STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

Public

December 5, 2007

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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90 Church Street – 4th Floor
New York, New York 10007-2919

RE: In the Matter of Gary Tsirelman, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 07-269) 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), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "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,

James F. Horan

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

IN THE MATTER

OF

GARY TSIRELMAN, M.D.

DETERMINATION
AND
ORDER

BPMC 07 - 269

COPY

Donald H. Teplitz, D.O. (Chairperson), Zoraida Navarro, M.D., and Randolph H. Manning, Ph.D., duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law (**P.H.L.**). Marc P. Zylberberg, Esq., Administrative Law Judge, ("**ALJ**") served as the Administrative Officer.

The Department of Health (**Department**) appeared by Terrence J. Sheehan, Esq., Associate Counsel.

Gary Tsirelman, M.D. (**Respondent**) appeared personally and was represented by Wood & Scher, William L. Wood, Jr., Esq. of Counsel and by Jacobson, Goldberg & Kulb, L.L.P., Amy Kulb, Esq. and Jeffrey A. Granat, Esq., of Counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges:	February 21, 2007
Date of Answer to Charges:	March 12, 2007
Pre-Hearing Conference Held:	March 20, 2007
Hearings Held: - (First Hearing day): April 27, 2007; May 25, 2007; June 1, 2007; June 22, 2007; and August 14, 2007	March 27, 2007;
Intra-Hearing Conferences Held: April 27, 2007; May 25, 2007; June 22, 2007; and August 14, 2007	March 27, 2007;
Location of Hearings:	Offices of New York State Department of Health 90 Church St., 4th Floor New York, NY 10007
Witnesses called by the Department of Health: (in the order they testified)	Joseph Carfi, M.D. Patient A[1] Patient F Richard A. D'Amato
Witnesses called by Gary Tsirelman, M.D.: (in the order they testified)	Gary Tsirelman, M.D. Edward S. Satran, Esq. Vladimir Friedman D.C. Julia Paskalova, Esq Steven Hochberg, Esq. Elena Rodriguez John David Lipani, M.D., Ph.D. Joseph L. Cain, R.N.

[1] In order to maintain patient confidentiality the patients are referenced by letter.

Department of Health's Proposed Findings of Fact, Conclusions of Law and Recommended Sanction:	Received October 11, 2007
Respondent's Proposed Findings of Fact, and Conclusions of Law:	Received October 11, 2007
Deliberations Held: (last day of Hearing)	Friday, October 26, 2007

STATEMENT OF CASE

The State Board for Professional Medical Conduct 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. This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct (**Petitioner** or **Department**) pursuant to §230 of the P.H.L. Gary Tsirelman, M.D. (**Respondent**) is charged with sixty-nine (69) specifications of professional misconduct as set forth in §6530 of the Education Law of the State of New York (**Education Law**).

Respondent is charged with professional misconduct by reason of: (1) practicing the profession of medicine fraudulently[2]; (2) willfully making or filing a false report[3]; (3) ordering excessive tests, or treatment not warranted by the condition of the patient[4]; and (4) engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice[5].

The Factual Allegations, Charges, and Specifications of professional misconduct result from Respondent's alleged acts and conduct in 2000 and 2001, and involve ten (10) specific patients.

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[2] Education Law §6530(2) - (First to Twenty-Ninth Specifications in the Statement of Charges [Department's Exhibit # 1]).

[3] Education Law §6530(21) - (Thirtieth to Fifty-Eighth Specifications in the Statement of Charges).

[4] Education Law §6530(35) - (Fifty-Ninth to Sixty-Eighth Specifications in the Statement of Charges).

[5] Education Law §6530(20) - (Sixty-Ninth Specification in the Statement of Charges).

Respondent admits to owning LAMED MEDICAL, P.C. (**LaMed**) from August 2000 through June 2001. Respondent denies all factual allegations and all specifications of misconduct contained in the Statement of Charges. A copy of the Statement of Charges is attached to this Determination and Order as Appendix 1. A copy of Respondent's Answer is attached to this Determination and Order as Appendix 2.

FINDINGS OF FACT

The following Findings of Fact (**Findings**) were made after a review of the entire record available to the Hearing Committee in this matter. These Findings represent documentary evidence and testimony found persuasive by the Hearing Committee. Where there was conflicting evidence the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable, or credible in favor of the cited evidence. The Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence. The Hearing Committee unanimously agreed on all Findings and all Findings were established by at least a preponderance of the evidence. It is noted that Findings are referenced in subsequent Findings to reduce, to some extent, duplication. The Findings referenced should be read together with the subsequent Findings.

1. Respondent was licensed to practice medicine in New York State on December 11, 1996 by the issuance of license number 205235 by the New York State Education Department (Stipulated by the Parties).

2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent and has jurisdiction over Respondent's license and this disciplinary proceeding (determination made by the ALJ; Respondent had no objection regarding service effected on him); (P.H.L. §230[10][d]); [P.H.T-7-8][6].

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[6] Numbers in brackets refer to Hearing transcript page numbers [T-], or to Pre-Hearing transcript page numbers [P.H.T-], or to Intra-Hearing transcript page numbers [I.H.T-]. The Hearing Committee was not present at, and did not review, the Pre-Hearing transcripts or the Intra-Hearing transcripts but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

3. Respondent owned and operated a clinic named LaMed, 7802 Flatlands Avenue, Brooklyn, N.Y. from August 4, 2000 through approximately July 16, 2001 (Respondent's Exhibit C); [T-564, 723-724].

4. On August 4, 2000 "all the rights, assets and shares of the Company LAMED MEDICAL PC" were "sold and transferred to GARY TSIRELMAN, M.D. for $10.00 as of 8/4/00." On August 4, 2000 Respondent became the sole director, secretary and president of the LaMed. Respondent accepted all the rights, assets and shares and appointments (Respondent's Exhibit C).

Patient A Factual Allegations A.1.

A. Respondent owned and operated a clinic named LaMed Medical, P.C. (LaMed), 7802 Flatlands Avenue, Brooklyn, N.Y. on or about the following dates and with respect to the following Patients (whose names appear in the attached Appendix), Respondent submitted claims to Allstate Insurance Company for the performance of nerve destruction procedures, specifically called destruction of the paravertebral facet joint nerve by neurolytic agent and destruction of the cervical spinal muscle by neurolytic agent. In fact, the procedures were not performed. The claims were knowingly false and were submitted by Respondent with the intent to deceive Allstate:

5. On June 26, 2001 Respondent submitted claims, regarding treatment rendered to Patient A, to Allstate Insurance Company (**Allstate**) for the performance of nerve destruction procedures (**NDPs**), specifically called destruction of the paravertebral facet joint nerve by neurolytic agent and destruction of the cervical spinal muscle by neurolytic agent (Department's Exhibit # 2 @ p.22-23).

6. The claims for payment were submitted to Allstate based on an accident of 03/27/2001 that Patient A had been involved in. According to the claim submission, Patient A first consulted Respondent on 03/28/2001 and was treated for "Application of surface neurostimulator (transcutaneous)" on 03/29/2001 (2 treatments); on 03/30/2001 (2 treatments); and on 04/02/2001 (2 treatments). Patient A was also treated for "Destruction by neurologic agent (chemodenervation

of muscle endplate); cervical spinal muscle [eg, for spasmodic torticollis]) (NDP) on 03/29/2001; on 03/30/2001; and on 04/02/2001. Patient A was also treated for "Destruction by neurologic agent; paravertebral facet joint nerve, lumbar, single level (NDP) on 03/29/2001; on 03/30/2001; and on 04/02/2001. The total charges billed or claimed by Respondent for the above treatments were $2,349.93 (Department's Exhibit # 2 @ p. 22-23).

7. The claims submitted are for specifically: (1) "Destruction by a neurolytic agent (chemodenervation of muscle endplate); cervical spine muscle (eg, for spasmodic torticollis)" and (2) "Destruction by a neurolytic agent; paravertebral facet joint nerve, lumbar, single level"and (3) "Application of surface neurostimulator (transcutaneous)" (**Synaptic procedures**) (Department's Exhibit # 2 @ p.22-23); [T-37].

8. The first NDP claim for Patient A is for treatment on March 29, 2001, two (2) days after the accident and one (1) day after the initial visit by Patient A (Department's Exhibit # 2 @ p.22-23); [T-37].

9. A nerve destruction procedure (NDP) is not an insignificant procedure. It is an invasive procedure and requires special training to be performed safely and correctly. A NDP is a permanent destruction of the nerve using either a chemical or some radio frequency treatment that destroys the function of the nerve. It is a procedure that is permanent, not reversible and has great impact on a patient. It is something which is done as a last resort after all other treatment options have been exhausted [T-38-39, 109, 30-207, 217-244, 379-519].

10. There is no information in the medical record of Patient A as to how the procedure was performed, who performed it, the need for the procedure, or how the patient tolerated the procedure. There is no imaging record of the procedure. The information provided by Respondent in the narrative report lacks history, observation, detail, and specificity (Department's Exhibit # 2); [T-33-41].

Conclusions

11. NDPs were not performed on Patient A (Department's Exhibit # 2); [T-31-127].

12. A review of the medical records of Patients A through J indicates that the claims (bills) are virtually identical. Aside from the dates of treatment, the bills contain the same information, in the same format and with the same spacing. When overlaid the letters and numbers line up exactly (Department's Exhibits # 2 @ p. 22-23; # 3 @ p. 1-2; # 4 @ p. 40-41; # 5 @ p. 1-2; # 6 @ p. 14-15; # 7 @ p. 1-2; # 8 @ p. 49-50; # 9 @ p. 25-26; # 10 @ p. 19-20; and # 11 @ p. 5-6).

13. As the owner and operator of LaMed, Respondent is responsible for all billing (payment claims) issued from LaMed. It is irrelevant whether Respondent submitted the billing claims by hand signature or by signature stamp. Respondent cannot escape liability or responsibility by claiming he did not sign anything. Respondent's assertion that his name stamp/signature was used without his knowledge and/or without his authorization for more than eleven (11) months is utterly and completely not credible or believable. Respondent knew that the NDPs were not performed on Patient A and he knew that the claims submitted were therefore false. Respondent did not stop or prevent the "billing" department of LaMed[7] from using his signature stamp. Respondent submitted the claims for Patient A with the intent to deceive Allstate (Department's Exhibit # 2); [T-104-105, 248-324, 30-127, 217-222, 231-244]. Factual allegation A.1. is sustained.

Factual Allegations B.1.

B. On or about the following dates and with respect to the following Patients, Respondent submitted claims to Allstate Insurance Company for the performance of electrocardiograms. In fact, the electrocardiograms were not performed. These claims were knowingly false and were submitted by Respondent with the intent to deceive Allstate:

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[7] **Flatlands was the management company for LaMed and it appears that billing was part of Flatlands' duties.**

14. On June 26, 2001 Respondent submitted claims, regarding treatment rendered to Patient A on 03/28/2001, to Allstate for the performance of an electrocardiogram (**EKG**) and for an initial visit (Department's Exhibit # 2 @ p. 38,40).

15. The total charges billed or claimed by Respondent for the above services were $209.98 (Department's Exhibit # 2 @ p. 40).

16. The custom and practice of LaMed was to attach the EKG results to the inside portion of the patient's medical record , on top of the sign in sheet [T-1212-1213, 1217-1221, 1229, 1288-1292, 1300, 1306, 1317-1318, 1385-1386, 1388].

17. Patient A's plan of care, as indicated in the June 20, 2001 narrative report by Respondent, includes a reference to an EKG as part of a diagnostic plan (Department's Exhibit # 2 @ p. 1-5).

18. A review of the medical records of Patients A through H and Patient J does not reveal any copies of EKG strips but does reveal bills for EKGs (Department's Exhibits # 2 @ p. 40; # 3 @ p. 6-7; # 4 @ p. 1-2; # 5 @ p. 6-7; # 6 @ p. 1-2; # 7 @ p. 6-7; # 8 @ p. 69-70; # 9 @ p. 1-2; and # 11 @ p. 38-39).

Conclusions

19. The evidence (value and weight) is equal as to whether an EKG was performed or not performed on Patient A. Since the Department has the burden of proving the allegations by a preponderance of the evidence, Factual allegation B.1. is not sustained.

Factual Allegations C.1.

C. Respondent, and LaMed employee acting under Respondent's direction, did not treat the Patients listed below in good faith and in the ordinary course of professional practice. Rather, Respondent treated each Patient as a vehicle by which to bill insurance companies for unnecessary, medically valueless, and sometimes non-existent services. These services included MRIs, EKGs, surface neurostimulation, EMGs, acupuncture, nerve destruction procedures, psychological

evaluations, chiropractic therapy and physical therapy. The bills Respondent submitted through LaMed for these services were designed to deceive the insurance companies that these services constituted appropriate, good faith medical care.

20. Respondent submitted claims, regarding services and treatment rendered to Patient A, to Allstate for the performance of an initial visit, an EKG, surface neurostimulation, NDPs, muscle testing, and range of motion (cervical and lumbar) (Department's Exhibit # 2 @ p. 23, 28, 40).

21. There is no information in the medical record of Patient A as to the above procedures alleged to have been performed, who performed it, the need for the procedure, or the results of the procedures (Department's Exhibit # 2); [T-31-127].

22. (a) The performance of the EKGs are addressed in factual allegation B.1. above.

(b) MRIs were performed by a separate professional not under the control of Respondent (Department's Exhibit # 2 @ p. 104-106).

(c) EMGs, (Electromyography) were performed by a separate professional not under the control of Respondent (Department's Exhibit # 2 @ p. 12, 39).

(d) Acupuncture was performed by a separate professional not under the control of Respondent (Department's Exhibit # 2).

(e) Psychological evaluations and treatments of Patient A were performed by a separate professional not under the control of Respondent (Department's Exhibit # 2 @ p. 107-115).

(f) Chiropractic evaluations and treatments of Patient A were performed by a separate professional not under the control of Respondent (Department's Exhibit # 2 @ p. 16-20, 41-42, 49).

(g) Physical therapy for Patient A was performed by a separate professional not under the control of Respondent (Department's Exhibit # 2 @ p. 43-47, 50-55).

Conclusions

23. The performance on Patient A of surface neurostimulation and nerve destruction procedures either did not occur or were unnecessary for the appropriate care and treatment of Patient A (Department's Exhibit # 2); [T-31-127]. Respondent knew that the surface neurostimulation and nerve destruction procedures were not performed and/or not appropriate medical care for Patient A and the claims were therefore false. Respondent did not stop or prevent the "billing" department of LaMed from using his signature stamp. Respondent submitted the claims for Patient A with the intent to deceive Allstate. In addition, the ordering of the test and/or treatment was unwarranted by the patient's condition (Department's Exhibit # 2); [T-103-117]. Factual allegation C.1. is sustained, in part.

24. The evidence (value and weight) is equal as to whether an EKG was performed or not performed on Patient A. Since the Department has the burden of proving the allegations by a preponderance of the evidence, that portion of factual allegation C.1. is not sustained.

25. The Hearing Committee declines to conclude that Respondent was responsible for the actions (billings) of the acupuncturist, the psychologist, the chiropractor or the physical therapist. That portion of factual allegation C.1. is not sustained.

Patient B Factual Allegations A.2.

26. On September 7, 2001 Respondent submitted claims, regarding treatment rendered to Patient B, to Allstate for the performance of NDPs (Department's Exhibit # 3 @ p.1-2)[8].

[8] The Hearing Committee understands that Respondent was no longer the owner of LaMed on September 7, 2001. The claims were for services allegedly provided to Patient B by Respondent in June 2001 when Respondent was still the owner and operator of LaMed. Respondent never took any steps to prevent the use of his signature stamp while he was the owner of LaMed nor after he left LaMed. Even as an attorney Respondent uses a signature stamp and continues to try to excuse his lack of handwritten signature as salvation of any responsibility. Respondent never took any steps to prevent or report the use of his signature and the Hearing Committee concludes that Respondent benefitted from the claims and has responsibility for their submissions. This footnote is equally applicable to Patients D, E, G, and I

27. The claims for payment were submitted to Allstate based on an accident of 06/01/2001 that Patient B had been involved in. According to the claim submission, Patient B first consulted Respondent on 06/01/2001 and was treated for "Application of surface neurostimulator (transcutaneous)" on 06/04/2001 (2 treatments); on 06/05/2001 (2 treatments); and on 06/07/2001 (2 treatments). Patient B was also treated for "Destruction by neurologic agent (chemodenervation of muscle endplate); cervical spinal muscle [eg, for spasmodic torticollis]) (NDP) on 06/04/2001; on 06/05/2001; and on 06/07/2001. Patient B was also treated for "Destruction by neurologic agent; paravertebral facet joint nerve, lumbar, single level (NDP) on 06/04/2001; on 06/05/2001; and on 06/07/2001. The total charges billed or claimed by Respondent for the above treatments were $2,349.93 (Department's Exhibit # 3 @ p. 1-2) (exact same treatment and exact same billing amount claimed as for Patient A).

28. The first NDP claim for Patient B is for treatment on June 4, 2001, three (3) days after the accident and three (3) days after the initial visit by Patient B (Department's Exhibit # 3 @ p. 1-2). - See also Finding # 7 above.

29. An NDP is permanent, not reversible, has great impact on a patient and should be done as a last resort after all other treatment options have been exhausted [T-38-39, 129-183, 217-222]. - See also Finding # 9 above.

30. There is no information in the medical record of Patient B - See also Finding # 10 above. The information provided by Respondent in the narrative report lacks history, observation, detail, and specificity (Department's Exhibit # 3); [T-40-41,129-183].

Conclusions

31. NDPs were not performed on Patient B (Department's Exhibit # 3); [T-129-183].

32. A comparison of the medical records of Patients A through J indicates that the claims are virtually identical - See also Finding # 12 above.

33. Respondent knew that the NDPs were not performed on Patient B and the claims were therefore false. Respondent did not stop or prevent Flatlands from using his signature stamp. Respondent submitted the claims for Patient B with the intent to deceive Allstate (Department's Exhibit # 3); [T-129-183] - See also Finding # 13 above. Factual allegation A.2. is sustained.

Factual Allegations B.2.

34. On September 7, 2001 Respondent submitted claims, regarding treatment rendered to Patient B on 06/01/2001, to Allstate for the performance of an EKG and for an initial visit (Department's Exhibit # 3 @ p. 6-7).

35. See Finding # 15 above (Department's Exhibit # 3 @ p.7). See Finding # 16 above.

36. Patient B's plan of care, as indicated in the August 1, 2001 narrative report by Respondent, includes a reference to an EKG as part of a diagnostic plan (Department's Exhibit # 3 @ p. 8-11).

37. The medical records for Patient B do not include copies of EKG strips (Department's Exhibit # 3) - See also Finding # 18 above.

Conclusions

38. The evidence (value and weight) is equal as to whether an EKG was performed or not performed on Patient B. See also Finding # 19 above. Factual allegation B.2. is not sustained.

Factual Allegations C.2.

39. Respondent submitted claims, regarding services and treatment rendered to Patient B, to Allstate for the performance of an initial visit, an EKG, surface neurostimulation, NDPs, muscle testing, and range of motion (cervical and lumbar) (Department's Exhibit # 3 @ p. 1-2, 6-7, 24-25).

40. See Findings # 21 and # 22 (a through g) and Department's Exhibit # 3.

Conclusions

41. The performance on Patient B of surface neurostimulation and nerve destruction procedures either did not occur or were unnecessary for the appropriate care and treatment of Patient B (Department's Exhibit # 3); [T-129-183]. Respondent knew that said procedures were not performed and/or not appropriate medical care for Patient B and knew the claims for payment were false. See also Finding # 23 above. Respondent submitted the claims for Patient B with the intent to deceive Allstate. In addition, the ordering of the test and/or treatment was unwarranted by the patient's condition (Department's Exhibit # 3); [T-129-183, 536-660]. Factual allegation C.2. is sustained, in part.

42. See Findings # 24 and 25 above. The Hearing Committee declines to conclude that Respondent was responsible for the billings of other professionals. That portion of factual allegation C.2. is not sustained.

Patient C Factual Allegations A.3.

43. On June 19, 2001 Respondent submitted claims, regarding treatment rendered to Patient C, to Allstate for the performance of NDPs (Department's Exhibit # 4 @ p. 40-41).

44. The claims for payment were submitted to Allstate based on an accident of 03/08/2001 that Patient C had been involved in. According to the claim submission, Patient C first consulted Respondent on 03/12/2001 and was treated for "Application of surface neurostimulator (transcutaneous)" on 03/15/2001 (2 treatments); on 03/16/2001 (2 treatments); and on 03/19/2001 (2 treatments). Patient C was also treated for "Destruction by neurologic agent (chemodenervation of muscle endplate); cervical spinal muscle [eg, for spasmodic torticollis]) (NDP) on 03/15/2001; on 03/16/2001; and on 03/19/2001. Patient C was also treated for "Destruction by neurologic agent; paravertebral facet joint nerve, lumbar, single level (NDP) on 03/15/2001; on 03/16/2001; and on 03/19/2001. The total charges billed or claimed by Respondent for the above treatments were

$2,349.93 (Department's Exhibit # 4 @ p. 41-42) (exact same treatment and exact same billing amount claimed as for Patient A and Patient B).

45. The first NDP claim for Patient C is for treatment on June 15, 2001, seven (7) days after the accident and three (3) days after the initial visit by Patient C (Department's Exhibit # 4 @ p. 41-42); [T-183-207]. - See also Finding # 7 above.

46. An NDP is permanent, not reversible, has great impact on a patient and should be done as a last resort after all other treatment options have been exhausted [T-38-39, 183-207]. - See also Finding # 9 above.

47. There is no information in the medical record of Patient C - See also Finding # 10 above. The information provided by Respondent in the narrative report lacks history, observation, detail, and specificity (Department's Exhibit # 4); [T-40-41, 183-207].

Conclusions

48. NDPs were not performed on Patient C (Department's Exhibit # 4); [T-183-207, 217-222].

49. A comparison of the medical records of Patients A through J indicates that the claims are virtually identical - See also Finding # 12 above.

50. Respondent knew that the NDPs were not performed on Patient C and the claims were therefore false. Respondent did not stop or prevent Flatlands from using his signature stamp. Respondent submitted the claims for Patient C with the intent to deceive Allstate (Department's Exhibit # 3); [T-183-207, 536-660] - See also Finding # 13 above. Factual allegation A.3. is sustained.

Factual Allegations B.3.

51. On June 19, 2001 Respondent submitted claims, regarding treatment rendered to Patient C on 03/12/2001, to Allstate for the performance of an EKG and for an initial visit (Department's Exhibit # 4 @ p. 1-2).

52. See Finding # 15 above (Department's Exhibit # 4 @ p.2). See Finding # 16 above.

53. Patient C's plan of care, as indicated in the June 12, 2001 narrative report by Respondent, includes a reference to an EKG as part of a diagnostic plan (Department's Exhibit # 4 @ p. 3-7).

54. The medical records for Patient C do not include copies of EKG strips (Department's Exhibit # 4) - See also Finding # 18 above.

Conclusions

55. The evidence (value and weight) is equal as to whether an EKG was performed or not performed on Patient C. See also Finding # 19 above. Factual allegation B.3. is not sustained.

Factual Allegations C.3.

56. Respondent submitted claims, regarding services and treatment rendered to Patient C, to Allstate for the performance of an initial visit, an EKG, surface neurostimulation, NDPs, muscle testing, and range of motion (cervical and lumbar) (Department's Exhibit # 4 @ p. 1-2, 31-32, 40-41).

57. See Findings # 21 and # 22 (a through g) and Department's Exhibit # 4.

Conclusions

58. The performance on Patient C of surface neurostimulation and nerve destruction procedures either did not occur or were unnecessary for the appropriate care and treatment of Patient C (Department's Exhibit # 4); [T-183-207]. Respondent knew that said procedures were not performed and/or not appropriate medical care for Patient C and knew the claims for payment were false. See also Finding # 23 above. Respondent submitted the claims for Patient C with the intent to deceive Allstate. In addition, the ordering of the test and/or treatment was unwarranted by the patient's condition (Department's Exhibit # 4); [T-183-207, 536-660]. Factual allegation C.3. is sustained, in part.

59. See Findings # 24 and 25 above. The Hearing Committee declines to conclude that Respondent was responsible for the billings of other professionals. That portion of factual allegation C.3. is not sustained.

Patient D Factual Allegations A.4.

60. On August 8, 2001 Respondent submitted claims, regarding treatment rendered to Patient D, to Allstate for the performance of NDPs (Department's Exhibit # 5 @ p.1-2).

61. The claims for payment were submitted to Allstate based on an accident of 05/05/2001 that Patient D had been involved in. According to the claim submission, Patient D first consulted Respondent on 05/07/2001 and was treated for "Application of surface neurostimulator (transcutaneous)" on 05/09/2001 (2 treatments); on 05/11/2001 (2 treatments); and on 05/15/2001 (2 treatments). Patient D was also treated for "Destruction by neurologic agent (chemodenervation of muscle endplate); cervical spinal muscle [eg, for spasmodic torticollis]) (NDP) on 05/09/2001; on 05/11/2001; and on 05/15/2001. Patient D was also treated for "Destruction by neurologic agent; paravertebral facet joint nerve, lumbar, single level (NDP) on 05/09/2001; on 05/11/2001; and on 05/15/2001. The total charges billed or claimed by Respondent for the above treatments were $2,349.93 (Department's Exhibit # 5 @ p. 1-2) (exact same treatment and exact same billing amount claimed as for Patient A, Patient B, and Patient C).

62. The first NDP claim for Patient D is for treatment on May 9, 2001, four (4) days after the accident and two (2) days after the initial visit by Patient D (Department's Exhibit # 5 @ p. 1-2); [T-379-415]. - See also Finding # 7 above.

63. An NDP is permanent, not reversible, has great impact on a patient and should be done as a last resort after all other treatment options have been exhausted [T-38-39, 379-415]. - See also Finding # 9 above.

64. There is no information in the medical record of Patient D - See also Finding # 10 above. The information provided by Respondent in the narrative report lacks history, observation, detail, and specificity (Department's Exhibit # 5); [T-40-41, 379-415].

Conclusions

65. NDPs were not performed on Patient D (Department's Exhibit # 5); [T-379-415].

66. A comparison of the medical records of Patients A through J indicates that the claims are virtually identical - See also Finding # 12 above.

67. Respondent knew that the NDPs were not performed on Patient D and the claims were therefore false. Respondent did not stop or prevent Flatlands from using his signature stamp. Respondent submitted the claims for Patient D with the intent to deceive Allstate (Department's Exhibit # 5); [T-379-415, 536-660] - See also Finding # 13 above. Factual allegation A.4. is sustained.

Factual Allegations B.4.

68. On August 8, 2001 Respondent submitted claims, regarding treatment rendered to Patient D on 05/07/2001, to Allstate for the performance of an EKG and for an initial visit (Department's Exhibit # 5 @ p. 6-7).

69. See Finding # 15 above (Department's Exhibit # 5 @ p.7). See Finding # 16 above.

70. Patient D's plan of care, as indicated in the July 19, 2001 narrative report by Respondent, includes a reference to an EKG as part of a diagnostic plan (Department's Exhibit # 5 @ p. 9-13).

71. The medical records for Patient D do not include copies of EKG strips (Department's Exhibit # 5) - See also Finding # 18 above.

Conclusions

72. The evidence (value and weight) is equal as to whether an EKG was performed or not performed on Patient D. See also Finding # 19 above. Factual allegation B.4. is not sustained.

Factual Allegations C.4.

73. Respondent submitted claims, regarding services and treatment rendered to Patient D, to Allstate for the performance of an initial visit, an EKG, surface neurostimulation, NDPs, muscle testing, and range of motion (cervical and lumbar) (Department's Exhibit # 5 @ p. 1-2, 6-7, 51-52).

74. See Findings # 21 and # 22 (a through g) and Department's Exhibit # 5.

Conclusions

75. The performance on Patient D of surface neurostimulation and nerve destruction procedures either did not occur or were unnecessary for the appropriate care and treatment of Patient D (Department's Exhibit # 5); [T-379-415]. Respondent knew that said procedures were not performed and/or not appropriate medical care for Patient D and knew the claims for payment were false. See also Finding # 23 above. Respondent submitted the claims for Patient D with the intent to deceive Allstate. In addition, the ordering of the test and/or treatment was unwarranted by the patient's condition (Department's Exhibit # 5); [T-379-415, 536-660]. Factual allegation C.4. is sustained, in part.

76. See Findings # 24 and 25 above. The Hearing Committee declines to conclude that Respondent was responsible for the billings of other professionals. That portion of factual allegation C.4. is not sustained.

Patient E Factual Allegations A.5.

77. On September 19, 2001 Respondent submitted claims, regarding treatment rendered to Patient E, to Allstate for the performance of NDPs (Department's Exhibit # 6 @ p. 14-15).

78. The claims for payment were submitted to Allstate based on an accident of 06/07/2001 that Patient E had been involved in. According to the claim submission, Patient E first consulted Respondent on 06/13/2001 and was treated for "Application of surface neurostimulator (transcutaneous)" on 06/14/2001 (2 treatments); on 06/15/2001 (2 treatments); and on 06/16/2001 (2 treatments). Patient E was also treated for "Destruction by neurologic agent (chemodenervation of muscle endplate); cervical spinal muscle [eg, for spasmodic torticollis]) (NDP) on 06/14/2001; on 06/15/2001; and on 06/16/2001. Patient E was also treated for "Destruction by neurologic agent; paravertebral facet joint nerve, lumbar, single level (NDP) on 06/14/2001; on 06/15/2001; and on 06/16/2001. The total charges billed or claimed by Respondent for the above treatments were $2,349.93 (Department's Exhibit # 6 @ p. 14-15) (exact same treatment and exact same billing amount claimed as for Patient A, Patient B, Patient C, and Patient D).

79. The first NDP claim for Patient E is for treatment on June 14, 2001, seven (7) days after the accident and one (1) day after the initial visit by Patient E (Department's Exhibit # 6 @ p. 14-15); [T-415-447]. - See also Finding # 7 above.

80. An NDP is permanent, not reversible, has great impact on a patient and should be done as a last resort after all other treatment options have been exhausted [T-38-39, 415-447]. - See also Finding # 9 above.

81. There is no information in the medical record of Patient E - See also Finding # 10 above. The information provided by Respondent in the narrative report lacks history, observation, detail, and specificity (Department's Exhibit # 6); [T-40-41, 415-447].

Conclusions

82. NDPs were not performed on Patient E (Department's Exhibit # 6); [T-415-447].

83. A comparison of the medical records of Patients A through J indicates that the claims are virtually identical - See also Finding # 12 above.

84. Respondent knew that the NDPs were not performed on Patient E and the claims were therefore false. Respondent did not stop or prevent Flatlands from using his signature stamp. Respondent submitted the claims for Patient E with the intent to deceive Allstate (Department's Exhibit # 6); [T-415-447] - See also Finding # 13 above. Factual allegation A.5. is sustained.

Factual Allegations B.5.

85. On September 19, 2001 Respondent submitted claims, regarding treatment rendered to Patient E on 06/13/2001, to Allstate for the performance of an EKG and for an initial visit (Department's Exhibit # 6 @ p. 1-2).

86. See Finding # 15 above (Department's Exhibit # 6 @ p.2). See Finding # 16 above.

87. Patient E's plan of care, as indicated in the August 2, 2001 narrative report by Respondent, includes a reference to an EKG as part of a diagnostic plan (Department's Exhibit # 6 @ p. 3-6).

88. The medical records for Patient E do not include copies of EKG strips (Department's Exhibit # 6) - See also Finding # 18 above.

Conclusions

89. The evidence (value and weight) is equal as to whether an EKG was performed or not performed on Patient E. See also Finding # 19 above. Factual allegation B.5. is not sustained.

Factual Allegations C.5.

90. Respondent submitted claims, regarding services and treatment rendered to Patient E, to Allstate for the performance of an initial visit, an EKG, surface neurostimulation, NDPs, muscle testing, and range of motion (cervical and lumbar) (Department's Exhibit # 6 @ p. 1-2, 14-15, 66-67).

91. See Findings # 21 and # 22 (a through g) and Department's Exhibit # 6.

Conclusions

92. The performance on Patient E of surface neurostimulation and nerve destruction procedures either did not occur or were unnecessary for the appropriate care and treatment of Patient E (Department's Exhibit # 6); [T-415-447]. Respondent knew that said procedures were not performed and/or not appropriate medical care for Patient E and knew the claims for payment were false. See also Finding # 23 above. Respondent submitted the claims for Patient E with the intent to deceive Allstate. In addition, the ordering of the test and/or treatment was unwarranted by the patient's condition (Department's Exhibit # 6); [T-415-447, 536-660]. Factual allegation C.5. is sustained, in part.

93. See Findings # 24 and 25 above. The Hearing Committee declines to conclude that Respondent was responsible for the billings of other professionals. That portion of factual allegation C.5. is not sustained.

Patient F Factual Allegations A.6.

94. On May 16, 2001 Respondent submitted claims, regarding treatment rendered to Patient F, to Allstate for the performance of NDPs (Department's Exhibit # 7 @ p. 1-2).

95. The claims for payment were submitted to Allstate based on an accident of 01/22/2001 that Patient F had been involved in. According to the claim submission, Patient F first consulted Respondent on 02/12/2001 and was treated for "Application of surface neurostimulator (transcutaneous)" on 02/14/2001 (2 treatments); on 02/17/2001 (2 treatments); and on 02/19/2001 (2 treatments). Patient F was also treated for "Destruction by neurologic agent (chemodenervation of muscle endplate); cervical spinal muscle [eg, for spasmodic torticollis]) (NDP) on 02/14/2001; on 02/17/2001; and on 02/19/2001. Patient F was also treated for "Destruction by neurologic agent; paravertebral facet joint nerve, lumbar, single level (NDP) on 02/14/2001; on 02/17/2001; and on 02/19/2001. The total charges billed or claimed by Respondent for the above treatments were

$2,349.93 (Department's Exhibit # 7 @ p. 1-2) (exact same treatment and exact same billing amount claimed as for Patient A, Patient B, Patient C, Patient D, and Patient E).

96. The first NDP claim for Patient F is for treatment on February 14, 2001, twenty three (23) days after the accident and two (2) day after the initial visit by Patient F (Department's Exhibit # 7 @ p. 1-2); [T-448-457]. - See also Finding # 7 above.

97. An NDP is permanent, not reversible, has great impact on a patient and should be done as a last resort after all other treatment options have been exhausted [T-38-39, 448-457, 328-376]. - See also Finding # 9 above.

98. There is no information in the medical record of Patient F - See also Finding # 7 above. The information provided by Respondent in the narrative report lacks history, observation, detail, and specificity (Department's Exhibit # 7); [T-40-41, 448-457].

Conclusions

99. NDPs were not performed on Patient F (Department's Exhibit # 7); [T-448-457, 328-376].

100. A comparison of the medical records of Patients A through J indicates that the claims are virtually identical - See also Finding # 12 above.

101. Respondent knew that the NDPs were not performed on Patient F and the claims were therefore false. Respondent did not stop or prevent Flatlands from using his signature stamp. Respondent submitted the claims for Patient F with the intent to deceive Allstate (Department's Exhibit # 7); [T-448-457, 328-376] - See also Finding # 13 above. Factual allegation A.6. is sustained.

Factual Allegations B.6.

102. On May 16, 2001 Respondent submitted claims regarding treatment rendered to Patient F on 02/12/2001, to Allstate for the performance of an EKG and for an initial visit (Department's Exhibit # 7 @ p. 6-7).

103. See Finding # 15 above (Department's Exhibit # 7 @ p.7). See Finding # 16 above.

104. Patient F's plan of care, as indicated in the April 20, 2001 narrative report by Respondent, includes a reference to an EKG as part of a diagnostic plan (Department's Exhibit # 7 @ p. 8-11).

105. The medical records for Patient F do not include copies of EKG strips (Department's Exhibit # 7) - See also Finding # 18 above.

Conclusions

106. The evidence (value and weight) is equal as to whether an EKG was performed or not performed on Patient F. See also Finding # 19 above. Factual allegation B.6. is not sustained.

Factual Allegations C.6.

107. Respondent submitted claims, regarding services and treatment rendered to Patient F, to Allstate for the performance of an initial visit, an EKG, surface neurostimulation, NDPs, muscle testing, and range of motion (cervical and lumbar) (Department's Exhibit # 7 @ p. 1-2, 6-7, 37-38).

108. See Findings # 21 and # 22 (a through g) and Department's Exhibit # 7.

Conclusions

109. The performance on Patient F of surface neurostimulation and nerve destruction procedures either did not occur or were unnecessary for the appropriate care and treatment of Patient F (Department's Exhibit # 7); [T-448-457, 328-376]. Respondent knew that said procedures were not performed and/or not appropriate medical care for Patient F and knew the claims for payment

were false. See also Finding # 23 above. Respondent submitted the claims for Patient F with the intent to deceive Allstate. In addition, the ordering of the test and/or treatment was unwarranted by the patient's condition (Department's Exhibit # 7); [T-448-457, 328-376, 536-660]. Factual allegation C.6. is sustained, in part.

110. See Findings # 24 and 25 above. The Hearing Committee declines to conclude that Respondent was responsible for the billings of other professionals. That portion of factual allegation C.6. is not sustained.

Patient G Factual Allegations A.7.

111. On August 11, 2001 Respondent submitted claims, regarding treatment rendered to Patient G, to Allstate for the performance of NDPs (Department's Exhibit # 8 @ p. 49-50).

112. The claims for payment were submitted to Allstate based on an accident of 05/22/2001 that Patient G had been involved in. According to the claim submission, Patient G first consulted Respondent on 05/22/2001 and was treated for "Application of surface neurostimulator (transcutaneous)" on 05/23/2001 (2 treatments); on 05/25/2001 (2 treatments); and on 05/29/2001 (2 treatments). Patient G was also treated for "Destruction by neurologic agent (chemodenervation of muscle endplate); cervical spinal muscle [eg, for spasmodic torticollis]) (NDP) on 05/23/2001; on 05/25/2001; and on 05/29/2001. Patient G was also treated for "Destruction by neurologic agent; paravertebral facet joint nerve, lumbar, single level (NDP) on 05/23/2001; on 05/25/2001; and on 05/29/2001. The total charges billed or claimed by Respondent for the above treatments were $2,349.93 (Department's Exhibit # 8 @ p. 49-50) (exact same treatment and exact same billing amount claimed as for Patient A, Patient B, Patient C, Patient D, Patient E, and Patient F).

113. The first NDP claim for Patient G is for treatment on May 23, 2001, one (1) day after the accident and one (1) day after the initial visit by Patient G (Department's Exhibit # 8 @ p. 49-50); [T-457-468]. - See also Finding # 7 above.

114. An NDP is permanent, not reversible, has great impact on a patient and should be done as a last resort after all other treatment options have been exhausted [T-38-39, 457-468]. - See also Finding # 9 above.

115. There is no information in the medical record of Patient G - See also Finding # 10 above. The information provided by Respondent in the narrative report lacks history, observation, detail, and specificity (Department's Exhibit # 8); [T-40-41, 457-468].

Conclusions

116. NDPs were not performed on Patient G (Department's Exhibit # 8); [T-457-468, 536-660].

117. A comparison of the medical records of Patients A through J indicates that the claims are virtually identical - See also Finding # 12 above.

118. Respondent knew that the NDPs were not performed on Patient G and the claims were therefore false. Respondent did not stop or prevent Flatlands from using his signature stamp. Respondent submitted the claims for Patient G with the intent to deceive Allstate (Department's Exhibit # 8); [T-457-468] - See also Finding # 13 above. Factual allegation A.7. is sustained.

Factual Allegations B.7.

119. On August 11, 2001 Respondent submitted claims, regarding treatment rendered to Patient G on 05/22/2001, to Allstate for the performance of an EKG and for an initial visit (Department's Exhibit # 8 @ p. 69-70).

120. See Finding # 15 above (Department's Exhibit # 8 @ p.70). See Finding # 16 above.

121. Patient G's plan of care, as indicated in the August 13, 2001 narrative report by Respondent, includes a reference to an EKG as part of a diagnostic plan (Department's Exhibit # 8 @ p. 1-5).

122. The medical records for Patient G do not include copies of EKG strips (Department's Exhibit # 8) - See also Finding # 18 above.

Conclusions

123. The evidence (value and weight) is equal as to whether an EKG was performed or not performed on Patient G. See also Finding # 19 above. Factual allegation B.7. is not sustained.

Factual Allegations C.7.

124. Respondent submitted claims, regarding services and treatment rendered to Patient G, to Allstate for the performance of an initial visit, an EKG, surface neurostimulation, NDPs, muscle testing, and range of motion (cervical and lumbar) (Department's Exhibit # 8 @ p. 6-7, 49-50, 69-70).

125. See Findings # 21 and # 22 (a through g) and Department's Exhibit # 8.

Conclusions

126. The performance on Patient G of surface neurostimulation and nerve destruction procedures either did not occur or were unnecessary for the appropriate care and treatment of Patient G (Department's Exhibit # 8); [T-457-468]. Respondent knew that said procedures were not performed and/or not appropriate medical care for Patient G and knew the claims for payment were false. See also Finding # 23 above. Respondent submitted the claims for Patient G with the intent to deceive Allstate. In addition, the ordering of the test and/or treatment was unwarranted by the patient's condition (Department's Exhibit # 8); [T-457-468, 536-660]. Factual allegation C.7. is sustained, in part.

127. See Findings # 24 and 25 above. The Hearing Committee declines to conclude that Respondent was responsible for the billings of other professionals. That portion of factual allegation C.7. is not sustained.

Patient H Factual Allegations A.8.

128. On May 14, 2001 Respondent submitted claims, regarding treatment rendered to Patient H, to Allstate for the performance of NDPs (Department's Exhibit # 9 @ p. 25-26).

129. The claims for payment were submitted to Allstate based on an accident of 01/13/2001 that Patient H had been involved in. According to the claim submission, Patient H first consulted Respondent on 01/13/2001 and was treated for "Application of surface neurostimulator (transcutaneous)" on 01/15/2001 (2 treatments); on 01/18/2001 (2 treatments); and on 01/19/2001 (2 treatments). Patient H was also treated for "Destruction by neurologic agent (chemodenervation of muscle endplate); cervical spinal muscle [eg, for spasmodic torticollis]) (NDP) on 01/15/2001; on 01/18/2001; and on 01/19/2001. Patient H was also treated for "Destruction by neurologic agent; paravertebral facet joint nerve, lumbar, single level (NDP) on 01/15/2001; on 01/18/2001; and on 01/19/2001. The total charges billed or claimed by Respondent for the above treatments were $2,349.93 (Department's Exhibit # 9 @ p. 25-26) (exact same treatment and exact same billing amount claimed as for Patient A, Patient B, Patient C, Patient D, Patient E, Patient F, and Patient G).

130. The first NDP claim for Patient H is for treatment on January 15, 2001, two (2) days after the accident and two (2) days after the initial visit by Patient H (Department's Exhibit # 9 @ p. 25-26); [T-470-485]. - See also Finding # 7 above.

131. An NDP is permanent, not reversible, has great impact on a patient and should be done as a last resort after all other treatment options have been exhausted [T-38-39, 470-485]. - See also Finding # 9 above.

132. There is no information in the medical record of Patient H - See also Finding # 10 above. The information provided by Respondent in the narrative report lacks history, observation, detail, and specificity (Department's Exhibit # 9); [T-40-41, 470-485].

Conclusions

133. NDPs were not performed on Patient H (Department's Exhibit # 9); [T-470-485].

134. A comparison of the medical records of Patients A through J indicates that the claims are virtually identical - See also Finding # 12 above.

135. Respondent knew that the NDPs were not performed on Patient H and the claims were therefore false. Respondent did not stop or prevent Flatlands from using his signature stamp. Respondent submitted the claims for Patient H with the intent to deceive Allstate (Department's Exhibit # 9); [T-470-485] - See also Finding # 13 above. Factual allegation A.8. is sustained.

Factual Allegations B.8.

136. On May 14, 2001 Respondent submitted claims, regarding treatment rendered to Patient H on 01/13/2001, to Allstate for the performance of an EKG and for an initial visit (Department's Exhibit # 9 @ p. 1-2).

137. See Finding # 15 above (Department's Exhibit # 9 @ p. 2). See Finding # 16 above.

138. Patient H's plan of care, as indicated in the May 2, 2001 narrative report by Respondent, includes a reference to an EKG as part of a diagnostic plan (Department's Exhibit # 9 @ p. 4-8).

139. The medical records for Patient H do not include copies of EKG strips (Department's Exhibit # 9) - See also Finding # 18 above.

Conclusions

140. The evidence (value and weight) is equal as to whether an EKG was performed or not performed on Patient H. See also Finding # 19 above. Factual allegation B.8. is not sustained.

Factual Allegations C.8.

141. Respondent submitted claims, regarding services and treatment rendered to Patient H, to Allstate for the performance of an initial visit, an EKG, surface neurostimulation, and NDPs (Department's Exhibit # 9 @ p. 1-2, 25-26).

142. See Findings # 21 and # 22 (a through g) and Department's Exhibit # 9.

Conclusions

143. The performance on Patient H of surface neurostimulation and nerve destruction procedures either did not occur or were unnecessary for the appropriate care and treatment of Patient H (Department's Exhibit # 9); [T-470-485]. Respondent knew that said procedures were not performed and/or not appropriate medical care for Patient H and knew the claims for payment were false. See also Finding # 23 above. Respondent submitted the claims for Patient H with the intent to deceive Allstate. In addition, the ordering of the test and/or treatment was unwarranted by the patient's condition (Department's Exhibit # 9); [T-470-485, 536-660]. Factual allegation C.8. is sustained, in part.

144. See Findings # 24 and 25 above. The Hearing Committee declines to conclude that Respondent was responsible for the billings of other professionals. That portion of factual allegation C.8. is not sustained.

Patient I Factual Allegations A.9.

145. On August 11, 2001 Respondent submitted claims, regarding treatment rendered to Patient I, to Allstate for the performance of NDPs (Department's Exhibit # 10 @ p. 19-20).

146. The claims for payment were submitted to Allstate based on an accident of 05/22/2001 that Patient I had been involved in. According to the claim submission, Patient I first consulted Respondent on 05/22/2001 and was treated for "Application of surface neurostimulator (transcutaneous)" on 05/23/2001 (2 treatments); on 05/25/2001 (2 treatments); and on 05/29/2001 (2 treatments). Patient I was also treated for "Destruction by neurologic agent (chemodenervation of muscle endplate); cervical spinal muscle [eg, for spasmodic torticollis]) (NDP) on 05/23/2001; on 05/25/2001; and on 05/29/2001. Patient I was also treated for "Destruction by neurologic agent; paravertebral facet joint nerve, lumbar, single level (NDP) on 05/23/2001; on 05/25/2001; and on

05/29/2001. The total charges billed or claimed by Respondent for the above treatments were $2,349.93 (Department's Exhibit # 10 @ p. 19-20) (exact same treatment and exact same billing amount claimed as for Patient A, Patient B, Patient C, Patient D, Patient E, Patient F, and Patient G); (It is noted that Patient I was a passenger in the car that Patient G was driving when a car accident occurred and that both patients were treated on the same days with the exact same testing).

147. The first NDP claim for Patient I is for treatment on May 23, 2001, one (1) day after the accident and one (1) day after the initial visit by Patient I (Department's Exhibit # 10 @ p. 19-20); [T-486-513]. - See also Finding # 7 above.

148. An NDP is permanent, not reversible, has great impact on a patient and should be done as a last resort after all other treatment options have been exhausted [T-38-39, 486-513]. - See also Finding # 9 above.

149. There is no information in the medical record of Patient I - See also Finding # 10 above. The information provided by Respondent in the narrative report lacks history, observation, detail, and specificity (Department's Exhibit # 10); [T-40-41, 486-513].

Conclusions

150. NDPs were not performed on Patient I (Department's Exhibit # 10); [T-486-513, 536-660].

151. A comparison of the medical records of Patients A through J indicates that the claims are virtually identical - See also Finding # 12 above.

152. Respondent knew that the NDPs were not performed on Patient I and the claims were therefore false. Respondent did not stop or prevent Flatlands from using his signature stamp. Respondent submitted the claims for Patient I with the intent to deceive Allstate (Department's Exhibit # 10); [T-486-513] - See also Finding # 13 above. Factual allegation A.9. is sustained.

Factual Allegations B.9.

Patient I is not included in paragraph B of the Statement of Charges - Findings below regarding Patient J.

Factual Allegations C.9.

153. Respondent submitted claims, regarding services and treatment rendered to Patient I, to Allstate for the performance of an initial visit, surface neurostimulation, NDPs, muscle testing, and range of motion (cervical and lumbar) (Department's Exhibit # 10 @ p. 12-13, 19-20, 41-42).

154. See Findings # 21 and # 22 (a through g) and Department's Exhibit # 10.

Conclusions

155. The performance on Patient I of surface neurostimulation and nerve destruction procedures either did not occur or were unnecessary for the appropriate care and treatment of Patient I (Department's Exhibit # 10); [T-486-513]. Respondent knew that said procedures were not performed and/or not appropriate medical care for Patient I and the claims for payments were false. See also Finding # 23 above. Respondent submitted the claims for Patient I with the intent to deceive Allstate. In addition, the ordering of the test and/or treatment was unwarranted by the patient's condition (Department's Exhibit # 10); [T-486-513, 536-660]. Factual allegation C.9. is sustained, in part.

156. See Findings # 24 and 25 above. The Hearing Committee declines to conclude that Respondent was responsible for the billings of other professionals. That portion of factual allegation C.9. is not sustained.

Patient J Factual Allegations A.10.

157. On May 16, 2001 Respondent submitted claims, regarding treatment rendered to Patient J, to Allstate for the performance of NDPs (Department's Exhibit # 11 @ p. 5-6).

158. The claims for payment were submitted to Allstate based on an accident of 01/22/2001 that Patient J had been involved in. According to the claim submission, Patient J first consulted Respondent on 01/24/2001 and was treated for "Application of surface neurostimulator (transcutaneous)" on 01/31/2001 (2 treatments); on 02/03/2001 (2 treatments); and on 02/05/2001 (2 treatments). Patient J was also treated for "Destruction by neurologic agent (chemodenervation of muscle endplate); cervical spinal muscle [eg, for spasmodic torticollis]) (NDP) on 01/31/2001; on 02/03/2001; and on 02/05/2001. Patient J was also treated for "Destruction by neurologic agent; paravertebral facet joint nerve, lumbar, single level (NDP) on 01/31/2001; on 02/03/2001; and on 02/05/2001. The total charges billed or claimed by Respondent for the above treatments were $2,349.93 (Department's Exhibit # 11 @ p. 5-6) (exact same treatment and exact same billing amount claimed as for Patient A, Patient B, Patient C, Patient D, Patient E, Patient F, Patient G, Patient H, and Patient I).

159. The first NDP claim for Patient J is for treatment on January 31, 2001, nine (9) days after the accident and seven (7) days after the initial visit by Patient J (Department's Exhibit # 11 @ p. 5-60); [T-514-519]. - See also Finding # 7 above.

160. An NDP is permanent, not reversible, has great impact on a patient and should be done as a last resort after all other treatment options have been exhausted [T-38-39, 514-519]. - See also Finding # 9 above.

161. There is no information in the medical record of Patient J - See also Finding # 10 above. The information provided by Respondent in the narrative report lacks history, observation, detail, and specificity (Department's Exhibit # 11); [T-40-41, 514-519].

Conclusions

162. NDPs were not performed on Patient J (Department's Exhibit # 11); [T-514-519].

163. A comparison of the medical records of Patients A through J indicates that the claims are virtually identical - See also Finding # 12 above.

164. Respondent knew that the NDPs were not performed on Patient J and the claims were therefore false. Respondent did not stop or prevent Flatlands from using his signature stamp. Respondent submitted the claims for Patient J with the intent to deceive Allstate (Department's Exhibit # 11); [T-514-519] - See also Finding # 13 above. Factual allegation A.10. is sustained.

Factual Allegations B.9.

165. On May 16, 2001 Respondent submitted claims, regarding treatment rendered to Patient J on 01/24/2001, to Allstate for the performance of an EKG and for an initial visit (Department's Exhibit # 11 @ p. 38-39).

166. See Finding # 15 above (Department's Exhibit # 11 @ p. 39). See Finding # 16 above.

167. Patient J's plan of care, as indicated in the April 20, 2001 narrative report by Respondent, includes a reference to an EKG as part of a diagnostic plan (Department's Exhibit # 11 @ p. 23-27).

168. The medical records for Patient J do not include copies of EKG strips (Department's Exhibit # 11) - See also Finding # 18 above.

Conclusions

169. The evidence (value and weight) is equal as to whether an EKG was performed or not performed on Patient J. See also Finding # 19 above. Factual allegation B.9. is not sustained.

Factual Allegations C.10.

170. Respondent submitted claims, for services and treatment rendered to Patient J, to Allstate for performance of an initial visit, an EKG, surface neurostimulation, NDPs, muscle testing, and range of motion (cervical and lumbar) (Department's Exhibit # 11 @ p. 5-6, 38-39, 42-43).

171. See Findings # 21 and # 22 (a through g) and Department's Exhibit # 11.

Conclusions

172. The performance on Patient J of surface neurostimulation and nerve destruction procedures either did not occur or were unnecessary for the appropriate care and treatment of Patient J (Department's Exhibit # 11); [T-514-519]. Respondent knew that said procedures were not performed and/or not appropriate medical care for Patient J and knew the claims for payment were false. See also Finding # 23 above. Respondent submitted the claims for Patient J with the intent to deceive Allstate. In addition, the ordering of the test and/or treatment was unwarranted by the patient's condition (Department's Exhibit # 11); [T-514-519, 536-660]. Factual allegation C.10. is sustained, in part.

173. See Findings # 24 and 25 above. The Hearing Committee declines to conclude that Respondent was responsible for the billings of other professionals. That portion of factual allegation C.10. is not sustained.

CONCLUSIONS OF LAW

The Hearing Committee makes the conclusions that the following Factual Allegations contained in the February 21, 2007 Statement of Charges are **SUSTAINED**:

Factual Allegations A., A.1. through A.10, and in part C. and C.1. through C.10.

The Hearing Committee makes the conclusions that the following Factual Allegations contained in the February 21, 2007 Statement of Charges are **NOT SUSTAINED**:

Factual Allegations B. and B.1 through B.9. and portions of C. and C.1. through C.10.

Based on the above, the complete Findings of Fact and the discussion below, the Hearing Committee unanimously concludes:

1. The FIRST through TENTH and the TWENTIETH through TWENTY-NINTH Specifications of FRAUDULENT PRACTICE contained in the Statement of Charges are **SUSTAINED**.

2. The THIRTIETH through THIRTY-NINTH and the FORTY-NINTH through FIFTY-EIGHTH Specifications of MAKING OR FILING A FALSE REPORT contained in the Statement of Charges are **SUSTAINED**.

3. The FIFTY-NINTH through SIXTY-EIGHTH Specifications of UNWARRANTED TESTS OR TREATMENT contained in the Statement of Charges are **SUSTAINED**.

4. The SIXTY-NINTH Specification of CONDUCT EVIDENCING MORAL UNFITNESS contained in the Statement of Charges is **SUSTAINED**.

5. The ELEVENTH through NINETEENTH Specifications of FRAUDULENT PRACTICE contained in the Statement of Charges are **NOT SUSTAINED**.

6. The FORTIETH through FORTY-EIGHTH Specifications of MAKING OR FILING A FALSE REPORT contained in the Statement of Charges are **NOT SUSTAINED**.

The rationale for the Hearing Committee's conclusions is set forth below.

DISCUSSION

Respondent is charged with 69 specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However §6530 does not provide definitions or explanations of some of the misconduct charged in this matter.

The ALJ provided to the Hearing Committee certain verbal instructions and verbal definitions of medical misconduct as alleged in this proceeding. These verbal instructions and definitions were obtained from a memoranda entitled Definitions of Professional Misconduct under

the New York Education Law[9] (ALJ's Exhibit # 2) and a one page document encompassing an interpretation and understanding of moral unfitness as used by previous Hearing Committees (ALJ's Exhibit # 3). During the course of its deliberations on these charges, the Hearing Committee considered the following instructions from the ALJ:

1. The Committee's determination is limited to the Charges set forth in the Statement of Charges.

Preponderance of the Evidence

2. The burden of proof in this proceeding rests on the Department. The Department must establish by a fair preponderance of the credible evidence that the allegations made are true. Credible evidence means the testimony or exhibits found worthy to be believed. Preponderance of the evidence means that the allegation presented is more likely than not to have occurred (more likely true than not true). The evidence that supports the claim must appeal to the Hearing Committee as more nearly representing what took place than the evidence opposed to its claim. The Specifications of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence. The Hearing Committee understands that the Department must establish each and every element of the Charges by a preponderance of the evidence.

Intent

3. For those charges that require a finding of intent, the Committee must determine the state of mind with which the act was done. If a person acts voluntarily with a desire to bring about a result, he is said to have intended that result. Further, although he has no desire to bring about the result, if he does the act knowing, with substantial certainty, that the result will follow, he is also said to have intended that result.

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[9] Copies of these definitions (ALJ Exhibits # 2 and # 3) were provided to both parties at the Pre-Hearing conference [P.H.T-4-7]; [T-4-5].

Witness Testimony

4. The Committee must determine the credibility of the witnesses in weighing each witness's testimony. First, the Hearing Committee must consider whether the testimony is supported or contradicted by other independent objective evidence. When the evidence is conflicting and presents a clear-cut issue as to the veracity of the opposing witnesses, it is for the Hearing Committee to pass on the credibility of the witnesses and base its inference on what it accepts as the truth. Where a witness's credibility is at issue, the Committee may properly credit one portion of the witness's testimony and, at the same time, reject another. The Hearing Committee also understood that we had the option of completely rejecting the testimony of a witness where we found that the witness testified falsely on a material issue.

Practicing the Profession Fraudulently

5. Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact in connection with the practice of medicine. An individual's knowledge that he is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts. In order to support the charge that medicine has been practiced fraudulently, the Department must prove by a preponderance of the evidence that (1) Dr. Tsirelman made a false representation, whether by words, conduct, or concealment of that which should have been disclosed; (2) Dr. Tsirelman knew that the representation was false; and (3) Dr. Tsirelman intended to mislead through the false representation.

There need not be either actual reliance on or actual injury caused by the misrepresentation to constitute the fraudulent practice of medicine. The focus is on the licensee's conduct in attempting to induce reliance, and not on whether the physician succeeds in causing reliance or whether any gain to the physician occurs to the detriment of the patient or to others. There is no requirement that someone actually be misled, as long as the intent of the "misrepresentation or

concealment of fact" is present. Fraud can also be established from evidence that a person made a statement or representation with reckless disregard as to its truth.

Moral Unfitness

6. To sustain a specification of moral unfitness, the Department must show that Respondent committed an act or acts which "evidences moral unfitness". The act or acts must be "conduct in the practice of the profession of medicine".

Moral unfitness in the practice of medicine constitutes either a violation of the public trust bestowed by virtue of the Doctor's license as a physician or a violation of the moral standards of the medical community. A doctor's poor judgment or mere "foolish" behavior will not sustain a charge of moral unfitness.

The Hearing Committee used ordinary English usage and understanding for all other terms and allegations. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony presented, the Hearing Committee evaluated all the witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility.

Credibility Determination

The Hearing Committee found the expert witnesses presented by the Department, Dr. Joseph Carfi, to be credible, forthright and objective. Dr. Carfi was flexible and provided a clear review of the medical records presented to him for analysis. Dr. Carfi also presented clear information regarding the bills contained in each patient's medical records. Even with substantially defective medical records, Dr. Carfi found reasons to be generous in agreeing to some of the treatments or treatment plans listed by Respondent (for example: EKGs and EMGs).

The Hearing Committee found both Patient A and Patient F to be clear in their belief that they were not given NDPs as billed by Respondent. We found these two (2) patients' testimony to be of great value to the process and the charges.

Respondent was authorized to practice medicine in New York State in 1996. Respondent gave up the practice of medicine around 2001 when he became an attorney and it appears that he has been practicing as an attorney since 2001. Respondent's testimony was not credible or believable. The Hearing Committee found that Respondent's testimony was fraught with inconsistencies with a disregard by Respondent for providing truthful answers. Some examples of Respondent's lack of candor and veracity include: Respondent was evasive about how many corporations (PCs) he owned and at first acknowledged to only one then more than one and then maybe three. Respondent denied any knowledge about the bills submitted by Flatlands. Respondent denied ever using or having a signature stamp even though one was used at LaMed and/or another clinic that he worked at as far back as 1997. Respondent, as an attorney, litigated the "appropriateness" of the bills that were submitted under his signature stamp, even though he never saw or authorized the bills to be signed or submitted. Respondent was cagey about working for LaMed prior to owning the corporation in 2000. Respondent even denied knowing R.P.A.C. Amimee Jean Baptiste, a registered physician's assistant, who was listed under Respondent's name in a prescription form.

The Hearing Committee cannot accept Respondent's attempts to refuse knowledge or accept responsibility for the billings submitted by LaMed to Allstate. We conclude that the bills under his signature, whether by stamp or by hand, were submitted with his knowledge, consent and authorization. The bills submitted to Allstate were under his name, his corporation and for his benefit for professional services that he alleged were done. One of the few words uttered by Respondent that we do find credible is his acknowledgment that the nerve destruction procedures were not done. This was corroborated by the two (2) patients that testified, by Dr. Carfi, and by the available medical records of the ten (10) patients. In other areas Respondent presented basically false information or could not recall any pertinent information.

Respondent fabricated testimony and was evasive in his responses to all questions posed, even questions from his own attorney. Respondent was not even forthcoming in his background and prior experiences and was purposely vague. Respondent tried to convince the Hearing Committee that he just came upon this great medical practice deal with very little knowledge about the practice or the operations of LaMed. After substantial prodding and confrontation Respondent was forced to admit that he worked for LaMed as far back as 1997. The Hearing Committee concludes that Respondent knew a great deal more about the LaMed/Flatlands relationship and organization than Respondent admitted. We do not believe Respondent's claim of naivety and claim of not knowing LaMed's or Flatlands' practices.

The Hearing Committee found the testimony of Elena Rodriguez to be limited in value except regarding the possible existence of more information that might have been included in each patient's medical records. Ms. Rodriguez was also helpful in establishing that Respondent had been involved with LaMed for more years than he had admitted. Most of the other witnesses presented by Respondent were of his character which we found interesting but of very little value to the factual allegations and specifications of misconduct. We did weigh their testimony in arriving at a fair and appropriate penalty (see discussion below).

The last witness presented by Respondent was Mr. Cain, a Department of Health investigator. His testimony was useful in pointing out that it is Respondent's responsibility to provide complete records of treatment of Respondent's patients.

The Hearing Committee was convinced by more than a preponderance of the evidence presented that the nerve destruction procedures that were billed for by Respondent were not performed on any of the ten (10) patients.

The following testimony by Dr. Carfi about the information that was contained in the patient's medical records was instructive and useful [T-79-80]:

My overall impression of this particular chart is that the -- I find the physical examination to be rudimentary. I don't see any support for the EKG that was done, and the PFT – that's pulmonary function test -- that was recommended as part of the diagnostic workup. A CT scan of the knee is what was recommended, which is virtually worthless when it comes to imaging of the knee, although an MRI was ultimately done. I see a lot of concurrent treatment which I don't feel is medically necessary. There was testing that were done that were, in my opinion, not medically necessary. Just a ... good physical examination will tell you all you need to know about strength and the range of motion. And, you know, again that psychiatric evaluation was recommended, but there were actually no behavioral or cognitive or emotional complaints from, from the patient. That's my overall statement.

SUMMARY

Patients A through J

The Hearing Committee understands that the medical; records in evidence (Department's Exhibits # 2 through # 11) for each patient possibly may not be the full and complete records that were present in 2000 and 2001. However we based our findings and conclusions on the information that was available. Even though we found Respondent's testimony completely lacked credibility, we gave Respondent the benefit of the doubt where there was even a slight possibility that the "missing information" (if it ever existed) would have helped Respondent's position. As an example, we did not conclude that if it was not documented, it was not done, which is normally a rational and acceptable conclusion to make.

The Hearing Committee also disregarded the materials contained in the medical records in evidence that had no relevance to Respondent or to LaMed. The fact that photocopies of non-relevant information may be present in the medical record of a patient poses one to query but does not result in a total disregard of what is relevant.

The information that is contained in the medical records of each patient show a summary (narrative report) which is inadequate within the four corners of the document itself. The pre-existing medical history, family history and physical examination described is wholly inadequate. The history of present condition is inadequate. The diagnostic impression is boiler plate for each patient and virtually identical. The diagnosis of Fibromyalgia is not a diagnosis for a car accident and the possibility of ten (10) patients presenting with Fibromyalgia to a facility, such as LaMed, within a one (1) year period is inconceivable. It is also extremely clinically suspect that every one of the ten (10) patients presented to the clinic with a diagnosis of spasmodic torticollis which is a relatively rare condition. The diagnostic plan for each patient is virtually identical and Respondent recommends an excessive and unwarranted amount of testing and treatment. Some of the treatment, both in length and in number of times per week, allegedly given to each patient (for example, chiropractic and physical therapy) should be attempted either separately or alternatively.

Even if the Hearing Committee were to accept Respondent's argument regarding the billing and improper coding, the fact remains that the alleged procedures were billed for twice. However, the Hearing Committee does not accept Respondent's position for a number of reasons. It is the treating physician's ultimate responsibility to submit true, accurate, and appropriate bills for his services. Respondent did not do this. The filling out of the actual forms can be assigned or delegated but the responsibility is retained by the physician and can not be avoided or dodged. It is completely incredulous to believe that Respondent practiced in a facility for eleven (11) months without knowledge of the bills. The Hearing Committee did not believe Respondent's testimony that he never saw the bills or the correspondence from the insurance companies relating to the bills.

Each bill is submitted on a New York Motor Vehicle No-Fault Insurance Law form with the following heading: "VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR PROVIDER OF HEALTH SERVICE". The last page of this "bill" has a place for the "Date", the

"Provider's signature", the "IRS/TIN Identification No.", and the "WCB Rating Code, if none, Specialty." Each bill that has Respondent's signature, stamped or otherwise, includes a date, the Tax Identification number of LaMed, and the license number of Respondent (205235).

Respondent billed for synaptic treatments and for nerve destruction procedures. It is clear and beyond doubt that he did not do both. Respondent, acting as an attorney, argued in a different forum the correctness of his billings. The billings and the procedures allegedly performed was a representation of medical care provided to Patients A through J. This representation had a permanent deleterious impact on each patient and their future medical care.

Respondent allowed the medical records of the patients to inaccurately reflect that they had undergone several destructive and irreversible medical procedures. Were a successor physician to obtain a copy of a patient's medical record containing this false information, one dreads to imagine the adverse consequences the patient might suffer.

The Hearing Committee finds to be knowingly false, Respondent's statements to the effect that he was not aware until 2007, that bills for nerve destruction procedures had been sent to insurance companies with his stamped signature on them. The Hearing Committee concludes that the Respondent was aware that his stamped signature was being placed on bills sent to insurance companies for NDPs that he knew were not being performed. We also conclude that he allowed his stamp to be used to "sign" fraudulent bills, for his benefit, even after he sold LaMed to another physician.

A. Respondent is charged with committing professional misconduct under Education Law §6530(2) by practicing the profession of medicine fraudulently.

Respondent submitted claims to Allstate Insurance Company for the performance of nerve destruction procedures on Patients A through J. In fact, the nerve destruction procedures described were not performed on Patients A through J. Respondent knew that the nerve destruction

procedures had not been performed but submitted the claims to Allstate Insurance Company to obtain payment for services he did not provide.

This course of conduct was false representations by Respondent to Patients A through J and to Allstate that he provided medical care to each patient which Respondent knew that he in fact did not do. Respondent knew that his representations were false and he mislead the patients and Allstate by trying to convince them that he had provided medical care by billing for nerve destruction procedures that were not done. It is further noted that the nerve destruction procedures were not appropriate procedures to perform on Patients A through J at the time they were alleged to have been performed. The Hearing Committee finds and determines that Respondent's conduct towards Patients A through J constituted the fraudulent practice of medicine. The First through Tenth Specifications of Charges are sustained. The Twentieth through Twenty-Ninth Specifications of Charges are sustained.

In regard to the electrocardiograms, the Hearing Committee believes that there is a possibility that EKGs were done but that information is not contained in the records in evidence. We therefore gave Respondent the benefit of the doubt and conclude that there is insufficient evidence to determine whether EKGs for each patient were or were not performed. We do not sustain the factual allegations or specifications of misconduct regarding this issue. The Eleventh through Nineteenth Specifications of Charges are not sustained.

In regard to the other services allegedly provided and contained in the medical records in evidence such as MRIs, EMGs, acupuncture, psychological evaluations, chiropractic therapy and physical therapy the Hearing Committee decided not to sustain the allegations. We did not sustain some of the factual allegations because the documents in evidence indicated billing by other professionals who may or may not have had a relationship with LaMed. Some bills by those professionals were submitted under different corporations using different Tax Identification numbers

than LaMed. We determined that it was a fairer process to hold Respondent responsible for his own billings under his name and the Tax Identification number of his corporation (LaMed). This is not to say that Respondent was not responsible for the billing which occurred under LaMed. The Hearing Committee decided that the evidence presented regarding this issue was insufficient to prove, by a preponderance of the evidence, that the billings in question (by the other professionals) were designed to deceive the insurance companies. There was also conflicting evidence, which was resolved in favor of Respondent, that some of the services (psychological evaluations, chiropractic therapy, acupuncture and physical therapy) were actually not provided but merely billed for.

Under the circumstances of this Hearing and taking into consideration all of the documents in evidence and all of the testimony presented, the Hearing Committee holds Respondent responsible for his fraudulent practice and submissions and not for the potentially fraudulent submissions of other professionals.

B. Respondent is charged with committing professional misconduct under Education Law §6530(21) by willfully making or filing a false report.

Respondent submitted bills to Allstate for nerve destruction procedures that were not done. The bills outlines activities by Respondent that were not done and were false. Respondent knew that the bills were false and willfully submitted them for his benefit. The Thirtieth through Thirty-Ninth Specifications of Charges are sustained. The Forty-Ninth through Fifty-Eighth Specifications of Charges are sustained.

In regard to the electrocardiograms, the Hearing Committee believes that there is insufficient evidence to determine whether they were or were not performed and therefore we do not sustain the factual allegations or specifications of misconduct regarding this issue. The Fortieth through Forty-Eighth Specifications of Charges are not sustained. See also the discussion in paragraph A above with regard to psychological evaluations, chiropractic therapy, acupuncture and physical therapy.

Under the circumstances of this Hearing and taking into consideration all of the documents in evidence and all of the testimony presented, the Hearing Committee holds Respondent responsible for his false submissions and not for the false submissions of other professionals.

C. Respondent is charged with committing professional misconduct under Education Law §6530(35) by ordering excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient.

Respondent submitted bills to Allstate for nerve destruction procedures that were not done. The bills outline treatment ordered by Respondent that was not warranted by the condition presented by Patients A through J. Respondent knew that the patients did not require nerve destruction procedures but indicated to the patients and to Allstate that those procedures were necessary for the appropriate care and treatment of the patients subsequent to their car accidents. The Fifty-Ninth through Sixty-Eighth Specifications of Charges are sustained.

Under the circumstances of this Hearing and taking into consideration all of the documents in evidence and all of the testimony presented, the Hearing Committee holds Respondent responsible for his ordering of excessive tests and/or treatments and not for the conduct of other professionals.

D. Respondent is charged with committing professional misconduct under Education Law §6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice.

The Hearing Committee finds and determines that Respondent intentionally submitted false information to Allstate for his own monetary benefit. Respondent also submitted false information into the medical records of Patients A through J which had the very real potential of causing grave and serious injury to each patient. These acts were done to satisfy Respondent's greed. We agree with Dr. Carfi that it is a departure from accepted medical ethical practices to bill for a procedure that is not done. Respondent's conduct violated the public trust granted to him as a physician.

Respondent engaged in conduct in the practice of the profession of medicine that evidences moral unfitness to practice the profession. The Sixty-Ninth Specification of Charges is sustained.

Respondent's other Arguments

1. Respondent claims that he did not have access to the LaMed bank account, LaMed checks, or to the operational authority of LaMed. The Hearing Committee finds Respondent's testimony in this assertion to be not credible. This is especially true because Respondent was the owner of LaMed for eleven (11) months. A normal, believable reaction to Respondent's assertion would have been to remove oneself from ownership immediately. Respondent did not do this. The same can be said regarding Respondent's assertion regarding the ordering of unnecessary services and tests for the patients. The medical license, and responsibility, belongs to Respondent and not to a management company.

2. Respondent argues that the billing codes were used in good faith, and at best, it is a mistaken interpretation of the correct billing codes and therefore there cannot be a finding of fraud. The Hearing Committee finds Respondent's testimony in this assertion to be not credible. Even if Respondent performed the synaptic procedures (which he may or may not have done), he clearly did not perform nerve destruction procedures. If Respondent claims that synaptic procedures were billed (incorrectly) as NDPs then why bill for the synaptic procedures twice. We believe that the NDPs billing codes were used by Respondent in an attempt to obtain greater reimbursement from Allstate. This attempt by Respondent was not an honest error or due to lack of experience. It was purposeful conduct meant to deceive.

3. Respondent claims that the medical records received in evidence for the Hearing Committee's review are not complete records and are unreliable and undermined the value of the expert's opinion. This claims was addressed above. The Hearing Committee notes that Respondent did not provide or make an attempt to obtain what he claims are the complete medical

records from his former medical office. We also note that Dr. Carfi was able to explain what he reviewed and acknowledged that the records may not be complete but that he was still able to fairly opine on the appropriate standard of care and the appropriateness of the billing information. The Department did not charge Respondent with inadequate record keeping or negligence or incompetence. A full and complete copy of each patient's medical records would have been preferable. However, the records that were before the Hearing Committee, established by a preponderance of the evidence, the factual allegations and specifications of misconduct brought by the Department as indicated in the findings, conclusions, and discussion above.

DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented and pursuant to the Findings of Fact, Conclusions of Law, Discussion, and Summary set forth above, the Hearing Committee determines that Respondent's license to practice medicine in New York State should be Revoked. In addition, a $100,000.00 fine should be assessed against Respondent.

This 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; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) A fine not to exceed ten thousand ($10,000.00) dollars on each specification of charges of which the respondent is determined to be guilty; (8) a course of education or training; (9) performance of up to five hundred (500) hours of public service; and (10) probation.

This case is about greed and billing fraud by a former practicing physician, who is now an attorney, who refuses to accept any responsibility for any thing at any time in the past or present. The Hearing Committee sees no hope that he will change in the future.

The Hearing Committee notes that the future medical care of the ten (10) patients were seriously and dangerously compromised by Respondent's fraudulent characterization of procedures that he claimed, on submissions to Allstate, were performed when he in fact did not perform said procedures. Respondent knew the procedures were not performed, knew the procedures should not be performed, and still verified to Allstate, and to the patients, that the procedures were performed and that he should be paid.

Respondent's attempt to convince us that this is merely a billing code dispute is an affront to the Hearing Committee and this professional conduct proceeding. Respondent's conduct is especially egregious given Respondent's legal representation to LaMed where he represented through the legal system (arbitration) that the bill coding was correct and payment should be made by Allstate (Department's Exhibit # 32).

The only sworn testimony given by Respondent that the Hearing Committee found believable was his admission that he never performed nerve destruction procedures on any patient and that he never saw or knew of anyone doing the procedures at LaMed.

Respondent's misconduct cannot be corrected or remedied by a censure or a reprimand, by probation, by performance of public service, or by retraining. A temporary suspension, limitations on Respondent's license, or monitoring are all inappropriate sanctions in this matter. Respondent denies the misconduct and the only remorse or regret that Respondent has provided to the Hearing Committee is that he was naive. The fact that he now practices law and no longer practice medicine is not mitigation for Respondent's misconduct. Considering that Respondent argued in a legal setting (arbitration) that his fraudulent billing was valid, the Hearing Committee would suggest that the Department submit a copy of this Determination and Order to the appropriate attorney grievance and disciplinary committee.

Respondent presented himself as the victim. He tried to present himself as having been taken advantage of and manipulated by Flatlands and its employees. The Hearing Committee does not accept that Respondent was the victim or the person who was tricked or taken advantage of. We believe that Respondent took advantage of the situation and profited from his actions. Rehabilitation or continued practice is only appropriate when a person has shown true remorse and wishes to amend his ways. Respondent has not shown true remorse or acknowledged that he has engaged in incorrect behavior.

Respondent's position that: he did not take part in any aspect of the billing process; he never saw the bills until after the proceedings were commenced; he did not review the bills; he did not authorize their submission; he never authorized the management company to use his stamp; and he did not make any referrals is completely unbelievable. Respondent's refusal to accept responsibility, continued denial, and attempts to minimize his culpability and involvement demonstrates the likelihood that he will continue to engage in such conduct if he retains his license.

Respondent's actions were intentional and deliberate and his attempt to insulate himself in ignorance was not believable or acceptable. Integrity is essential to the practice of medicine. It is imperative that physicians deal truthfully not only with patients and other physicians, but with third party insurers and state regulators. This standard and its enforcement is the foundation on which our health care system rests. Allowing physicians who make a habit of placing their own interests above those of the patient population erodes our health care system for everyone.

Respondent has committed fraud. This act is a serious transgression as it belies a fundamental lack of integrity. Physicians are not infallible nor are they held to that standard; however, honesty and accountability are standards that are inviolate. Their breach corrupts the profession, endangers the public, and taints the trust and respect that society places in their physicians, an effect which cannot be minimized.

Respondent's conduct was guided by greed. The Hearing Committee believes that the imposition of a monetary penalty is appropriate. A fine of $10,000.00 for Respondent's Fraudulent Practice, False Reporting, Unwarranted Testing, and Moral Unfitness in the Practice of medicine is assessed for each patient. The Hearing Committee considered a fine of $510,000.00 ($10,000 for each specification of charges [51 specifications]) that Respondent has been found guilty). However, the Hearing Committee believes that the punishment would be duplicative of the same course of conduct and chose to be lenient and only assess Respondent a total of $100,000 for his 51 instances of guilt of the specifications of misconduct.

The Hearing Committee believes the total fine of $100,000.00 to be an appropriate assessment (in addition to license revocation) for Respondent's fraudulent practice, false reporting, unwarranted testing, and moral unfitness.

The Hearing Committee concludes that Respondent's use of his license to commit fraud, standing alone, provides sufficient grounds to revoke Respondent's license and to fine him as indicated above. The false billings constituted fraud in the practice of medicine, engaging in conduct that evidences moral unfitness and willfully filing false reports. The treatment ordered by Respondent that was not warranted by the condition presented by Patients A through J standing alone, provides sufficient grounds to revoke Respondent's license and to fine him as indicated above. Respondent knew that the patients did not require the treatment ordered but indicated to the patients and to Allstate that those procedures were necessary for their care.

The Hearing Committee believes that the penalty imposed should help protect the public, curb future unprofessional practice by Respondent, deter other licensees from similar temptations, and is in the interest of justice.

Taking all of the facts, details, circumstances, and particulars in this matter into consideration, the Hearing Committee determines that the above is the appropriate action under the circumstances. All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein. Specifically, Respondent's arguments are either rendered academic by the Hearing Committee's decision or have been found to be lacking in merit.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

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

1. The FIRST through TENTH (1-10); TWENTIETH through TWENTY-NINTH (20-29), THIRTIETH though THIRTY-NINTH (30-39), FORTY-NINTH through FIFTY-EIGHTH (49-58), and FIFTY-NINTH through SIXTY-NINTH (59-69) SPECIFICATIONS contained in the Statement of Charges (Department's Exhibit # 1) are SUSTAINED; and

2. The ELEVENTH through NINETEENTH (11-19), and FORTIETH through FORTY-EIGHTH (40-48) SPECIFICATIONS contained in the Statement of Charges (Department's Exhibit # 2) are **NOT SUSTAINED**; and

3. Respondent's license to practice medicine in the State of New York is hereby **REVOKED**; and

4. Within thirty (30) days from the effective date of this decision Respondent shall pay a fine of **ONE HUNDRED THOUSAND ($100,000.00) DOLLARS**; and

5. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes, but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non renewal of permits or licenses (Tax Law §171[27]; State Finance Law §18; CPLR §5001; Executive Law §32); and

6. This Order shall be effective on personal service on the Respondent or seven (7) days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: **New York**
December, 05 **2007**

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ZORAIDA NAVARRO, M.D.
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APPENDIX 1

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

IN THE MATTER

OF

GARY TSIRELMAN, M.D.

STATEMENT

OF

CHARGES

Gary Tsirelman, M.D., the Respondent, was authorized to practice medicine in New York State on or about December 11, 1996, by the issuance of license number 205235 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent owned and operated a clinic named LaMed Medical, P.C. (LaMed), 7802 Flatlands Avenue, Brooklyn, N.Y. on or about the following dates and with respect to the following Patients (whose names appear in the attached Appendix), Respondent submitted claims to Allstate Insurance Company for the performance of nerve destruction procedures, specifically called destruction of the paravertebral facet joint nerve by neurolytic agent and destruction of the cervical spinal muscle by neurolytic agent. In fact, the procedures were not performed. The claims were knowingly false and were submitted by Respondent with the intent to deceive Allstate:

	Patients	Date of Claim
1.	A	06/26/01
2.	B	09/07/01
3.	C	06/19/01
4.	D	08/08/01
5.	E	09/19/01

6.	F	05/16/01
7.	G	08/11/01
8.	H	05/14/01
9.	I	08/11/01
10.	J	05/16/01

B. On or about the following dates and with respect to the following Patients, Respondent submitted claims to Allstate Insurance Company for the performance of electrocardiograms. In fact, the electrocardiograms were not performed. These claims were knowingly false and were submitted by Respondent with the intent to deceive Allstate:

	Patients	Date of Claim
1.	A	06/26/01
2.	B	09/07/01
3.	C	06/19/01
4.	D	08/08/01
5.	E	09/19/01
6.	F	05/16/01
7.	G	08/11/01
8.	H	05/14/01
9.	J	05/16/01

C. Respondent, and LaMed employee acting under Respondent's direction, did not treat the Patients listed below in good faith and in the ordinary course of professional practice. Rather, Respondent treated each Patient as a vehicle by which to bill insurance companies for unnecessary, medically valueless,

and sometimes non-existent services. These services included MRIs, EKGs, surface neurostimulation, EMGs, acupuncture, nerve destruction procedures, psychological evaluations, chiropractic therapy and physical therapy. The bills Respondent submitted through LaMed for these services were designed to deceive the insurance companies that these services constituted appropriate, good faith medical care.

1. Patient A
2. Patient B
3. Patient C
4. Patient D
5. Patient E
6. Patient F
7. Patient G
8. Patient H
9. Patient I
10. Patient J

SPECIFICATION OF CHARGES

FIRST TO TWENTY-NINTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent 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 paragraphs:

1. A and A(1)
2. A and A(2)
3. A and A(3)
4. A and A(4)
5. A and A(5)
6. A and A(6)
7. A and A(7)
8. A and A(8)
9. A and A(9)
10. A and A(10)
11. B and B(1)
12. B and B(2)
13. B and B(3)
14. B and B(4)
15. B and B(5)
16. B and B(6)
17. B and B(7)

18. B and B(8)

19. B and B(9)

20. C and C(1)

21. C and C(2)

22. C and C(3)

23. C and C(4)

24. C and C(5)

25. C and C(6)

26. C and C(7)

27. C and C(8)

28. C and C(9)

29. C and C(10)

THIRTIETH TO FIFTY-EIGHTH SPECIFICATION

FALSE REPORT

Respondent 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 the following paragraphs:

30. A and A(1)

31. A and A(2)

32. A and A(3)

33. A and A(4)

34. A and A(5)

35. A and A(6)
36. A and A(7)
37. A and A(8)
38. A and A(9)
39. A and A(10)
40. B and B(1)
41. B and B(2)
42. B and B(3)
43. B and B(4)
44. B and B(5)
45. B and B(6)
46. B and B(7)
47. B and B(8)
48. B and B(9)
49. C and C(1)
50. C and C(2)
51. C and C(3)
52. C and C(4)
53. C and C(5)
54. C and C(6)
55. C and C(7)
56. C and C(8)
57. C and C(9)
58. C and C(10)

FIFTY-NINTH TO SIXTY-EIGHTH SPECIFICATION

UNWARRANTED TESTS/TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(35) by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of the following paragraphs:

59. C and C(1).
60. C and C(2).
61. C and C(3).
62. C and C(4).
63. C and C(5).
64. C and C(6).
65. C and C(7).
66. C and C(8).
67. C and C(9).
68. C and C(10).

SIXTY-NINTH SPECIFICATION

MORAL UNFITNESS

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

69. A and A(1) - A(10), B and B(1) - B(9) and C and C(1) - C(10).

DATE: February 21, 2007
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX 2

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

IN THE MATTER

OF

GARY TSIRELMAN, M.D.

ANSWER

TO: ***By Fax: 1-518-402-0751 and mail***
NEW YORK STATE DEPARTMENT
OF HEALTH
Bureau of Adjudication
Hedley Park Place
433 River Street, 5th Fl
Troy, NY 12180
Att: Hon. Sean D. O'Brien, Director

- and-

By Fax: 212-417-4392 and Mail
NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, NY 10007
Att: Terrence Sheehan, Associate Counsel

RESPONDENT, GARY TSIRELMAN, M.D., through his attorneys, WOOD & SCHER, hereby ANSWERS the STATEMENT OF CHARGES as follows:

1. Respondent owned LAMED MEDICAL, P.C. (LAMED) from August 2000 through June 2001.

2. Other than as set forth in paragraph 1 above, respondent denies each and every other factual allegation contained in the Statement of Charges.

3. Respondent denies each and every specification of misconduct contained in the Statement of Charges including Specification First through Specification Sixty-Ninth.

WHEREFORE, respondent requests that each and every specification contained in the Statement of Charges be dismissed.

Dated: March 12, 2007
White Plains, NY

William L. Wood, Jr.
WOOD & SCHER
Attorneys for Respondent
GARY TSIRELMAN, M.D.
222 Bloomingdale Road
Suite 311
White Plains, NY 10605
(914) 328-5600