NEW YORK
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HEALTH

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Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

October 2, 2014

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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

Nathan L. Dembin, Esq.
Nathan L. Dembin & Associates, P.C.
1123 Broadway – Suite 1117
New York, New York 10010

RE: In the Matter of Surinder Jindal, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 14-243) 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.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2013) and §230-c subdivisions 1 through 5, (McKinney Supp. 2013), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

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., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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
James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cah

Enclosure

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

COPY

IN THE MATTER OF SURINDER JINDAL, M.D.	DETERMINATION AND ORDER BPMC #14-243

A Notice of Hearing and Statement of Charges, both dated June 4, 2013, were served upon **SURINDER JINDAL, M.D.** ("Respondent"). **JERRY WAISMAN, M.D.**, Chairperson, **JAY A. ROSENBLUM, M.D.**, and **CONSTANCE DIAMOND, D.A.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) of the Public Health Law of the State of New York ("Public Health Law"). **WILLIAM J. LYNCH, ESQ., ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer.

The Department of Health, Office of Professional Medical Conduct ("Petitioner" or "Department") appeared by JAMES E. DERING, General Counsel, by **LESLIE EISENBERG, ESQ.**, of Counsel. The Respondent was represented by Nathan L. Dembin & Associates, P.C., by **NATHAN L. DEMBIN, ESQ.** Evidence was received, witnesses sworn and heard, and transcripts of the proceedings were made.

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

PROCEDURAL HISTORY

Pre-Hearing Conference:	July 2, 2013
Hearing Dates:	September 23, 2013 November 4, 2013 November 18, 2013 January 14, 2014 January 21, 2014 March 6, 2014 March 27, 2014 April 3, 2014 May 22, 2014
Witness for the Petitioner:	Dale J. Lange, M.D.
Witnesses for the Respondent:	Michael Rubin, M.D. Stephen J. Marks, M.D. Surinder Jindal, M.D.
Deliberations Held:	July 15, 2014 July 30, 2014

STATEMENT OF CASE

The Respondent is charged with thirty-two specifications of professional misconduct, as defined in § 6530 of the Education Law of the State of New York ("Education Law"). A copy of the Statement of Charges is 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 the Respondent, the Hearing Committee hereby makes the following findings of fact:

1. The Respondent was authorized to practice medicine in New York State on December 21, 1987 by issuance of license number 173284 (Department Ex. 2).

2. The Respondent treated Patient A between June 3, 2003 and January 30, 2004, as a neurology consultant for injuries related to a motor vehicle accident that occurred on May 22, 2003 (Department Ex. 3).

3. The Respondent treated Patient B between January 17, 2000 and June 16, 2000, as a neurology consultant for injuries related to a motor vehicle accident that occurred on January 9, 2000 (Department Ex. 4).

4. The Respondent treated Patient C between January 18, 2001 and July 19, 2001, as a neurology consultant for injuries related to a motor vehicle accident that occurred on August 18, 2000 (Department Ex. 5).

5. The Respondent treated Patient D between October 26, 2000 and November 3, 2000, as a neurology consultant for injuries related to a

motor vehicle accident that occurred on October 21, 2000 (Department Ex. 6).

6. The Respondent treated Patient E between May 25, 1999 and July 27, 1999, as a neurology consultant for injuries related to a motor vehicle accident that occurred on April 18, 1999 (Department Ex. 7).

7. The Respondent treated Patient F between December 14, 2001 and January 9, 2004, as a neurology consultant for injuries related to motor vehicle accidents that on occurred September 20, 2001, August 20, 2002, and November 20, 2003 (Department Ex. 8).

8. The Respondent treated Patient G between October 26, 2000 and November 30, 2000, as a neurology consultant for injuries related to a motor vehicle accident that occurred on October 21, 2000 (Department Ex. 9).

9. The Respondent treated Patient H between January 24, 2001 and May 24, 2001, as a neurology consultant for injuries related to a motor vehicle accident that occurred on December 22, 2000 (Department Ex 10).

10. The Respondent treated Patient I between February 27, 2004 and December 7, 2004, as a neurology consultant for injuries related to a motor vehicle accident that occurred on January 14, 2003 (Department Ex. 11).

11. The Respondent treated Patient J between June 26, 2003 and June 11, 2004, as a neurology consultant for injuries related to a motor

vehicle accident that occurred on February 24, 2003 (Department Ex. 12).

12. As required by the Public Health Law, the Respondent maintained his medical records for Patients A through H for six years subsequent to his last patient encounter with them. However, he had already shredded their records when the Petitioner interviewed him about his care of these patients (T. 1156-1163).

13. On March 6, 2008, Respondent provided a copy of his medical records for Patients I and J to the Petitioner which are in evidence. (Department Ex. 11 and 12).

14. The Respondent has a reputation in the community for competence, compassion and integrity (T. 1093-1119; Respondent Ex. P).

DISCUSSION AND CONCLUSIONS OF LAW

As required by § 230(10)(f) of the Public Health Law, the Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Statement of Charges were more probable than not. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department (see Prince, Richardson on Evidence § 3-206 [R. Farrell 11th ed. 1995]). Having considered the complete record in this matter, the Hearing Committee concludes that the Department has proved

none of the charges against Respondent by a preponderance of the evidence.

The charges in this matter are based on records of the medical care the Respondent provided to ten patients as a neurology consultant for injuries arising from motor vehicle accidents. The Petitioner sent records of the Respondent's treatment of several patients to its expert witness, Dale Lange, M.D., for a review and opinion as to whether the Respondent had practiced within acceptable medical standards.

In February 2009, Dr. Lange submitted a written report which in summary stated

> Opinion on adequacy of care: Given the several unusual features as noted in the EMG and nerve conduction studies, waveforms are necessary to formulate and opine about the standard of care. Without the waveforms and the inconsistencies as noted above, it is my medical opinion that Dr. Jindal has indeed deviated from minimally accepted standards of treatment in each of the cases because of the lack of providing supportive documentation to support the unusual pattern of findings. Further, the format of reporting the results does not conform to current standards of practice (Department Ex. 17).

Two of the patients from that review are included in the charges of this proceeding: Patient I who was treated by the Respondent in 2004, and Patient J who was treated by the Respondent in 2003 and 2004. The Respondent's medical record for these patients are in evidence as Department Exhibits 11 and 12.

The Petitioner then sent Dr. Lange records of the Respondent's treatment for several more patients for a review and opinion. In December 2011, Dr. Lange submitted a second written report which reviewed the Respondent's care of those patients. In his clinical summary, Dr. Lange stated

> It is standard medical practice to ensure that each patient has a unique encounter with the physician and that unique encounter is accurately reflected in the data. The repetition of phrases in the history and examination, follow up encounters, statements in the medical examination that are identical in multiple patients, and recurrence of the same numbers in the exam (e.g. straight leg raising) and diagnostic procedures and the simplistic delivery of a diagnosis without any attempt to synthesize history and examination raises the concern that the uniqueness of the encounter was compromised (Department Exhibit 16)

Eight of the patients from that review are included in the charges of this proceeding: Patient E who was treated in 1999; Patients B, D and G who were treated in 2000; Patients C and H who were treated in 2001; Patient F who was treated in 2001 and 2004; and Patient A who was treated in 2003 and 2004.

The Petitioner never obtained a copy of the Respondent's medical records for these latter eight patients (Patients A through H). Instead, the Petitioner obtained only a copy of the medical information that an insurance company had received from the Respondent. At his interview and the hearing, the Respondent asserted that his practice was to shred his medical records of patients whose last encounter was more than six

years prior as is appropriate under New York State's record retention statute. Therefore, his medical records for eight of the ten patients charged were no longer available.

The Department contended that the records received from the insurance company regarding Patients A through H were copies of the Respondent's complete medical records for those patients because the records looked the same as the records received from the Respondent's office for Patients I and J which were certified by his office as complete. The Hearing Committee, however, was not persuaded that the similarity of the records established that the insurance company documents for Patients A through H in evidence in this proceeding were the Respondent's complete medical records for those patients.

Based on the Petitioner's having sought Dr. Lange's opinion regarding several more patients after his initial 2009 report, the Hearing Committee inferred that the Petitioner decided that further investigation of the Respondent's practice was warranted. If that was the case, the Committee could not fathom a reason for the Petitioner's having obtained a second review related to the Respondent's medical care of patients dating back a decade or more instead of looking forward at the Respondent's more recent practice of medicine. The Hearing Committee understands that no statute of limitations prevents the prosecution of misconduct charges against a physician, but the age of the charges related to Patients A through H made it permissible for the

Respondent to have shredded those medical records and plausible that he would have a limited recollection of his encounters with the patients, particularly in a situation such as this where there is no allegation of any patient harm.

The Department claimed that the Hearing Committee should find that Respondent fraudulently billed an insurance company for the highest level of reimbursement for patient encounters which merited reimbursement at a much lower rate. One of the Hearing Committee members raised the possibility that the Respondent was operating a neurology consultant mill in which he hurriedly evaluated a large number of upstate automobile injured patients on a daily basis, but charged the insurance companies for thorough patient consultations. After some discussion, the Committee unanimously agreed that the evidence did not establish that possibility. In any event, the insurance company in each instance had the option of denying a claim if it was not supported by the Respondent's medical record submission, but there was no evidence at the hearing that one of Respondent's claims remained unpaid or had been reduced to a lower level of reimbursement.

The Hearing Committee's determination regarding the credibility of the expert witnesses called to testify by the Department and Respondent was the single most significant factor in reaching its conclusions. The Department offered the testimony of Dr. Lange who is board certified in neurology and is the Chairman of the Department of Neurology at the

Hospital for Special Surgery in New York City. The Respondent provided the testimony of Dr. Rubin who is also board certified in neurology and is a Professor of Clinical Neurology at Weill Cornell Medical College. Although the parties' two opposing expert opinions could not be reconciled, the Hearing Committee determined that both of these expert witnesses were well qualified, and that they both testified honestly. The experienced members of the Hearing Committee could not recall a prior hearing where two credible expert witnesses had such opposing opinions. The Hearing Committee decided that neither expert opinion was entitled to greater weight than the other. Since the opinions had equal weight, the Department did not meet its burden of proof by a preponderance of the evidence.

The information contained in the patient histories, physical examinations and diagnostic studies of the ten patients is indisputably similar. The Department's expert testified that the constancy of the numbers seen in Respondent's NCS and EMG reports for the ten patients is not possible. Based on this testimony, the Department argued that the similarity of the patient information and data from the diagnostic tests could mean that either Respondent did not perform the examinations and tests or he performed them inadequately. However, Respondent's expert countered that all of the cases involved patients who had suffered an injury in an automobile accident so the similarity of information was not surprising and the similarity of the numbers in the

testing data was unusual, but not impossible. He further stated the similarity of the data could be accounted for by the Respondent having rounded out the numbers which generally indicated normal values.

Both the Department and the Respondent spent an inordinate amount of time at the hearing on whether the Respondent was required to maintain copies of the wave forms from his diagnostic testing of these patients. While it is true that if Respondent had copies of the wave forms then he would have further evidence that he performed the diagnostic tests, the converse is not true. Since a physician is not required to maintain copies of the wave forms, their unavailability is not proof that the diagnostic tests were not performed.

The Respondent testified himself. He has an obvious stake in the outcome of this proceeding which could provide a motivation to testify falsely, and his routine shredding of records even after he became aware that he was under investigation raised a suspicion that he intentionally destroyed records to conceal his conduct rather than merely maintain a standard record retention policy. Since a physician is required to maintain patient records for only six years, the Hearing Committee accepted his having shredded his records for Patients A through H. However, the Respondent also shredded his copy of the records for Patient I and J, including his billing records, when he knew that the Petitioner was investigating his care of those two patients. He also shredded his appointment books and sign-in sheets which would have

required a calculation of the six year period from the last encounter with each of the patients on the sign-in sheet or in appointment book. On the other hand, the Respondent offered the testimony of the physician who is the Director of the student teaching for the neurology department at Westchester Medical Center and a letter from the Dutchess County Medical Society which established that he had a reputation in the medical community for integrity, compassion and competence.

Having considered the complete record in the matter, the Hearing Committee concludes that none of the charges against the Respondent have been established by a preponderance of the evidence. The Hearing Committee made these conclusions of law pursuant to the factual findings listed above, and all conclusions resulted from a unanimous vote of the Hearing Committee.

ORDER

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

1. The thirty-two specifications of professional misconduct set forth in the Statement of Charges are **DISMISSED**;

2. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon the Respondent at his 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
Sept. 30, 2014

REDACTED

JERRY WAISMAN, M.D. (CHAIR)

JAY A. ROSENBLUM, M.D.
CONSTANCE DIAMOND, D.A.

TO: Leslie Eisenberg, Esq.
Associate Counsel
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, New York 10007

Nathan L. Dembin, Esq.
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1123 Broadway, Suite 1117
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APPENDIX I

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

IN THE MATTER

OF

SURINDER JINDAL, M.D.

STATEMENT

OF

CHARGES

Surinder Jindal, M.D., the Respondent, was authorized to practice medicine in New York State on or about December 21, 1987, by the issuance of license number 173284 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A between June 3, 2003 and January 30, 2004, as a neurology consultant for injuries related to a motor vehicle accident that occurred on May 22, 2003. During the course of treatment, Respondent performed nerve conduction studies (NCS), a needle electromyography (EMG), an electroencephalogram (EEG) and, Somato-Sensory Evoked Potentials (SSEP). (Patient names are set forth in Appendix A attached). Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to take and note an adequate history.

2. Respondent purportedly performed physical examinations on or about June 3, 2003, June 17, 2003, July1, 2003, July 29, 2003, August 26, 2003, September 26, 2003, October 24, 2003, November 21, 2003, December 19, 2003, and January 30, 2004.

   a. Respondent did not, in fact, perform the physical examinations as noted. Respondent falsely charted and falsely billed for physical examinations on each of those occasions, intending to mislead.

b. In the event that the physical examinations were in fact performed as charted, they were inadequate.

3. Respondent purportedly performed an EMG on July 1, 2003, and SSEP on July 29, 2003.

a. Respondent did not, in fact, perform the tests. Respondent falsely charted purported results of the tests, and falsely billed intending to mislead.

b. In the event that the tests were in fact performed, Respondent failed to maintain a record of waveforms and failed to adequately interpret the results and failed to appropriately incorporate those results into the patient's evaluation and treatment.

4. Respondent submitted bills for reimbursement for which he was not entitled.

a. Respondent did so knowingly, intending to mislead.

5. Respondent failed to maintain medical records that accurately reflect the care and treatment rendered to this patient.

B. Respondent treated Patient B between January 17, 2000 and June 16, 2000, as a neurology consultant for injuries related to a motor vehicle accident that occurred on January 9, 2000. During the course of treatment Respondent performed NCS and EMG. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to take and note an adequate history.

2. Respondent purportedly performed physical examinations on or about January 17, 2000, February 2, 2000, February 10, 2000, March 13, 2000, March 31, 2000, May 15, 2000 and, June 16, 2000.

a. Respondent did not, in fact, perform the physical examinations as noted. Respondent falsely charted and falsely billed for physical examinations on each of these occasions, intending to mislead.

b. In the event that the physical examinations were in fact performed as charted, they were inadequate.

3. Respondent purportedly performed EMGs on February 2, 2000, and on February 10, 2000.

a. Respondent did not, in fact, perform the tests. Respondent falsely charted purported results of the tests, and falsely billed, intending to mislead.

b. In the event that the tests were in fact performed, Respondent failed to maintain a record of waveforms, and failed to adequately interpret the results and failed to appropriately incorporate those results into the patient's evaluation and treatment.

4. Respondent submitted bills for reimbursement for which he was not entitled.

a. Respondent did so, intending to mislead.

5. Respondent failed to maintain medical records that accurately reflect the care and treatment rendered to this patient.

C. Respondent treated Patient C between January 18, 2001 and July 19, 2001, as a neurology consultant for injuries related to a motor vehicle accident that occurred on August 18, 2000. During the course of treatment Respondent performed NCS, EMG, EEG and, SSEP. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to take and note an adequate history.

2. Respondent purportedly performed physical examinations on or about January 18, 2001, January 23, 2001, January 24, 2001, February 7, 2001, February 28, 2001, March 29, 2001, April 26, 2001, May 24, 2001, June 21, 2001, and July 19, 2001.

a. Respondent did not, in fact, perform the physical examinations as noted. Respondent falsely charted and falsely billed for physical examinations on each of these occasions, intending to mislead.

b. In the event that the physical examinations were in fact performed as charted, they were inadequate.

3. Respondent purportedly performed an EEG on January 23, 2001, an EMG on January 24, 2001, and on February 7, 2001, and, a SSEP on March 29, 2001.

a. Respondent did not, in fact, perform the tests. Respondent falsely charted purported results of the tests, and falsely billed intending to mislead.

b. The EEG was not medically indicated and even if performed, was not performed for a good faith medical purpose. In billing for it as if medically indicated, Respondent intended to mislead.

c. In the event that the tests were in fact performed, Respondent failed to maintain a record of waveforms and failed to adequately interpret the results and failed to appropriately incorporate those results into the patient's evaluation and treatment.

4. Respondent submitted bills for reimbursement for which he was not entitled.

a. Respondent did so knowingly, intending to mislead.

5. Respondent failed to maintain medical records that accurately reflect the care and treatment rendered to this patient.

D. Respondent treated Patient D between October 26, 2000 and November 3, 2000, as a neurology consultant for injuries related to a motor vehicle accident that occurred on October 21, 2000. During the course of treatment Respondent performed NCS, EMG and EEG. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to take and note an adequate history.

2. Respondent purportedly performed physical examinations on or about October 26, 2000, November 9, 2000, and November 30, 2000.

a. Respondent did not, in fact, perform the physical examinations as noted. Respondent falsely charted and falsely billed for physical examinations on each of those occasions, intending to mislead.

b. In the event that the physical examinations were in fact performed as charted, they were inadequate.

3. Respondent purportedly performed an EMG on November 9, 2000, and on November 30, 2000.

a. Respondent did not, in fact, perform the tests. Respondent falsely charted purported results of the tests, and falsely billed, intending to mislead.

b. In the event that the tests were in fact performed, Respondent failed to maintain a record of waveforms and failed to adequately interpret the results and

failed to appropriately incorporate those results into the patient's evaluation and treatment.

4. Respondent submitted bills for reimbursement for which he was not entitled.

   a. Respondent did so knowingly, intending to mislead.

5. Respondent failed to maintain medical records that accurately reflect the care and treatment rendered to this patient.

E. Respondent treated Patient E between May 25, 1999 and July 27, 1999, as a neurology consultant for injuries related to a motor vehicle accident that occurred on April 18, 1999. During the course of treatment Respondent performed NCS, a needle EMG and EEG. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to take and note an adequate history.

2. Respondent purportedly performed physical examinations on or about May 25, 1999, June 8, 1999, and July 27, 1999.

   a. Respondent did not, in fact, perform the physical examinations as noted. Respondent falsely charted and falsely billed for physical examinations on each of those occasions, intending to mislead.

   b. In the event that the physical examinations were in fact performed as charted, they were inadequate.

3. Respondent purportedly performed an EMG on June 8, 1999, and on July 27, 1999.

   a. Respondent did not in fact perform the tests. Respondent falsely charted purported results of the tests, and falsely billed, intending to mislead.

   b. In the event that the tests were in fact performed, Respondent failed to maintain a record of waveforms and failed to adequately interpret the results and failed to appropriately incorporate those results into the patient's evaluation and treatment.

4. Respondent submitted bills for reimbursement for which he was not entitled.

   a. Respondent did so knowingly, intending to mislead.

5. Respondent failed to maintain medical records that accurately reflect the care and treatment rendered to this patient.

F. Respondent treated Patient F between December 14, 2001 and January 9, 2004, as a neurology consultant for injuries related to motor vehicle accidents that occurred on September 20, 2001, and November 20, 2003. During the course of treatment Respondent performed NCS and a needle EMG. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to take and note an adequate history.

2. Respondent purportedly performed physical examinations on or about December 14, 2001, December 21, 2001, December 28, 2001, January 25, 2002, February 22, 2002, March 25, 2002, May 10, 2002, May 31, 2002, June 27, 2002, July 23, 2002, August 23, 2002, September 11, 2002, October 10, 2002, November 8, 2002, December 13, 2002, November 26, 2003, and January 9, 2004.

   a. Respondent did not, in fact, perform the physical examinations as noted. Respondent falsely charted and falsely billed for physical examinations on each of those occasions, intending to mislead.

   b. In the event that the physical examinations were in fact performed as charted, they were inadequate.

3. Respondent purportedly performed an EMG on December 21, 2001, and on December 28, 2001.

   a. Respondent did not, in fact, perform the tests. Respondent falsely charted purported results of the tests, and falsely billed, intending to mislead.

   b. In the event that the tests were in fact performed, Respondent failed to maintain a record of waveforms and failed to adequately interpret the results and failed to appropriately incorporate those results into the patient's evaluation and treatment.

4. Respondent submitted bills for reimbursement for which he was not entitled.

   a. Respondent did so knowingly, intending to mislead.

5. Respondent failed to maintain medical records that accurately reflect the care and treatment rendered to this patient.

G. Respondent treated Patient G between October 26, 2000 and November 30, 2000, as a neurology consultant for injuries related to a motor vehicle accident that occurred on October 21, 2000. During the course of treatment Respondent performed NCS, EMG and EEG. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to take and note an adequate history.

2. Respondent purportedly performed physical examinations on or about October 26, 2000, November 9, 2000, and November 30, 2000.

   a. Respondent did not, in fact, perform the physical examinations as noted. Respondent falsely charted and falsely billed for physical examinations on each of those occasions, intending to mislead.

   b. In the event that the physical examinations were in fact performed as charted, they were inadequate.

3. Respondent purportedly performed an EEG on November 9, 2000, and, EMG on November 9, 2000 and November 30, 2000.

   a. Respondent did not, in fact, perform the tests. Respondent falsely charted purported results of the tests, and falsely billed, intending to mislead.

   b. The EEG was not medically indicated and even if performed, was not performed for a good faith medical purpose. In billing for it as if medically indicated, Respondent intended to mislead.

   c. In the event that the tests were in fact performed, Respondent failed to maintain a record of waveforms and failed to adequately interpret the results and failed to appropriately incorporate those results into the patient's evaluation and treatment.

4. Respondent submitted bills for reimbursement for which he was not entitled.

   a. Respondent did so knowingly, intending to mislead.

5. Respondent failed to maintain medical records that accurately reflect the care and treatment rendered to this patient.

H. Respondent treated Patient H between January 24, 2001 and May 24, 2001, as a neurology consultant for injuries related to a motor vehicle accident that occurred on December 22, 2000. During the course of treatment Respondent performed NCS, EMG, an EEG and, Median Sensory Evoked Potential (MSEP). Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to take and note an adequate history.

2. Respondent purportedly performed physical examinations on or about January 24, 2001, February 1, 2001, February 15, 2001, March 8, 2001, March 29, 2001, April 26, 2001, and May 24, 2001.

   a. Respondent did not, in fact, perform the physical examinations as noted. Respondent falsely charted and falsely billed for physical examinations on each of those occasions, intending to mislead.

   b. In the event that the physical examinations were in fact performed as charted, they were inadequate.

3. Respondent purportedly performed an EEG on or about February 1, 2001, EMG on February 1, 2001, and February 15, 2001, and MSEP on March 29, 2001.

   a. Respondent did not in fact perform the tests. Respondent falsely charted purported results of the tests, and falsely billed, intending to mislead.

   b. In the event that the tests were in fact performed, Respondent failed to maintain a record of waveforms and failed to adequately interpret the results and failed to appropriately incorporate those results into the patient's evaluation and treatment.

4. Respondent submitted bills for reimbursement for which he was not entitled.

   a. Respondent did so knowingly, intending to mislead.

5. Respondent failed to maintain medical records that accurately reflect the care and treatment rendered to this patient.

I. Respondent treated Patient I between February 27, 2004 and December 7, 2004, as a neurology consultant for injuries related to a motor vehicle accident that occurred on January 14, 2003. During the course of treatment Respondent performed NCS and

a needle EMG. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to take and note an adequate history.

2. Respondent purportedly performed physical examinations on or about February 27, 2004, March 26, 2004, April 23, 2004, May 24, 2004, June 7, 2004, July 6, 2004, August 3, 2004, September 8, 2004, October 11, 2004, November 9, 2004, and December 7, 2004.

   a. Respondent did not, in fact, perform the physical examinations as noted. Respondent falsely charted the physical examinations on each of those occasions, intending to mislead.

   b. In the event that the physical examinations were in fact performed as charted, they were inadequate.

3. Respondent purportedly performed an EMG on March 26, 2004, and on May 24, 2004.

   a. Respondent did not in fact perform the tests. Respondent falsely charted purported results of the tests, intending to mislead.

   b. In the event that the tests were in fact performed, Respondent failed to maintain a record of waveforms and failed to adequately interpret the results and failed to appropriately incorporate those results into the patient's evaluation and treatment.

4. Respondent failed to maintain medical records that accurately reflect the care and treatment rendered to this patient.

J. Respondent treated Patient J between June 26, 2003 and June 11, 2004, as a neurology consultant for injuries related to a motor vehicle accident that occurred on February 24, 2003. During the course of treatment Respondent performed NCS, EMG and SSEP. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to take and note an adequate history.

2. Respondent purportedly performed physical examinations on or about June 26, 2003, July 17, 2003, August 29, 2003, September 19, 2003, October 17, 2003,

November 14, 2003, December 12, 2003, January 16, 2004, February 13, 2004, March 12, 2004, May 13, 2004, and June 10, 2004.

a. Respondent did not, in fact, perform the physical examinations as noted. Respondent falsely charted the physical examinations on each of those occasions, intending to mislead.

b. In the event that the physical examinations were in fact performed as charted, they were inadequate.

3. Respondent purportedly performed an EMG on July 17, 2003, and on December 12, 2003 and, SSEP on October 17, 2003.

a. Respondent did not in fact perform the tests. Respondent falsely charted purported results of the tests, intending to mislead.

b. In the event that the tests were in fact performed, Respondent failed to maintain a record of waveforms and failed to adequately interpret the results and failed to appropriately incorporate those results into the patient's evaluation and treatment.

4. Respondent failed to maintain medical records that accurately reflect the care and treatment rendered to this patient.

SPECIFICATION OF CHARGES
FIRST THROUGH TENTH SPECIFICATIONS

FRAUDULENT PRACTICE

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

1. Paragraph A and A2, A2a, A3, A3a, A4 and A4a.

2. Paragraph B and B2, B2a, B3, B3a, B4 and B4a.

3. Paragraph C and C2, C2a, C3, C3a, C3b, C4 and C4a.

4. Paragraph D and D2, D2a, D3, D3a, D4 and D4a.

5. Paragraph E and E2, E2a, E3, E3a, E4 and E4a.

6. Paragraph F and F2, F2a, F3, F3a, F4 and F4a.

7. Paragraph G and G2, G2a, G3, G3a, G3b, G4 and G4a.

8. Paragraph H and H2, H2a, H3, H3a, H4 and H4a.

9. Paragraph I and I2, I2a, I3 and I3a.

10. Paragraph J and J2, J2a, J3 and J3a.

ELEVENTH THROUGH TWENTIETH SPECIFICATIONS

FALSE REPORT

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

11. Paragraph A and A2, A2a, A3, A3a, A4 and A4a.

12. Paragraph B and B2, B2a, B3, B3a, B4 and B4a.

13. Paragraph C and C2, C2a, C3, C3a, C3b, C4 and C4a.

14. Paragraph D and D2, D2a, D3, D3a, D4 and D4a.

15. Paragraph E and E2, E2a, E3, E3a, E4 and E4a.

16. Paragraph F and F2, F2a, F3, F3a, F4 and F4a.

17. Paragraph G and G2, G2a, G3, G3a, G3b, G4 and G4a.

18. Paragraph H and H2, H2a, H3, H3a, H4 and H4a.

19. Paragraph I and I2, I2a, I3 and I3a.

20. Paragraph J and J2, J2a, J3 and J3a.

TWENTY-FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

21. Paragraph A, A1, A2, A2b, A3, A3b and 5 and/or Paragraph B, B1, B2, B2b, B3, B3b and 5 and/or Paragraph C, C1, C2, C2b, C3, C3c and 5 and/or Paragraph D, D1, D2, D2b, D3, D3b and 5 and/or Paragraph E, E1, E2, E2b, E3, E3b and 5 and/or Paragraph F, F1, F2, F2b, F3, F3b and 5 and/or Paragraph G, G1, G2, G2b, G3, G3c and 5 and/or Paragraph H, H1, H2, H2b, H3, H3b and 5 and/or Paragraph I, I1, I2, I2b, I3, I3b and 4 and/or Paragraph J, J1, J2, J2b, J3, J3b and 4.

TWENTY-SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

22. Paragraph A, A1, A2, A2b, A3, A3b and 5 and/or Paragraph B, B1, B2, B2b, B3, B3b and 5 and/or Paragraph C, C1, C2, C2b, C3, C3c and 5 and/or Paragraph D, D1, D2, D2b, D3, D3b and 5 and/or Paragraph E, E1, E2, E2b, E3, E3b and 5 and/or Paragraph F, F1, F2, F2b, F3, F3b and 5 and/or Paragraph G, G1, G2, G2b, G3, G3c and 5 and/or Paragraph H, H1, H2, H2b, H3, H3b and 5 and/or Paragraph I, I1, I2, I2b, I3, I3b and 4 and/or Paragraph J, J1, J2, J2b, J3, J3b and 4.

TWENTY-THIRD THROUGH THIRTY-SECOND SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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

23. Paragraph A and A5.

24. Paragraph B and B5.

25. Paragraph C and C5.

26. Paragraph D and D5.

27. Paragraph E and E5.

28. Paragraph F and F5.

29. Paragraph G and G5.

30. Paragraph H and H5.

31. Paragraph I and I4.

32. Paragraph J and J4.

DATE: June 7, 2013
New York, New York

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct