New York State Board for Professional Medical Conduct

Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

Barbara A. DeBuono, M.D., M.P.H.
Commissioner of Health

Charles J. Vacanti, M.D.
Chair

April 22, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Samih Rajab Abbassi, M.D.
11 Gorga Place
Washington Township, New Jersey 07675

Re: NY License No. 171180
Effective Date: 04/29/96

Dear Dr. Abbassi:

Enclosed please find Order #BPMC 96-96 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Tower Building-Room 438
Albany, New York 12237-0756

If the penalty imposed by the Order is a fine, please write the check payable to the New York State Department of Health. Noting the BPMC Order number on your remittance will assist in proper crediting. Payments should be directed to the following address:

Bureau of Accounts Management
New York State Department of Health
Empire State Plaza
Tower Building-Room 1245
Albany, New York 12237

Sincerely,

Charles Vacanti

Charles Vacanti, M.D.
Chair
Board for Professional Medical Conduct

Enclosure

cc: Robert S. Asher, Esq.
295 Madison Avenue, Suite 700
New York, New York 10017

Terrence Sheehan, Esq.

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

IN THE MATTER

OF

SAMIH RAJAB ABBASSI, M.D.

CONSENT ORDER

BPMC #96-96

Upon the application of SAMIH RAJAB ABBASSI, M.D. (Respondent) for Consent Order, which application is made a part hereof, it is

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall take effect as of the date of the personal service of this order upon Respondent, upon receipt by Respondent of this order via certified mail, or seven days after mailing of this order by certified mail, whichever is earliest.

SO ORDERED.

DATED: April 22 1996

CHARLES J. VACANTI, M.D.
Chairperson
State Board for Professional
Medical Conduct

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

IN THE MATTER

OF

SAMIH RAJAB ABBASSI, M.D.

APPLICATION FOR CONSENT ORDER

1

STATE OF NEW YORK)
ss.:
COUNTY OF NEW YORK)

SAMIH RAJAB ABBASSI, M.D., being duly sworn, deposes and says:

That on or about July 28, 1987, I was licensed to practice as a physician in the State of New York, having been issued License No. 171180 by the New York State Education Department.

My current address is 11 Gorga Place, Washington Township, N.J. 07675. I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I understand that the New York State Board for Professional Medical Conduct has charged me with 176 specifications of professional misconduct.

A copy of the Statement of Charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

I do not contest the first specification of professional misconduct, in full satisfaction of the charges against me. I hereby agree to surrender my license to practice medicine and to pay a fine of $5,000 at the rate of $1,000 per month, for five consecutive months, with the first payment due seven days after receipt by me of an executed copy of the within Consent Order.

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this Application is not granted by the

Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive any right I may have to contest the Consent Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted.

SAMIH RAJAB ABBASSI, M.D.
RESPONDENT

Sworn to before me this
20 day of MARCH, 1996

NOTARY PUBLIC

York

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

IN THE MATTER

OF

SAMIH RAJAB ABBASSI, M.D.

APPLICATION

FOR

CONSENT ORDER

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: _____ _____

SAMIH RAJAB ABBASSI, M.D.
Respondent

DATE: 5/20/96 _____

ROBERT ASHER, ESQ.
Attorney for Respondent

DATE: _____ _____

TERRENCE SHEEHAN
Associate Counsel
Bureau of Professional
Medical Conduct

DATE: April 18 1996

ANNE F. SAILE
Acting Director
Office of Professional Medical Conduct

DATE: April 22 1996

for CHARLES J. VACANTI, M.D.
Chairperson
State Board for Professional Medical Conduct

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

IN THE MATTER

OF

SAMIH RAJAB ABBASSI, M.D.

STATEMENT

OF

CHARGES

SAMIH RAJAB ABBASSI, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 28, 1987, by the issuance of license number 171180 by the New York State Education Department. During all times mentioned in the instant Charges, Respondent was enrolled as a physician provider with the New York State Medical Assistance Program holding Provider number 01032888. Patients A through I and the approximate four hundred other patients referred to herein, were all recipients enrolled in the New York State Medical Assistance Program. (Patients A through I are identified in the attached Appendix A and the approximate four hundred other patients referred to herein are identified in the attached Appendix B).

FACTUAL ALLEGATIONS

A. Between on or about June 10, 1988 and on or about January 20, 1989, Respondent undertook the care and treatment of Patient A at his medical offices, known as Bronx Medical & Dental Office, located at 95 East 161st Street, Bronx, N.Y. 10451 (hereinafter referred to as "his medical offices").

1. On each visit by Patient A, Respondent failed to:

a. Obtain and note an adequate history.

Exhibit A

b. Perform and note a physical examination.

2. Respondent inappropriately and without legitimate medical purpose prescribed:

a. Tagamet

b. Naprosyn

c. Proventil Inhaler

d. Keflex

3. On or about June 11, 1988, Respondent inappropriately and without legitimate medical purpose ordered Hepatic, Gall Bladder, Renal, Splenic and Pancreatic Sonograms.

4. Respondent failed to perform and/or note an adequate work-up and evaluation of Patient A's complaints and/or Respondent's diagnoses of :

a. Asthma

b. Peptic Ulcer Disease

c. Arthritis

5. On or about June 28, 1988 and on or about July 18, 1988, Respondent ordered, and specimen(s) were collected, for blood tests on Patient A which were never performed. The results of these tests were never obtained. The Respondent:

a. Ordered these tests without legitimate medical purpose.

b. Failed to follow-up on and obtain the results of these tests.

6. Respondent knowingly falsely billed and received reimbursement from the Medical Assistance Program (hereinafter referred to as "the Program") for the following services which were never rendered:

a. Comprehensive service and Muscle Testing, including total evaluation of body and hands (hereinafter referred to as "Total Muscle Testing") on June 11, 1988

b. Intermediate service and Total Muscle Testing on June 28, 1988

c. Total Muscle Testing on each and every other visit.

7. Respondent failed to maintain a record for Patient A which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

8. Respondent, or an individual acting at the direction and/or under the supervision of the Respondent, created a record for Patient A which is false and inaccurate and does not reflect legitimate patient care and treatment.

B. Between on or about May 7, 1988 and on or about August 15, 1988, Respondent undertook the care and treatment of Patient B at his medical offices.

1. Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination

2. Respondent inappropriately and without legitimate medical purpose prescribed:

   a. Zantac

   b. Tagamet

   c. Naprosyn

d. Clinoril

e. Proventil Inhaler

f. Keflex

3. Respondent failed to perform and/or note an adequate work-up and evaluation of Patient B's complaints and/or Respondent's diagnoses of :

a. Asthma

b. Peptic Ulcer Disease

c. Arthritis/Lower Back Pain

4. Respondent knowingly falsely billed and received reimbursement from the Program for the following services which were never rendered:

a. Comprehensive service and Total Muscle Testing on May 7, 1988.

b. Total Muscle Testing on each and every other visit

c. Spirometry on August 15, 1988.

5. Respondent failed to maintain a record for Patient B which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

6. Respondent, or an individual acting at the direction and/or under the supervision of the Respondent, created a record for Patient B which is false and inaccurate and does not reflect legitimate patient care and treatment.

C. Between on or about June 11, 1988 and on or about January 13, 1989, Respondent undertook the care and treatment of Patient C at his medical offices.

1. Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note a physical examination.

2. Respondent inappropriately and without legitimate medical purpose prescribed:

   a. Tagamet

   b. Proventil Inhaler

c. Feldene

d. Theodur

3. Respondent failed to perform and/or note an adequate work-up and evaluation of Patient C's complaints and/or Respondent's diagnoses of:

a. Peptic Ulcer Disease

b. Arthritis

c. Asthma

4. On or about July 11, 1988, Respondent ordered, and specimen(s) were collected, for blood tests on Patient C which were never performed. The results of these tests were never obtained. The Respondent:

a. Ordered these tests without legitimate medical purpose.

b. Failed to follow-up on and obtain the results of these tests.

5. Respondent knowingly falsely billed and received reimbursement from the Program for the following services which were never

rendered:

a. Comprehensive service and Total Muscle Testing on June 11, 1988 and July 11, 1988.

b. Total Muscle Testing, additionally, on September 15, 1988 and October 29, 1988.

6. Respondent failed to maintain a record for Patient C which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

7. Respondent, or an individual acting at the direction and/or under the supervision of the Respondent, created a record for Patient C which is false and inaccurate and does not reflect legitimate patient care and treatment.

D. Between on or about September 29, 1987 and on or about January 28, 1989, Respondent undertook the care and treatment of Patient D at his medical offices.

1. Respondent failed to

a. Obtain and note a history.

b. Perform and note a physical examination.

2. Respondent inappropriately and without legitimate medical purpose prescribed:

   a. Proventil Inhaler

   b. Ventolin Inhaler

   c. Tagamet

   d. Zantac

   e. Naprosyn

   f. Dolobid

   g. Keflex

   h. Valisone Cream

3. Respondent failed to perform and/or note an adequate work-up and evaluation of:

   a. Patient D's complaints and/or diagnoses of:

      i. Peptic Ulcer Disease

      ii. Arthritis

iii. Asthma

b. Abnormal test results, including serologies reported on August 9, 1988 consistent with a past infection of both Hepatitis A and B.

4. Respondent knowingly falsely billed and received reimbursement from the Program for the following services which were never rendered:

a. Intermediate service and Total Muscle Testing on October 15, 1987, November 2, 1987, November 24, 1987, and November 15, 1988.

b. Total Muscle Testing on each and every other visit from September 29, 1987 through December 2, 1988, a total of 19 visits.

5. Respondent failed to maintain a record for Patient D which accurately reflects the patient's history, examination, diagnosis tests, and treatment rendered.

6. Respondent, or an individual acting at the direction and/or under the supervision of the Respondent, created a record for Patient D which is false and inaccurate and does not reflect legitimate patient care and treatment.

E. **Between** on or about September 28, 1987 or on or about November 14, 1987 **and** on or about June 25, 1988, Respondent undertook the care and treatment of Patient E at his medical offices.

1. Respondent failed to:

   a. Obtain and note a history.

   b. Perform and note a physical examination.

   c. Reach and note any diagnoses.

2. Respondent inappropriately and without legitimate medical purpose prescribed:

   a. Zantac

   b. Tagamet

   c. Clinoril

   d. Naprosyn

   e. Proventil Inhaler

   f. Keflex

g. Penicillin

h. Valisone Cream

i. Lotrimin Cream

j. Flexeril

k. Dyazide

3. Respondent inappropriately and without legitimate medical purpose ordered the following Sonograms:

a. Hepatic

b. Renal

c. Gall Bladder

d. Pancreatic

e. Abdominal Aortic

4. Respondent knowingly falsely billed and received reimbursement from the Program for the following services which were never rendered:

a. Intermediate service and Total Muscle Testing on September 28, 1987 and October 15, 1987.

b. Total Muscle Testing on each and every other visit.

5. Respondent failed to maintain a record for Patient E which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

6. Respondent, or an individual acting at the direction and/or under the supervision of the Respondent, created a record for Patient E which is false and inaccurate and does not reflect legitimate patient care and treatment.

F. Between on or about March 12, 1988 and on or about September 24, 1988, Respondent undertook the care and treatment of Patient F at his medical offices.

1. Respondent failed to

a. Obtain and note an adequate history

b. Perform and note a physical examination.

2. Respondent inappropriately and without legitimate medical purpose prescribed

a. Zantac

b. Tagamet

c. Clinoril

d. Naprosyn

e. Proventil Inhaler

f. Ceclor

3. Respondent inappropriately and without legitimate medical purpose ordered:

a. Complete 2D & M Mode Echocardiography.

b. The following Sonograms:

i. Renal

ii. Splenic

iii. Hepatic

iv. Gall Bladder

v. Pancreatic

4. Respondent failed to perform and/or note an adequate work-up and evaluation of Patient F's complaints and/or diagnoses of:

a. Asthma

b. Peptic Ulcer Disease

c. Arthritis/ Low Back Pain

5. Respondent knowingly falsely billed and received reimbursement from the Program for performing Total Muscle Testing on Patient F on each and every visit when said testing was never performed

6. Respondent failed to maintain a record for Patient F which accurately reflects the patient's history, examination, diagnosis tests, and treatment rendered.

7. Respondent, or an individual acting at the direction and/or under the supervision of the Respondent, created a record for Patient F which is false and inaccurate and does not reflect legitimate patient care and treatment.

G. Between on or about May 23, 1988 and on or about February 6, 1989 Respondent undertook the care and treatment of Patient G at his medical offices.

1. Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note a physical examination.

2. Respondent inappropriately and without legitimate medical purpose prescribed:

   a. Tagamet

   b. Zantac

   c. Naprosyn

   d. Feldene

   e. Proventil Inhaler

   f. Flexeril

   g. Keflex

   h. Theodur

   i. Valisone Cream

j. Aldomet

3. Respondent inappropriately and without legitimate medical purpose ordered:

a. Renal and Splenic Sonograms

b. Approximately 50 blood tests

4. Respondent failed to perform and/or note an adequate work-up and evaluation of:

a. Patient G's complaints and/or diagnoses of:

i. Peptic Ulcer Disease

ii. Arthritis

iii. Asthma

b. Reported abnormal blood tests.

c. Invalid blood tests results due to improper collection and storage.

5. Respondent knowingly falsely billed and received reimbursement

from the Program for the following services which were never rendered:

a. Comprehensive service and Total Muscle Testing on May 23, 1988.

b. Total Muscle Testing on each and every other visit.

6. Respondent failed to maintain a record for Patient G which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

7. Respondent, or an individual acting at the direction and/or under the supervision of the Respondent, created a record for Patient G which is false and inaccurate and does not reflect legitimate patient care and treatment.

H. Between on or about December 30, 1987 and on or about November 30, 1988, Respondent undertook the care and treatment of Patient H at his medical offices.

1. Respondent failed to

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination

2. Respondent inappropriately and without legitimate medical purpose prescribed:

a. Tagamet

b. Zantac

c. Feldene

d. Clinoril

e. Naprosyn

f. Proventil Inhaler

g. Keflex

h. Valisone Cream

i. Lotrimin Cream

3. Respondent inappropriately and without legitimate medical purpose ordered the following Sonograms:

a. Hepatic

b. Renal

c. Splenic

d. Gall Bladder

e. Pancreatic

4. Respondent failed to perform and/or note an adequate work-up and evaluation of Patient H's complaints and/or diagnoses of:

a. Asthma

b. Lower Back Pain

c. Ulcer

d. Arthritis

5. Respondent knowingly falsely billed and received reimbursement from the Program for the following services which were never rendered:

a. Small burn treatment and Total Muscle Testing on February 16, 1988.

b. Intermediate service and Total Muscle Testing on June 11, 1988.

c. Total Muscle Testing on each and every other visit.

6. Respondent failed to maintain a record for Patient H which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

7. Respondent, or an individual acting at the direction and/or under the supervision of the Respondent, created a record for Patient H which is false and inaccurate and does not reflect legitimate patient care and treatment.

I. Between on or about September 28, 1987 and on or about January 13, 1989, Respondent undertook the care and treatment of Patient I at his medical offices.

1. Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination

2. Respondent inappropriately and without legitimate medical purpose prescribed:

a. Tagamet

b. Zantac

c. Clinoril

d. Motrin

e. Feldene

f. Flexeril

g. Alupent Inhaler

h. Proventil Inhaler

i. Catapress

j. Valisone Cream

3. Respondent inappropriately and without legitimate medical purpose ordered approximately 53 blood tests.

4. Respondent failed to perform and/or note adequate work-up and evaluation of Patient I's:

a. Complaints and/or diagnoses of:

i. Asthma

ii. Peptic Ulcer Disease

iii. Arthritis/Lower Back Pain

iv. Hypertension

b. Abnormal Blood tests.

5. Respondent knowingly falsely billed and received reimbursement from the Program for the following services which were never rendered:

a. Small burn treatment and Total Muscle Testing on November 27, 1987.

b. Total Muscle Testing on each and every other visit.

6. Respondent failed to maintain a record for Patient I which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

7. Respondent, or an individual acting at the direction and/or under the supervision of the Respondent, created a record for Patient I which is false and inaccurate and does not reflect legitimate patient care and treatment.

J. **Between** on or about January 26, 1988 and on or about January 13, 1989, **Respondent** undertook the care and treatment, at his medical offices, of a person who represented himself as a patient and Medicaid recipient by the name of James Johnson (herein after referred to as J.J.).

1. At J.J.'s visit of on or about January 26, 1988, Respondent:

   a. Failed to obtain or note a history.

   b. Failed to perform or note a physical examination.

   c. Inappropriately and without legitimate medical purposes prescribed:

      i. Naprosyn

      ii. Tagamet

      iii. Proventil Inhaler

      iv. Elavil

      v. Valisone Cream

      vi. Flexeril

vii. Condoms

viii. Alcohol

ix. Alcohol Prep

x. Multivitamins

2. At J.J.'s visit of on or about February 10, 1988, J.J. was told to submit to blood tests and Sonograms without legitimate medical purpose. J.J. refused and was told he would not be given prescriptions for Proventil Inhaler, Tagamet, nor Naprosyn which were going to be prescribed inappropriately and without legitimate medical indication. Respondent additionally:

a. Failed to obtain and note a history.

b. Failed to perform and note a physical examination.

c. Offered to prescribe, without legitimate medical purpose, medications for back pain, ulcers, and asthma,(conditions which J.J. did not suffer from) provided J.J. agreed to submit to blood tests and Sonograms.

d. Inappropriately and without legitimate medical purpose, prescribed:

i. Keflex

ii. Robitussin

iii. Actifed

iv. Vitamin C

e. Respondent knowingly and with intent to defraud the Program, refused to give J.J. the written prescription for the medications set out above and, instead, directed that J.J. could only have said prescription dispensed by the Pharmacy located within the same building as Respondent's medical office.

3. At J.J.'s visit of on or about April 14, 1988, Respondent:

a. Failed to obtain and note a history.

b. Failed to perform and note a physical examination.

c. Inappropriately and without legitimate medical purpose prescribed:

i. Proventil Inhaler

ii. Tagamet

iii. Naprosyn

4. At J.J.'s visit of on or about January 13, 1989, Respondent:

a. Failed to obtain and note a history.

b. Failed to perform and note a physical examination.

c. Inappropriately and without legitimate medical purpose prescribed:

i. Proventil Inhaler

ii. Zantac

iii. Naprosyn

iv. Valisone Cream

d. Inappropriately and without legitimate medical basis noted in the patient chart the diagnoses of:

i. Peptic Ulcer Disease

ii. Asthma

iii. Arthritis

5. Respondent failed to maintain a record for J.J. which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

6. Respondent, or an individual acting at the direction and/or under the supervision of the Respondent, created a record for J.J. which is false and inaccurate and does not reflect legitimate patient care and treatment.

K. Between on or about January 26, 1988 and on or about January 13, 1989, the Respondent undertook the care and treatment, at his medical offices, of a person who represented herself as a patient and Medicaid recipient by the name of Margaret Brown (hereinafter referred to as M.B.).

1. At M.B's visit of on or about January 26, 1988, Respondent:

a. Failed to obtain and note an adequate and/or legitimate history.

b. Failed to perform and note an adequate and/or legitimate physical examination.

c. Inappropriately and without legitimate medical purpose prescribed:

i. Flexeril

ii. Naprosyn

iii. Vitamin C

iv. Multivitamin

v. Robitussin

vi. Condoms

vii. Cotton balls

viii. Q-tips

ix. Petroleum Jelly

2. At M.B.'s visit of on or about April 14, 1988, Respondent:

a. Failed to obtain and note an adequate and/or legitimate history.

b. Failed to perform and note an adequate and/or legitimate physical examination.

c. Inappropriately and without legitimate medical

purpose prescribed:

i. Proventil Inhaler

ii. Flexeril

iii. Naprosyn

3. At M.B.'s visit of on or about May 26, 1988, Respondent:

a. Failed to obtain and note an adequate and/or legitimate history.

b. Failed to perform and note an adequate and/or legitimate physical examination.

c. Inappropriately and without legitimate medical purpose prescribed:

i. Proventil Inhaler

ii. Tagamet

iii. Naprosyn

4. At M.B.'s visit of on or about January 13, 1989, Respondent:

a. Failed to obtain and note a history.

b. Failed to perform and note a physical examination.

c. Inappropriately and without legitimate medical purpose prescribed:

i. Zantac

ii. Proventil Inhaler

iii. Naprosyn

iv. Valisone Cream

v. Keflex

vi. Condoms

vii. Alcohol

viii. Alcohol Prep

ix. Q-tips

x. Petroleum Jelly

xi. Multivitamins

xii. Vitamin C

d. Inappropriately and without legitimate medical purpose ordered Hepatic, Gallbladder, and Renal Sonograms.

e. Without legitimate medical basis, noted in the patient chart the diagnoses of:

i. Peptic Ulcer Disease

ii. Asthma

iii. Arthritis

5. Respondent failed to maintain a record for M.B. which accurately reflects the patient's history, examination, diagnosis, tests and treatment rendered

6. Respondent, or an individual acting at the direction and/or under the supervision of the Respondent, created a record for M.B. which is false and inaccurate and does not reflect legitimate patient care and treatment.

L. A review of the Respondent's records for the approximately 400 patients listed in Appendix B reveals that:

1. Respondent failed to obtain and/or note a history in approximately thirty-three percent (33%) of the charts. (132 charts). Of the remaining charts in which a history was noted, approximately ninety-seven percent (97%) were inadequate. (255 charts).

2. Respondent failed to perform and/or note a physical examination in approximately seventy-eight percent (78%) of the charts (311 charts). Of the remaining charts in which a physical examination was noted, approximately ninety percent (90%) were inadequate. (73 charts)

3. Respondent ordered laboratory tests in approximately two hundred forty-seven (247) cases. In approximately sixty-three percent (63%) of the cases, Respondent ordered the tests inappropriately and without legitimate medical purpose. (134 cases). In approximately twenty-five percent (25%) of the cases the blood was improperly taken and/or stored by Respondent 53 cases)

4. Respondent and/or an individual acting at the direction and/or under the supervision of the Respondent, failed to maintain records for these patients which accurately reflect each patient's history, examination, diagnosis, tests, and treatment rendered

5. Respondent and/or an individual acting at the direction and/or under the supervision of the Respondent, created records for these patients which are false and inaccurate and do not reflect legitimate patient care and treatment.

M. Between on or about December 19, 1987 and on or about March 16, 1989, Respondent employed an unlicensed person, GREGORY DANE PEARSON, to act as a physician's assistant and to undertake the day to day care and treatment of patients who came to Respondent's medical offices. During said period of time, Patients A through I, Patient James Johnson, Patient Margaret Brown, and the approximate 400 patients listed in Appendix B were cared for and treated by said unlicensed person at Respondent's office. The Respondent:

1. Permitted and/or delegated said unlicensed person to render professional medical care to said patients when Respondent knew or had reason to know that GREGORY DANE PEARSON was not qualified by training, experience, and/or licensure to perform professional medical care.

2. Permitted, aided and/or abetted said unlicensed person to perform the activities requiring a physician's assistant's license

3. Billed the Program, under Respondent's Medicaid provider number, and received reimbursement for all services purportedly rendered by said unlicensed person.

N. In addition to GREGORY DANE PEARSON, as set forth in paragraph M above, from in or about September, 1987 to in or about March. 1989, Respondent employed other Physician Assistants to render care and treatment to all patients who came to his medical offices, including the patients referred to herein, and billed the Program for all services purportedly rendered by said Physician Assistants. Respondent failed to exercise appropriate supervision over these Physician Assistants.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1996) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. The facts in paragraphs A, A (1) through A (5) and each and every subparagraph thereof, A(7), B, B(1) through B(3) and each and every subparagraph thereof, B(5), C, C(1) through C(4) and each and every subparagraph thereof, C(6), D, D(1) through D(3) and each and every subparagraph thereof, D(5), E, E(1) through E(3) and each and every subparagraph thereof, E(5), F, F(1) through F(4) and each and every subparagraph thereof, F(6), G, G(1) through G(4) and each and every subparagraph thereof, G(6), H, H(1) through H(4) and each and every

subparagraph thereof, H(6), I, I(1) through I(4) and each and every subparagraph thereof, I(6), J, J(1)(a), J(1)(b), J(1)(c)(i) through J(1)(c)(x), J(2)(a) through J(2)(c), J(2)(d)(i) through J(2)(d)(x), J(3) through J(5) and each and every subparagraph thereof, K, K(1) through K(5) and each and every subparagraph thereof, L, L(1) through L(4), M, M(1), M(2), and N.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1996) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. The facts in paragraphs A, A (1) through A (5) and each and every subparagraph thereof, A(7), B, B(1) through B(3) and each and every subparagraph thereof, B(5), C, C(1) through C(4) and each and every subparagraph thereof, C(6), D, D(1) through D(3) and each and every subparagraph thereof, D(5), E, E(1) through E(3) and each and every subparagraph thereof E(5), F, F(1) through F(4) and each and every subparagraph thereof, F(6), G, G(1) through G(4) and each and every subparagraph thereof, G(6), H, H(1) through H(4) and each and every subparagraph thereof, H(6), I, I(1) through I(4) and each and every subparagraph thereof, I(6), J, J(1)(a), J(1)(b), J(1)(c)(i)

through J(1)(c)(x), J(2)(a) through J(2)(c), J(2)(d)(i) through J(2)(d)(x), J(3) through J(5) and each and every subparagraph thereof, K, K(1) through K(5) and each and every subparagraph thereof, L, L(1) through L(4), M, M(1), M(2), and N.

THIRD THROUGH FIFTHTEENTH SPECIFICATIONS
FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1996) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. Paragraphs A(2)(a) through A(2)(d), A(3) A(5), A(5)(a), A(5)(b), A(6), A(6)(a), A(6)(b), A(6)(c), A(7), and A(8).

4. Paragraphs B(2)(a) through B(2)(f), B(4), B(4)(a), B(4)(b), B(4)(c), B(5), and B(6).

5. Paragraphs C(2)(a) through C(2)(d), C(4)(a), C(4)(b), C(5), C(5)(a), C(5)(b), C(6) and C(7).

6. Paragraphs D(2)(a) through D(2)(h), D(4), D(4)(a), D(4)(b), D(5) and D(6).

7. Paragraphs E(1)(a) through E(1)(c), E(2)(a) through E(2)(k), E(3)(a) through E(3)(e), E(4), E(4)(a), E(4)(b), E(5) and E(6)

8. Paragraphs F(2)(a) through F(2)(f), F(3)(a), F(3)(b)(i) through F(3)(b)(v), F(5), F(6) and F(7).

9. Paragraphs G(2)(a) through G(2)(j), G(3)(a), G(3)(b), G(5), G(5)(a), G(5)(b), G(6) and G(7).

10. Paragraphs H(2)(a) through H(2)(i), H(3)(a) through H(3)(e), H(5)(a), H(5)(b), H(5)(c), H(6) and H(7).

11. Paragraphs I(2)(a) through I(2)(j), I(3), I(5)(a),I(5)(b), I(6) and I(7).

12. Paragraph J and each and every subparagraph thereof.

13. Paragraph K and each and every subparagraph thereof.

14. Paragraph L and each and every subparagraph thereof.

15. Paragraphs M, and M(3).

SIXTEENTH SPECIFICATION

PERMITTING, AIDING OR ABETTING UNLICENSED PERSON

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law Sec. 6530(11) (McKinney Supp. 1996) by permitting, aiding and/or abetting an unlicensed person to perform activities requiring a license, as alleged in the facts of:

16. Paragraphs M, M(1), and M(2).

SEVENTEENTH SPECIFICATION

DELEGATING PROFESSIONAL RESPONSIBILITIES

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(25)(McKinney Supp. 1996) by delegating professional responsibilities to a person when Respondent knew or had reason to know that such person was not qualified by training, by experience, or by licensure, to perform them, as alleged in the facts of:

17. Paragraphs M, M(1), and M(2).

EIGHTEENTH THROUGH ONE HUNDRED SIXTY-SECOND SPECIFICATIONS

UNNECESSARY TESTS AND/OR TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 1996) by ordering excessive tests and/or treatments not warranted by the condition of the patient, as alleged in the facts of:

18. Paragraphs A(2)(a) through A(2)(d), A(3), and A(5), and A(5)(a).

19. Paragraphs B(2)(a) through B(2)(f).

20. Paragraph C(2)(a) through C(2)(d), and C(4)(a).

21. Paragraphs D(2)(a) through D(2)(h).

22. Paragraphs E(2)(a) through E(2)(k), and E(3)(a) through E(3)(e).

23. Paragraphs F(2)(a) through F(2)(f), F(3)(a), and F(3)(b)(i) through F(3)(b)(v).

24. Paragraphs G(2)(a) through G(2)(j), G(3)(a), and G(3)(b).

25. Paragraphs H(2)(a) through H(2)(i) and G(3)(a) through G(3)(e).

26. Paragraphs I(2)(a) through I(2)(j), and I(3).

27. Paragraphs J(1)(c)(i) through J(1)(c)(x), J(2), J(2)(c), J(2)(d)(i) through J(2)(iv), J(3)(c)(i), J(3)(c)(ii), J(3)(c)(iii), and J(4)(c)(i) through J(4)(c)(iv).

28. Paragraphs K(1)(c)(i) through K(1)(c)(ix), K(2)(c)(i), K(2)(c)(ii), K(2)(c)(iii), K(3)(c)(i), K(3)(c)(ii), K(3)(c)(iii), and K(4)(c)(i) through K(3)(c)(xii).

29 - 162. Paragraphs L(3).

ONE HUNDRED SIXTY-THIRD SPECIFICATION

EXERCISING UNDUE INFLUENCE

Respondent is charged with committing professional misconduct as defined in

N.Y. Educ. Law Sec. 6530(17) (McKinney Supp. 1996) by exercising undue influence on the patient, including the promotion of the sale of services and/or drugs in such a manner as to exploit the patient for the financial gain of the licensee or of a third party, as alleged in the facts of:

163. Paragraphs J(2), J(2)(c), and J(2)(e).

ONE HUNDRED SIXTY-FOURTH SPECIFICATION
FAILING TO APPROPRIATELY SUPERVISE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law Sec. 6530(33) (McKinney Supp. 1996), by failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of the licensee, as alleged in the facts of:

164. Paragraph N.

ONE HUNDRED SIXTY-FIFTH THROUGH ONE HUNDRED SEVENTY-SIXTH SPECIFICATIONS
FAILING TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law Sec. 6530(32) (McKinney Supp. 1996), by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of

165. Paragraphs A(1)(a), A(1)(b), A(4)(a), A(4)(b), A(4)(c), and A(7).

166. Paragraphs B(1)(a), B(1)(b), B(3)(a), B(3)(b), B(3)(c), and B(5).

167. Paragraphs C(1)(a), C(1)(b), C(3)(a), C(3)(b), C(3)(c), and C(6).

168. Paragraphs D(1)(a), D(1)(b), D(3)(a)(i), D(3)(a)(ii), D(3)(a)(iii), D(3)(b), and D(5).

169. Paragraphs E(1)(a), E(1)(b), E(1)(c), and E(5).

170. Paragraphs F(1)(a), F(1)(b), F(4)(a), F(4)(b), F(4)(c), and F(6).

171. Paragraphs G(1)(a), G(1)(b), G(4)(a)(i), G(4)(a)(ii), G(4)(a)(iii), G(4)(b), G(4)(c), and G(6).

172. Paragraphs H(1)(a), H(1)(b), H(4)(a) through H(4)(d), and H(6).

173. Paragraphs I(1)(a), I(1)(b), I(4)(a)(i) through I(4)(a)(iv), I(4)(b) and I(6).

174. Paragraphs J(1)(a), J(1)(b), J(2)(a), J(2)(b), J(3)(a), J(3)(b) J(4)(a), J(4)(b), J(4)(d)(i), J(4)(d)(ii), J(4)(d)(iii), and J(5).

175. Paragraphs K(1)(a), K(1)(b),K(2)(a), K(2)(b), K(3)(a), K(3)(b) K(4)(a), K(4)(b), K(4)(e)(i), K(4)(e)(ii), K(4)(e)(iii), and K(5).

176. Paragraph L(4).

DATED: January 3[illegible], 1996
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct