STATE OF NEW YORK DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

January 12, 2009

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Prem Nath, M.D.

Redacted Address

Prem Nath, M.D.

Redacted Address

Anthony Z. Scher, Esq.
Wood & Scher Esqs.
222 Bloomingdale Road, Suite 311
White Plains, New York 10605

Christine Radman, Esq.
NYS Department of Health
Division of Legal Affairs
90 Church Street – 4th Floor
New York, New York 10007

Richard F. X. Guay, Esq.
Meyer, Suozzi, English & Klein, P.C.
1350 Broadway – Suite 501
New York, New York 10018-0822

RE: In the Matter of Prem Nath, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 09-08) 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,

Redacted Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:djh

Enclosure

COPY

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

IN THE MATTER OF PREM NATH, M.D.	DETERMINATION AND ORDER

BPMC NO. 09 -08

A Notice of Violation of Probation, dated February 22, 2008, was served upon the Respondent, Prem Nath, M.D. **JERRY WAISMAN, M.D.**, Chairperson, **STEVEN PINSKY, M.D.**, and **JOAN MARTINEZ-McNICHOLAS**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **WILLIAM J. LYNCH, ESQ., ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer.

The Department of Health ("the Department") appeared by THOMAS CONWAY, General Counsel, by **CHRISTINE RADMAN, ESQ.**, of Counsel. The Respondent appeared by WOOD & SCHER, **ANTHONY Z. SCHER, ESQ.**, of Counsel, and by MEYER, SUOZZI, ENGLISH & KLEIN, P.C., **RICHARD F.X. GUAY, ESQ.**, of Counsel. Evidence was received and witnesses sworn and heard, and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Violation of Probation Letter:	February 22, 2008
Answer with Hearing Request:	March 10, 2008
Notice of Proceeding:	March 10, 2008
Hearing Dates:	May 13, 2008 June 19, 2008 June 26, 2008 August 14, 2008 September 25, 2008
Witnesses for Petitioner:	Vincent Monaco, M.D. Ann Cea, M.D.
Witnesses for Respondent:	Prem Nath, M.D. Edward Hannan, M.D. Lisa Moreno, M.D. Robert Traflet, M.D. Karl Greaves Vedeta Hanley Adam Singer, M.D. Hedva Shamir, M.D.
Receipt of Submissions:	November 7, 2008
Deliberation Held:	November 17, 2008

STATEMENT OF CASE

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

This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to §230 of the P.H.L. Prem Nath, M.D. ("Respondent") entered into a Consent Agreement and Order (BPMC #99-150) which imposed a penalty including a five-year probationary period to commence on or about April 7, 2000. The Director of the Office of Professional Medical Conduct concluded that Respondent violated the term of his probation requiring him to conduct himself in all ways in a manner befitting his professional status, and conforming to the moral and professional standards of conduct and obligations imposed by law and by his profession. The Director based this conclusion on Respondent's deviation from the minimally acceptable standard of care of a patient and his preparation of false billing documents during the period from January 8, 2001 until February 13, 2004. A motion was granted to amend the Director's letter to include an allegation that Respondent continued to use the designation "F.A.C.S." in correspondence when he was no longer a member of the American College of Surgeons. A copy of the Director's Violation of Probation letter, the Consent Agreement and Order, and the Notice of Violation of Probation Proceeding are attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

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

1. Prem Nath, M.D., the Respondent, was authorized to practice medicine in New York State on December 16, 1977, by the issuance of license number 133218 (Ex. 2).

2. Respondent entered into a Consent Agreement and Order (BPMC #99-150), effective July 7, 1999. In the Agreement, Respondent did not contest two specifications charging that he committed professional misconduct under N.Y. Education Law §6530(6) by reason of his having practiced the profession with gross incompetence, and he admitted that he was guilty of seven specifications charging that he committed professional misconduct under Education Law §6530(32) by

reason of having failed to maintain a record for seven patients which accurately reflected his evaluation and treatment (Ex. 1, 3).

3. BPMC #99-150 fined Respondent $25,000.00, suspended his license for thirty-six months with nine months actual suspension and the last twenty-seven months stayed, permanently limited his practice of medicine to exclude the practice of pain management, and imposed a five-year probationary period to commence after the period of actual suspension (Ex 1, 3).

4. Respondent resigned his hospital affiliations in July 1999 when his medical license was suspended (T. 320).

5. Patient A previously worked in the admitting office of a New Jersey Hospital (T. 224).

6. Patient A was working as the office manager for a physician in New Jersey when she met Respondent who shared office space in 1995 or 1996 (T. 225-226, 279).

7. For the time period from 2001 until 2008, Patient A alleges that she visited Respondent's office two or three times per week for treatment to relieve, among other things, neck pain, migraines, sinus infections and abscesses (T. 235-236, 277-279).

8. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $9700.00 for a surgery allegedly performed on Patient A on January 8, 2001. Respondent described the operation as 1) Muscle flap advancement with debridement of muscles with repair of

muscles left leg; 2) Excision deep infected mass left leg with mobilization of flaps with rearrangement of flaps; 3) Incision and drainage of deep multiloculated abscess left leg deep to muscles.(Ex. 8, pp. 2-5; Ex. 4, pp. 6-9).

9. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $7800.00 for a surgery allegedly performed on Patient A on February 9, 2001. Respondent described the operation as 1) Excision deep infected mass left foot with mobilization of flaps with rearrangement of flaps; 2) Incision and drainage deep muliloculated abscess left foot with debridement complicated deep to fascia (Ex 8, pp. 6-9; Ex. 4, pp. 12-15).

10. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $9600.00 for a surgery allegedly performed on Patient A on March 12, 2001. Respondent described the operation as 1) Muscle flap advancement left leg with mobilization of flaps; 2) Excision deep infected mass left leg with mobilization of flaps with rearrangement of flaps; and 3) Incision and drainage of deep multiloculated abscess left leg complicated type with debridement (Ex. 8, pp. 10-13; Ex. 4, pp. 19-22).

11. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $2500.00 for a surgery allegedly performed on Patient A on April 9, 2001. Respondent described the operation as debridement deep infected wound left leg with mobilization of flaps,

with advancement (Ex 8, pp. 14-15).

12. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $7700.00 for a surgery allegedly performed on Patient A on April 16, 2001. Respondent described the operation as 1) Excision deep infected mass left foot with mobilization of flaps for repair with rearrangement of flaps with advancement of flaps; 2) Incision and drainage multiloculated abscess left foot deep to plantar fascia with debridement (Ex 8, pp. 16-18, 20; Ex. 4, pp. 26-29).

13. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $2500.00 for a surgery allegedly performed on Patient A on April 26, 2001. Respondent described the operation as repair with debridement infected wound left foot with mobilization of flaps for repair with advancement of flaps (Ex. 8, pp. 14, 19).

14. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $8700.00 for a surgery allegedly performed on Patient A on July 6, 2001. Respondent described the operation as 1) Muscle flap advancement left leg with debridement and repair of muscles; 2) Excision infected mass left leg with mobilization of flaps with rearrangement; 3) Incision and drainage of deep abscess left leg (Ex. 8, pp. 21-23; Ex. 4, pp. 37-39).

15. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $6900.00 for a surgery allegedly performed on

Patient A on August 11, 2001. Respondent described the operation as 1) Excision deep infected mass left foot with mobilization of flaps for repair with realignment of tissues; 2) Incision and drainage of deep multiloculated abscess foot solar aspect deep to plantar fascia (Ex. 8, pp. 24-26; Ex. 4, pp. 45-47).

16. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $2500.00 for a surgery allegedly performed on Patient A on September 9, 2001. Respondent described the operation as debridement deep infected wound left leg with mobilization of flaps, with advancement (Ex. 8, pp. 27-28).

17. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $8700.00 for a surgery allegedly performed on Patient A on September 15, 2001. Respondent described the operation as 1) Mobilization of muscle flap with advancement with debridement of infected muscles; 2) Excision deep infected mass left leg with mobilization of flaps with rearrangement; 3) Incision and drainage of deep multiloculated abscess left leg (Ex. 8, pp. 30-33; Ex. 4, pp. 49-52).

18. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $2500.00 for a surgery allegedly performed on Patient A on September 26, 2001. Respondent described the operation as repair with debridement infected wound left foot with mobilization of flaps for repair, with advancement of flaps (Ex. 8, pp. 27, 29).

19. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $2900.00 for a surgery allegedly performed on Patient A on October 10, 2001. Respondent described the operation as debridement and plastic repair deep infected wound left leg with mobilization of flaps (Ex. 8, pp. 34-35; Ex. 4, pp. 55-57).

20. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $2900.00 for a surgery allegedly performed on Patient A on October 31, 2001. Respondent described the operation as debridement and plastic repair deep infected wound left foot with mobilization of flaps (Ex. 8, pp. 42-43; Ex. 4, pp. 60-62).

21. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $7800.00 for a surgery allegedly performed on Patient A on November 23, 2001. Respondent described the operation as 1) Excision deep infected mass left foot with mobilization of flaps for primary repair with realignment of flaps with rearrangement of flaps; and 2) Incision and drainage of deep multiloculated abscess left foot, deep to the plantar fascia (Ex. 8, pp. 45-48; Ex. 4, pp. 67-70).

22. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $9800.00 for a surgery allegedly performed on Patient A on December 14, 2001. Respondent described the operation as 1) muscle flap advancement left leg with debridement of muscles with repair of muscles left leg; 2) Excision deep infected mass left

leg with mobilization of flaps for repair with rearrangement of flaps with realignment of flaps; 3) Incision and drainage of deep multiloculated abscess left leg with debridement (Ex. 8, pp. 53-56; Ex. 4, pp. 74-77).

23. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $7300.00 for a surgery allegedly performed on Patient A on January 2, 2002. Respondent described the operation as 1) muscle flap advancement left leg; 2) Incision and drainage of deep abscess left leg; and 3) Debridement and plastic repair infected wound left leg with mobilization of flaps for repair with rearrangement (Ex. 8, pp. 57-59; Ex. 5, pp. 1-4).

24. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $6400.00 for a surgery allegedly performed on Patient A on February 6, 2002. Respondent described the operation as 1) Debridement tissue necrosis left foot with mobilization of flaps for repair with rearrangement of flaps; 2) Incision and drainage of deep abscess left foot (Ex. 8, pp. 63-64; Ex. 5, pp. 5-7).

25. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $8200.00 for a surgery allegedly performed on Patient A on April 10, 2002. Respondent described the operation as 1) Debridement of muscles with mobilization of muscle flap; 2) Excision infected mass left leg with mobilization of flaps for repair; 3) Drainage of deep abscess left leg (Ex. 8, pp. 65-67; Ex.

5, pp. 8-10).

26. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $7900.00 for a surgery allegedly performed on Patient A on May 3, 2002. Respondent described the operation as 1) Advancement of muscle flap with debridement of muscles left leg; 2) Excision infected mass left leg; 3) Incision and drainage of deep abscess left leg with mobilization of flaps with realignment (Ex. 8, pp. 68-70; Ex. 5, pp. 11-13).

27. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $6800.00 for a surgery allegedly performed on Patient A on May 31, 2002. Respondent described the operation as 1) Excision infected mass left foot with mobilization of flaps for repair with rearrangement; 2) Incision and drainage of deep abscess left foot (multiloculated abscess)(Ex. 8, pp. 71-73; Ex. 5, pp. 14-16).

28. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $8900.00 for a surgery allegedly performed on Patient A on June 21, 2002. Respondent described the operation as 1) Muscle flap advancement left leg with debridement of muscles with repair of muscles; 2) Excision deep infected mass left leg with mobilization of flaps with rearrangement of flaps; 3) Incision and drainage of deep multiloculated abscess left leg deep to the muscles (Ex. 8, pp. 74-77; Ex. 5, pp. 17-20).

29. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $10700.00 for a surgery allegedly performed on Patient A on November 6, 2002. Respondent described the operation as 1) Infected deep mass left leg with muscle necrosis and tissue loss; 2) Deep multiloculated abscess left leg with loss of tissues (Ex. 8, pp. 78-81; Ex. 5, pp. 21-24).

30. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $9700.00 for a surgery allegedly performed on Patient A on December 20, 2002. Respondent described the operation as 1) Muscle flap advancement with debridement of infected muscle tissues with mobilization of muscle flaps with rearrangement of muscle flaps chest; 2) Excision deep infected mass with mobilization of flaps with rearrangement of flaps with advancement of flaps chest; 3) Incision and drainage of deep abscesses back with drainage of pockets of pus with debridement (Ex. 8, pp. 82-85; Ex. 5, pp. 25-28).

31. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $9900.00 for a surgery allegedly performed on Patient A on January 31, 2003. Respondent described the operation as 1) Muscle flap advancement neck with debridement of muscles with mobilization of muscle flaps with realignment of muscle flap; 2) Excision deep infected mass neck with mobilization of flaps with rearrangement of flaps for repair; 3) Incision and drainage of deep abscess deep to the muscles in the neck (Ex. 8, pp. 86-89; Ex. 6, pp.

1-3).

32. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $9500.00 for a surgery allegedly performed on Patient A on July 7, 2003. Respondent described the operation as 1) Excision deep infected mass wall of abdomen with mobilization of flaps for repair with rearrangement of flaps with reconstruction; 2) Repair fascial defect wall of the abdomen; 3) Incision and drainage of multiloculated abscess wall of abdomen with debridement of tissues wall of abdomen (Ex. 8, pp. 90-93).

33. Respondent prepared an operative report for a surgery allegedly performed on Patient A on August 13, 2003. Respondent described the operation as 1) Debridement muscles left leg with muscle flap advancement with rearrangement of muscle flaps; 2) Excision deep infected mass left leg with mobilization of flaps for repair with rearrangement of tissues; 3) Incision and drainage deep multiloculated abscess left leg with debridement of abscess walls (Ex. 6, pp. 4-6).

34. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $8800.00 for a surgery allegedly performed on Patient A on October 1, 2003. Respondent described the operation as 1) Excision tumor left foot with mobilization of flaps for repair with rearrangement of flaps with advancement of flaps; 2) Incision and drainage subfascial multiloculate abscess left foot with

debridement of abscess left foot with debridement of abscess walls with debridement of tissues (Ex. 8, pp. 94-97; Ex. 6, pp. 7-9).

35. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $8900.00 for a surgery allegedly performed on Patient A on November 3, 2003. Respondent described the operation as 1) Excision deep infected mass right Inguinal area with mobilization of flaps for repair with advancement of flaps with rearrangement of flaps; 2) Incision and drainage complicated abscess right Inguinal area with debridement of abscess walls (Ex. 8, pp. 98-102; Ex. 6, pp. 10-12).

36. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $8800.00 for a surgery allegedly performed on Patient A on December 15, 2003. Respondent described the operation as 1) Debridement infected damaged tissues left foot with mobilization of flaps for repair with advancement of flaps; 2) Incision and drainage deep complicated plantar spaces abscess left foot with debridement of abscess walls (Ex. 8, pp. 103-107; Ex. 6, pp. 13-15).

37. Respondent prepared a bill submitted to Blue Cross Blue Shield in the amount of $7800.00 for a surgery allegedly performed on Patient A on February 13, 2004. Respondent described the operation as 1) Excision infected mass right breast with mobilization of flaps for repair with advancement of flaps with rearrangement of flaps; 2)

Incision and drainage deep abscess right breast with debridement of abscess walls (Ex. 8, pp. 108-111; Ex. 7, pp. 1-3).

38. Respondent did not have privileges at any hospital when he allegedly performed these surgeries in his office (T. 337).

39. Respondent alleged that Patient A told him that prior treating physicians had formed the diagnostic impression that she had an immune deficiency problem (T. 330).

40. Respondent alleged that he tried to obtain records from the hospitals which had previously provided treatment to Patient A, but that the hospitals gave him excuses such as being unable to find the records (T.331).

41. Respondent alleged that Patient A developed infections in different places of the body because of an immune deficiency disease (T. 334).

42. Respondent acknowledged that the usual treatment of a superficial abscess is to leave the wound open after incision and drainage (T. 342).

43. Respondent alleged that he loosely closed Patient A's wounds after incision and drainage because she had immune deficiency disease (T. 342).

44. Respondent failed to document consideration of any cause for these recurrent infections before proceeding to the alleged surgeries on Patient A's chest, neck, abdominal wall, groin and

breast (T. 91-101, 616-617; Ex. 4, 5, 6, 7).

45. Respondent failed to obtain a culture on pus and/or failed to obtain a pathology report on removed or disease adjacent tissues from any of the alleged surgeries referenced in the above paragraphs (T. 345-346; Ex. 4, 5, 6, 7).

46. Respondent allegedly removed tissue from Patient A's right breast and failed to send it for analysis. Failure to send the tissue for analysis would have been a violation of the standard of care (T. 193-195).

47. Failure to send excised tissue and exudate from the patient's chest, neck, abdomen, groin and breast for a culture and/or biopsy was a serious deviation from the standard of medical care (T. 26, 101, 165-166, 189-190, 631-632, 755-757).

48. Respondent failed to document both the type and the amount of anesthesia used during the alleged surgical procedures described in the above paragraphs (T. 413-414).

49. The accepted standard of medical care requires a physician to document the amount of anesthesia administered (T. 413-414).

50. Respondent failed to document the precise anatomical locations of the abscesses described in above paragraphs (T. 24, 54, 81-84, 413).

51. During the period of time between 2005 and 2006 when Patient A was not covered by health insurance, Respondent alleges

that he did not perform any surgeries because none was needed (T. 472-473).

52. An immunocompromised patient's underlying susceptibility to infection would not spontaneously resolve itself without exogenous treatment (T. 818-819).

53. In May 2004, Respondent was previously charged, inter alia, with violating his probation by administering trigger point injections. (T. 322, Ex. 3, pp. 34-44).

54. In his testimony on June 19, 2008, Respondent admitted that he had given patients trigger point injections, but he denied that he had prescribed any narcotics during his probationary period (T. 323-324).

55. An exhibit introduced by Respondent at the hearing on September 25, 2008, indicates that he prescribed narcotics to Patient A on at least ten occasions during the probationary period (Ex. T).

56. The May 2004 charges were resolved by a second Consent Agreement and Order (BPMC #05-208), effective October 5, 2005. In the Agreement, Respondent admitted that he had violated New York Education Law §6530(9)(b) and §6530(9)(d) in that the Connecticut Medical Board had found him guilty of professional misconduct and taken disciplinary action against him (Ex. 3).

57. In addition to its consideration of BPMC #99-150, the Connecticut Board based its disciplinary action upon Respondent

storing controlled substances in an unsecure container in an unsecure room; acting as a wholesaler of controlled substances without a wholesaler license on various occasions between November 4, 1999 and May 18, 2000; ordering and/or distributing controlled substances when his controlled substance registration was expired from on or about February 28, 2000, to on or about May 18, 2000; possessing and/or distributing controlled substances in his Livingston, New Jersey office on or about October 6, 2000 when he did not have a valid registration with the Drug Enforcement Agency for that location; storing, possessing and distributing controlled substances at his Paramus, New Jersey office on or about October 6, 2000 without maintaining invoices from the wholesalers or drug suppliers and appointment logs for the most recent two years; and failing to comply with a subpoena duces tecum issued by the Connecticut Board to produce records from his Paramus, New Jersey office (Ex. 3).

58. BPMC #05-208, effective October 5, 2005, placed Respondent on probation for a two-year period, limited Respondent from the practice of chronic pain management, permitted the practice of acupuncture, and restricted Respondent from ordering, prescribing, administering and/or dispensing controlled substances during the additional two-year probationary period (Ex. 3).

CONCLUSIONS OF LAW

The Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony.

The Department presented testimony by Vincent Monaco, M.D. Dr. Monaco is board certified in general surgery. Dr. Monaco testified in a thoughtful manner, and, if anything, appeared to give Respondent the benefit of any doubt. The Hearing Committee found that Dr. Monaco's testimony was credible and gave it great weight.

Respondent offered the testimony of Edward Hannan, M.D. Dr. Hannan is also board certified in general surgery. The Hearing Committee found that Dr. Hannan's testimony was evasive and inconsistent. For example, when asked about Respondent's practice of closing Patient A's incisions, Dr. Hannan began by stating that he had no personal experience, but he ultimately testified that he would consider doing a loose closure for a patient with an immunodeficiency (T. 587). Thus, he avoided stating forthrightly whether the Respondent's practice was within the accepted standard of care.

Respondent presented testimony by Lisa Moreno, M.D. Dr. Moreno is board certified in general pediatrics and in allergy immunology. The Hearing Committee found that Dr. Moreno was very credible. Her testimony, however, did not assist in Respondent's defense. In fact, her testimony further established that Respondent failed to confirm whether Patient A suffered from an immunodeficiency, and that Respondent should have obtained a culture on the pus removed from the numerous abscesses that he treated.

Respondent offered the testimony of Robert Traflet, M.D. Dr. Traflet is board certified in radiology. In rebuttal, the Department offered the testimony of a radiologist, Ann Cea, M.D. The Hearing Committee found that both witnesses appeared to testify in a credible manner. The Committee, however, felt that Dr. Cea's testimony regarding several possible etiologies to explain the changes shown on the MRI of Patient A's left calf muscle and bottom of her left foot was more credible than Dr. Traflet's testimony that these changes were caused by multiple surgeries. The other possible etiologies outlined by Dr. Cea included a congenital abnormality, prior injury that affected the lymphatics of the leg, recent trauma, stasis, tourniquet effect, salt overload, renal disease, or even injected fluid. Accordingly, the Hearing Committee concluded that the MRI failed to confirm whether or not the alleged surgeries had been performed.

Respondent presented testimony by Adam Singer, M.D. Dr. Singer is board certified in emergency medicine. His testimony regarding primary closure after drainage of abscesses in wound management, however, did not assist in Respondent's defense. To the contrary, his testimony further established that primary closure is not a recognized and respected minority view, particularly when treating deep abscesses of patients with an immunodeficiency.

Respondent offered the testimony of two character witnesses, Karl Greaves and Vedeta Hanley. While their testimony appeared genuine, they expressed little knowledge of Respondent's qualifications or credentials.

The Hearing Committee concluded that Respondent's testimony was not credible. Respondent acknowledged that his license was limited to exclude the practice of pain management in 1999, but Patient A testified that she visited Respondent's office two times per week throughout the probationary period in large part for relief of pain from neck problems and migraines. The record further establishes that Respondent continued to administer trigger point injections to several other patients after the limitation was imposed. The Committee rejected Respondent's explanation that this was merely a misunderstanding of the limitation placed upon his license. In addition, Respondent's testimony at the hearing contradicted the documentary evidence which he offered. Respondent

testified that he did not write any narcotics for Patient A, and Patient A testified that she did not receive any "pills." Later, however, Respondent offered a prescription log (Ex. T) which showed that he had prescribed narcotics for Patient A on several occasions.

The Hearing Committee also concluded that Patient A's medical records were false. The dates and medications in the prescription log offered by Respondent do not correspond to Respondent's office notes for Patient A. For example, the medical record shows no office visit on August 12, 2003, yet the log shows an entry for Respondent having prescribed Nitrofurantoin. There are multiple discrepancies between the medical record and the prescription log. The falsity of the medical record is also inferred from the fact that detailed documentation of the information necessary to justify payment of tens of thousands of dollars from the insurance company was prepared, but Respondent prepared no documentation of the routine care that would have accompanied these surgeries, such as follow-up care including removal of sutures.

Turning to the surgeries which Respondent allegedly performed, the record establishes that these would have been complex surgeries involving deep abscess infiltration through the subcutaneous skin infecting the muscles below. Respondent contended that these surgeries, which were performed in his office without assistance, required drainage of pus and debridement of necrotic

tissue, frequently followed by muscle flap advancement and mobilization. Further, Respondent stated that he only used a local anesthetic when he allegedly cut deep into Patient A's neck, abdominal wall and breast.

The evidence established that Respondent would have acted with gross negligence if his testimony and his medical record of Patient A's treatment were truthful. Respondent failed to document the type and amount of anesthesia used during the surgeries; failed to document the precise anatomical location of the abscesses; and failed to document any post-surgical care such as checking the wound or removing the sutures. Respondent also sutured the skin over these drained abscesses; failed to obtain a culture on pus or a pathology report on removed tissue from the multiple abscesses which he allegedly treated on a patient who he presumed to be immunocompromised; and failed to confirm Patient A's history of an immunodeficiency impression. The testimony of Respondent's own expert established that identifying the organism would not only dictate treatment, but also lead toward determining the type of immunodeficiency, if one existed. The Hearing Committee, however, did not find that Respondent's medical record and testimony was truthful.

Instead, the Hearing Committee found that Respondent's testimony was false and his medical record and billing documents

fraudulent. The Committee infers Respondent's knowledge and intent in part upon the evidence that Respondent never obtained a culture of the pus allegedly removed during these multiple procedures, never sent excised tissue to pathology, and never confirmed the diagnostic impression of immunodeficiency. The fact that the need for such surgeries all but ceased when Patient A's health insurance was cut off served as a further basis for inferring that the alleged surgeries were fraudulent, particularly in light of evidence from Respondent's own expert that the underlying susceptibility to recurrent abscesses in a patient with an immune defect would not spontaneously resolve without exogenous treatment.

The Hearing Committee also infers that Patient A acted in concert with Respondent to commit this fraud. The Committee makes this inference based upon several of its factual findings. Respondent prepared bills for all of the alleged surgeries, and Patient A received checks for those surgeries from Blue Cross/ Blue Shield. Patient A alleged that she paid some of these checks over to Respondent and deposited others into her personal checking account, contending that her lack of organization prevented her from ascertaining how and whether the funds had been paid to Respondent. The Hearing Committee did not find this testimony credible. Patient A was previously employed as an office manager for a medical practice. As such, she was likely to be knowledgeable of billing

practices and systems to maintain billing records. Patient A's assertion that she had traveled from New Jersey to New York two or more times per week to obtain treatment of recurrent abscesses by a physician who was being disciplined for misconduct was not credible, particularly in light of Patient A's contention that she had not followed up on referrals to a infectious disease specialist and immunologist in her home State of New Jersey, "just [because she] didn't want to go" (T. 241).

The billing records for surgeries performed in April and September 2001 are flagrant examples of Respondent's fraud. Respondent prepared a bill for a surgery to Patient A's left leg on "4/9/01" and to her left foot on "4/26/01" (Ex. 8, p. 14). Respondent later prepared a bill for a surgery to Patient A's left leg on "9/9/01" and to her left foot on "9/26/01" (Ex. 8, p. 27). The number for the ninth month in the second bill is written more darkly and appears to have been written over the fourth month in the earlier bill. The two bills are identical is several aspects even down to the number of sutures required to repair the wound; all four surgical sites were closed with 20 sutures. Further evidence that these surgeries are fictitious is the fact that Respondent also alleged that he performed surgeries on Patient A's left lower extremity on April 16, 2001 and September 15, 2001. In spite of the record of three alleged surgeries in each of these two months, there

is no documentation that Respondent ever obtained a culture, checked the wound or removed any sutures.

Several other instances formed a basis for the Committee's inference that the surgeries on Patient A were fictitious. For example, the surgeries allegedly performed on December 14, 2001 (Ex. 8, pp. 53-55) and on January 2, 2002 (Ex. 8, pp. 57-59), are nearly identical. In each case, Respondent alleges to have excised a deep infected mass on Patient A's leg with mobilization of flaps for repair with rearrangement of flaps. Blue Cross/Blue Shield was billed $9800.00 for the first surgery and $7300.00 for the surgery performed on the same leg less than three weeks later.

In addition, the Hearing Committee finds that Respondent continued to represent himself as a Fellow of the American College of Surgeons after his expulsion in 1998 due to his nonpayment of dues. The Hearing Committee found that Respondent's testimony that he always believed dues were not required for membership lacked credibility, particularly in light of the fact that he had apparently maintained his membership from approximately 1981 until 1998. Moreover, his testimony regarding his belief that he had remained a Fellow of the American College of Surgeons for the past ten years was inconsistent with his testimony that he never went to their website, yet learned of conferences and meeting on the internet.

Based on the foregoing, the Hearing Committee unanimously

concluded that a preponderance of the evidence demonstrated that Respondent violated the terms of probation set forth in BPMC Order #99-150, as alleged in the Director's February 22, 2008 letter (Ex. 1).

DETERMINATION AS TO PENALTY

Petitioner recommended that Respondent's license be revoked and that a $100,000 fine be imposed. Respondent asked that the charges be dismissed in their entirety, contending that these proceedings demonstrated an intolerable practice by the Office of Professional Medical Conduct to press charges against "fully competent physicians who have reasonably and effectively provided their patients with proper, beneficial medical care using treatment modalities not universally accepted by the medical profession."

The Hearing Committee, pursuant to the Findings of fact and Conclusions of Law set forth above, unanimously concluded that Respondent's license to practice medicine in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

Respondent engaged in fraudulent conduct while on probation, and two previous attempts to rehabilitate his behavior

were unsuccessful. Respondent's total lack of integrity means that no sanction short of revocation will adequately protect the public. The Hearing Committee considered imposing the monetary penalty recommended by Petitioner in addition to revocation. Petitioner's recommendation for a monetary penalty, however, was based upon the number of specifications which potentially could have been written into a Statement of Charges. Since Petitioner did not commence this proceeding with a Statement of Charges and opted instead to proceed solely upon a Violation of Probation letter, the Hearing Committee did not assess any monetary penalty.

ORDER

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

1. The allegation of a violation of Respondent's terms of probation, as set forth in the February 22, 2008 letter of the Director of the Office of Professional Medical Conduct (Ex. 1) is **SUSTAINED**;

2. Respondent's license to practice medicine as a physician in New York State is hereby **REVOKED**;

3. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail,

whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: New York, New York
1/9 , 2009

Redacted Signature

JERRY WAISMAN (CHAIR)

STEVEN PINSKY, M.D.
JOAN MARTINEZ-McNICHOLAS

TO: Christine Radman, Esq.
Associate Counsel
New York State Department of Health
90 Church Street -4th Floor
New York, New York 10007

Prem Nath, M.D.

Redacted Address

Prem Nath, M.D.

Redacted Address

Anthony Z. Scher, Esq.
Wood & Scher, Esqs.
Co-counsel for Respondent
222 Bloomingdale Road - Suite 311
White Plains, New York 10605

Richard F.X. Guay, Esq.
Meyer, Suozzi, English & Klein, P.C.
Co-counsel for Respondent
1350 Broadway - Suite 501
New York, New York 10018-0822

APPENDIX I

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

..chard F. Daines, M.D.
Commissioner of Health

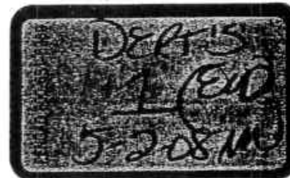
Wendy E. Saunders
Chief of Staff

February 22, 2008

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Prem Nath, M.D.

Redacted Address



Prem Nath, M.D.

Redacted Address

RE: **VIOLATION OF PROBATION**
BPMC Order No. 99-150

Dear Dr. Nath:

After an investigation pursuant to Section 230(19) of the Public Health Law, as Director of the Office of Professional Medical Conduct of the New York State Department of Health, I have determined that you have violated the terms of probation, specifically Paragraph One of Exhibit "B" of Consent Order Number 99-150 (hereinafter the "Order") imposed upon you by, attached and marked as "Appendix A," effective on or about July 7, 1999.

My conclusion that you have violated the term of your probation requiring that you conduct yourself in all ways in a manner befitting your professional status, conforming fully to the moral and professional standards of conduct and obligations imposed by law (including applicable Education Law sections) and by your profession is based on the information contained in "Appendix B."

This letter initiates a violation of probation proceeding against you pursuant to New York State Public Health Law Section 230(19). Please take notice that if you do not dispute the facts forming the basis of my determination within 20 days of the date of this letter, I shall submit this matter to a committee on professional conduct for its review and determination.

If within 20 days of the date of this letter you do dispute the facts forming the basis of my determination, you shall be afforded a hearing before a committee on professional conduct to

hear and make findings of fact, conclusions of law and a determination, during which you may be represented by counsel.

Since this violation of probation proceeding may result in a determination that your license to practice medicine in New York State be revoked, I urge you to consult with an attorney.

Sincerely,

Redacted Signature

Keith W. Servis
Director
Bureau of Professional Medical Conduct

Enclosures

cc: Anthony Z. Scher, Esq.
222 Bloomingdale Road, Suite 311
White Plains, N.Y. 10605

Christine Radman
Associate Counsel
NYS Department of Health
Division of Legal Affairs
90 Church Street, 4th Fl.
New York, NY 10007

APPENDIX A

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

IN THE MATTER OF PREM NATH, M.D.	CONSENT AGREEMENT AND ORDER BPMC #99-150

PREM NATH, M.D., (Respondent) deposes and says:

That on or about December 16, 1977, I was licensed to practice as a physician in the State of New York, having been issued License No. 133218 by the New York State Education Department.

My current address is Redacted Address and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I understand that the New York State Board for Professional Medical Conduct has charged me with 36 specifications of professional misconduct.

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

I admit guilt to the Twenty fourth through the Thirtieth Specifications, and I do not contest the Eleventh and Twelfth Specifications, in full satisfaction of the charges against me. I hereby agree to the following penalty:

> My medical license will be suspended for a period of thirty six months, with nine months actual suspension and the last twenty seven months stayed. The suspension shall commence upon the effective date of the Order herein. The terms of the suspension are more fully

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set forth in Exhibit "C", annexed hereto, which terms are made a part of this Order and which terms shall begin on the effective date of the Order herein. Following the nine month period of suspension and before I resume the private practice of medicine, I will complete an initial 500 hours of community service in a medical setting and as further provided in the terms and conditions as set forth in the Terms of Probation, annexed hereto as Exhibit "B", which terms are made a part of this Agreement and which terms shall begin on the effective date of the Order. Additionally, from the effective date of the Order herein, my practice of medicine in New York State shall be limited to exclude the practice of pain management, that is, a prohibition from treating patients with chronic pain. Following the 9 month period of suspension and for a period of five (5) years thereafter, I shall be placed on probation and my practice of medicine in New York State shall be monitored upon such terms and conditions as set forth in Exhibit B. I will also complete Continuing Medical Education courses as set forth in Exhibit B. Finally, I shall pay a $25,000 fine as set forth below:

FINE PAYMENTS

Unless otherwise specified herein, the fine is payable according to the following schedule:

a. $6,250.00 to be paid within thirty (30) days of the effective date of this Order;
b. $6,250.00 to be paid by November 15, 1999;
c. $6,250.00 to be paid by March 15, 2000; and
d. $6,250.00 to be paid by July 15, 2000.

Payments must be submitted to:

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

I further agree that the Consent Order for which I hereby apply shall impose the following conditions:

That, except during periods of actual suspension, Respondent shall maintain current registration of Respondent's license with the New York State Education Department Division of Professional Licensing Services, and pay all registration fees. This condition shall be in effect beginning thirty days after the effective date of the Consent Order and will continue while the licensee possesses his/her license; and

That Respondent shall fully cooperate in every respect with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigation of all matters regarding Respondent. Respondent shall respond in a timely manner to each and every request by OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall meet with a person designated by the Director of OPMC as directed. Respondent shall respond promptly and provide any and all documents and information within Respondent's control upon the direction of OPMC. This condition shall be in effect beginning

upon the effective date of the Consent Order and will continue while the licensee possesses his/her license.

I hereby stipulate that any failure by me to comply with such conditions shall constitute misconduct as defined by New York State Education Law §6530(29)(McKinney Supp. 1999).

I agree that in the event I am charged with professional misconduct in the future, this agreement and order shall be admitted into evidence in that proceeding.

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

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

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same. I agree that such order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to me at the address set forth in this agreement, or to my attorney, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this

matter without the various risks and burdens of a hearing on the merits, I knowingly waive any right I may have to contest the Consent Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted.

AFFIRMED:

DATED June 16, 1999

Redacted Signature

PREM NATH, M.D.
RESPONDENT

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

DATE: 6/17/99

Redacted Signature

ANTHONY Z. SCHER, Esq.
Attorney for Respondent

DATE: 6/21/99

Redacted Signature

MICHAEL HISER, Esq.
Associate Counsel
Bureau of Professional
Medical Conduct

DATE: 6/28/99

Redacted Signature

ANNE F. SAILE
Director
Office of Professional
Medical Conduct

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

IN THE MATTER OF PREM NATH, M.D.	CONSENT ORDER

Upon the proposed agreement of PREM NATH, M.D. (Respondent) for Consent Order, which application is made a part hereof, it is agreed to and

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

ORDERED, that this order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: 7/1/99

Redacted Signature

WILLIAM P. DILLON, M.D.
Chair
State Board for Professional Medical Conduct

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

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

IN THE MATTER	: STATEMENT
OF	: OF
PREM NATH, M.D.	: CHARGES

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

PREM NATH, M.D., the Respondent, was authorized to practice medicine in New York State on December 16, 1977 by the issuance of license number 133218 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department for the period April 1, 1998, through March 31, 2000.

FACTUAL ALLEGATIONS

A. At various times from on or about September 11, 1992 to on or about September 1997, Respondent provided medical care to Patient A (Patients are identified in the Appendix) at Respondent's office(s) at Route 32 and Shuit Valley, Central Valley, New York ("the Central Valley office"). Respondent's care and treatment failed to meet acceptable standards of medical care in that:

(10)

1. Respondent failed to prescribe and/or adequately document the prescription of non-narcotic analgesics for Patient A prior to prescribing narcotic analgesics.

2. Respondent failed to adequately explore or document alternative treatment modalities other than the use of controlled substances and/or failed to adequately consult with appropriate specialists.

3. Respondent failed to maintain an accurate record of medications prescribed for Patient A, including but not limited to, prescriptions for Lorcet, Percocet and Phenergan with Codeine.

4. Respondent prescribed controlled substances for Patient A, including but not limited to Lorcet, Percocet and Valium, in inappropriate dosages and for an excessive period of time.

5. Respondent, on numerous occasions, prescribed controlled substances to Patient A without adequate medical justification and/or failed to document such.

6. Respondent failed to manage, or treat Patient A's psychiatric problems or make a referral for such management or treatment and/or failed to adequately document such.

7. Respondent failed to follow up and/or document any follow up on an April 1994 thoracic surgeon recommendation and/or on tests recommended for anemia in March 1994 and/or failed to monitor the anemia and/or failed to adequately document such.

8. Respondent ordered excessive treatment of Patient A which was not warranted by her condition.

(11)

9. Respondent failed to provide and/or adequately document adequate and/or appropriate preventive health measures for Patient A.

10. Respondent, at various times from October 1993 through December 1996 intentionally misrepresented in writing the evaluation or treatment of Patient A as having occurred on a specific date or time when, in fact, the evaluation or treatment never occurred or occurred on a different date or time.

11. Respondent failed to maintain records for Patient A which adequately reflect the evaluation and treatment for Patient A.

12. Respondent, on numerous occasions, failed to document in Patient A's medical record his prescription(s) of controlled substances to Patient A.

B. At various times from on or about November 28, 1994 to on or about May 1996, Respondent provided medical care to Patient B at the Central Valley office. Respondent's care and treatment of Patient B. failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document a adequate medical history of Patient B.

2. Respondent, prescribed controlled substances to Patient B without adequate medical justification and/or failed to adequately document such.

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3. Respondent failed to adequately explore or document alternative treatment modalities other than the use of controlled substances and/or failed to adequately consult with appropriate specialists.

4. Respondent failed to appropriately monitor and/or document the monitoring of Patient B's ischemic heart disease and palpitations.

5. Respondent failed to provide and/or document adequate and/or appropriate preventive health measures for Patient B.

6. Respondent failed to provide and/or document adequate instructions to Patient B regarding pain management of herniated disc.

7. Respondent failed to maintain adequate records for Patient B which adequately reflect the evaluation and/or treatment for Patient B.

8. Respondent, on numerous occasions, failed to document in Patient B's medical record his prescription(s) of controlled substances to Patient B.

C. Respondent provided care to Patient C, date of birth, June 21, 1983, on or about October 6, 1993 to on or about February 8, 1996, at the Central Valley office. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care, in that:

(13)

1. Respondent failed to obtain and/or document an adequate

medical history of Patient C.

2. Respondent, at various times during the course of treatment, failed to perform and/or document the performance of an adequate physical examination of Patient C.
3. Respondent ordered excessive treatment of Patient C which was not warranted by his condition.
4. Respondent failed to follow up and/or appropriately treat recurrent Upper Respiratory Infections, failed to make an adequate referral for such and/or failed to adequately document such.
5. Respondent failed to adequately explore or document alternative treatment modalities other than the use of controlled substances and/or failed to adequately consult with appropriate specialists.
6. Respondent prescribed Phenergan with Codeine and Vicodin in inappropriate dosages for Patient C, for an excessive period, and /or without adequate justification and/or failed to document such.
7. Respondent failed to provide and/or document appropriate and adequate preventive health measures to Patient C.
8. Respondent failed to maintain adequate records for Patient C which adequately reflect the evaluation and/or treatment for Patient C.
9. Respondent, on numerous occasions, failed to record his prescriptions of controlled substance(s) to Patient C in Patient C's medical record.

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D. Respondent provided care to Patient D, date of birth November 13, 1981, from on or about November 8, 1993 to on or about February 8, 1996 at the Central Valley office. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history of Patint D, including failure to obtain a complete immunization record for Patient D.
2. Respondent, at various times during the course of treatment, failed to conduct and/or document an adequate physical examination of Patient D.
3. During the course of treatment, Respondent ordered excessive treatment for Patient D.
4. Respondent failed to follow up and/or evaluate the diagnosis of infectious mononucleosis, failed to treat recurrent Upper Respiratory Infections, failed to make an adequate referral for such and/or failed to adequately document such.
5. Respondent diagnosed Patient D with a migraine headache, with weight loss and with chronic fatigue syndrome without adequate justification and/or failed to adequately document such.
6. Respondent failed to provide and/or document adequate and/or appropriate preventive health measures to Patient D.
7. Respondent failed to adequately explore or document alternative treatment modalities other than the use of

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controlled substances and/or failed to adequately consult with appropriate specialists.

8. Respondent prescribed Phenergan with Codeine and Vicodin in inappropriate dosages for Patient D, for an excessive period, without adequate justification and/or failed to adequately document such.

9. Respondent inappropriately prescribed Ciprofloxacin to Patient D, given that Patient D was a child under the age of eighteen.

10. Respondent failed to maintain adequate records for Patient D which adequately reflect the evaluation and/or treatment for Patient D.

11. Respondent, on numerous occasions, failed to record his prescription(s) of controlled substances to Patient D in Patient D's medical record.

E. Respondent provided care to Patient E from on or about July 22, 1991 through on or about April 14, 1998, at the Central Valley office. Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate medical history of Patient E.

2. Respondent prescribed controlled substances, including Fiorinal and Vicodin, to Patient E without adequate medical justification, for an excessive period of time and/or failed to adequately document such.

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3. Respondent inappropriately prescribed Vicodin, Fiorinal and/or Phenergan with Codeine for Patient E contemporaneously and/or within the same or overlapping periods.

4. Respondent prescribed Zoloft for Patient E in inappropriate dosages.

5. Respondent prescribed controlled substances including Fiorinal, Vicodin and/or Phenergan with Codeine to Patient E without attempting other treatment modalities and/or failed to adequately document such.

6. Respondent diagnosed Patient E with Pyelonephritis and disc herniation without adequate medical justification and/or failed to adequately document such.

7. Respondent failed to timely refer Patient E to an expert in pain management and/or other modality to address pain management.

8. Respondent failed to follow up on the request(s) for chemical screens and/or failed to document such.

9. Respondent failed to provide and/or document appropriate preventive health measures to Patient E.

10. During the course of treatment, Respondent ordered excessive treatment for Patient E.

11. Respondent, at various times from August 1991 through on or about July 1997 intentionally misrepresented in writing the evaluation or treatment of Patient E as having occurred on a specific date or time when, in fact, the evaluation or treatment either never occurred or occurred at a different date and time.

(17)

12. Respondent failed to maintain records for Patient E which adequately reflect the evaluation and/or treatment of Patient E.

13. Respondent, on numerous occasions, failed to record his prescription(s) of controlled substances to Patient E in Patient E's medical record.

F. Respondent provided care to Patient F from on or about September 3, 1991 to on or about April 14, 1998, at the Central Valley office. Respondent's care and treatment of Patient F failed to meet acceptable standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate medical history of Patient F.
2. Respondent failed to adequately explore or document alternative treatment modalities other than the use of controlled substances and/or failed to adequately consult with appropriate specialists.
3. Respondent prescribed controlled substances including Vicodin, Fiorinal and/or Fioricet for Patient F without adequate medical justification, for an excessive period of time and/or failed to adequately document such.
4. Respondent failed to provide and/or document adequate or appropriate preventive health measures to Patient F.
5. Respondent prescribed Prozac without adequate medical justification and/or without appropriate discussion, and/or failed to document such.
6. Respondent failed to appropriately treat Patient F's

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hypertension and depression and/or failed to adequately document such.

7. Respondent failed to order a radiograph to view the ribs of Patient F on August 9, 1994 and/or failed to adequately document such.

8. Respondent prescribed antibiotics to treat upper respiratory infections without adequate medical justification and/or failed to adequately document such.

9. Respondent failed to appropriately treat Patient F's epididymitis and headache complaints, failed to order appropriate tests and/or failed to document such.

10. Respondent failed to timely refer Patient F to an expert in pain management and/or other modality to address pain management.

11. During the course of treatment, Respondent ordered excessive treatment for Patient F.

12. Respondent, at various time from October 1991 through on or about September 1997 intentionally misrepresented in writing the evaluation or treatment of Patient F as having occurred on a specific date or time when, in fact, the evaluation or treatment never occurred or occurred at a different date or time.

13. Respondent failed to maintain records for Patient F which adequately reflect the evaluation and treatment of Patient F.

14. Respondent, on numerous occasions, failed to record his prescription(s) of controlled substances to Patient F

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in Patient F's medical record.

G. At various times, from on or about January 1998 to on or about May 22, 1998, Respondent provided medical care to Patient G at Respondent's Central Valley office. Respondent's care and treatment of Patient G failed to meet acceptable standards of medical care, in that:

1. Respondent, on or about January 16, January 22, March 13 and/or April 24, 1998, intentionally misrepresented in writing the evaluation or treatment of Patient G as having occurred on a specific date or time when, in fact, the evaluation or treatment never occurred or occurred at a different date or time.
2. Respondent failed to perform an initial physical examination of Patient G.
3. Respondent failed to obtain an adequate medical history from Patient G.
4. Respondent provided and/or prescribed controlled substances to Patient G without adequate medical justification.
5. Respondent failed to provide appropriate health maintenance to Patient G and/or failed to adequately document such.

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SPECIFICATIONS

FIRST THROUGH SEVENTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with having committed professional misconduct under N.Y. Education Law §6530(4) by reason of his having practiced the profession with gross negligence on a particular occasion, in that Petitioner charges:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.4, A and A.5, A and A.6, A and A.7, A and A.10, A and A.11, and/or A and A.12.
2. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.7, and/or B and B.8.
3. The facts in Paragraphs C and C.1, C and C.2, C and C.3, C and C.5, C and C.6, and/or C and C.9.
4. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.6, D and D.7, D and D.8, D and D.10, and/or D and D.11.
5. The facts in Paragraphs E and E.1, E and E.2, E and E.5, E and E.6, E and E.7, E and E.9, E and E.11, E and E.12, and/or E and E.13.
6. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.10, F and F.12, F and F.13, and/or F and F.14.
7. The facts in Paragraphs G and G.1, G and G.2, G and G.3, and/or G and G.4.

EIGHTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with having committed professional misconduct under N.Y. Education Law §6530(3) by reason of having practiced the profession with negligence on more than one occasion, in that Petitioner charges that Respondent committed at

least two of the following:

8. The facts in Paragraphs A and A.1, A and A.2, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, A and A.11, and/or A and A.12, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, D and D.10, D and D.11, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, E and E.13, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.10, F and F.11, F and F.12, F and F.13, F and F.14, G and G.1, G and G.2, G and G.3, G and G.4, and/or G and G.5.

NINTH THROUGH FIFTEENTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Respondent is charged with having committed professional misconduct under N.Y. Education Law §6530(6) by reason of his having practiced the profession with gross incompetence in that Petitioner charges:

9. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.10, A and A.11, and/or A and A.12

10. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.7, and/or B and B.8.

11. The facts in Paragraphs C and C.1, C and C.2, C and C.3, C and C.5, C and C.6, and/or C and C.9.

12. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.6, D and D.7, D and D.8, D and D.10, and/or D and D.11.

13. The facts in Paragraphs E and E.1, E and E.2, E and E.5, E and E.6, E and E.7, E and E.9, E and E.11, E and E.12, and/or E and E.13.

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14. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.10, F and F.12, F and F.13, and/or F and F.14.

15. The facts in Paragraphs G and G.1, G and G.2, G and G.3, and/or G and G.4.

SIXTEENTH SPECIFICATION

PRACTICING THE PROFESSION WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with having committed professional misconduct under N.Y. Education Law §6530(5) by reason of having practiced the profession with incompetence on more than one occasion, in that Petitioner charges that Respondent committed at least two of the following:

16. The facts in Paragraphs A and A.1, A and A.2, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, A and A.11, and/or A and A.12, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, D and D.10, D and D.11, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, E and E.13, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.10, F and F.11, F and F.12, F and F.13, F and F.14, G and G.1, G and G.2, G and G.3, G and G.4, and/or G and G.5.

SEVENTEENTH THROUGH TWENTY-THIRD SPECIFICATIONS

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with having committed professional misconduct under N.Y. Education Law §6530(2) by reason of having

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practiced the profession fraudulently or beyond its authorized scope, in that Petitioner charges:

17. The facts in Paragraphs A and A.3, A and A.5, A and A.8, A and A.10, A and A.11 and/or A and A.12.

18. The facts in Paragraphs B and B.2, B and B.7 and/or B and B.8.

19. The facts in Paragraphs C and C.3, C and C.8 and/or C.9.

20. The facts in Paragraphs D and D.3, D and D.5, D and D.10 and/or D and D.11.

21. The facts in Paragraphs E and E.2, E and E.3, E and E.10, E and E.11, E and E.12, and/or E and E.13.

22. The facts in Paragraphs F and F.3, F and F.5, F and F.8, F and F.11, F and F.12, F and F.13, and/or F and F.14.

23. The facts in Paragraphs G and G.1, G and G.2, G and G.3, and/or G and G.4.

TWENTY FOURTH THROUGH THIRTIETH SPECIFICATIONS

FAILING TO MAINTAIN ADEQUATE RECORDS

Respondent is charged with having committed professional misconduct under N.Y. Education Law §6530(32) by reason of having failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient, in that Petitioner charges:

24. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.5, A and A.6, A and A.7, A and A.9, A and A.10, A and A.11, and/or A and A.12.

25. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, and/or B and B.8.

26. The facts in Paragraphs C and C.1, C and C.2, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8 and/or C and C.9.

27. The facts in Paragraphs D and D.1, D and D.2, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.10, and/or D and D.11.

28. The facts in Paragraphs E and E.1, E and E.2, E and E.5, E and E.6, E and E.8, E and E.9, E and E.10., E and E.11 and/or E and E.12.

29. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.11, F and F.12, and/or F and F.13.

30. The facts in Paragraphs G and G.1, G and G.2, G and G.4, and/or G and G.5.

THIRTY-FIRST THROUGH THIRTY-SIXTH SPECIFICATIONS

ORDERING OF EXCESSIVE TREATMENT

Respondent is charged with having committed professional misconduct under N.Y. Education Law §6530(35) by reason of his having ordered excessive treatment not warranted by the condition of the patient, in that Petitioner charges:

31. The facts in Paragraphs A and A.4 and/or A and A.8.

32. The facts in Paragraphs C and C.3, and/or C and C.6.

33. The facts in Paragraphs D and D.3, D and D.5, and/or D and D.8.

34. The facts in Paragraphs E and E.2, E and E.3, E and E.4, and/or E and E.10.

35. The facts in Paragraphs F and F.3, F and F.5, and/or F. and F.11.

36. The facts in Paragraphs G and G.4.

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DATED: April 7, 1999
Albany, New York

Redacted Signature

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

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EXHIBIT "B"

TERMS OF PROBATION

1. Respondent shall conduct himself/herself in all ways in a manner befitting his/her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director of the Office of Professional Medical Conduct, New York State Department of Health, 433 River Street, Suite 303, Troy, NY 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. 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 section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].

4. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

5. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

6. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

CONTINUING MEDICAL EDUCATION

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7. Respondent shall enroll in and complete a continuing medical education program in the areas of (1) medical record documentation and (2) the principles of family practice, equivalent to at least 30 credit hours each year over a three year

period. Said continuing education program shall be subject to the prior written approval of the Director of OPMC and be completed within the first three years of probation.

COMMUNITY/PUBLIC SERVICE

8. Respondent shall perform 1000 hours of community service. The service must be medical in nature, and delivered in a facility or with an organization equipped to provide medical services and serving a needy or medically underserved population. A written proposal for community service must be submitted to, and is subject to the written approval of the Director of OPMC. Community service performed prior to written approval shall not be credited toward compliance with this Order. The initial five hundred (500) hours of this requirement must be performed immediately following the nine month suspension period. Respondent may not resume the private practice of medicine or the practice of medicine for compensation until the initial 500 hour requirement is satisfied. Thereafter, Respondent shall complete the balance of 500 hours of community service over the next two years, as measured from the time that Respondent again begins the private practice of medicine or the practice of medicine for compensation.

PRACTICE MONITOR

9. Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

   a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no less than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

   b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

   c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

   d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of

OPMC prior to Respondent's practice after the effective date of this Order.

At the conclusion of Respondent's third year of monitoring, Respondent may petition the Director to evaluate his medical practice and the need for continuation of a practice monitor and may request that such monitoring be terminated. Any determination by the Director to discontinue monitoring at that time is subject to the full discretion of the Director.

10. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

EXHIBIT C

TERMS OF SUSPENSION

1. Respondent shall immediately cease and desist from engaging in the practice of medicine in accordance with the terms of the Order. In addition, Respondent shall refrain from providing an opinion as to professional practice or its application and from representing himself as being eligible to practice medicine during the period of actual suspension.

2. Respondent shall have delivered to OPMC at Hedley Park Place, 433 River Street 4th Floor, Troy, NY 12180-2299 his original license to practice medicine in New York State and current biennial registration within thirty (30) days of the effective date of the Order.

3. Respondent shall within fifteen (15) days of the Order notify his patients of the suspension of his medical practice and will refer all patients to another licensed practicing physician for their continued care, as appropriate.

4. Respondent shall make arrangements for the transfer or maintenance of the medical records of his patients (including maintenance of the medical records by Respondent). Within thirty days of the effective date of the Order, Respondent shall notify OPMC of these arrangements including the appropriate and acceptable contact person's name, address, and telephone number who shall have access to these records. Original records shall be retained for at least six years after the last date of service rendered to a patient or, in the case of a minor, for at least six years after the last date of service or three years after the patient reaches the age of majority whichever time period is longer. Records shall be maintained in a safe and secure place which is reasonably accessible to former patients. The arrangements shall include provisions to ensure that the information on the record is kept confidential and made available only to authorized persons. When a patient or and/or his or her representative requests a copy of the patient's medical record or requests that the original medical record be forwarded to another health care provider, a copy of the record shall be promptly provided or forwarded at a reasonable cost to the patient (not to exceed seventy-five cents per page.) Radiographic, sonographic and like materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of their inability to pay.

5. Respondent shall not charge, receive or share any fee or distribution of dividends for professional services rendered by himself or others while barred from engaging in the practice of medicine. Respondent may be compensated for the reasonable value of services lawfully rendered and disbursements incurred on a patient's behalf prior to the effective date of this Order.

6. If Respondent is a shareholder in any professional service corporation organized to engage in the practice of medicine and if his license is revoked, surrendered or suspended for a term of six months or more under the terms of this Order, Respondent shall divest himself of all financial interest in the professional services corporation in accordance with New York Business Corporation Law. Such divesture shall occur within 90 days. If Respondent is the sole shareholder in a professional services corporation, the corporation must be dissolved or sold within ninety (90) days of the effective date of this Order.

7. Failure to comply with the above directives may result in a civil penalty or further criminal penalties as may be authorized pursuant to the law. Under Section 6512 of the Education Law it is a Class E Felony, punishable by imprisonment of up to 4 years, to practice the profession of medicine when such professional license has been suspended, revoked or annulled. Such punishment is in addition to the penalties for professional misconduct set forth in section 230-a of the Public Health Law, which includes fines of up to $10,000 for each specification of charges of which the Respondent is found guilty and may include revocation of a suspended license.

APPENDIX B

1. On or about the enumerated dates below, you deviated from the minimally acceptable standard of care by failing to appropriately diagnose Patient A's condition:

   a. January 8, 2001
   b. February 9, 2001
   c. March 12, 2001
   d. April 9, 2001
   e. April 16, 2001
   f. April 26, 2001
   g. July 6, 2001
   h. August 11, 2001
   i. September 9, 2001
   j. September 15, 2001
   k. September 26, 2001
   l. October 10, 2001
   m. October 31, 2001
   n. November 23, 2001
   o. December 14, 2001
   p. January 2, 2002
   q. February 6, 2002
   r. April 10, 2002
   s. May 3, 2002
   t. May 31, 2002
   u. June 21, 2002
   v. November 6, 2002
   w. December 20, 2002
   x. January 31, 2003
   y. July 7, 2003
   z. August 13, 2003
   a1. October 1, 2003
   b1. November 3, 2003
   c1. December 15, 2003
   d1. February 13, 2004

2. On or about the enumerated dates below, you deviated from the minimally acceptable standard of care by failing to appropriately treat Patient A:

   a. January 8, 2001
   b. February 9, 2001
   c. March 12, 2001
   d. April 9, 2001
   e. April 16, 2001

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f. April 26, 2001
g. July 6, 2001
h. August 11, 2001
i. September 9, 2001
j. September 15, 2001
k. September 26, 2001
l. October 10, 2001
m. October 31, 2001
n. November 23, 2001
o. December 14, 2001
p. January 2, 2002
q. February 6, 2002
r. April 10, 2002
s. May 3, 2002
t. May 31, 2002
u. June 21, 2002
v. November 6, 2002
w. December 20, 2002
x. January 31, 2003
y. July 7, 2003
z. August 13, 2003
a1. October 1, 2003
b1. November 3, 2003
c1. December 15, 2003
d1. February 13, 2004

3. On or about the enumerated dates below, you deviated from the minimally acceptable standard of care by failing to appropriately provide post-surgical care to Patient A:

a. January 8, 2001
b. February 9, 2001
c. March 12, 2001
d. April 9, 2001
e. April 16, 2001
f. April 26, 2001
g. July 6, 2001
h. August 11, 2001
i. September 9, 2001
j. September 15, 2001
k. September 26, 2001
l. October 10, 2001
m. October 31, 2001
n. November 23, 2001
o. December 14, 2001

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p. January 2, 2002
q. February 6, 2002
r. April 10, 2002
s. May 3, 2002
t. May 31, 2002
u. June 21, 2002
v. November 6, 2002
w. December 20, 2002
x. January 31, 2003
y. July 7, 2003
z. August 13, 2003
a1. October 1, 2003
b1. November 3, 2003
c1. December 15, 2003
d1. February 13, 2004

4. For each and every date of service enumerated below, you knowingly and intentionally prepared and supplied bills for surgery to Blue Cross/Blue Shield of New Jersey for Patient A, which you knew to be false:

a. January 8, 2001
b. February 9, 2001
c. March 12, 2001
d. April 9, 2001
e. April 16, 2001
f. April 26, 2001
g. July 6, 2001
h. August 11, 2001
i. September 9, 2001
j. September 15, 2001
k. September 26, 2001
l. October 10, 2001
m. October 31, 2001
n. November 23, 2001
o. December 14, 2001
p. January 2, 2002
q. February 6, 2002
r. April 10, 2002
s. May 3, 2002
t. May 31, 2002
u. June 21, 2002
v. November 6, 2002
w. December 20, 2002
x. January 31, 2003
y. July 7, 2003

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a1. October 1, 2003
b1. November 3, 2003
c1. December 15, 2003
d1. February 13, 2004

5. For each and every date of service enumerated below, you knowingly and intentionally prepared and supplied bills for surgery to Blue Cross/Blue Shield of New Jersey for Patient A, which you knew to be false, with the intent to deceive:

a. January 8, 2001
b. February 9, 2001
c. March 12, 2001
d. April 9, 2001
e. April 16, 2001
f. April 26, 2001
g. July 6, 2001
h. August 11, 2001
i. September 9, 2001
j. September 15, 2001
k. September 26, 2001
l. October 10, 2001
m. October 31, 2001
n. November 23, 2001
o. December 14, 2001
p. January 2, 2002
q. February 6, 2002
r. April 10, 2002
s. May 3, 2002
t. May 31, 2002
u. June 21, 2002
v. November 6, 2002
w. December 20, 2002
x. January 31, 2003
y. July 7, 2003
a1. October 1, 2003
b1. November 3, 2003
c1. December 15, 2003
d1. February 13, 2004

…aragraph #6. …dded by amendment …n 9/25/08 W.L.

6. You were expelled from the American College of Surgeons effective …ctober 23, 1998, yet have consistently continued to use that designation in …orrespondence with public and private entities and individuals, including but not limited …o New York State Physician Profile and OPMC Physician Monitoring Program.

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

IN THE MATTER OF PREM NATH, M.D.	NOTICE OF VIOLATION OF PROBATION PROCEEDING

TO: PREM NATH
12 Calvin Street
Blauvelt, New York 10913

PLEASE TAKE NOTICE:

In response to your request for a hearing pursuant to the provisions of New York Public Health Law §230(19), a Violation of Probation Proceeding will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The proceeding will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on May 13, 2008, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, N.Y., N.Y. 10007, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON.JAMES F. HORAN, DIRECTOR, BUREAU OF

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ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10), you may file an Answer no less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, §51.5(c) requires that an answer be filed, but allows the filing of such answer up until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken, based, inter alia, upon any violation found and upon the misconduct resulting in the imposition of the terms of probation. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A

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DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
March 10, 2008

Redacted Signature

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Christine M. Radman
Associate Counsel
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, N.Y. 10007
(212)417-4450

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SECURITY NOTICE TO THE LICENSEE

The proceeding will be held in a secure building with restricted access. Only individuals whose names are on a list of authorized visitors for the day will be admitted to the building.

No individual's name will be placed on the list of authorized visitors unless written notice of that individual's name is provided by the licensee or the licensee's attorney to one of the Department offices listed below.

The written notice may be sent via facsimile transmission, or any form of mail, but must be received by the Department **no less than two days prior to the date of the proceeding.** The notice must be on the letterhead of the licensee or the licensee's attorney, must be signed by the licensee or the licensee's attorney, and must include the following information:

Licensee's Name________________ Date of Proceeding________

Name of person to be admitted_________________________________

Status of person to be admitted_______________________________
(Licensee, Attorney, Member of Law Firm, Witness, etc.)

____
Signature (of licensee or licensee's attorney)

This written notice must be sent to:

New York State Health Department
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor South
Troy, NY 12180
Fax: 518-402-0751

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Prem Nath, M.D.
Skyview Plaza
Route 59 - Suite 25
9 Ingalls Street
Central Nyack, NY 10960
Phone: (845) 641-6778

NYS DEPT. OF HEALTH
DIVISION OF LEGAL AFFAIRS-NYC
PROFESSIONAL MEDICAL CONDUCT
MAR 12 2008
RECEIVED

March 10, 2008

By: Overnight Delivery
Mr. Keith W. Servis
New York State Department of Health
Office of Professional Medical Conduct
433 River Street, Suite 303
Troy, NY 12180

RE: Alleged Violation of Probation
BPMC Order No.: 99-150

Dear Mr. Servis,

I am in receipt of you letter dated February 22, 2008 which initiates a violation of probation proceeding against me. Please be advised that I dispute each and every fact contained in Appendix B to your letter. I also dispute that I violated the terms of probation set forth in Consent Order Number 99-150.

Accordingly, I request a hearing.

Very truly yours,

Prem Nath, M.D.

Cc: Christine Radman, Esq.
Associate Counsel
NYS Department of Health
Division of Legal Affairs
90 Church Street, 4th Fl.
New York, NY 10007

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