelet count of 580 and an elevated ESR of 118. There were no timely follow up office visits or mention made in Patient A's medical record concerning the abnormal Platelet and ESR results (Spector, T. 283; Pet's Ex. 3, 2d pg. 101).

PATIENT B

26. Dr. Rattray, individually and in his capacity as officer/shareholder of Rochdale, treated Patient B, a 65 year old female, between August 26, 2000 and September 28, 2002, for hypertension, diabetes and dry skin (Pet's Ex. 4; Spector, T. 288).

27. Dr. Rattray caused insurance claims to be submitted to Group Health Insurance ("GHI") for dual views of Patient B's chest, billed under CPT code 71020, purportedly taken of Patient B and interpreted on February 9 and May 25, 2002 (Pet's Ex. 4A, 4B, 10 and 32).

28. Dr. Rattray provided one x-ray to the Department of a single view of Patient B's chest, purportedly in support of the claim for the date of February 9, 2002. However, the x-ray lacks both patient identifying information and a date (Pet's Ex. 4C; T. 56-65).

29. Patient B's medical record contains progress notes dated November 10, 2001 and February 9 and 18 and July 27, 2002 and a progress note of indeterminate date which indicated that EKGs were performed upon Patient B (Spector, T. 288; Pet's Ex. 4).

30. Dr. Rattray caused claims to be submitted to GHI for EKGs (code # 93000) of Patient B for dates of service of June 16, 2001, November 10, 2001, February 9 and 18, May 25, July 26, 2002 (Pet's Ex. 4A, 4B and 10).

31. There were no EKG tracings in Patient B's medical record (Spector, T. 288-289).

32. Patient B's results on a March 3, 2001 laboratory report demonstrated a low blood platelet count of one hundred thirteen thousand and a high percentage, in the area of 20%, of monocytes. These results are possibly indicative of bone marrow disease (Pet's Ex. 4, pgs. 38; Spector, T. 289-291).

33. Patient B returned for a follow up visit on March 17, 2001 at which time Dr. Rattray wrote a progress note indicating that Patient B's laboratory results were "OK" rather than repeating the blood work to verify the March 3, 2001 results (Spector, T. 290-291; Pet's Ex. 4, pg. 5).

PATIENT C

34. Dr. Rattray, individually and in his capacity as officer/shareholder of Rochdale, treated Patient C, a 75 year old male, beginning on July 25, 2000 and continuing through at least December 17, 2002, for gastritis, degenerative joint disease, hypertension, diabetes and coronary artery disease (Pet's Ex. 5; Spector, T. 295-296).

35. Dr. Rattray caused claims to be submitted to Medicare for dual view x-rays, billed as CPT Code # 71020, purportedly taken of Patient C and interpreted on, among other dates, 10/12/00, 5/24/01, 6/4/02, 9/26/02, 11/4/02 and 11/26/02 (Pet's Ex. 5, 5A, 5B 10 and 32).

36. During the January 23, 2003 record review, Mr. Cain requested Patient C's June 4, 2002 x-ray film. The x-ray film could not be located (Cain, T. 199-204).

37. Dr. Rattray provided x-rays to the Department for Patient C, purportedly dated January 31 and June 4, 2002, which only depict posterior/anterior views of Patient C's chest rather than the dual views billed for. Both films were identical with the same artifacts and positioning of the patient including the patient's hemidiaphram and clavicular distance in that the distance between the clavicular heads and location of the shoulders including the degree of elevation appeared to be exactly the same (Cjaka, T. 79-85 Cain, T. 208; Pet's Ex.5C).

38. Patient C's medical record contains progress notes, dated March 10, July 21 and December 20, 2001 and February 18, April 29, June 4, July 23, October 12 and November 4, 2002, which indicate that EKGs were performed upon Patient C (Spector, T. 296; Pet's Ex. 5).

39. Dr. Rattray caused claims to be submitted to Medicare for EKGs (code # 93000) of Patient C for dates of service of, among other dates, March 10, July 21 and 23, November 15 and December 20, 2001 and February 18, June 4, October 12 and November 4, 2002 (Pet's Ex. 5A, 5B, 10 and 32).

40. While claims were submitted for EKGs on at least nine occasions, only three EKG tracings, and part of a 4th tracing are found in Patient C's medical record. An October 12, 2002 tracing is the only one which can be linked through a date to the above claims (Spector, T. 296-298; Pet's Ex. 5).

41. June 4 and August 5, 2002 progress notes in Patient C's certified medical record submitted to Mr. Cain by Dr. Rattray contain significant differences from the progress notes for those dates scanned by Mr. Cain during his January 23, 2003 record review. An interval history had been added to the June 4, 2002 progress note as well as impressions and diagnoses including hypertension, diabetes, coronary artery disease and increased cholesterol. A plan was included for treatment. An EKG and chest x-ray with results were also put into the record in the interval (Pet's Ex. 5, pg. 27; Cain, T. 147-150).

42. The certified copy of the August 5, 2002 record submitted by Dr. Rattray had been altered by the addition of, among other things, an interval history and diagnoses of hypertension, diabetes, coronary artery disease and increased cholesterol stable and a signature (Cain, T. 149-150; Pet's Ex. 5, pg. 27).

43. A July 21, 2001 blood test indicated that Patient C had a slight drop in his hematocrit to 33 and

was mildly anemic. Although, the drop in hematocrit should have led Dr. Rattray to order an additional blood test, he did not do so for approximately four months which was too long a period. Patient C was still anemic as of a November 19, 2001 laboratory report. A September 26, 2002 blood test indicated a hematocrit of 27. Dr. Rattray did not comment on the hematocrit of 27 on Patient C's next visit of October 12, 2002 (Spector, T.298-305; Pet's Ex. 5, lab results are on pgs. 41, 43 and 50).

44. Dr. Rattray failed to follow up on other abnormal laboratory results, most significantly a low platelet count and an increase in monocytes on a January 31, 2002 blood test, and a white blood count of zero on a September 26, 2002 blood test. Dr. Rattray did not comment on these significantly abnormal lab values and failed to promptly reorder the laboratory tests to determine the accuracy of the results (Spector, T. 300-306; Pet's Ex. 5, lab results are on pgs. 46 and 50).

PATIENT D

45. Dr. Rattray, individually and in his capacity as officer/shareholder of Rochdale, treated Patient D, a 93 year old male, beginning on August 26, 1999 and continuing through at least September 17, 2002 (Pet's Ex. 6; Spector, T. 314).

46. Patient D's medical record contains progress notes, dated January 21, 2000 and February 13, March 14, July 2 and September 7, 2002 which indicate that chest x-rays were done on those dates (Spector, T. 316; Pet's Ex. 6).

47. Respondent caused claims to be submitted to Medicare for dual view x-rays (billed as CPT Code # 71020) purportedly taken of Patient D on, among other dates, January 21, 2000, March 20, 2001, September 12, 2001, March 14, 2002, April 18, 2002, June 8, 2002, July 2, 2002 and September 7, 2002 (Pet's Ex. 6a, 6b, 10 and 32).

48. Following Mr. Cain's January 23, 2003 record review, Dr. Rattray submitted 7 x-rays for Patient D, purportedly dated January 31, February 13, March 14, April 18, June 8, July 2 and September 7, 2002. None of the x-rays submitted were for the years 2000 or 2001 (Czajka, T. 89; Pet's Ex. 6c).

49. With respect to the seven films submitted for 2002, all of the films provided by Dr. Rattray are duplicates of each other based on the rotation of the patient and the hemidiaphragms, the degree of inspiration of the lungs, the positioning of the clavicles and the shoulders, the shape of the heart, the location of the aortic knob and a small mass, likely a granuloma, in the left upper lung (Czajka, T. 88- 106).

50. Progress notes are present in Patient D's medical record which indicate that EKGs were performed on, among other dates, August 26, 1999, January 21, May 11 and November 9, 2000, October 9, November 19, December 6, 2001 and January 31, February 13, March 14, June 8, July 2 and September 7, 2002. Tracings are present for at least November 19, 2001 and February 13 and June 8, 2002 as well as other strips whose dates are difficult to decipher (Spector, T. 314-316; Pet's Ex. 6).

51. Dr. Rattray caused insurance claims to be submitted to Medicare for EKGs purportedly taken and interpreted on, among other dates, 1/21/00, 4/6/00, 5/11/00, 11/9/00, 3/20/01, 9/12/01, 10/9/01, 1/10/02, 1/11/02, 1/31/02, 3/14/02, 4/18/02, 7/2/02 and 9/7/02 (Pet's Ex. 6a, 6b, 10 and 32).

52. There are no EKG tracings in Patient D's medical record with dates matching the dates of the claims which were submitted (Pet's Ex. 6, 6A, 6B, 10 and 32; Spector, T. 314-316).

53. Tracings for November 19, 2001, February 13 and June 8, 2002 are virtually identical, except for the handwritten dates (Pet's Ex. 6, pgs. 85-87; Spector, T. 319-320).

54. During the January 23, 2003 record review, Mr. Cain scanned progress notes, dated June 22 and July 2, 2002, from Patient D's medical record (Pet's Ex. 27; Cain, T. 153-154).

55. The June 22 and July 2, 2002 progress notes found in the certified medical record produced by Dr. Rattray following the January 23, 2003 record review, differed from the June 22 and July 2, 2002 progress notes scanned by Mr. Cain. On the certified copy of the record, Dr. Rattray added spirometry findings to the June 22, 2002 progress note. To the July 2, 2002 progress note, Dr. Rattray added chest x-ray, EKG and spirometry findings. Respondents submitted Medicare claims for chest x-rays and EKGs that were purportedly performed on Patient D on July 2, 2002 (Pet's Ex. 6, pg. 19 and Ex. 6b and 27; Cain, T. 152-162).

PATIENT E

56. Dr. Rattray, individually and in his capacity as officer/shareholder of Rochdale, treated Patient E, a 75 year old female, beginning on May 11, 2001 and continuing through at least January 25, 2003 (Pet's Ex. 7; Spector, T. 323).

57. Patient E's medical record contains progress notes of July 19 and December 29, 2001 and February 23, March 2 and 15, May 11, June 1 and August 27, 2002 which indicate that chest x-rays were performed upon Patient E on those dates (Spector, T. 324; Pet's Ex. 7).

58. Respondent caused claims to be submitted to Medicare for dual view x-rays (billed as CPT Code # 71020) purportedly taken of Patient D on, among other dates, 8/22/01, 2/6/02, 2/23/02, 3/2/02 and 3/15/02 (Pet's Ex. 7a, 7b, 10 and 32).

59. Following the January 23 record review, Respondent did not produce any films which could be connected to the dates of the the above claims. The only films produced for Patient E were a chest x-ray, purportedly dated January 9, 2003, and an undated film with no patient image or identifying factors on it (Pet's Ex. 7c; Czajka, T. 111-112).

60. Patient E's medical record contains progress notes of, among other dates, August 22, September 6, December 1 and 29 of 2001 and February 23, March 15, May 11, July 2 and August 27, 2002, which indicate the performance of EKGs on those dates (Spector, T. 323-324; Pet's Ex. 7).

61. Dr. Rattray caused claims to be submitted to Medicare for EKGs purportedly taken of Patient E and interpreted on, among other dates, 5/24/01, 2/6/02, 2/23/02, 3/2/02, 3/15/02, 4/26/02, 5/11/02, 7/2/02, 8/27/02, 9/21/02, 11/4/02, 11/22/02 and 1/9/03 (Pet's Ex. 7a, 7b, 10 and 32).

62. EKG tracings were only present in the medical record for May 11, 2001 and January 9, 2003. There were, also, four undated EKGs (Pet's Ex. 7; Spector, T. 323-324).

63. Spirometry is a test of lung function. The spirometry machine generates a paper tracing that is the basis of the physician interpretation. The report generated by the spirometry machine should be kept as part of a patient's record (Spector, T. 324-325).

64. Dr. Rattray caused claims to be submitted on superbills for submission to Synergy for spirometry evaluations (CPT Code # 94060) purportedly taken of Patient E and interpreted on 9/6/01, 10/8/01, 5/11/02, 8/27/02, 9/21/02, 11/4/02, and 11/22/02 (Pet's Ex. 7a).

65. There are no spirometry reports in Patient E's record for the dates in question that would support billing for the procedure on those dates (Pet's Ex. 7; Spector, T.325).

PATIENT F

66. Dr. Rattray, individually and in his capacity as officer/shareholder of Rochdale, treated Patient F, a 73 year old female, beginning on August 10, 1998 and continuing through at least January 11, 2003 (Pet's Ex. 8).

67. Patient F's medical record contains progress notes, dated 7/19/01, 9/29/01, 11/17/01, 2/9/02, 4/20/02, 5/25/02, 6/15/02, 8/3/02, 8/31/02, 10/19/02 and 11/25/02 and a progress note of indeterminate date (Pet's Ex. 8, pg. 30) which indicate that chest x-rays were performed upon

Patient F on those occasions (Spector, T. 327-328; Pet's Ex. 8).

68. Dr. Rattray caused claims to be submitted to Medicare for dual view x-rays (billed as CPT Code # 71020) purportedly taken of Patient F on, among other dates, 7/19/01, 9/29/01, 11/17/01, 2/9/02, 4/20/02, 5/4/02, 5/25/02, 6/15/02, 6/29/02, 8/3/02, 8/13/02, 8/31/02, 10/19/02, 11/23/02 and 1/11/03 (Pet's Ex. 8a, 8b, 10 and 32).

69. Following the January 23 record review, Dr. Rattray submitted x-rays purportedly for the following dates: March 9, April 20, May 25 and June 29, 2002. Three of the dated x-rays submitted and a fourth x-ray of indeterminate date are duplicates of each other based on the structure of the ribs and lungs, hilar structrures in the blood vessels and shape of the heart. It is highly unlikely that x-rays taken on different dates would be identical in all respects. Dr. Rattray, also, submitted four unlabelled films, three of which have no images and one with a minimal image (Czajka, T. 113-125, 128; Pet's Ex. 8c).

70. Patient F's medical record contains progress notes for the dates of 7/19/01, 10/13/01, 11/17/01, 2/9/02, 3/9/02, 3/23/02, 4/20/02, 5/25/02, 6/15/02, 8/31/02, 10/19/02 and 11/25/02 which indicate that EKGs were performed on those dates (Pet's Ex. 8).

71. Dr. Rattray caused claims to be submitted to Medicare for EKGs purportedly taken of Patient F and interpreted on, among other dates, 7/19/01, 10/13/01, 11/17/01, 2/9/02, 3/23/02, 5/4/02, 5/25/02, 6/15/02, 6/29/02, 8/13/02, 10/19/02 and 11/23/02 (Pet's Ex. 8a, 8b, 10 and 32).

72. There is only one EKG tracing in the medical record for Patient F which is dated May 4, 1999 (Pet's Ex. 8; Spector, T. 327).

PATIENT G

73. Dr. Rattray, individually and in his capacity as an officer/shareholder of Rochdale, treated Patient G, a 59 year old female, beginning on at least May 1, 1999 and continuing through at

least January 10, 2003 (Pet's Ex. 9, Spector, T. 329).

74. There are progress notes in Patient G's medical record indicating that chest x-rays were performed on September 27, 2001 and January 31 and February 4, 2002 (Pet's Ex. 9, Spector, T. 330).

75. Dr. Rattray caused claims to be submitted to Medicare for dual view chest x-rays (code # 71020) purportedly taken on, among other dates, 1/31/02, 2/4/02, 6/15/02, 8/13/02 and 9/21/02 (Pet's Ex. 9a, 9b, 10 and 32).

76. Following the January 23 record review, Dr. Rattray submitted 4 x-rays, purportedly dated January 31, 2002, February 4. 2002, June 15, 2002 and September 21, 2002. The four x-rays submitted are exact duplicates of each other based upon the positioning of the patient, the degree of inspiration, the positioning of the artifacts, and the blank lucent structure in the upper left portion of all four films where the name marker should have been showing which suggests that the identification was added later in the right upper hand corner (Czajka, T. 128-132; Pet's Ex. 9c).

77. Patient G's medical record contains progress notes indicating that, among other dates, EKGs were performed on September 27, 2001 and January 31, February 4 and April 26, 2002 (Pet's Ex. 9; Spector, pg. 329).

78. Dr. Rattray caused Medicare claims to be submitted for payment for EKGs purportedly taken of Patient G and interpreted on, among other dates, 1/31/02, 2/4/02, 4/9/02, 6/15/02, 8/13/02, and 9/21/02 (Pet's Ex. 9a, 9b and 10).

79. There are two EKG tracings in Patient G's medical record neither of which match the dates of the above claims (Pet's Ex. 9; Spector, T. 329-330).

PATIENT H

80. In the course of the January 23, 2003 record review at Respondents' office, Mr. Cain discovered a copy of an "Explanation of Benefits" ("EOB") that had been faxed to Dr. Rattray by Patient H who wrote the following note on the EOB:

> "To Dr. Rattray, My insurance mailed this copy of medical claim you got paid for. This is not correct- You charged my insurance for "Electrocardio". This procedure was not done, why would you charge for something that was not done..."

The EOB indicated that the "electro-cardio" was performed on May 2, 2002 (Pet's Ex. 28; Cain, T. 162-164,168).

81. M. Cain photo scanned a copy of the EOB for Patient H, and he subsequently confirmed with Patient H that she had, in fact, faxed Dr. Rattray the EOB and note. Patient H subsequently mailed Mr. Cain a copy of the EOB (Cain, T. 165-167; Pet's Ex. 29).

82. 93015 is the CPT code for Exercise Stress Tests (see Pet's Ex. 3A, pages pertaining to 3/21/02, 6/7/02).

83. Cigna, Patient H's health insurance company, reimbursed Respondents for the performance of a stress test (CPT number 93015) on Patient H, on May 2, 2002 (Pet's Ex. 30; Cain, T. 168-173).

84. Dr. Rattray claimed he had never treated Patient H. He ultimately did not provide OPMC with a copy of Patient H's record, in response to a written request (Cain, T. 168).

FACTUAL ALLEGATIONS J-L
DR. RATTRAY'S HOSPITAL AFFILIATIONS AND EDUCATION DEPARTMENT APPLICATION

85. Dr. Rattray has had hospital affiliations with Franklin Hospital Medical Center ("Franklin Hospital") and Mary Immaculate Hospital, an affiliate of the Saint Vincent's Catholic Medical Center (Rattray, T. 418).

86. By a November 15, 2001 letter, sent certified mail and return receipt requested, Franklin Hospital restricted Dr. Rattray's privileges based on a finding by their Practitioner Review Committee that he inappropriately managed an asthmatic patient. (Pet's Ex. 15).

87. Dr. Rattray was placed on probation and was required to obtain a consult/second opinion from an appropriately privileged physician on all admitted patients during the period of probation (Pet's Ex. 15).

88. The November 15, 2001 letter indicated that Dr. Rattray would be given thirty days to request a hearing. He did not request a hearing and waived his right to an appeal (Pet's Ex. 15; Rattray, T. 422-424).

89. Via a February 18, 2002 letter which was signed for by Dr. Rattray's office, Franklin Hospital suspended Dr. Rattray from the hospital staff due to a lapse in his malpractice coverage. Dr. Rattray did not reapply for privileges at Franklin Hospital subsequent to the February 18, 2002 suspension (Pet's Ex. 15, pg. 2, and Ex. 22; Rattray, T. 424-428).

90. On December 18, 2002, Dr. Rattray signed the re-credentialing application to St. Vincent's Catholic Medical Center (Pet's Ex. 21).

91. On that application, Dr. Rattray concealed, with the intent to mislead, that he no longer had privileges at Franklin Hospital. The application incorrectly indicates that Dr. Rattray held privileges from "1988 to present" (Pet's Ex. 21, pg. 3).

92. Dr. Rattray, knowingly and falsely, represented that he had never had his hospital privileges restricted, reduced, and/or been place on probation by a hospital on his New York State Physician Profile Survey, dated February 14, 2003, on his Aperture Credentialing Applications dated October 27, 2003 and May 14, 2004, on his United Health Care credentialing application, dated September 6, 2002, and on his Reappointment application to St. Vincent's Catholic

Medical Center, dated December 18, 2002 (Pet's Ex. 15, 17, 18, 19, 20, and 21).

93. Dr. Rattray, knowingly and falsely, represented on his New York State Department of Education License Registration Application, dated March 26, 2002, that since he had last registered, no hospital had terminated and/or restricted his privileges "due to professional misconduct, unprofessional conduct, incompetence or negligence". Dr. Rattray knew that, on November 15, 2001, Franklin Hospital had restricted his privileges based on a finding by their Practitioner Review Committee that he inappropriately managed an asthmatic patient (Pet's Ex. 16).

WITNESSES

In its deliberations, the Committee initially considered the credibility of the various witnesses presented by the parties. Ellen Czajka, M.D., and Henry Spector, M.D., testified as expert witnesses for the Department. Joseph L. Cain, R.N., testified as to the Department's investigation of Respondents. Each of these witnesses was convincing and credible. In particular, Dr. Czajka impressed the Committee with her explanation of the x-rays presented by the Department. She was clear, credible and exhibited a high level of expertise. She explained in great detail why she was convinced that Dr. Rattray had submitted bogus copies of x-rays and how the positioning of the patient in relation to the x-rays affected her conclusions. When she was unsure, she was not hesitant to acknowledge doubt.

The Committee regarded Mr. Cain as both very credible and as having the requisite investigative expertise. Particularly noteworthy were Mr. Cain's efforts to obtain copies of Respondent's records on his scanner so that he had proof positive to compare against the records that Dr. Rattray eventually submitted.

Dr. Spector was regarded as well qualified to testify as to Dr. Rattray's care of Patients A through G. The Committee took particular note of his testimony that Patient D's EKGs, ostensibly taken on 11/19/01, 2/13/02 and 6/8/02, were identical and, therefore, highly suspicious (T. 319-320).

Dr. Rattray testified in his own behalf and presented no other witnesses. The Committee noted that Respondents' attorney represented, at the conclusion of the June 7, 2005 hearing date, that Respondents would be calling at least one expert, a radiologist, to testify on Respondents' behalf (T. 342). Ultimately, however, Respondents did not present any witnesses other than Dr. Rattray.

The Committee concluded that Dr. Rattray's testimony was biased by his self interest in keeping his medical license, and did not find his testimony credible. Additionally, Dr. Rattray exhibited a patent disregard for the hearing process by consistently coming late to the hearing despite being admonished repeatedly to be present at the start of the hearing day (T. 6-7, 184-185, 210, 344, 350-351).

The Committee found that Dr. Rattray's testimony lacked credibility and that he consistently failed to take responsibility for his actions. For example, the Committee found Dr. Rattray's testimony not to be believable when he testified that his wife had signed the various hospital applications or that he did not receive the letters from Franklin Hospital notifying him that his privileges had been restricted/suspended. Dr. Rattray acknowledged adding notes to the certified medical records which he ultimately submitted to Mr. Cain and testified that he did so because he did not want to submit a blank note (T. 503-506). The Committee concluded that Dr. Rattray, with respect to a number of patients, submitted altered

records. The correct procedure would have been to clarify the earlier record through a later note, properly dated.

The Committee, also, found that Dr. Rattray's testimony, concerning the many procedures he billed for but did not perform, was not credible. The documentary evidence demonstrated that Respondents had billed for numerous procedures which had not been performed. To cite but one example, Respondents submitted numerous insurance claims for radiologic examinations on which they billed for two views of the chest. Respondents were unable to produce x-rays to substantiate all or the great majority of these claims. Often, x-rays were submitted for single views. When x-rays were produced, purportedly for different dates, they were often copies of each other. While Dr. Rattray represented that x-rays were taken on dates certain, he was often unable to locate the x-rays in support of the representations.

In one instance, Dr. Spector testified that three EKGs in Patient D's medical record, purportedly for the dates of November 19, 2001 and February 13 and June 8, 2002, were most likely copies of the same EKG rather than independently taken tracings (T. 319-320). The Committee, also, observed that Dr. Rattray initially did not respond to the government's request for medical records (Cain, T. 141; Pet's Ex. 25), and viewed this failure to respond as further evidence of Dr. Rattray's wish to avoid responsibility for his actions. Dr. Rattray's testimony neither provided an acceptable or believable explanation for the charges concerning his billing practices nor did he adequately accept responsibility for his actions. The Committee concluded that Dr. Rattray exhibited a callous disregard toward the responsibilities

which arose from his medical practice.

GENERAL CONCLUSIONS

Respondents are charged with numerous specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct that constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Committee consulted a memorandum prepared by the former General Counsel for the Department of Health. This memorandum, which is entitled "Definitions of Professional Misconduct Under the New York State Education Law", sets forth suggested definitions for, among other things, negligence, incompetence and fraudulent practice. The following definitions, taken from this memorandum, were utilized by the Committee:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. Bogdan v. New York State Board for Professional Medical Conduct, 195 A.D.2d 86, 88, 606 N.Y.S. 2d 381 (3d Dept. 1993). It involves a deviation from acceptable medical standards in the treatment of patients. Injury, damages and proximate cause are not essential elements in a medical disciplinary proceeding (Id.).

Incompetence is the lack of requisite skill or knowledge to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D. 2d 609, 651 N.Y.S. 2d 249 (3d Dept. 1996). The statutory definition requires proof of practicing with incompetence "on more than one occasion". "On more than one occasion" carries the same meaning it does in relation to negligence on more than

one occasion, as set forth above.

The **fraudulent practice of medicine** is the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine and with the intent to deceive. Choudry v. Sobol ("Choudry"), 170 A.D. 2d 893, 566 N.Y.S. 2d 723 (3d Dept. 1991) citing Brestin v. Commissioner of Education ("Brestin") 116 A.D. 2d 357, 501 N.Y.S. 2d 923 (3d Dept. 1986) (dentistry). To sustain a charge that a licensee has engaged in the fraudulent practice of medicine, the Committee must find that 1) a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been disclosed, 2) the licensee knew the representation was false, and 3) the licensee intended to mislead through the false representation. Sherman v. Board of Regents, 24 A.D. 2d 315, 266 N.Y.S. 2d 39 (3d Dept. 1966), aff'd. 19 N.Y. 2d 679, 278 N.Y.S. 2d 870 (1967). The licensee's knowledge and intent may properly be inferred from facts found by the Committee, but the Committee must specifically state the inferences it is drawing regarding knowledge and intent, Choudry, supra at 894 citing Brestin. Fraudulent intent may be inferred from evidence that the licensee was aware of the true state of facts at the time false responses were given. Saldanha v. DeBuono, 256 A.D.2d 935, 681 N.Y.S. 2d 874 (3d Dept. 1998).

Submitting false bills or claims for services rendered, with knowledge that they were false supports a charge of fraudulent practice, as does the submission of false and exaggerated medical reports, Holmstrand v. Board of Regents, 71 A.D. 2d 725, 419 N.Y.S. 2d 223 (3d Dept., 1979), Wasserman v. Board of Regents, 11 NY 2d 173, 227 N.Y.S. 2d 649 (1962), appeal dismissed 371 U.S. 23, 9 L.Ed. 2d 96, 83

S. Ct. 121 (1962). False statements made on application for hospital privileges have also been found to constitute fraudulent practice. Kim v. Board of Regents, 172 A.D. 2d 880, 567 N.Y.S. 2d 949 (3d Dept. 1991), appeal denied, 78 N.Y, 2d 856, 574 N.Y.S. 2d 938 (1991).

While "the mere making or filing of a false report, without intent or knowledge of the falsity..." (Brestin, supra at 359) does not constitute fraudulent practice, the Committee is free to reject, as not credible, 1) a licensee's mitigating explanations Kenna v. Ambach, 61 A.D.2d 1091, 403 N.Y.S. 2d 351 (3d Dept., 1978) 2) a claim of mere "mistake" (Dilluvio v. Board of Regents, 60 A.D. 2d 699, 400 N.Y.S. 2d 871 (3d Dept., 1977) or a claim that negligence was the cause of the misrepresentation (Schmelzer v. Ambach, 86 A.D. 2d 901, 448 N.Y.S. 2d 270 (3d Dept., 1982). The Committee must base its inferences on that which it accepts as the truth. Klein v. Sobol, 167 A.D. 2d 625, 562 N.Y.S. 2d 856 (3d Dept., 1990), appeal denied at 77 N.Y. 2d 809 (1991) (podiatry) citing Ragazzino v. Ross, 52 N.Y. 2d 858, 437 N.Y.S. 2d 74 (1981).

Fraud can also be established when a person makes a statement or representation with reckless disregard as to its truth. See Kountze v. Kennedy, 147 N.Y. 124, 129-130 (1895); State Street Trust Co. v. Ernst, 278 N.Y. 104, 112 (1938). This is so because representation of a fact to another carries with it the implied assurance that the party has adequate knowledge to make the assertion. Kountze, supra at 130; State Street Trust Co., supra at 112.

In determining whether Respondents had filed Medicare or other insurance claims on various dates for Patients A through G, reliance was not placed, in all

cases, upon the superbills submitted by the Department. Because the copies of the superbills produced in many cases were poor copies, it was impossible to determine from the superbills in a number of instances whether claims had been filed, as alleged. The findings and conclusions found in the Findings of Fact above, are instead largely based upon the summaries of claims produced by the Department based on submissions from Medicare (Ex. 5B, 6B, 7B, 8B, 9B and 32). The Committee noted that the summaries prepared by the Department were uncontroverted by the testimony and evidence presented by Respondents. Even in Respondents' closing briefs, the billing problems were attributed to the outsourcing of billing to Synergy or to Dr. Rattray's employees and wife who it was claimed were responsible for claims filed or for the disarray in Respondents' office. As discussed at length in this decision, the Committee did not find Dr. Rattray credible and gave little weight to his responses to the charges. *Suffice it to say that Respondents did not question the accuracy of the Department's summary of claims which Dr. Rattray made to Medicare, and the Committee consequently gave great weight to those summaries.*

In considering whether Respondents performed acts which brought them within the definition of fraudulent practice or of filing false reports, the Committee was guided by the Administrative Law Judge's instruction that to meet these definitions, Respondents had to have willfully or intentionally committed the conduct in order to deceive. The Committee concluded that Respondents had knowingly intended to deceive and reached this conclusion based on a number of circumstances.

First, Respondents did not immediately respond when records were requested by the Department. When certified records were ultimately produced, in a number of cases, they were altered. In the case of Patient C and his brother, Respondents represented that an x-ray procedure had been performed on a certain date, yet they had no idea where the x-rays were (Cain, T. 199-203). The x-rays provided to the Department, purportedly performed on different dates, were often copies of each other. Finally, the Committee, in finding that Respondents had the intent to deceive, noted the incident involving Patient H in the course of which Patient H complained that Dr. Rattray billed for an "electrocardio" procedure which was not actually performed. After weighing all of the evidence and testimony, the Committee concluded that the allegations resulted not from record keeping problems but from a deliberate pattern of deceit by Dr. Rattray. Thus, in each of the instances in which Respondents were charged with fraud or filing false reports, as set forth below, the Committee concluded that, to the extent to which Factual Allegations were sustained, the Respondents' actions were done knowingly and with the intent to deceive.

Dr. Rattray was the sole shareholder, director and officer of Rochdale, a medical corporation. He was, in effect, both the owner and an employee of the corporation, and the medical corporation was for all intents and purposes, indistinguishable from him. Much as business corporations are liable under the doctrine of respondeat superior for the torts of their employees committed within the scope of the corporate business, professional service corporations are similarly vicariously liable for the torts of their servants. Under the doctrine of respondeat

superior, Rochdale was liable for those acts which its agent, Dr. Rattray, performed on behalf of the professional corporation. Thus, the Committee found that in all cases where Rochdale was charged, it was liable for Dr. Rattray's actions.

PATIENT A

The Committee sustains Factual Allegation A based upon the finding that Respondents treated Patient A at Dr. Rattray's Rochdale offices at 137-04 Guy R. Brewer Boulevard, Jamaica, New York during the dates in question.

FACTUAL ALLEGATION A.1

Factual Allegation A.1 alleges that Respondents, with intent to deceive, submitted and/or caused to submit insurance claims, for the dates of January 10, June 7 and August 5, 2002, to Oxford Health, Inc. ("Oxford") in which they represented that they had performed and/or interpreted radiologic examinations of the chest (two views) billed under CPT code 71020, when Respondents knew they had neither performed nor interpreted such radiologic studies.

The Committee sustains Factual Allegation A.1. The documentary evidence produced by the Department substantiates that Dr. Rattray caused insurance claims to be submitted for two of the claims charged. The Committee concludes that Dr. Rattray falsely represented that he had performed x-rays on the dates for which the claims were made. The four x-ray films provided to OPMC in support of the billing for Patient A are exact duplicate copies of each other even though the dates on the x-ray identification markers are different. The degree of similarity between all of the films, including the positioning of the patient, the location of artifacts and the location of various anatomy, is scientifically and medically impossible. The only reasonable

conclusion that can be drawn is that Respondent knew that he copied over an x-ray and simply changed the dates on the various x-ray copies. The Committee, therefore, concluded that Respondent's billing for dual view x-rays was based on x-rays which had never been performed or interpreted with the aim of profiting on the payment for performing and interpreting the x-rays.

FACTUAL ALLEGATION A.2

Factual Allegation A.2 alleges that Respondents knowingly and falsely represented the dates of x-rays provided to OPMC and intended to create the false impression that these were separate x-ray studies taken on different days, when Respondents actually submitted multiple copies of single x-ray studies with false dates affixed to the x-ray identification label.

The Committee sustains this allegation. The Committee found Dr. Czajka's testimony persuasive in this regard and concluded that the four films which were represented as having been taken on October 20, 2001 and July 5, August 5 and October 1, 2002 were, in fact, exact duplicates of each other. The degree of similarity between all of the films, including the positioning of the patient, the location of artifacts and location of various anatomy was considered highly unlikely to have occurred, unless the x-rays were duplicates.

FACTUAL ALLEGATION A.3

Factual Allegation A.3 alleges that Respondents, with intent to deceive, submitted and/or caused to be submitted insurance claims, for March 27, July 12 and October 20, 2001 and January 10, March 21, June 7 and August 5, 2002 to Oxford in which they falsely represented that they had performed and interpreted multiple

EKGs when they knew they had neither performed nor interpreted the EKGs.

The Committee sustains Factual Allegation A.3 only insofar as the allegation pertains to the June 7 and August 5, 2002 claims which were processed by Oxford Health, Inc. While there are superbills present for other claims, the June 7 and August 5, 2002 claims are the only claims listed by Petitioner's Exhibit 3B as actually having been submitted to Oxford. There are no EKG tracings present in Patient A's medical record for June 7, August 5 or any other dates.

FACTUAL ALLEGATION A.4

Factual Allegation A.4 alleges that Respondents, with the intent to mislead, altered Patient A's medical record prior to its submission to OPMC, including a March 21, 2002 progress note. Dr. Rattray certified that the record submitted was "a true and exact copy" of Patient A's record when he knew he had significantly altered the record.

The Committee sustains this allegation. The March 21st, 2002 progress note submitted by Dr. Rattray as part of a certified copy of Patient A's medical record contains significant alterations from the progress note scanned and copied by Mr. Cain on his earlier visit to Dr. Rattray's office. Respondent, in his own testimony, acknowledged altering Patient A's medical record prior to submitting it to the Department.

FACTUAL ALLEGATION A.5

Factual Allegation A.5 alleges that Respondent inappropriately interpreted substandard x-rays. The Committee finds scant or no discussion of Respondent's

actual interpretation of x-rays in the record and declines to sustain this allegation.

FACTUAL ALLEGATION A.6

Factual Allegation A.6 alleges that Respondents failed to follow up on abnormal laboratory results, including Patient A's elevated cholesterol levels and elevated platelet counts. The Committee sustains this allegation insofar as a December 28, 2000 laboratory test indicated that Patient A had elevated blood platelet levels which were abnormal, and which test was not timely followed up on or noted in Patient A's medical record.

FACTUAL ALLEGATION A.7

Factual Allegation A.7 alleges that Respondents failed to maintain a record which accurately reflects Patient A's treatment and evaluation including but not limited to a failure to maintain x-rays and EKG tracings. The Committee sustains this allegation. Patient A's medical record contains progress notes indicating that x-rays were performed on certain dates. The x-rays produced for the Department were copies of each other and did not substantiate the progress notes. The Committee concluded that the x-rays were not performed on the dates in question.

PATIENT B

The Committee sustains Factual Allegation B based upon the finding that Respondents treated Patient B at Dr. Rattray's Rochdale offices at 137-04 Guy R. Brewer Boulevard, Jamaica, New York during the dates in question.

FACTUAL ALLEGATION B.1

Factual Allegation B.1 alleges that Respondents, with intent to deceive, submitted and/or caused to submit insurance claims, for the dates of February 9, May

25 and July 27, 2002, to GHI, in which they represented that they had performed and/or interpreted radiologic examinations of the chest (two views) billed under CPT code 71020, when Respondents knew they had neither performed nor interpreted such radiologic studies.

Factual Allegation B.1 is sustained. The documentary evidence of the claims produced by the Department substantiates that Dr. Rattray caused insurance claims to be submitted for February 9 and May 25. Respondents were only able to provide one x-ray to the Department in support of the above claims, purportedly for the February 9, 2002 x-ray. This x-ray lacked both patient identification and a date which would tie it to the February 9, 2002 claim for Patient B. The Committee concluded that Respondent had not, in fact, performed radiologic studies for February 9 and May 25, 2002.

FACTUAL ALLEGATION B.2

Factual Allegation B.2 alleges that Respondents, with intent to deceive, submitted and/or caused to be submitted insurance claims, for June 16 and November 10, 2001 and February 9 and 18, May 25 and July 26 and 27, 2002, to GHI, in which they falsely represented that they had performed and interpreted multiple EKGs when they knew they had neither performed nor interpreted the EKGs.

The Committee sustains Factual Allegation B.2 only insofar as the allegation pertains to the June 16 and November 10, 2001 and February 9 and 18, May 25 and July 26, 2002 claims. With respect to these claims, the evidence demonstrated that Respondents caused claims to be submitted to GHI claiming payment for an EKG on

those dates, and there was no indication in Patient B's medical record of an EKG tracing.

FACTUAL ALLEGATION B.3

Factual Allegation B.3 is sustained. The allegation alleges that Respondents failed to follow up on abnormal laboratory results including depressed platelet counts. This allegation is sustained because Dr. Rattray failed to adequately follow up on Patient B's March 3, 2001 laboratory results which showed a low blood platelet count of one hundred thirteen thousand and a high percentage, in the area of 20%, of monocytes, which are possibly indicative of bone marrow disease. In the March 17, 2001 follow up progress note, Dr. Rattray failed to appreciate the significance of the laboratory results and simply wrote that the results were "OK".

FACTUAL ALLEGATION B.4

Factual Allegation B.4 is not sustained. This allegation alleges that Respondents inappropriately interpreted substandard chest x-rays. The Committee finds scant or no discussion of Respondent's actual interpretation of x-rays in the record and declines to sustain this allegation.

FACTUAL ALLEGATION B.5

Factual Allegation B.5 alleges that Respondents failed to maintain a record which accurately reflects Patient B's treatment and evaluation including but not limited to a failure to maintain x-rays and EKG tracings. The Committee sustains this allegation based on Respondent's progress notes of November 10, 2001 and February 9, 18 and July 27, 2002 which indicated Respondent had performed EKGs even though there were no EKG tracings present in Patient B's medical record.

PATIENT C

The Committee sustains Factual Allegation C based upon the finding that Respondents treated Patient C at Dr. Rattray's Rochdale offices at 137-04 Guy R. Brewer Boulevard, Jamaica, New York during the dates in question.

FACTUAL ALLEGATION C.1

Factual Allegation C.1 alleges that Respondents, with intent to deceive, submitted and/or caused to submit Medicare claims, for the dates of October 12, 2000, May 24, 2001, June 4, September 26 and November 4 and 26, 2002. Respondents represented that they had performed and/or interpreted radiologic examinations of the chest (two views) billed under CPT code 71020, when Respondents knew they had neither performed nor interpreted such radiologic studies.

The Committee sustains Factual Allegation C.1. The documentary evidence of the claims produced by the Department substantiates that Dr. Rattray caused Medicare claims to be submitted for the dates charged. The January 31 and June 4, 2002 x-rays provided by Dr. Rattray to the Department pursuant to Mr. Cain's request for Patient C's medical record only depict posterior/anterior views of Patient C's chest rather than the dual views billed for. Both films submitted were identical copies of another film with identical artifacts and positioning of the patient including the patient's hemidiaphram and clavicular distance in that the distance between the clavicular heads and location of the shoulders including the degree of elevation appeared to be exactly the same. The Committee, also, notes in this regard that during the January 23, 2003 record review, Mr. Cain requested the x-ray film for

June 4, 2002 and Dr. Rattray was unable to locate it (T. 200). The Committee can only conclude that the copies were made and submitted to OPMC for the purpose of obscuring that Respondent had not peformed or interpreted x-rays for the billing dates in question.

FACTUAL ALLEGATION C.2

Factual Allegation C.2 is sustained. This allegation charges that Respondents, with intent to deceive, submitted and/or caused to be submitted Medicare insurance claims, for March 10, July 21, 23 and 27, November 15 and December 20, 2001 and January 31, February 18, June 4, September 26, October 12 and November 4 and November 26, 2002 to GHI in which they falsely represented that they had performed and interpreted mulitiple EKGs when they knew they had neither performed nor interpreted the EKGs.

The Committee found that Medicare claims for EKGs were submitted on at least nine occasions. However, only three EKG tracings, and part of a 4th tracing are found in Patient C's medical record. Only the February 3, 2001 and October 12, 2002 tracings are identifiable by date. The Committee concludes that the billings for the EKGs in question were in nearly all of the cases unsupported by the record, and that Respondent had deliberately submitted false claims on occasions when no EKG was performed.

FACTUAL ALLEGATION C.3

Factual Allegation C.3 alleges that Respondents, with the intent to mislead, altered Patient C's medical record prior to its submission to OPMC, including June 4 and August 5, 2002 progress notes. Dr. Rattray certified that the record submitted

was "a true and exact copy" of Patient C's record when he knew he had significantly altered the record.

The Committee sustains this allegation. As noted in the Findings of Fact pertaining to this charge, the June 4 and August 5, 2002 progress notes found in the certified copy of Patient A's medical record contain significant alterations from the June 4 and August 5, 2002 progress notes scanned and copied by Mr. Cain on his earlier visit to Dr. Rattray's office. Respondent, in his own testimony, acknowledged altering Patient C's medical record prior to submitting it to the Department. The Committee believes that the alteration was done with the intent to mislead.

FACTUAL ALLEGATION C.4

Factual Allegation C.4 alleges that Respondent failed to adequately evaluate and/or treat Patient C for anemia and bracycardia. The Committee sustains this allegation only with respect to allegation C4a concerning the anemia. Dr. Rattray did not recognize the significance of or treat Patient C's low hematocrit as indicated by the Findings of Fact pertaining to Patient C. With respect to the bracycardia, the Committee did not find that the record supported a finding that Patient C had bracycardia and does not sustain that part of the allegation.

FACTUAL ALLEGATION C.5

Factual Allegation C.5 is not sustained. This allegation alleges that Respondents failed to adequately interpret Patient C's October 12, 2000 EKG. The Committee finds scant discussion of Dr. Rattray's interpretation of this EKG in the record (T. 307-308) and declines to sustain this allegation.

FACTUAL ALLEGATION C.6

Factual Allegation C.6 alleges that Respondents failed to follow up on abnormal laboratory results. The Committee sustains this allegation and notes that Dr. Rattray failed to follow up on abnormal laboratory results, most significantly a low platelet count, an increase in monocytes in January 2002 and a white blood count of zero on a 9/26/02 blood test. Respondent did not comment on these significantly abnormal lab values and failed to promptly reorder the laboratory tests to determine the accuracy of the results.

FACTUAL ALLEGATION C.7

Factual Allegation C.7 alleges that Respondents failed to maintain a record which accurately reflects Patient C's treatment and evaluation including a failure to maintain x-rays and EKG tracings. The Committee sustains this allegation on the basis that Patient C's record contains numerous notations that EKGs had been performed when the tracings were not present in the medical record.

PATIENT D

The Committee sustains Factual Allegation D based upon the finding that Respondents treated Patient D at Dr. Rattray's Rochdale offices at 137-04 Guy R. Brewer Boulevard, Jamaica, New York during the dates in question.

FACTUAL ALLEGATION D.1

Factual Allegation D.1 alleges that Respondents, with intent to deceive, submitted and/or caused to submit Medicare claims, for the dates of 1/21/00, 2/13/01, 3/20/01, 9/12/01, 3/14/02, 4/18/02, 6/8/02, 7/2/02 and 9/7/02. Respondents represented that they had performed and/or interpreted radiologic examinations of

the chest (two views) billed under CPT code 71020, when Respondents knew they had neither performed nor interpreted such radiologic studies.

The Committee sustains Factual Allegation D.1. The documentary evidence of the claims produced by the Department substantiates that on nearly all of the above dates, Dr. Rattray caused Medicare claims to be submitted. Dr. Rattray submitted 7 x-rays from the year 2002. None of the x-rays submitted were for the years 2000 or 2001. With respect to the seven 2002 films, all of the films are exact duplicates of each other as discussed in the Findings of Fact. The Committee, therefore, concludes that the x-rays are not a legitimate basis for Dr. Rattray's Medicare claims and that he knew that he neither took nor interpreted chest x rays for the dates on which Medicare claims were submitted. The Committee can only conclude that the copies were made and submitted to OPMC for the purpose of obscuring that Respondent had not performed or interpreted x-rays for the billing dates in question.

FACTUAL ALLEGATION D.2

Factual Allegation D.2 alleges that Respondents, with intent to deceive, submitted and/or caused to be submitted Medicare insurance claims, for EKGs purportedly taken and interpreted on 1/21/00, 4/6/00, 5/11/00, 11/9/00, 3/20/01, 9/12/01, 10/9/01, 1/10/02, 1/11/02, 1/31/02, 3/14/02, 4/18/02, 7/2/02 and 9/7/02 when in fact Respondents knew they had neither performed nor interpreted the tests.

The Committee sustains this allegation. The documentary evidence of the claims produced by the Department substantiates that Dr. Rattray caused Medicare

claims to be submitted for EKGs on the dates charged. There are no EKG tracings in Patient D's medical record for the dates for which the claims were submitted. The Committee concludes that the billings for the EKGs in question were unsupported by the record and that Respondents had deliberately submitted false claims when no EKG was performed or interpreted.

FACTUAL ALLEGATION D.3

Factual Allegation D.3 alleges that Respondents, with the intent to deceive, submitted and/or caused to be submitted Medicare insurance claims, for performing and interpreting spirometry tests on various occasions. This allegation is not sustained. No testimony was offered in support of this allegation.

FACTUAL ALLEGATION D.4

Factual Allegation D.4 alleges that Respondents, with the intent to mislead, altered Patient D's medical record prior to its submission to OPMC, including June 22 and July 2, 2002 progress notes. Dr. Rattray certified that the record submitted was "a true and exact copy" of Patient D's record when he knew he had significantly altered the record.

The Committee sustains this allegation. As noted in the Findings of Fact, the June 22 and July 2, 2002 progress notes found in the certified copy of Patient D's medical record submitted by Dr. Rattray were significantly different from the progress notes viewed by Mr. Cain when he scanned Patient D's medical record. The Committee can only conclude that the record was altered with the intent to mislead and observes that Respondents submitted Medicare claims for chest x-rays and EKGs that were purportedly performed on Patient D on July 2, 2002. The

Committee believes that the July 2, 2002 record was altered to substantiate those claims.

FACTUAL ALLEGATION D.5

Factual Allegation D.5 alleges that Respondents failed to maintain a record which accurately reflects Patient D's treatment and evaluation including a failure to maintain x-rays and EKG tracings. The Committee sustains this allegation on the basis that Patient D's record contains numerous notations that EKGs had been performed when the tracings were not present in the medical record, and notations that x-rays were performed when they were not present in the record.

PATIENT E

The Committee sustains Factual Allegation E based upon the finding that Respondents treated Patient E at Dr. Rattray's Rochdale offices at 137-04 Guy R. Brewer Boulevard, Jamaica, New York during the dates in question.

FACTUAL ALLEGATION E.1

Factual Allegation E.1 alleges that Respondents, with intent to deceive, submitted and/or caused to submit Medicare claims, for the dates of 8/22/01, 2/6/02, 2/23/02, 3/2/02 and 3/15/02 in which Respondents falsely represented that they had performed and/or interpreted radiologic examinations of the chest (two views) billed under CPT code 71020, when Respondents knew they had neither performed nor interpreted such radiologic studies.

The Committee sustains Factual Allegation E.1. The documentary evidence produced by the Department substantiates that Dr. Rattray caused Medicare claims to be submitted for the dates charged. The evidence demonstrated that Dr. Rattray did

not produce any films for OPMC which could be connected to the dates of the claims in question. The Committee concludes that Dr. Rattray did not, in fact, take the x-rays which would have served to support the claims and that the claims were submitted with the intent to deceive to receive payment for the claims.

FACTUAL ALLEGATION E.2

Factual Allegation E.2 alleges that Respondents, with intent to deceive, submitted and/or caused to be submitted Medicare insurance claims, for EKGs purportedly taken and interpreted on 5/24/01, 2/6/02, 2/23/02, 3/2/02, 3/15/02, 4/26/02, 5/11/02, 7/2/02, 8/27/02, 9/21/02, 11/4/02 and 11/22/02 when in fact Respondents knew they had neither performed nor interpreted the tests.

The Committee sustains this allegation. The documentary evidence of the claims produced by the Department substantiates that Dr. Rattray caused Medicare claims to be submitted for EKGs on the dates charged. For the majority of the dates claimed, there was no corresponding tracing in the medical record.

Dr. Spector's testimony demonstrates that EKG tracings were only present for the dates of May 11, 2001 and January 9, 2003. There were, also, four undated EKGs in Patient E's medical record. The Committee, therefore, concludes that allegation E.2 should be sustained. The Committee does not believe that EKGs were performed and interpreted on all of the dates claimed.

The Committee concludes that the billings for the EKGs in question were unsupported by the record and that Respondent had deliberately submitted false claims when no EKG was performed or interpreted.

FACTUAL ALLEGATION E.3

Factual Allegation E.3 alleges that Respondents, with the intent to deceive, submitted and/or caused to be submitted Medicare insurance claims, for performing and interpreting spirometry tests for the dates of 9/6/01, 10/8/01, 5/11/02, 7/2/02, 8/27/02, 9/21/02, 11/4/02, and 11/22/02. This allegation is sustained. In this instance, the wrong coding for spirometry tests appears to have been used in the Department's summary of Medicare claims. The Committee chose to rely on the superbills (Ex. 7A) which demonstrated that with the exception of July 2, 2002, Dr. Rattray had submitted superbills for spirometry tests on the dates in question which presumably would have been submitted to Medicare by Synergy.

There are no spirometry reports present in the record which would substantiate the claims for the dates in question. The Committee concludes that Respondent submitted the claims with the intent to mislead.

FACTUAL ALLEGATION E.4

Factual Allegation E.4 alleges that Respondents failed to maintain a record which accurately reflects Patient E's treatment and evaluation including a failure to maintain x-rays and EKG tracings. The Committee sustains this allegation on the basis that Patient E's record contains notations that EKGs had been performed when the tracings were not present in the medical record, and notations that x-rays were performed when they were not present in the record.

PATIENT F

The Committee sustains Factual Allegation F based upon the finding that Respondents treated Patient F at Dr. Rattray's Rochdale offices at 137-04 Guy R. Brewer Boulevard, Jamaica, New York during the dates in question.

FACTUAL ALLEGATION F.1

Factual Allegation F.1 alleges that Respondents, with intent to deceive, submitted and/or caused Medicare claims to be submitted to GHI, for the dates of 7/19/01, 9/29/01, 11/17/01, 2/9/02, 4/20/02, 5/4/02, 5/25/02, 6/15/02, 6/29/02, 8/3/02, 8/13/02, 8/31/02, 10/19/02, 11/23/02 and 1/11/03 in which Respondents falsely represented that they had performed and/or interpreted radiologic examinations of the chest (two views) billed under CPT code 71020, when Respondents knew they had neither performed nor interpreted such radiologic studies.

The Committee sustains Factual Allegation F.1. The documentary evidence produced by the Department substantiates that Dr. Rattray caused Medicare claims to be submitted for payment for the dates charged. The evidence demonstrated that Dr. Rattray only submitted x-rays for March 9, April 20, May 25 and June 29, 2002 along with four unlabelled films, three of which have no images and one with a minimal image. The Committee concluded that the dated x-rays submitted were multiple copies of a single x-ray with false dates affixed. Ultimately, Dr. Rattray did not produce any films for OPMC which could be connected to the dates of the claims in question. The Committee concludes that Dr. Rattray did not, in fact, take the x-rays which would have served to support the claims, and that the claims were submitted with the intent to deceive in order to receive payment for the claims.

FACTUAL ALLEGATION F.2

Factual Allegation F.2 alleges that Respondents, knowingly and falsely represented the date of x-rays provided to OPMC with the intent to create the false

impression that the x-rays submitted to OPMC were separate x-ray studies taken on different days when Respondents had, in fact, submitted multiple copies of a single x-ray study with false dates attached to the x-ray identification label.

Factual Allegation F.2 is sustained for the reasons cited in the discussion of Factual Allegation F.1.

FACTUAL ALLEGATION F.3

Factual Allegation F.3 alleges that Respondents, with intent to deceive, submitted and/or caused to be submitted Medicare insurance claims to GHI, for EKGs purportedly taken and interpreted on 7/19/01, 9/29/01, 10/13/01, 11/17/01, 2/9/02, 3/9/02, 3/23/02, 4/20/02, 5/4/02, 5/25/02, 6/15/02, 6/29/02, 8/3/02, 8/13/02, 8/31/02, 10/19/02 and 11/23/02 when in fact Respondents knew they had neither performed nor interpreted the tests.

The Committee sustains this allegation. The documentary evidence of the claims produced by the Department substantiates that Dr. Rattray caused Medicare claims to be submitted for EKGs for at least twelve of the dates charged. There is only one EKG tracing in the medical record for Patient F, dated May 4, 1999. The Committee does not believe that EKGs were performed and interpreted on the dates claimed. The Committee concludes that the billings for the EKGs in question were unsupported by the record and that Respondents had deliberately submitted false claims when no EKGs were performed or interpreted.

FACTUAL ALLEGATION F.4

Factual Allegation F.4 alleges that Respondents inappropriately interpreted substandard chest x-rays. This allegation is not sustained. The Committee finds

scant or no discussion of Respondents' actual interpretation of x-rays in the record and declines to sustain this allegation.

FACTUAL ALLEGATION F.5

Factual Allegation F.5 alleges that Respondents failed to maintain a record which accurately reflects Patient F's treatment and evaluation including a failure to maintain x-rays and EKG tracings. The Committee sustains this allegation on the basis that Patient F's record contains numerous notations that EKGs had been performed when the tracings were not present in the medical record.

PATIENT G

The Committee sustains Factual Allegation G based upon the finding that Respondents treated Patient G at Dr. Rattray's Rochdale offices at 137-04 Guy R. Brewer Boulevard, Jamaica, New York during the dates in question.

FACTUAL ALLEGATION G.1

Factual Allegation G.1 alleges that Respondents, with intent to deceive, submitted and/or caused Medicare claims to be submitted to GHI, for the dates of 1/31/02, 2/4/02, 6/15/02, 8/13/02 and 9/21/02, in which Respondents falsely represented that they had performed and/or interpreted radiologic examinations of the chest (two views) billed under CPT code 71020, when Respondents knew they had neither performed nor interpreted such radiologic studies.

The Committee sustains Factual Allegation G.1. The documentary evidence produced by the Department substantiates that Dr. Rattray caused Medicare claims to be submitted for payment for the dates charged. Ultimately, Dr. Rattray produced four x-rays to OPMC, dated January 31, February 4, June 15 and one purportedly

dated September 21, 2002. The four x-rays submitted were exact duplicates of each other. The Committee concludes, based upon Dr. Czajka's testimony that the dates of the x-rays were doctored and that Dr. Rattray did not produce any films which could be connected to the dates of the claims in question. The Committee concludes that Dr. Rattray did not, in fact, take the x-rays which would have served to support the claims, and that the claims were submitted with the intent to deceive in order to receive payment for the claims.

FACTUAL ALLEGATION G.2

Factual Allegation G.2 alleges that Respondents, knowingly and falsely represented the date of x-rays provided to OPMC with the intent to create the false impression that the x-rays submitted to OPMC were separate x-ray studies taken on different days when Respondents had, in fact, submitted multiple copies of a single x-ray study with false dates attached to the x-ray identification label.

Factual Allegation G.2 is sustained for the reasons cited in the discussion of Factual Allegation G.1.

FACTUAL ALLEGATION G.3

Factual Allegation G.3 alleges that Respondents, with intent to deceive, submitted and/or caused to be submitted Medicare insurance claims to GHI, for EKGs purportedly taken and interpreted on 1/31/02, 2/4/02, 4/9/02, 6/15/02, 8/13/02, and 9/21/02 when Respondents knew they had neither performed nor interpreted the tests.

The Committee sustains this allegation. The documentary evidence of the claims produced by the Department substantiates that Dr. Rattray caused Medicare

claims to be submitted for EKGs on the dates charged. There are no EKG tracings in Patient G's medical record which match the dates of the claims. The Committee concludes that the billings for the EKGs in question were unsupported by the record and does not believe that EKGs were performed and interpreted on the dates claimed, and further concludes that Dr. Rattray deliberately submitted false claims when no EKG was performed or interpreted.

FACTUAL ALLEGATION G.4

Factual Allegation G.4 alleges that Respondents failed to maintain a record which accurately reflects Patient G's treatment and evaluation including a failure to maintain x-rays and EKG tracings. The Committee sustains this allegation on the basis that Patient G's record contains numerous notations that EKGs had been performed when the tracings were not present in the medical record and numerous notations that chest x-rays were performed when legitimate x-rays were not present in the medical record.

FACTUAL ALLEGATION H

Factual Allegation H alleges that with regard to Patients C through G, Respondents failed to comply with substantial provisions of federal law, rules or regulations governing the practice of medicine in that on multiple occasions, Respondents willfully/and or grossly negligently billed Medicare for services and procedures that they did not perform, in violation of Title 42 of the United States Code § 1320a-7b (Medicare Fraud).

Factual Allegation H is sustained. The facts in support of this conclusion are discussed in the previous Findings of Fact and Conclusions concerning Patient A

through G.

Education Law Section 6530(16) defines professional misconduct as willfully or grossly negligently failing to comply with substantial provisions of federal, state or local law governing the practice of medicine. A federal law, Title 42 of the United States Code ("42 USCA") Section 1320a-7b(a)(1) makes it unlawful to knowingly and willfully make or cause to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program. Compliance with federal Medicare billing requirements are a substantial provision of federal law governing the practice of medicine. By fraudulently billing Medicare for diagnostic tests that they knew were not performed, Respondents filed false claims for payment under a Federal health care program. They knowingly and willfully made false statements or representations of material fact in applications for Medicare benefits or payments with respect to at least Patients C through G for whom Medicare claims were filed by Respondents. Respondents, thereby, willfully violated federal law.

FACTUAL ALLEGATION I

The Committee sustains Factual Allegation I to the extent that Patient H presented to Respondents on May 2, 2002. There is no evidence or testimony that Patient H presented with a complaint of an allergy attack, as alleged.

FACTUAL ALLEGATION I.1

Factual Allegation I.1 alleges that Respondents knowingly and falsely, and with intent to deceive, represented to Cigna Insurance Company that on or about May 2, 2002, the patient had a cardiovascular stress test when, Respondents knew

that she did not have such a test.

Factual Allegation I.1 is sustained. The documentary evidence demonstrates that Dr. Rattray submitted an insurance claim for Patient H to Cigna for services performed on May 2, 2002, under CPT code # 93015 which is the CPT code for "Exercise Stress Tests". Patient H sent Dr. Rattray a note questioning why her insurance was billed by him for an "electrocardio" when the procedure had never been performed, and further stating that Cigna had advised her to request that Dr. Rattray resubmit a billing which was correct. Mr. Cain testified that when the Department made a written demand for Patient H's medical record, Dr. Rattray did not comply with the request and claimed that he had never treated Patient H. Dr. Rattray offered no testimony to rebut this allegation.

The Committee concludes, based upon the evidence presented, that Respondents, with intent to deceive, knowingly and falsely presented to Cigna Insurance that, on or about, May 2, 2002, Patient H had a cardiovascular stress test when Respondents in fact, knew that Patient H did not have such a test. The Committee observed that an identical price, $250, was noted on the exhibits for both the "electro-cardio" and exercise stress tests, and that the price of $250 is consistent with what an exercise stress test would cost. The Committee concluded that the term "electro-cardio" referred to an exercise stress test. This allegation was deemed significant because Patient H's complaint had been made independent of the Department's investigation.

FACTUAL ALLEGATION I.2

Factual Allegation I.2 alleges that Respondents failed to make available to

the Department relevant records with respect to an inquiry or complaint within 30 days of the Department's February 21, 2003 written request. The Committee declines to sustain this allegation. The Department failed to produce anything in writing from the date of February 21, 2003 which would serve as a basis for sustaining allegation I.2 and the Committee dismisses the allegation.

FACTUAL ALLEGATION I.3

Factual Allegation I.3 alleges that Respondent failed to maintain a record that accurately relected his evaluation and treatment of Patient H. None of Dr. Rattray's records were produced for Patient H and the Committee has no way of assessing the truth of this allegation.

RESPONDENT'S HOSPITAL AFFILIATIONS AND EDUCATION DEPARTMENT APPLICATION

FACTUAL ALLEGATIONS J-L

Factual Allegations J through L charge that Dr. Rattray intended to deceive, when he made the following knowing and false representations; 1) on his New York State Department of Education License Registration Application, dated March 26, 2002, that since he had last registered, no hospital had terminated and/or restricted his privileges "due to professional misconduct, unprofessional conduct, incompetence or negligence" [Allegation J], 2) on his New York State Physician Profile Survey, dated February 14, 2003 [Allegation K.1], on his Aperture Credentialing Applications, dated October 27, 2003 and May 14, 2004 [Allegation K.2], on his United Health Care credentialing application, dated September 6, 2002 [Allegation K.3] and on his Reappointment application to St. Vincent's Catholic Medical Centers, Brooklyn & Queens Division, dated December 18, 2002

[Allegation K.4], that he had never had his hospital privileges restricted or reduced and/or that he had never been placed on probation by a hospital, and 3) on his St. Vincent Catholic Medical Center re-appointment application, dated December 8, 2002, he concealed, with the intent to mislead, that Franklin Hospital suspended his membership from the hospital staff effective February 18, 2002 [Allegation L].

Factual Allegations J through L are all sustained. The Committee observes that by a letter to Dr. Rattray, dated November 15, 2001, Franklin Hospital restricted Dr. Rattray's privileges. The letter was sent certified mail, return receipt requested. Dr. Rattray did not appeal the restriction. The Committee does not believe Dr. Rattray's testimony that he did not recall the letters relating to his being placed on probation (T. 422-424).

Similarly, the Committee does not find credible Dr. Rattray's testimony that he did not receive the February 18, 2002 letter from Franklin Hospital which suspended him from the hospital staff due to a lapse in his malpractice coverage. Dr. Rattray acknowledged that he never reapplied for privileges at Franklin Hospital subsequent to the February 18, 2002 suspension. With respect to the February 18, 2002 letter, a return receipt is attached indicating that it was signed for by someone from Dr. Rattray's office. The Committee believes that Dr. Rattray received the letter, was duly notified of the suspension from Franklin Hospital and that the suspension was sufficiently important that he would remember it when filling out professional applications.

The Committee rejected Dr. Rattray's testimony that his wife filled out the St. Vincent's hospital application, and concluded that he signed the application. Dr.

Rattray acknowledged, in fact, that he may have signed the application (T. 429-433). The Committee did not find it credible that Dr. Rattray would not know his own signature.

The Committee ultimately concluded that Dr. Rattray did misstate his history with Franklin Hospital on the various applications he submitted by omitting his probation and/or suspension, and sustains Factual Allegations J through L. Based on all of the circumstances, the Committee is convinced that Dr. Rattray's misstatements were knowing and deliberate and made with the intent to mislead the recipients of the applications.

SPECIFICATIONS

SPECIFICATIONS ONE TO EIGHT

FRAUDULENT PRACTICE

The first eight specifications, all of which allege that Respondents practiced the profession of medicine fraudulently, are sustained. These specifications are sustained on the basis of Factual Allegations A and A1 though A4, B and B1 and B2, C and C1 through C3, D and D1 through D4, E and E1 though E3, F and F1 through F3 and G and G1 through G3 and I and I1, to the extent that the subparts of each of these allegations were sustained. The sustained allegations concern instances where Respondents intentionally submitted claims for insurance payments for procedures such as x-rays (allegations A1, B1, C1, D1, E1, F1 and G1), EKGs (allegations A3, B2, C2, D2, E2, F3 and G3), spirometries (allegation E3) or a stress test (allegation I1) which the Committee concluded were not done. A number of the underlying allegations concerned the intentional misrepresentation of x-ray dates to OPMC with

the intent to create the false impression that the x-rays submitted were separate x-ray studies taken on different days when Respondents had actually submitted multiple copies of a single x-ray study with false dates affixed to the x-ray identification label (allegations A2, F2 and G2). Additionally, a number of the underlying allegations (allegations A4, C3 and D4) involved charges that Respondents had intentionally altered medical records submitted to OPMC for the purpose of misleading OPMC. The Committee sustained each of the Factual Allegations and concluded that Dr. Rattray, and thereby Rochdale through its agent, Dr. Rattray, intended to mislead. The Committee sustains the specifications of fraudulent practice.

In each of these instances, as discussed above, the Committee concludes that Respondents committed the acts alleged with the intent to deceive and that the acts were knowing and deliberate. The Committee concludes that the acts were done with the intent of profiting from claims for medical tests which were not done, or in the case of the x-rays and altered medical records with the intent of misleading OPMC with regard to the medical care and tests which Respondents provided.

SPECIFICATIONS NINE TO ELEVEN

FRAUDULENT PRACTICE

The ninth through eleventh specifications are sustained. The Committee finds that, as alleged in these specifications, Dr. Rattray practiced the profession fraudulently by virtue of the facts alleged in Factual Allegations J, K, K1, K2, K3, K4 and L. Each of these allegations concerned deliberate misrepresentations made by Dr. Rattray on professional applications concerning his professional affiliations and were sustained by the Committee. The Committee found that the

misrepresentations were designed to mislead the entities to which the applications were directed.

SPECIFICATIONS TWELVE TO NINETEEN

WILLFULLY MAKING OR FILING FALSE REPORTS

The twelfth through nineteenth specifications are sustained. The Committee finds that, as alleged in these specifications, Respondents willfully made false reports by intentionally submitting billing claims for insurance payments for procedures such as x-rays (allegations A1, B1, C1, D1, E1, F1 and G1), EKGs (allegations A3, B2, C2, D2, E2, F3 and G3), a spirometry reading (allegation E3) or a cardiovascular stress test (I and I1) which the Committee concluded were not done. A number of the underlying allegations concern the intentional misrepresentation of x-ray dates to OPMC with the intent to create the false impression that the x-rays submitted were separate x-ray studies taken on different days when Respondents had actually submitted multiple copies of a single x-ray study with false dates affixed to the x-ray identification label (allegations A2, F2 and G2). Additionally, a number of the underlying allegations (allegations A4, C3 and D4) involved charges that Respondents had intentionally altered medical records submitted to OPMC for the purpose of misleading OPMC. The Committee sustained each of the Factual Allegations and concluded that Dr. Rattray, and thereby Rochdale through its agent, Dr. Rattray, intended to mislead through the information which was submitted. The Committee, thus, sustains the twelfth through nineteenth specifications.

SPECIFICATIONS TWENTY TO TWENTY TWO

WILLFULLY MAKING OR FILING FALSE REPORTS

The twentieth through twenty second specifications arise from allegations J, K, K1, K2, K3, K4 and L which allege essentially that Dr. Rattray knowingly and with intent to deceive made false statements in health care credentialing applications and on an Education Department licensure application. The Committee sustained the allegations underlying the Twentieth through Twenty Second Specifications. The Committee concludes that the intentionally false statements made upon the applications constituted the willful making of false reports by Dr. Rattray, and the Committee sustains the specifications.

TWENTY THIRD SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

The twenty third specification is sustained. This specification alleges that Dr. Rattray practiced medicine with negligence on more than one occasion. The Committee concludes that Dr. Rattray was negligent by having failed to adequately follow up on Patient B's March 3, 2001 laboratory results which showed a low platelet count and a high percentage of monocytes (sustained allegation B.3), by having failed to recognize the significance of or treat Patient C's low hematocrit (sustained allegations C, C4 and C4a) and by having failed to follow up on Patient C's abnormal laboratory results such as a low platelet and white blood count (sustained allegation C6), and that he, thereby, practiced with negligence on more than one occasion. The twenty third specification is, therefore, sustained.

In determining that Dr. Rattray committed negligence on more than one occasion, the Committee found that Dr. Rattray had committed record keeping violations by documenting that x-rays or EKGs had been performed when x-rays or

EKG tracings did not exist to support the documentation that these procedures had been done (see twenty fifth specification below and sustained allegations A7, B5, C7, D5, E4, F5 and G4). The Committee was instructed by the Administrative Law Judge that in order to find negligence on the basis of medical record keeping, the Committee would need to find that the questionable entries in the medical record were such that they would impact upon the patient's future care because subsequent treating professionals would rely on such entries in treating the patient. The Committee ultimately concluded that the absence of back up documentation for multiple progress notes in which it was documented that EKGs and x-rays had been performed, rendered Dr.Rattray's records inherently unreliable to subsequent treating physicians, and reflected the disarray present in his records. The Committee, therefore, concluded that the record keeping allegations supported a finding of negligence.

TWENTY FOURTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

The twenty fourth specification which alleges incompetence by Dr. Rattray is not sustained. Dr. Rattray had the requisite training needed to practice medicine competently and the Committee does not believe that the charged acts of misconduct can be ascribed to incompetence.

TWENTY FIFTH SPECIFICATION

FAILING TO MAINTAIN RECORDS REFLECTING EVALUATION AND TREATMENT

The twenty fifth specification is sustained. This specification alleges that Dr.

Rattray failed to maintain a record for each patient which accurately reflects the care and treatment of the patient, and is predicated on the facts alleged in Factual Allegations A7, B5, C7, D5, E4, F5 and G4 which were sustained by the Committee. These allegations charge that Dr. Rattray failed to maintain x-ray and EKG tracings. The Committee found that in each instance either x-rays or EKG tracings or both were missing from the records in instances where progress notes in the records indicated that x-rays or EKGs had been performed.

The Committee did not rely on Factual Allegations I or I3 in sustaining the twenty fifth specification. Dr. Rattray did not provide Patient H's medical record to the Department. The Committee had, therefore, no basis upon which to determine whether or not Dr. Rattray had maintained a record for Patient H which accurately reflected Dr. Rattray's evaluation and treatment.

TWENTY SIXTH SPECIFICATION

FAILING TO PROVIDE RECORDS

The twenty sixth specification is not sustained. Dr. Rattray is charged with failing to respond within thirty days to written communications from the Department and to make available any relevant records with respect to the inquiry and complaint. This specification is predicated upon Factual Allegations I and I2 which alleged, among other things, that the Department had made a written request on February 21, 2003 for Patient H's medical record. The Department failed to produce its February 21, 2003 written request as part of its evidence and the Committee declines to sustain the allegation on that basis.

TWENTY SEVENTH SPECIFICATION

FALSE REPORT TO HOSPITAL

The twenty seventh specification is sustained. The specification alleges that Dr. Rattray committed professional misconduct under Education Law § 6530(14) in that he violated Public Health Law § 2805-k regarding the reporting of a discontinuance of privileges to hospitals. The Department cited Factual Allegation L as support for this specification in that it was charged that Dr. Rattray concealed his suspension from the Franklin Hospital medical staff in his reappointment application to St. Vincent Catholic Medical Center. The Committee sustained allegation L as true and the Committee concludes that Dr. Rattray intentionally failed to report the suspension in order to conceal it. The Committee believes that notwithstanding his testimony, Dr. Rattray understood that his suspension was an important matter which needed to be disclosed on the application.

TWENTY EIGHTH SPECIFICATION

FAILING TO COMPLY WITH FEDERAL LAW

The twenty eighth specification is sustained. This allegation charges that Dr. Rattray committed professional misconduct under Education Law § 6530(16) by his willful or grossly negligent failure to comply with substantial provisions of federal law governing the practice of medicine. The Department alleged the facts contained in Factual Allegation H as support for this specification and cited therein that Dr. Rattray failed to comply with substantial provisions of federal law by violating 42 USCA § 1320a-7b. The Committee concludes that 42 USCA § 1320a-7b is a federal statute governing the practice of medicine in that, among other things, it criminalizes certain billing practices in the practice of medicine. As discussed in its analysis of

Factual Allegation H, the Committee concluded that Dr. Rattray willfully violated 42 USCA § 1320a-7b.

DETERMINATION AS TO PENALTY

The Committee unanimously concludes that Dr. Rattray's license to practice medicine should be revoked.

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

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license to a specified area or type of practice; (4) Revocation of the license; (5) Annulment of the license or registration; (6) Limitations on registration or the issuance of any further license; (7) The imposition of monetary penalties; (8) A course of education or training; (9) Performance of public service, and (10) Probation.

The Committee believes that Dr. Rattray's fraudulent actions demonstrate a lack of honesty which additional training or probation would not remediate. Additionally, Dr. Rattray demonstrated no genuine remorse which would give the Committee cause to consider other less stringent penalties. Because the problems involved in this case go to Dr. Rattray's basic probity, the Committee had no confidence that his self-imposed remedial measures such as the institution of the "Mr. Notes" system would resolve his problems.

The Committee, also, took into account Dr. Rattray's demonstrated lack of care for his medical license. He showed disdain for the Committee and the hearing process by being consistently late for all three hearing days even though he was repeatedly admonished for his lateness. He also failed to provide records to the Department in a timely manner when requested by Mr. Cain. The Committee, therefore, concludes that revocation of Dr. Rattray's medical license is the only

appropriate penalty.

Dr. Rattray was the sole officer, director and shareholder of Rochdale Medical, P.C., and he used it as the vehicle for the fraudulent transactions which gave rise to this proceeding. The Committee concludes that the Certificate of Incorporation of Rochdale Medical, P.C. should be revoked.

ORDER

IT IS HEREBY ORDERED THAT:

1. The **FIRST THROUGH TWENTY THIRD, THE TWENTY FIFTH, THE TWENTY SEVENTH AND THE TWENTY EIGHTH SPECIFICATIONS** are hereby **SUSTAINED;**
2. The **TWENTY FOURTH** AND **TWENTY SIXTH SPECIFICATIONS** are hereby **DISMISSED;**
3. The license to practice medicine of **HERON RATTRAY, M.D.** is hereby **REVOKED;**
4. The Certificate of Incorporation of **ROCHDALE MEDICAL, P.C.** is hereby **REVOKED;** and
5. This **DETERMINATION AND ORDER** shall be effective upon service on **HERON RATTRAY, M.D.** pursuant to Public Health Law § 230(10)(h) and upon **ROCHDALE MEDICAL, P.C..**

DATED: Lake Success, New York
November 14, 2005

Frank E. Iaquinta M.D.

FRANK E. IAQUINTA, M.D.
Chairperson
ELEANOR KANE, M.D.
WILLIAM McCAFFERTY

TO: Daniel Guenzburger, Esq.
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Division of Legal Affairs
New York State Department of Health
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APPENDIX I

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

IN THE MATTER

OF

HERON RATTRAY, M.D.

ROCHDALE MEDICAL, P.C.

STATEMENT

OF

CHARGES

HERON RATTRAY, M.D., Respondent, was authorized to practice medicine in New York State on or about October 18, 1993 by the issuance of license number 193948 by the New York State Education Department.

ROCHDALE MEDICAL, P.C., Respondent, was authorized as a professional service corporation by the New York State Department of State in or about April 1997. Respondent Heron Rattray, M.D. is an officer and shareholder of Rochdale Medical, P.C.

FACTUAL ALLEGATIONS

A. On or about and between November 13, 1999 and January 25, 2003 the Respondent Heron Rattray, M.D., individually and in his capacity as an officer/shareholder of Rochdale Medical, P.C., treated Patient A, a 60 year old female at 137-04 Guy R. Brewer Boulevard, Jamaica, New York. (Patients A through H are identified in the annexed Appendix.) During the period of treatment regarding Patient A, Respondents:

1. Submitted and/or caused to submit insurance claims to Oxford Health, Inc. ("Oxford") in which they represented that they had performed and/or interpreted radiologic examinations of the chest, two views (billed under CPT Code 71020), when, in fact, Respondents knew that they had neither performed nor interpreted such radiologic studies. Respondents intended to deceive with respect to claims for radiologic services purportedly performed on the dates set forth below:

   a. January 10, 2002.

   b. June 7, 2002.

   c. August 5, 2002.

2. Knowingly and falsely represented the date of x-rays provided to the Office of Professional Medical Conduct ("OPMC"). Respondents intended to create the false impression that the x-rays submitted to OPMC were separate x-ray studies taken on different days, when, in fact, Respondents submitted multiple copies of a single x-ray study with false dates affixed to the x-ray identification label.

3. Submitted and/or caused to submit insurance claims to Oxford in which Respondents falsely represented that they had performed and interpreted multiple electrocardiograms ("EKGs"), when, in fact, they knew that they had neither performed nor interpreted the tests. Respondents intended to deceive with respect to claims for services

purportedly performed on the dates set forth below :

a. March 27, 2001.

b. July 12, 2001.

c. October 20, 2001.

d. January 10, 2002.

e. March 21, 2002,

f. June 7, 2002.

g. August 5, 2002.

4. Concealed, with the intent to mislead, that the Respondents had altered the medical record submitted to the Office of Professional Medical Conduct ("OPMC"), including progress notes dated March 21, 2002. Respondent Rattray certified that the medical record was a "true and exact copy" of Patient A's record, when, in fact, he knew that he had significantly altered the record.

5. Inappropriately interpreted substandard x-rays.

6. Failed to adequately follow up on abnormal laboratory results, including elevated cholesterol levels and elevated platelet counts.

7. Failed to maintain a record that accurately reflects the evaluation and treatment, including but not limited to failing to maintain x-rays and EKG tracings.

B. On or about and between August 26, 2000 and September 28, 2002, Respondent Heron Rattray, M.D., individually and in his capacity as an officer/shareholder of Rochdale Medical, P.C., treated Patient B, a 65 year old female at the onset of treatment. During the period of treatment regarding Patient B, Respondents:

1. Submitted and/or caused to submit insurance claims to the Group Health Insurance ("GHI") in which the they falsely represented that they had performed and/or interpreted radiologic examinations of the chest, two views (billed under CPT Code 71020), when, in fact, Respondents knew that they had neither performed nor interpreted such radiologic studies. Respondents intended to deceive with respect to claims for services purportedly performed on the dates set forth below :

   a. February 9, 2002.

   b. May 25, 2002.

   c. July 27, 2002.

2. Submitted and/or caused to submit insurance claims to GHI in which Respondents falsely represented that they had performed and interpreted multiple EKGs, when, in fact, they knew that they had neither performed nor interpreted the tests. Respondents intended to deceive with respect to claims for services purportedly performed on the dates set forth below :

   a. June 16, 2001.

b. November 10, 2001.

c. February 9, 2002.

d. February 18, 2002.

e. May 25, 2002.

f. July 26, 2002.

g. July 27, 2002.

3. Failed to follow-up on abnormal laboratory test results, including depressed platelet counts.

4. Inappropriately interpreted substandard chest x-rays.

5. Failed to maintain a record that accurately reflects the evaluation and treatment, including but not limited to failing to maintain x-rays and EKG tracings.

C. On or about and between July 25, 2000 and December 17, 20002, the Respondent Heron Rattray, M.D., individually and in his capacity as an officer/shareholder of Rochdale Medical, P.C., treated Patient C, a 74 year old male at the onset of treatment. During the period of treatment regarding Patient C, Respondents:

1. Submitted and/or caused to submit Medicare claims to GHI , the affiliate carrier for the Center for Medicare and Medicaid Services ("CMS"), in which they falsely represented that they had performed and/or interpreted radiologic examinations of the chest, two views (billed under CPT Code 71020), when, in fact, they knew that they had

neither performed nor interpreted such radiologic studies. Respondents intended to deceive with respect to claims for radiologic studies purportedly performed on the dates set forth below:

a. October 12, 2000.

b. May 24, 20001.

c. June 4, 2002.

d. September 26, 2002.

e. November 4, 2002.

f. November 26, 2002.

2. Submitted and/or caused to submit Medicare claims to GHI in which they falsely represented that they had performed and interpreted multiple EKGs, when, in fact, they knew that they had neither performed nor interpreted the tests. Respondents intended to deceive with respect to claims for services purportedly performed on the dates set forth below:

a. March 10, 2001.

b. July 21, 2001.

c. July 23, 2001.

d. July 27, 2001.

e. November 15, 2001.

f. December 20, 2001.

g. January 31, 2002.

h. February 18, 2002.

i. June 4, 2002.

j. September 26, 2002.

k. October 12, 2002.

l. November 4, 2002.

m. November 26, 2002.

3. Concealed, with the intent to mislead, that the Respondents had altered the medical record submitted to OPMC, including progress notes dated June 4 and August 5, 2002. Respondent Rattray certified that the record was a "true and exact copy" of Patient C's medical record, when, in fact, he knew that he had significantly altered the record.

4. Failed to adequately evaluate and/or treat the Patient for:

   a. Anemia.

   b. Bradycardia.

5. Failed to adequately interpret Patient C's electrocardiogram dated October 12, 2000.

6. Failed to adequately follow-up on abnormal laboratory results.

7. Failed to maintain a record that accurately reflected the evaluation and treatment, including failing to maintain x-ray and EKG tracings.

D. On or about and between August 26, 1999 and September 17, 2002, Respondents treated Patient D, a 93 year old male. During the period of treatment regarding Patient D, Respondents:

1. Submitted and/or caused to submit Medicare claims to GHI in which they falsely represented that they had performed and/or interpreted radiologic examinations of the chest, two views (billed under CPT Code 71020), when, in fact, they knew that they had neither performed nor interpreted such radiologic studies. Respondents intended to deceive with respect to claims for radiologic studies purportedly performed on the dates set forth below:

   a. January 21, 2000.

   b. February 13, 2001.

   c. March 20, 2001.

   d. September 12, 2001.

   e. March 14, 2002.

   f. April 18, 2002.

   g. June 8, 2002.

   h. July 2, 2002.

   i. September 7, 2002.

2. Submitted and/or caused to submit Medicare claims to GHI in which Respondents falsely represented that they had performed and interpreted multiple EKGs, when, in fact, they knew that they had

neither performed nor interpreted the tests. Respondents intended to deceive with respect to claims for services purportedly performed on the dates set forth below:

a. January 21, 2000.

b. April 6, 2000.

c. May 11, 2000.

d. November 9, 2000.

e. March 20, 20001.

f. September 12, 2001.

g. October 9, 2001.

h. January 10, 2002.

i. January 11, 2002.

j. January 31, 2002.

k. March 14, 2002.

l. April 18, 2002.

m. July 2, 2002.

n. September 7, 2002.

3. Submitted and/or caused to submit Medicare claims in which Respondents falsely represented that they had performed and interpreted spirometry on various occasions, when, in fact, they knew that they had neither performed nor interpreted such tests. Respondents intended to deceive with respect to claims for

spirometry purportedly performed and/or interpreted on the dates set forth below:

a. April 18, 2002.

b. June 8, 2002.

c. June 22, 2002.

d. September 20, 2002.

4. Concealed, with the intent to mislead, that the Respondents had altered the medical record submitted to OPMC, including progress notes dated June 22, 2002 and July 2, 2002. Respondent Rattray certified that the record he provided was a "true and exact copy" of Patient D's medical record, when, in fact, he knew that he had significantly altered the record.

5. Failed to maintain a record that accurately reflects the evaluation and treatment, including but not limited to failing to maintain x-rays and EKG tracings.

E. On or about and between May 11, 2001 and January 25, 2003 the Respondents treated Patient E, a 75 year old female at the onset of treatment. During the period of treatment regarding Patient E, Respondents:

1. Submitted and/or caused to submit Medicare claims to GHI in which they falsely represented that they had performed and/or interpreted radiologic examinations of the chest, two views (billed under CPT

Code 71020), when, in fact, they knew that they had neither performed nor interpreted such radiologic studies. Respondents intended to deceive with regard to claims for radiologic studies purportedly performed on the dates set forth below:

a. August 22, 2001

b. February 6, 2002.

c. February 23, 2002.

d. March 2, 2002.

e. March 15, 2002.

2. Submitted and/or caused to submit Medicare claims to GHI in which Respondents falsely represented that they had performed and interpreted multiple EKGs, when, in fact, they knew that they had neither performed nor interpreted the tests. Respondents intended to deceive with respect to claims for services purportedly performed on the dates set forth below:

a. May 24, 2001

b. February 6, 2002.

c. February 23, 2002.

d. March 2, 2002.

e. March 15, 2002.

f. April 26, 2002.

g. May 11, 2002.

h. July 2, 2002.

i. August 27, 2002.

j. September 21, 2002.

k. November 4, 2002.

l. November 22, 2002.

3. Submitted and/or caused to submit Medicare claims in which Respondents falsely represented that they had performed and interpreted spirometry on various occasions, when, in fact, they knew that they had neither performed nor interpreted such tests. Respondents intended to deceive with respect to claims for spirometry purportedly performed and/or interpreted on the dates set forth below:

a. September 6, 2001.

b. October 8, 2001.

c. May 11, 2002.

d. July 2, 2002.

e. August 27,2002.

f. September 21, 2002.

g. November 4, 2002.

h. November 22, 2002.

4. Failed to maintain a record that accurately reflects the evaluation and treatment, including but not limited to failing to maintain x-rays and

EKG tracings.

F. On or about and between August 10, 1998 and January 11, 2003 the Respondents treated Patient F, a 73 year old female at the onset of treatment. During the period of treatment regarding Patient F, Respondents:

1. Submitted and/or caused to submit Medicare claims to GHI in which they falsely represented that they had performed and/or interpreted radiologic examinations of the chest, two views (billed under CPT Code 71020), when, in fact, they knew that they had neither performed nor interpreted such radiologic studies. Respondents intended to deceive with respect to claims for radiologic studies purportedly performed on the dates set forth below:

   a. July 19, 2001.

   b. September 29, 2001.

   c. November 17, 2001.

   d. February 9, 2002.

   e. April 20, 2002.

   f. May 4, 2002.

   g. May 25, 2002.

   h. June 15, 2002.

   i. June 29, 2002.

   j. August 3, 2002.

k. August 13, 2002.

l. August 31, 2002.

m. October 19, 2002.

n. November 23, 2002.

o. January 11, 2003

2. Knowingly and falsely represented the date of x-rays provided to the Office of Professional Medical Conduct ("OPMC"). Respondents intended to create the false impression that the x-rays submitted to OPMC were separate x-ray studies taken on different days, when, in fact, the Respondents submitted multiple copies of a single x-ray study with false dates affixed to the x-ray identification label.

3. Submitted and/or caused to submit Medicare claims to GHI in which Respondents falsely represented that they had performed and interpreted multiple EKGs, when, in fact, they knew that they had neither performed nor interpreted the tests. Respondents intended to deceive with respect to claims for services purportedly performed on the dates set forth below:

a. July 19, 2001.

b. September 29, 2001.

c. October 13, 2001.

d. November 17, 2001.

e. February 9, 2002.

f. March 9, 2002.

g. March 23, 2002.

h. April 20, 2002.

i. May 4, 2002.

j. May 25, 2002.

k. June 15, 2002.

l. June 29, 2002.

m. August 3, 2002.

n. August 13, 2002.

o. August 31, 2002.

p. October 19, 2002.

q. November 23, 2002.

4. Inappropriately interpreted substandard chest x-rays.

5. Failed to maintain a record that accurately reflects the evaluation and treatment, including but not limited to failing to maintain x-rays and EKG tracings.

G. On or about and between May 1, 1999 and January 10, 2003 Respondents treated Patient G, a 59 year old female at the onset of treatment. During the period of treatment regarding Patient G, Respondents:

1. Submitted and/or caused to submit Medicare claims to GHI in which they falsely represented that they had performed and/or interpreted

radiologic examinations of the chest, two views (billed under CPT Code 71020), when, in fact, they knew that they had neither performed nor interpreted such radiologic studies. Respondents intended to deceive with respect to claims for radiologic studies purportedly performed on the dates set forth below:

a. January 31, 2002.

b. February 4, 2002.

c. June 15, 2002.

d. August 13, 2002.

e. September 21, 2002.

2. Knowingly and falsely represented the date of x-rays provided to the Office of Professional Medical Conduct ("OPMC"). Respondents intended to create the false impression that the x-rays submitted to OPMC were separate x-ray studies taken on different days, when, in fact, the Respondents submitted multiple copies of a single x-ray study with false dates affixed to the x-ray identification label.

3. Submitted and/or caused to submit Medicare claims to GHI in which they falsely represented that they had performed and interpreted multiple EKGs, when, in fact, they knew that they had neither performed nor interpreted the tests. Respondents intended to deceive with respect to claims for services purportedly performed on the dates set forth below:

a. January 31, 2002.

b. February 4, 2002.

c. April 9, 2002.

d. June 15, 2002.

e. August 13, 2002.

f. September 21, 2002.

4. Failed to maintain a record that accurately reflects the evaluation and treatment, including but not limited to failing to maintain x-rays and EKG tracings.

H. With regard respectively to Patients C through G the Respondents failed to comply with substantial provisions of federal law, rules, or regulations governing the practice of medicine in that on multiple occasions Respondents willfully and/or grossly negligently billed Medicare for services and procedures that they did not perform. Said conduct violates Title 42 of the United States Code Section 1320a-7b (Medicare Fraud).

I. On or about May 2, 2002, Patient H presented to Respondents with a complaint of having suffered an allergy attack. During the period of treatment regarding Patient H, Respondents:

1. Knowingly and falsely represented to Cigna insurance company that on or about May 2, 2002 Patient D had a cardiovascular stress test,

when, in fact, Respondents knew that the Patient did not have such a test. Respondents intended to deceive.

2. Failed to make available to the Department of Health relevant records with respect to an inquiry or complaint within 30 days of a written request. On or about February 21, 2003 the OPMC made a written request for Patient H's record.

3. Failed to maintain a record that accurately reflected his evaluation and treatment of the Patient.

J. In Respondent Rattray's New York State Department of Education License Registration Application dated March 26, 2002, he knowingly and falsely represented that since he had last registered no hospital had terminated and/or restricted his privileges "due to professional misconduct, unprofessional conduct, incompetence or negligence", when, in fact, he knew that on or about November 15, 2001 the Franklin Hospital Medical Center restricted Respondent's privileges because of inappropriate clinical management of an asthmatic patient and inadequate medical documentation. Respondent intended to deceive.

K. With regard to responses to questions asked about hospital affiliations on the documents listed below, Respondent Rattray knowingly and falsely represented that he had never had his hospital privileges restricted, reduced and/or been placed on probation by a hospital. Respondent intended to deceive.

1. New York State Physician Profile Survey dated February 14, 2003.
2. Aperture credentialing applications dated October 27, 2003 and May 14, 2004.
3. United Healthcare provider credentialing application dated September 6, 2002.
4. Reappointment application to St. Vincent Catholic Medical Centers-Brooklyn & Queens Division dated December 18, 2002.

L. On Respondent Rattray's St. Vincent Catholic Medical Center re-appointment application dated December 8, 2002, Respondent concealed, with the intent to mislead, that the Franklin Hospital Medical Center suspended his membership from the hospital staff effective February 18, 2002.

SPECIFICATION OF CHARGES

FRAUDULENT PRACTICE

SPECIFICATIONS ONE to EIGHT

Respondents Rattray and Rochdale Medical, P.C. are charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

1. A, A1, A1(a), A1(b), A1(c), A2, A3, A3(a), A3(b), A3(c), A3(d), A3(e), A3(f), A3(g), and/or A4.

2. B, B1, B1(a), B1(b), B(c), B2, B2(a), B2(b), B2(c), B2(d), B2(e), B2(f), and/or B2(g).
3. C, C1, C1(a), C1(b), C1(c), C1(d), C1(e), C1(f), C2, C2(a), C2(b), C2(c), C2(d), C2(e), C2(f), C2(g), C2(h), C2(i), C2(j), C2(k), C2(l), C2(m) and/or C3.
4. D, D1, D1(a), D1(b), D1(c), D1(d), D1(e), D1(f) D1(g) D1(h), D1(i), D2, D2(a), D2(b), D2(c), D2(d), D2(e), D2(f), D2(g), D2(h), D2(i), D2(j), D2(k), D2(l), D2(m), D2(n), D3, D3(a), D3(b), D3(c), D3(d) and/or D4.
5. E, E1, E1(a), E1(b), E1(c), E1(d), E1(e), E2, E2(a), E2(b), E2(c), E2(d), E2(e), E2(f), E2(g), E2(h), E2(i), E2(j), E2(k), E2(l), E3, E3(a), E3(b), E3(c), E3(d), E3(e), E3(f), E3(g), and/or E3(h).
6. F, F1, F1(a), F1(b), F1(c), F1(d), F1(e), F1(f), Fi(g), F1(h), F1(g), F1(h), F1(i), F1(j), F1(j), F1(k), F1(l), F1(m), F1(n), F1(o), F2, F3, F3(a), F3(b), F3(c), F3(d), F3(e), F3(f), F3(g), F3(h), F3(i), F3(j), F3(k), F3(l), F3(m), F3(n), F3(o), F3(p), and/or F3(q).
7. G, G1, G1(a), G1(b), G1(c), G1(d), G1(e), G1(f), G2, G3, G3(a), G3(b), G3(c), and/or G3(d).
8. I and I1.

SPECIFICATIONS NINE to ELEVEN

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

9. J.

10. K, K1, K2, K3 and/or K4.

11. L.

FALSE REPORT

SPECIFICATIONS TWELVE to NINETEEN

Respondents Rattray and Rochdale Medical, P.C. are charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

12. A, A1, A1(a), A1(b), A1(c), A2, A3, A3(a), A3(b), A3(c), A3(d), A3(e), A3(f), A3(g) and/or A4.

13. B, B1, B1(a), B1(b), B(c), B2, B2(a), B2(b), B2(c), B2(d), B2(e), B2(f), and/or B2(g).

14. C, C1, C1(a), C1(b), C1(c), C1(d), C1(e), C1(f), C2, C2(a), C2(b), C2(c), C2(d), C2(e), C2(f), C2(g), C2(h), C2(i), C2(j), C2(k), C2(l), C2(m) and/or C3.

15. D, D1, D1(a), D1(b), D1(c), D1(d), D1(e), D1(f) D1(g) D1(h), D1(i), D2, D2(a), D2(b), D2(c), D2(d), D2(e), D2(f), D2(g), D2(h), D2(i), D2(j), D2(k), D2(l), D2(m), D2(n), D3, D3(a), D3(b), D3(c), D3(d) and/or D4.

16. E, E1, E1(a), E1(b), E1(c), E1(d), E1(e), E2, E2(a), E2(b), E2(c), E2(d), E2(e), E2(f), E2(g), E2(h), E2(i), E2(j), E2(k), E2(l), E3, E3(a), E3(b), E3(c),

E3(d), E3(e), E3(f), E3(g), and/or E3(h).

17. F, F1, F1(a), F1(b), F1(c), F1(d), F1(e), F1(f), Fi(g), F1(h), F1(g), F1(h), F1(i), F1(j), F1(j), F1(k), F1(l), F1(m), F1(n), F1(o),F2, F3, F3(a), F3(b), F3(c), F3(d), F3(e), F3(f), F3(g), F3(h), F3(i), F3(j), F3(k), F3(l), F3(m), F3(n), F3(o), F3(p) and/or F3(q).

18. G, G1, G1(a), G1(b), G1(c), G1(d), G1(e), G1(f), G2, G3, G3(a), G3(b), G3(c), and/or G3(d).

19. I and I1.

SPECIFICATIONS TWENTY to TWENTY-TWO

Respondent Rattray is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

20. J.

21. K, K1, K2, K3 and/or K4.

22. L.

TWENTY-THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) 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:

23. A, A5, A6, A7, B, B3, B4, B5,C,C, C4, C4(a), C4(b), C5, C6, C7, D, D5, E, E4, F, F4, F5, G and/or G4.

TWENTY-FOURTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) 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:

24. A, A5, A6, A7, B, B3, B4, B5,C,C, C4, C4(a), C4(b), C5, C6, C7, D, D5, E, E4, F, F4, F5, G and/or G4.

TWENTY-FIFTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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

25. A, A7, B, B5, C, C7, D, D5, E, E4. F, F5, G, G4, I, and/or I3

TWENTY-SIXTH SPECIFICATION

FAILING TO PROVIDE RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(28) by failing to respond within thirty days to written communications from the department of health and to make available any relevant records with respect to an inquiry or complaint about the licensee's professional misconduct as alleged in the facts of:

26. I and I2.

TWENTY-SEVENTH SPECIFICATION

FALSE REPORT TO A HOSPITAL

Respondent is charged with committing professional misconduct as defined in N.Y.Educ.Law §6530(14) by violating Public Health Law Section 2805(k) as alleged in the facts of:

27. L.

TWENTY-EIGHTH SPECIFICATION

FAILING TO COMPLY WITH FEDERAL LAW

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(16) by his wilful or grossly negligent failure to comply with substantial

provisions of federal law governing the practice of medicine, as alleged in the facts of:

28. Paragraph H.

DATED: March 16, 2005
New York, New York

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct