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Executive Deputy Commissioner

April 3, 2017

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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90 Church Street – 4th Floor
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RE: In the Matter of Jaime Gabriel Gutierrez, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.17-103) 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. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "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: nm
Enclosure

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

COPY

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IN THE MATTER **DETERMINATION**

OF **AND**

JAIME GABRIEL GUTIERREZ, M.D. **ORDER**

---x BPMC #17-103

The New York State Department of Health ("Department") charged Jaime Gabriel Gutierrez, M.D. ("Respondent"), with professional misconduct. A hearing was held in New York, New York. Steven I. Sherman, D.O., Chair, Michael Reichgott, M.D., PhD, and Constance G. Diamond, D.A., duly designated members of the Board for Professional Medical Conduct ("BPMC"), served as the Hearing Committee ("Committee"), pursuant to New York State Public Health Law ("PHL") § 230 (10) (e). Jankhana Desai served as the Administrative Law Judge.

The Department appeared by Daniel Guenzburger, Associate Counsel for the Bureau of Professional Medical Conduct. Respondent appeared by Anthony Z. Scher and Barry Zone, Attorneys at Law. Evidence was received, arguments were heard, and transcripts of the proceedings were made. Both parties submitted closing briefs. After consideration of the entire record, the Committee issues this Determination and Order.

HEARING RECORD

Hearing Dates:	July 26, 2016 August 16, 2016 August 17, 2016 September 14, 2016 November 21, 2016 November 22, 2016 December 8, 2016 December 9, 2016
Department's Witnesses:	Joseph Carfi, M.D. Patient D's Mother (Mrs. W) Patient A (Mrs. MB) Ronald Primas, M.D. Andrea Trimmingham
Respondent's Witnesses:	Manoeli Cenci Joseph Ginarte Respondent Jamie Gabriel Gutierrez, M.D. Colin Plotkin, M.D. Alexander Weingarten, M.D.
Hearing Transcript:	Pages 1-1540
Deliberations Held:	January 30, 2017
Department's Exhibits:	1 through 57[1]
Respondent's Exhibits:	A through H[2]

BACKGROUND

This case was brought pursuant to PHL § 230. Respondent was charged with thirteen specifications of professional misconduct, as defined in § 6530 of the New York State Education Law ("Education Law"), including:

- § 6530(2): practicing the profession of medicine fraudulently.

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1 Exhibit 57 is the Department's post-hearing submissions, collectively.
2 Exhibit H is Respondent's post-hearing brief.

- § 6530(3): practicing the profession of medicine with negligence on more than one occasion.
- § 6530(5): practicing the profession of medicine with incompetence on more than one occasion.
- § 6530(17): exercising undue influence on the patient in such manner as to exploit the patient for the financial gain of the licensee or of a third party.
- § 6530(20): engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice.
- § 6530(21): willfully making or filing a false report, or failing to file a report required by law or by the Department or the Education Department.
- § 6530(32): failing to maintain a record of the patient that accurately reflects the evaluation and treatment of the patient.

The factual allegations upon which the specifications of professional misconduct can be grouped in three distinct areas: (1) hotel concierge medical practice pertaining to Patients A, B, C, and D, (2) trigger point injections administered by Respondent to Patients E, F, G, and H2 to H20, and (3) fabricated nerve conduction studies for which claims were submitted to GEICO, on Patients I through O.

FINDINGS OF FACT

The Committee made the following findings of fact unanimously.

1. On December 23, 2010, Respondent was authorized to practice medicine in New York State, by the issuance of license number 259768, by the New York State Education Department ("Education Department").

Hotel Physician Concierge Practice

2. In 2008, Respondent started working in a hotel physician concierge practice. In June 2012, Respondent and his fiancée, Manoeli Cenci, set up their own hotel physician concierge service called Doctors 24 HS Inc. Respondent's role in this service was to provide on-site, on demand medical care to patients, while Cenci handled the administrative side of the business. (Transcript, p. 886, 888.)

3. On May 3, 2016, Respondent treated Patient A (also Patient MB-3)[3], a patient with a history of heart disease, who felt sore and sick, at the Hotel Belnord in New York City. (Transcript, p. 360, 368.) Respondent charged $3,700 for the visit. (Transcript, p. 360, 379; Exhibits 46, 47.)

4. On September 1, 2013, Respondent treated Patient B (also Patient TT) for an upper respiratory infection and sinusitis at the Holiday Inn in New York City. Patient B's insurance company paid Respondent $5,000 for the visit. (Exhibit 3.)

5. On January 25, 2013, Andrea Trimmingham, a physician assistant working under Respondent's supervision, treated Patient C (also Patient SZ) for vomiting, nausea, and diarrhea, at the Club Quarters Hotel in New York City. Respondent charged $3,000 for the visit. (Exhibits 48-50.)

6. On October 28, 2011, Respondent treated Patient D (also Patient AW), who suffered from a severe flu, at the Hotel Thirty-Thirty in New York City. Respondent charged $5,000 for the visit. Patient D's travel insurance company did not reimburse the $5,000. (Transcript, p. 310, 313; Exhibit 51.)

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[3] In this Determination and Order, patients are identified according to the Second Amended Statement of Charges. The initials in parentheses refer to how the patient was identified in the transcript.

Trigger Point Injections

7. In approximately January 2011, Respondent commenced performing trigger point injections while working for Dr. Jean Claude Compas at a practice in Brooklyn, New York. He worked at the practice until September or October 2012. (Transcript, p. 839, 884.)

8. A trigger point is a point in a muscle which when palpitated is tender. There are several options to treat trigger points, including injections. Trigger point injections are administered to relieve muscle pain and reduce inflammation. (Transcript, p. 163-64, 681-84.)

9. On June 7, 2011 and June 24, 2011, Respondent administered trigger point injections to Patient E (also Patient RF). (Exhibit 5.) On the first day, following a motor vehicle accident ("MVA"), Respondent administered 28 injections. (Exhibit 5; Transcript, p. 175.) On the second day, Respondent administered 26 injections. (Exhibit 5; Transcript, p. 180.)

10. From June 17, 2011 to November 12, 2011, Respondent and/or a physician assistant working under his supervision administered trigger point injections to Patient F (also Patient JF) on five separate occasions, following a MVA on June 16, 2011. On June 17, Respondent administered 25 injections. Subsequent visits occurred on July 13, July 29, August 30, and October 7, 2011. (Exhibit 6; Transcript, p. 214, 217-19.)

11. From June 16, 2011 to November 27, 2011, Respondent administered trigger point injections to Patient G (also Patient YV) on four separate occasions, following a MVA on June 15, 2011. On June 16, 2011, Respondent administered 29 injections. Subsequent visits occurred on June 30, July 12, and September 27, 2011. (Exhibit 7; Transcript, p. 220-24.)

12. In 2011, Respondent administered trigger point injections to Patients H2 through H20, all within 30 days of MVAs. Patients H2 through H20 were insured by GEICO. (Exhibits 5 through 24.)

Nerve Conduction Studies

13. From March 9, 2011 to August 11, 2011, while Respondent was working at the Brooklyn, New York practice (*see* factual finding 7), claims for fabricated nerve conduction studies performed on Patients I through O were submitted to GEICO. Respondent denied submitting these claims. (Stipulation at hearing.; Transcript, p. 234.)

DISCUSSION

The Department's Second Amended Statement of Charges contains factual allegations A through I. Factual allegations A through D refer to the hotel physician concierge service; E through H refer to the trigger point injections; and I refers to the nerve conduction studies.

Hotel Physician Concierge Business

Patient A

Factual allegation A

Factual allegation A refers to Respondent's May 3, 2016 hotel visit to provide medical care to Patient A, a 65-year-old female from France who was visiting New York City with her husband. It alleges that neither Respondent nor anyone from Respondent's service apprised Patient A of Respondent's fee. It further alleges that Patient A felt disoriented because of her weakened condition and unfamiliar environment. It alleges that although Patient A complained of the $3,700 fee, her husband, who was not fluent in English, nevertheless signed the credit card authorization.

Patient A testified that she did not know of the price of the visit until completion of the medical examination. (Transcript, p. 370, 373.) She told Respondent that the $3,700 fee was too high. (Transcript, p. 404.) However, Patient A admitted that she provided her credit card information to Respondent's service in advance of the visit, that she asked her husband to sign

the credit card authorization, and that she knew what he was signing. (Transcript, p. 389-90, 404-408.) She had also informed Respondent's service that she had traveler's insurance. (Transcript, p. 389, 404.) The Committee found that although Patient A may have been weak at the time of Respondent's visit, she was in no way disoriented. Supporting this decision is the fact that Patient A was translating between English and French to facilitate communication between Respondent and her husband. (Transcript, p. 396-97.)

Factual allegation A1: Dismissed

Factual allegation A1 charges that Respondent exploited Patient A for financial gain by exercising undue influence on the patient in the sale of medical services. The Committee unanimously found that Respondent did not exercise any undue influence in this case. Upon arriving to Patient A's room, Respondent focused first on medical care, and not on collection of his fees. Even according to Patient A's testimony, Respondent did not attempt to get his fees prior to providing services. (Transcript, p. 395.) Patient A voluntarily and knowingly entered into the transaction. The Committee, therefore, unanimously dismissed factual allegation A1.

Patient B

Factual allegation B

Factual allegation B refers to Respondent's September 1, 2013 hotel visit to provide medical care to Patient B, a 32-year-old male visiting New York City from Montreal, Canada. It alleges that prior to the visit, an individual associated with Respondent's service had told Patient B that the fee would be $600. Lacking any testimony from Patient B or other evidence supporting this allegation, the Committee unanimously dismissed this allegation.

Factual allegation B1a: Sustained

Patient B's insurance company paid Respondent $5,000. Factual allegation B1a alleges that Respondent knowingly and falsely used Current Procedural Terminology (CPT) codes on the insurance claim to reflect provision of the following services: a comprehensive history, a comprehensive physical examination, and medical decision making of high complexity. (Exhibits 3, 45.) Respondent's witness, Colin Plotkin, M.D., a travel insurance expert, testified that travel insurance companies do not rely on CPT coding in determining reimbursement. (Transcript, p. 613.) For this reason, Respondent said he indiscriminately "pick[s] [the] codes and use it as a cookie cutter in all [claims]." (Transcript, p. 956-57.) He admitted, nevertheless, that the visit with Patient B was not one that required a "complex medical evaluation." (Transcript, p. 962.) The Committee agreed that the CPT codes are irrelevant to travel insurance reimbursement, but found nevertheless that Respondent mischaracterized the services he provided based on the CPT coding. Therefore, the Committee unanimously sustained this factual allegation.

Factual allegation B1b: Sustained

Factual allegation B1b alleges that Respondent knowingly and falsely represented, through the use of a CPT code, that his treatment of Patient B disrupted scheduled office visits. Respondent admitted that he did not shut down his office in order to visit Patient B. (Transcript, p. 961.) Therefore, the Committee unanimously sustained this allegation.

Factual allegation B1c: Sustained

Factual allegation B1c alleges that Respondent knowingly and falsely represented, through the use of a CPT code, that he and/or another qualified health care professional had provided Patient B with a telephone evaluation and management service. Respondent admitted

that he did not conduct a telephone evaluation of Patient B. (Transcript, p. 963-64.) Therefore, the Committee unanimously sustained this allegation.

Patient C

Factual allegation C

Factual allegation C refers to the January 25, 2013 hotel visit made by Trimmingham, a physician assistant working for Respondent, to provide medical care to Patient C, a 52-year-old female visiting New York City from Israel. It alleges that Respondent instructed Trimmingham to charge $3,000 for the visit. It further alleges that when Patient C complained about the charge, Trimmingham initiated a telephone call between Respondent and Patient C, after which Patient C authorized the full payment.

Although Patient C did not testify, the Committee sustained this allegation based on Trimmingham's testimony. Trimmingham explained that Respondent had instructed her to collect $3,000 in fees, prompting Patient C's dissatisfaction. (Transcript, p. 416.) After an approximate 10-minute telephone call between Respondent and Patient C, Patient C agreed to pay the fees. (Transcript, p. 426-27.)

Factual allegation C1: Dismissed

Factual allegation C1 alleges that Respondent exploited Patient C for financial gain by exercising undue influence on the patient in the sale of medical services. However, no evidence was presented that Respondent coerced Patient C to pay, nor was there any direct testimony from Patient C. The Committee noted that Trimmingham first provided medical care without discussing billing, thereby not holding medical care hostage until fees were paid. In short, there was simply no evidence presented of undue influence, and the Committee dismissed this allegation.

Patient D

Factual allegation D

Factual allegation D refers to Respondent's October 28, 2011 hotel visit to provide medical care to Patient D, a 22-year-old female of Finnish origin visiting New York City with her mother. It alleges that Patient D's mother had inquired about the cost of Respondent's services at first contact and was told that the cost could only be determined following evaluation and treatment. It further alleges that Respondent took pictures of the mother's credit card and informed her that the visit fee was $5,000. Despite the mother's objection, Respondent charged the credit card $5,000.

Although Patient D did not testify at hearing, the Committee sustained this allegation based on the mother's testimony. When the mother first called Respondent's service and inquired about the visit fee, she was told that the after-midnight visit would be costly. (Transcript, p. 309, 324-25.) After Respondent treated Patient D at about 1:00 a.m., he asked the mother for her credit card. The mother provided the credit card not anticipating a charge as high as $5,000. Despite the mother's expressions of dissatisfaction, Respondent proceeded with the charge. (Transcript, p. 311-312, 318, 325, 330.)

Factual allegation D1: Dismissed

Factual allegation D1 alleges that Respondent exploited Patient D for financial gain by exercising undue influence on the patient in the sale of medical services. The Committee found no evidence of undue influence and dismissed this allegation. After learning of the $5,000 price, and while Respondent was still in the hotel room, the mother called Patient D's travel insurance company and understood that she would be reimbursed for the full fee. (Transcript, p. 313.) When the insurance company later declined payment, she called Respondent in an unsuccessful

attempt to get the price lowered. (Transcript, p. 314-15.) The mother admitted that, had the insurance company reimbursed the $5,000, she would not be testifying. (Transcript, p. 332-34, 342.) In dismissing the allegation, the Committee noted that when Respondent arrived to Patient D's hotel room, his first priority was to treat Patient D, not collect payment. (Transcript, p. 330-31.)

Trigger Point Injections

Patient E, F, and G

Factual allegations E1, F1, and G1: Dismissed

Factual allegations E1, F1 and G1 charge that Respondent deviated from medically accepted standards by administering trigger point injections to Patient E, F, and G, respectively, without adequate indication.

The Department proffered the testimony of Joseph Carfi, M.D., a board certified physician in Physical Medicine and Rehabilitation who administers trigger point injections in his medical practice. (Transcript, p. 160-64.) In Dr. Carfi's opinion, trigger points were not indicated for: Patient E on June 7, 2011, when he was administered 28 injections the day of his MVA (Transcript, p. 172.); Patient F on June 17, 2011, when he was administered 25 injections the day after his MVA (Transcript, p. 214-15.); and Patient G on June 16, 2011, when he was administered 29 injections the day after his MVA. (Transcript p. 220-21.) Dr. Carfi opined that a "more conservative approach," such as physical therapy, gentle stretching, massage, and pain medication, would be "the more prudent way to go." Dr. Carfi explained that a reasonably prudent physician should wait at least two weeks before commencing trigger point injections as a treatment modality. (Transcript, p. 174.) Notably, Dr. Carfi admitted that he was not able to refer to any medical textbook or journal that states that a physician should not utilize trigger

point injections shortly after an acute injury, and in fact, "sometimes a trigger point or two acutely may be beneficial." (Transcript, p. 192-94.)

Respondent's expert, Alexander Weingarten, M.D., an anesthesiologist who devotes 95 percent of his practice to pain management which includes trigger point injections, explained: "The standard of care does not require a physician to first start with physical therapy or more conservative modalities as opposed to going right to trigger point injections." (Transcript, p. 676-77, 702.) The Committee concluded that there was no evidence presented establishing the standard of care for trigger point injections, and therefore that it could not conclude that Respondent deviated from medical standards. The Committee unanimously dismissed factual allegations E1, F1, and G1.

Factual allegations E2, F2, and G2: Dismissed

Factual allegations E2, F2, and G2 charge that Respondent deviated from medically accepted standards by administering an excessive number of trigger point injections per session. Although Dr. Carfi testified that in certain instances, the trigger point injections administered by Respondent were excessive in number, he acknowledged that he was not aware of any literature establishing a maximum number of trigger point injections per session. (Transcript, p. 203.) Dr. Carfi stated, "...there is no published protocol that indicates a maximum number of trigger points that could be provided in a session." (Transcript, p. 203-04.) Likewise, Dr. Weingarten explained that there is no standard of practice that limits the number of trigger point injections that can be administered at a particular session. (Transcript, p. 685-86.) Neither physician testified that Respondent administered any dosage that would be considered unsafe. The Committee dismissed these allegations noting that a medically accepted standard for the number of trigger point injections was not established.

Factual allegations E3, F3, and G3: Part 1: Sustained; Part 2: Dismissed

Factual allegations E3, F3, and G3 charge that Respondent deviated from medically accepted standards by failing to maintain a record that adequately reflects the evaluation and treatment of the patient, including failing to note the total amount of anesthetic medication administered per trigger point injection session. The Committee separated this allegation into two parts: (1) Respondent deviated from medically accepted standards by failing to maintain a record that adequately reflects the evaluation and treatment of the patient and (2) Respondent failed to note the total amount of anesthetic medication administered per trigger point session.

The Committee unanimously sustained Part 1 of E3, F3, and G3 based on the following. Looking at Exhibits 5 through 7, the Committee found that the records were repetitive and were not sufficiently detailed. Respondent argued that the Committee had incomplete records, but the Committee determined that the records that were available were sufficient to make this judgment. (Respondent's Closing Brief, p. 20.)

The Committee unanimously dismissed Part 2 of E3, F3, and G3. Looking at Exhibits 5 through 7, the Committee found that the records contained adequate documentation regarding the anesthetic medication. Importantly, the Committee noted that Dr. Weingarten established that the information contained in Respondent's records was sufficient for any practitioner to deduce the anesthetic dose using simple arithmetic. (Transcript, p. 718-19.)

Patients H2 through H20

Factual allegation H

The evidence establishes, as factual allegation H alleges, that Respondent administered trigger point injections to Patients H2 through H20 within 30 days of patients' involvement in MVAs, and that they were all insured by GEICO. (Exhibits 5 through 24.)

Factual allegation H1: Dismissed

Factual allegation H1 charges that Respondent deviated from acceptable medical standards by routinely initiating treatment with trigger point injections prior to attempting conservative medical therapies, such as physical therapy, muscle relaxants or other medications, chiropractic techniques, and acupuncture. This factual allegation is substantively similar to factual allegations E1, F1, and G1. Having determined that there is no medical standard for the prioritization of these treatment modalities, the Committee unanimously dismissed this factual allegation.

Factual allegation H2: Dismissed

Factual allegation H2 alleges that Respondent failed to maintain medical records for Patients H2 through H20. The Department supports this allegation by arguing that Respondent, by his own admission, submitted original patient records to a law firm without retaining copies. (Department's Proposed Findings of Fact and Conclusions of Law, p. 10.) Respondent testified that lacking the original full records, he relied on patient "summary" records in future patient encounters. (Transcript, p. 1011-12, 1093.) Exhibits 5 through 24 provided records for patients H2 through H20. The Committee reviewed these records and found them to be of sufficient depth to dismiss this allegation.

Patients I through O

Factual allegation I

Factual allegation I alleges that Respondent submitted to GEICO claims for fabricated nerve conduction studies performed on Patients I through O.

Both parties stipulated that these claims were fabricated. The question remained whether Respondent was complicit in the submission of these claims. The Committee concluded that,

although the claims were billed under Respondent's name, the Department "offered absolutely no proof that [Respondent] was aware of the fraudulent billing done in this matter." (Respondent's Closing Brief, p. 26.)

Factual allegations I1a, I1b, I2, and I3: Dismissed

Factual allegation I1a charges that Respondent deviated from medically accepted standards by failing to identify, note, and/or appropriately diagnose abnormalities in the nerve conduction studies. Factual allegation I1b alleges that Respondent deviated from medically accepted standards by basing his interpretations on nerve conduction studies that were not reflective of patients' conditions. Factual allegation I2 charges that Respondent intended to deceive by knowingly creating the false impression that the nerve conduction reports were based on genuine studies. Factual allegation I3 alleges that Respondent failed to maintain medical records for Patients I through O.

The Committee found a lack of evidence supporting these allegations. The evidence did not demonstrate that Respondent had any role in the fabricated nerve conduction studies. For example, the Committee noted that Exhibits 25 through 27 lacked Respondent's signature. (Exhibits 25-27.) The Committee concluded that there was no persuasive evidence presented that established that Respondent saw these patients, submitted the claims, or even read the nerve conduction studies himself. The Committee unanimously dismissed these allegations.

VOTE OF THE COMMITTEE

FIRST SPECIFICATION: DISMISSED

The Committee unanimously dismissed the first charge that Respondent committed professional misconduct as defined in Educ. Law § 6530(20), by engaging in conduct that evidences moral unfitness to practice medicine.

Vote: Dismissed (3-0).

This specification was based on all of the factual allegations, A through I. The Committee concluded that even though it sustained the factual allegations with respect to the CPT coding, the coding is immaterial in the travel insurance business. The Committee found that Respondent's use of inaccurate coding demonstrated his lack of coding education, not any moral unfitness. Importantly, the Committee found that Respondent first rendered the appropriate medical care to his patients during hotel visits and that he did not withhold care until he was paid. Finally, no evidence of moral unfitness was presented with respect to the trigger point injections and the nerve conductions studies.

SECOND SPECIFICATION: DISMISSED

The Committee unanimously dismissed the second charge that Respondent committed professional misconduct as defined in Educ. Law § 6530(2), by practicing medicine fraudulently.

Vote: Dismissed (3-0).

To sustain a charge that Respondent fraudulently practiced medicine, the Committee must find that (1) a false representation was made by licensee, whether by words, conduct or concealment of that which should have been disclosed, (2) the licensee knew the representation was false, and (3) the licensee intended to mislead through the false representation. Sherman v. Board of Regents, 24 A.D. 2d 315, 266 N.Y.S.2d 39 (3d Dept.1966).

This specification was based on factual allegations B and B1. Letters of guarantee presented at hearing showed that a travel insurance company may guarantee a fee for service even before the doctor sees the patient, rendering irrelevant the use of CPT codes in these travel

insurance claims. (Exhibit E.) The Committee found that Respondent's use of erroneous CPT codes was based on lack of knowledge, not on intent to mislead.

THIRD SPECIFICATION: DISMISSED

The Committee unanimously dismissed the third charge that Respondent committed professional misconduct as defined in Educ. Law § 6530(2), by practicing medicine fraudulently.

Vote: Dismissed (3-0).

This specification was based on factual allegations I and I2, both dismissed by the Committee.

FOURTH SPECIFICATION: DISMISSED

The Committee unanimously dismissed the fourth charge that Respondent committed professional misconduct as defined in Educ. Law § 6530(21), by willfully making or filing a false report, or failing to file a report required by law, the Department, or Education Department.

Vote: Dismissed (3-0).

This specification was based on factual allegations B and B1. The Committee found that Respondent lacked the proper CPT coding education, but found no evidence that Respondent willfully filed false reports in violation of any law or Department regulation.

FIFTH SPECIFICATION: DISMISSED

The Committee unanimously dismissed the fifth charge that Respondent committed professional misconduct as defined in Educ. Law § 6530(21), by willfully making or filing a

false report, or failing to file a report required by law, the Department, or Education Department.

Vote: Dismissed (3-0).

This specification was based on factual allegations I and I2, both dismissed by the Committee.

SIXTH SPECIFICATION: DISMISSED

The Committee unanimously dismissed the sixth charge that Respondent committed professional misconduct as defined in Educ. Law § 6530(17), by exercising undue influence on the patient to exploit the patient for financial gain.

Vote: Dismissed (3-0).

This specification was based on factual allegations A and A1. Undue influence involves a person in a position of power taking advantage of another person. The Department argues that "Patients A, C, and D were susceptible to Respondent's undue influence because of their compromised position." (Department's brief, p. 3.) The Committee was not persuaded by this argument.

A high fee is not the basis for sustaining a charge of undue influence. There is no law that regulates physician fees in a hotel concierge setting such as Respondent's. The Department introduced Ronald Primas, M.D., a physician who also practices in the hotel physician concierge industry, whose fees are significantly lower than Respondent's. (Transcript, p. 1142-1147, 1173-74, 1193-96.) Dr. Primas's testimony did not establish any upper limit for hotel physician fees. More importantly, the Committee found that Respondent's patients voluntarily sought and paid for Respondent's services. Finally, the Committee considered that Respondent

never attempted to collect fees prior to rendering care to the patient. The Committee dismissed the sixth specification.

SEVENTH SPECIFICATION: DISMISSED

The Committee unanimously dismissed the seventh charge that Respondent committed professional misconduct as defined in Educ. Law § 6530(17), by exercising undue influence on the patient to exploit the patient for financial gain.

Vote: Dismissed (3-0).

This specification was based entirely on factual allegation B, which was dismissed by the Committee.[4]

EIGHTH SPECIFICATION: DISMISSED

The Committee unanimously dismissed the eighth charge that Respondent committed professional misconduct as defined in Educ. Law § 6530(17), by exercising undue influence on the patient to exploit the patient for financial gain.

Vote: Dismissed (3-0).

This specification was based on factual allegations C and C1. For the reasons set forth in the discussion for the sixth specification, the Committee dismissed this specification.

NINTH SPECIFICATION: DISMISSED

The Committee unanimously dismissed the ninth charge that Respondent committed professional misconduct as defined in Educ. Law § 6530(17), by exercising undue influence on the patient to exploit the patient for financial gain.

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[4] Also, the Department withdrew factual allegation B2 on the Second Amended Statement of Charges.

Vote: Dismissed (3-0).

This specification was based on factual allegations D and D1. For the reasons set forth in the discussion for the sixth specification, the Committee dismissed this specification.

TENTH SPECIFICATION: DISMISSED

The Committee unanimously dismissed the tenth charge that Respondent committed professional misconduct as defined in Educ. Law § 6530(3), by practicing medicine with negligence on more than one occasion.

Vote: Dismissed (3-0).

This specification was based on factual allegations E through I. Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. Bogdan v. New York State Board of Professional Medical Conduct 195 A.D. 2d, 86, 88, 606 N.Y.S.2d 381 (3d Dept. 1993). The Committee found that Respondent's medical records, while suboptimal, did not justify a negligence finding.

ELEVENTH SPECIFICATION: DISMISSED

The Committee unanimously dismissed the eleventh charge that Respondent committed professional misconduct as defined in Educ. Law § 6530(5), by practicing medicine with incompetence on more than one occasion.

Vote: Dismissed (3-0).

This specification was based on factual allegations E through I. Incompetence is the lack of skill or knowledge necessary to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D. 2d 609, 651 N.Y.S. 2d 249 (3d Dept. 1996). The statutory definition requires proof of practicing with "incompetence on more than one

occasion." Educ. Law § 6530 (5). The Committee found that although Respondent's medical records were suboptimal, they did not rise to the level of establishing incompetence.

TWELFTH SPECIFICATION: SUSTAINED

The Committee unanimously sustained the twelfth charge that Respondent committed professional misconduct as defined in Educ. Law § 6530(32), by failing to maintain a record for each patient, which accurately reflects the patient's evaluation and treatment.

Vote: SUSTAINED (3-0).

This specification was based on factual allegations E3, F3 and/or G3. The Committee sustained this specification, noting that Respondent's records were "cookie cutter," in that they were repetitive in language and boxes checked, with differences in medication doses and the number and location of injections. The Committee also noted that Respondent failed to maintain control of his records and that he was treating patients using summary sheets when he should have had access to the entire record.

THIRTEENTH SPECIFICATION: DISMISSED

The Committee unanimously dismissed the thirteenth charge that Respondent committed professional misconduct as defined in Educ. Law § 6530(32), by failing to maintain a record for each patient, which accurately reflects the patient's evaluation and treatment.

Vote: Dismissed (3-0).

This specification was based on factual allegations H, H2, and/or I3. Other than sustaining factual allegation H, which charges that Respondent administered trigger point injections to Patients H2 through H20 within 30 days of patients' involvement in MVAs, and that they were all insured by GEICO, the Committee dismissed H2 and I3 and therefore dismissed this specification.

PENALTY DETERMINATION

Respondent was charged with thirteen specifications of professional misconduct, as defined in § 6530 of the Education Law. The Committee sustained one of the thirteen specifications. The Committee considered the full spectrum of penalties available by statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee concluded that the appropriate penalty in this case is censure and reprimand. The Committee made this determination on several factors. Importantly, the Committee unanimously found that Respondent did not exert any undue influence in charging patients' fees in his hotel concierge practice. The Committee noted that undue influence cannot be found simply because Respondent's fees may be considered high.

With respect to the trigger point injections, the Committee heard no evidence of an established standard of care, and therefore could not sustain a charge that Respondent deviated from accepted standards. The Committee did not find any evidence that Respondent was negligent in his medical practice, nor that he had caused harm to his patients. It determined that the Department also failed to provide persuasive evidence that Respondent submitted claims for fabricated nerve conduction studies. It did conclude, however, that Respondent's record keeping skills were "sloppy" and that his coding skills were subpar. Under these circumstances, the Committee determined that censure and reprimand, with courses in medical record keeping and CPT coding, is the appropriate penalty.

ORDER

IT IS HEREBY ORDERED THAT:

1. The twelfth specification of professional misconduct, as set forth in the Second Amended Statement of Charges, is SUSTAINED.

2. The first through eleventh, and thirteenth specifications of professional misconduct, as set forth in the Second Amended Statement of Charges, are DISMISSED.

3. Respondent's penalty shall be Censure and Reprimand.

4. Within six months of the effective date of this decision, Respondent must complete, to the satisfaction of the Director of the Office of Professional Medical Conduct ("OPMC"), a course approved by the OPMC in medical record keeping and in CPT coding.

5. This Determination and Order shall be effective upon service on the Respondent by personal service or by registered or certified mail as required by PHL 230(10)(h).

DATED: March 31, 2017

[redacted]

Steven I. Sherman, D.O., Chair

Michael Reichgott, M.D., PhD
Constance Diamond, D.A.

To:

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

IN THE MATTER OF JAIME GABRIEL GUTIERREZ, M.D.	SECOND AMENDED STATEMENT OF CHARGES

JAIME GABRIEL GUTIERREZ, M.D., the Respondent, was authorized to practice medicine in New York State on or about December 23, 2010, by the issuance of license number 259768 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about May 3, 2016, the Respondent treated Patient A for abdominal pain at the Hotel Belnord, 209 West 89th Street, New York, New York. Patient A, a 65 year old female from France, was visiting New York City with her husband. The Patient had a history of coronary artery disease that included two cardiac stent replacements. Respondent conducted a brief evaluation, diagnosed cholecystitis and instructed the patient to go to the Emergency Room for further evaluation. Respondent charged $3700 for the hotel physician visit. Prior to the visit, neither Respondent nor anyone associated with his hotel concierge service provided information to Patient A about Respondent's charge. Patient A felt disoriented because of her weakened condition and because she was dealing with an acute health issue in an unfamiliar environment. Although Patient A complained to Respondent about the charge, Patient A's husband, who was not fluent in English, signed the credit card authorization slip for the $3700 that Respondent had requested.

EXHIBIT
1

1. Respondent exploited Patient A for his financial gain and/or that of a third party by exercising undue influence on a patient in the sale of medical services.

B. On or about September 1, 2013, Respondent treated Patient B for an upper respiratory infection and sinusitis at the Holiday Inn, 343 West 39th Street, New York, New York. Patient B, a 32 year old male, was visiting New York City from Montreal, Canada. Respondent conducted a brief evaluation and prescribed an anti-biotic. Prior to the visit, Patient B had been told by an individual associated with Respondent's concierge service that the fee for a hotel physician visit was $600.

1. Respondent gave Patient B a health insurance claim which he submitted to his travel insurance company. The insurance company paid Respondent $5000 on the claim. With regard to the insurance claim, Respondent:

a. Knowingly and falsely represented that his evaluation and management of Patient B consisted of the following components: a comprehensive history; a comprehensive physical examination; and medical decision making of high complexity, (Current Procedure Terminology Code -"CPT code"- number 99345);

b. Knowingly and falsely represented that his treatment of Patient B disrupted scheduled office visits (CPT code # 99060), when, in fact, Respondent knew that he did not disrupt a scheduled office visit to treat Patient B;

c. Knowingly and falsely represented that he and/or another qualified health care professional had provided Patient B with a telephone evaluation and management service (CPT code # 99441).

2. Respondent exploited Patient B for his financial gain and/or that of a third party by exercising undue influence on a patient in the sale of medical services.

C. On or about January 25, 2013, a physician assistant working under Respondent's supervision, treated Patient C at the Club Quarters Hotel, 25 West 51st Street, New York, New York. Patient C, a 52 year old female visiting New York City from Israel,

reported experiencing episodes of nausea, vomiting and diarrhea. The physician assistant conducted a brief evaluation, diagnosed gastroenteritis, and prescribed Pedialyte and Reglan. Respondent instructed the physician assistant to charge three thousand dollars ($3000) for the visit. When Patient C complained about the charge, the physician assistant telephoned Respondent and had Patient C speak to him directly. After Patient C finished speaking with Respondent, she signed a credit card receipt authorizing payment to Respondent's company for $3000.00.

1. Respondent exploited Patient C for his financial gain and/or that of a third party by exercising undue influence on a patient in the sale of medical services.

D. On or about October 28, 2011, Respondent treated Patient D for an upper respiratory infection at the Hotel Thirty-Thirty, 29 East 29th Street, New York, New York. Patient D, a 22 year old female of Finnish origin, was visiting New York City with her mother. Patient D's mother inquired about the cost of the visit when she made arrangements for a doctor to see her daughter. She was told that the cost of the visit could only be determined by the physician after he had treated the patient. Respondent conducted a brief evaluation, prescribed Erythromycin and, after taking pictures of the Patient's mother's credit card, informed Patient D and her mother that the cost of the visit was $5,000.00 dollars. Patient D's mother objected to the price for the visit. However, with the credit card information that Respondent had obtained, Respondent was able to charge Patient D's credit card $5000.00.

1. Respondent exploited Patient D for his financial gain and/or that of a third party by exercising undue influence on a patient in the sale of medical services.

E. On or about and between June 7, 2011 and June 24, 2011 the Respondent administered trigger point injections to Patient E on two separate occasions, including administering injections the same day that Patient E had been in a motor vehicle accident. Respondent deviated from medically accepted standards, in that he:

1. Administered trigger point injections without adequate indication.
2. Administered an excessive number of injections per trigger point session.

3. Failed to maintain a record that adequately reflects the evaluation and treatment of the Patient, including failing to note the total amount of anesthetic medication administered per trigger point session.

F. On or about and between June 17, 2011 and November 12, 2011, the Respondent and/or a physician assistant working under his supervision administered trigger point injections to Patient F on 5 separate occasions, including administering injections the day after Patient F had been in a motor vehicle accident. Respondent deviated from medically accepted standards, in that he:

1. Administered trigger point injections without adequate indication.
2. Administered an excessive number of injections per trigger point session.
3. Failed to maintain a record that adequately reflects the evaluation and treatment of the Patient, including failing to note the total amount of anesthetic medication administered per trigger point session.

G. On or about and between June 16, 2011 and November 27, 2011, the Respondent administered trigger point injections to Patient G on 4 separate occasions, including administering injections the day after Patient G had been in a motor vehicle accident. Respondent deviated from medically accepted standards, in that he:

1. Administered trigger point injections without adequate indication.
2. Administered an excessive number of injections per trigger point session.
3. Failed to maintain a record that adequately reflects the evaluation and treatment of the Patient, including failing to note the total amount of anesthetic medication administered per trigger point session.

H. In or about and between April 2011 and January 2012, Respondent administered trigger point injections to Patients ~~H1 – H306~~ H2-H2C within 30 days of the patient having been in a motor vehicle accident ("MVA"). Patients ~~H1 – H306~~ H2-H2C were insured by the Governmental Employees Insurance Company ("GEICO"). (Patients ~~H1through H306~~ H2 through H2C are identified in the annexed Appendix B. Appendix B also identifies the date of the

MVA, the date Respondent initiated trigger point injections and the number of days between the date of the MVA and the date of the first trigger point injection that Respondent administered.) With regards to Patients ~~H1-H300~~ H2-H20, Respondent:

1. Deviated from accepted medical standards by routinely initiating treatment with trigger point injections without first attempting conservative medical therapies, such as physical therapy, NSAIDs, muscle relaxants chiropractic and acupuncture.
2. Failed to maintain medical records for Patients ~~H1-H300~~ H2-H20.

I. In or about and between March 9, 2011 and August 11, 2011 the Respondent submitted, or caused to submit to GEICO, claims for nerve conduction studies performed on Patients I through O. Respondent submitted the claims personally and/or through his professional service corporation, Alleviation Medical Services PC. Respondent submitted, or caused to submit, nerve conduction studies which had physiologically impossible identical tabular data (to the .01 decimal point) and identical wave forms. With respect to the electro-diagnostic evaluations for Patients I through O, Respondent:

1. Deviated from medically accepted standards in that he:
   a. Failed to identify, note and/or appropriately diagnose abnormalities in the nerve conduction studies
   b. Based his interpretations on nerve conduction studies that were not, in fact, reflective of the conditions of the respective patients.
2. Knowingly created the false impression that the nerve conduction reports for Patients I through O were based on genuine studies reflective of the condition of the respective patients, when, in fact, Respondent knew that the reports were based on fabricated test results. Respondent intended to deceive.
3. Respondent failed to maintain medical records for Patients I through O.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

MORAL UNFITNESS

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

1. A, A1, B, B1, B1 (a), B1 (b), B1 (c), B2, C, C1, D, D1, E, E1,E2, E3, F, F1, F2, F3, G, G1, G2, G3, H, H1, H2, I, I1, I1 (a), I1 (b), I2 and/or I3.

SECOND AND THIRD 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:

2. B, B1, B1 (a), B1 (b) and B1(c).
3. I and I2.

FOURTH AND FIFTH SPECIFICATIONS

FALSE REPORTS

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:

4. B, B1, B1 (a), B1 (b) and B1 (c).

5. I and I2.

SIXTH THROUGH NINETH SPECIFICATIONS

EXERCISING UNDUE INFLUENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(17) by exercising undue influence on the patient in such manner as to exploit the patient for the financial gain of the licensee or of a third party, as alleged in the facts of:

6. A and A1.

7. B and B2.

8. C and C1.

9. D and D1.

TENTH 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:

10. E, E1, E2, E3, F, F1, F2, F3, G, G1, G2, G3, H, H1, H2, I, I1, I1 (a) and/or I1(b).

ELEVENTH 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:

11. E, E1, E2, E3, F, F1, F2, F3, G, G1, G2, G3, H, H1, H2, I, I1, I1 (a) and/or I1 (b).

TWELFTH AND THIRTEENTH 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:

12. E3, F3 and/or G3.

13. H, H2, and/or I3.

DATE: July / , 2016
New York, New York

[redacted]

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct