



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

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

Karen Schimke
Executive Deputy Commissioner

August 31, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrance Sheehan, Esq.
NYS Department of Health
Metropolitan Regional Office
5 Penn Plaza-Sixth Floor
New York, New York 10001

Robert Asher, Esq.
295 Madison Avenue
New York, New York 10017

James E. Lowe, Jr., M.D.
133 East 73rd Street
New York, New York 10021

RECEIVED
AUG 31 1995
OFFICE OF PROFESSIONAL
MEDICAL CONDUCT

RE: In the Matter of James E. Lowe, Jr., M.D.

Dear Mr. Sheehan, Mr. Asher and Dr. Lowe:

Enclosed please find the Determination and Order (No. 95-199) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

NEW YORK STATE DEPARTMENT OF HEALTH 19

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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,

Tyrone T. Butler/nm
Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

**IN THE MATTER
OF
JAMES E. LOWE, JR., M.D.**

**DETERMINATION
AND
ORDER
BPMC-95-199**

KENNETH KOWALD, Chairperson, JOHN A. D'ANNA, JR., M.D., and STEVEN M. LAPIDUS, M.D., duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **JANE B. LEVIN, ESQ.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	February 9, 1995
Pre-hearing Conference:	April 17, 1995
Hearing dates:	May 3, 1995 June 2, 1995 June 16, 1995 June 20, 1995
Deliberation date:	August 8, 1995

Place of Hearings: NYS Department of Health
5 Penn Plaza
New York, New York 10001

Petitioner appeared by: Jerome Jaskinski, Esq.
Acting General Counsel
NYS Department of Health
BY: Terrence Sheehan, Esq.
Associate Counsel

Respondent appeared by: Robert Asher, Esq.
295 Madison Avenue
New York, New York 10017

WITNESSES

For the Petitioner: Mary Ellen Cisar
Dr. Marvin Matz
Patient F
Patient G

For the Respondent: Dr. James E. Lowe, Jr., Respondent
Dr. Mansanipalli Vittal

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct in that he practiced fraudulently, made false reports, practiced with negligence, ordered excessive treatment, willfully harassed a patient, failed to obtain informed consent, failed to maintain records, and evidenced moral unfitness to practice medicine. The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers (T.) and exhibit numbers (Ex.). These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

GENERAL FINDINGS

1. James E. Lowe, Jr., M.D., the Respondent, is a physician who was duly licensed to practice medicine in New York State on or about October 5, 1979 by the issuance of license number 140031 by the New York State Education Department. (Pet. Ex. 1)
2. The Respondent maintains medical offices for the practice of plastic surgery at 133 East 73rd Street, New York, New York. (Pet. Ex. 21)

FINDINGS OF FACT AS TO PATIENT A

3. Between April 10, 1986 and April 26, 1986, the Respondent rendered surgical services to Patient A, a 59 year old woman, at his medical offices. (T. 379)
4. Respondent billed Aetna Life and Casualty Company, Patient A's insurer, Five Hundred Dollars (\$500.00) for a nasal pharyngoscopy under general anesthesia. (Pet. Ex. 18)
5. The Respondent testified that he did not use general anesthesia and that the bill was in error. (T. 379)

6. Respondent testified that he performed a biopsy of a lesion of the patient's right eyelid and billed the insurance company Two Hundred (\$200.00) for this procedure, although he was not able to produce a copy of the biopsy report and did not offer an explanation as to why it could not be found. (T. 403; Pet. Ex. 18)
7. On or about April 14, 1986, Respondent submitted to Aetna Life and Casualty Company an operative report and bill for Five Thousand Dollars (\$5, 000.00) for an excision from the patient's right eyelid of a malignant basal cell carcinoma measuring 8 cm., and for the total surgical reconstruction of the eyelid, sub-mucous resection, bilateral turbinectomy and bilateral Caldwell-Luc procedures.
8. Marvin I. Matz, M.D., a board certified otolaryngologist, who is the chief of Ear, Nose and Throat at Lady of Mercy Hospital, testified that it is unlikely, and in fact dangerous, for a practitioner to perform these multiple procedures during the same surgery. (T. 77)
9. On or about April 14, 1986, the Respondent also submitted to Aetna a pathology report on the letterhead of Universal Diagnostic Laboratories, which indicated that the lesion of the eyelid was a basal cell carcinoma and that bilateral turbinates were removed.
(Pet. Ex. 18)
10. A letter from Universal Diagnostic Laboratories indicated that it had no record of any service provided to this patient. (Pet. Ex. 18)
11. The pathology reports on Universal Diagnostic's letterhead which were submitted by Respondent for both Patient A and B bear the same specimen number, UDL 85/520.
(Pet. Exs. 15, 17 and 18)

12. Respondent admitted multiple errors and inaccuracies in his records. (T. 408-410)

CONCLUSIONS AS TO PATIENT A

1. The Respondent knowingly and intentionally submitted a fraudulent operative report to the patient's insurance company. It is medically improbable the Respondent would have performed these multiple surgical procedures simultaneously under local anesthesia in an office setting.
2. The Respondent knowingly and intentionally submitted a fraudulent pathology report, fabricated by the Respondent, to the patient's insurance company. There is clear evidence that Universal Diagnostic Laboratory had no reports for a pathology specimen of any kind for this patient.
3. The Respondent submitted fraudulent reports because he performed cosmetic procedures on Patient A for which the insurance company would not reimburse the practitioner.
4. By virtue of the submission of the fraudulent pathology and operative reports and Respondent's own admissions, these medical records failed to comport with the generally acceptable standards for medical records.

FINDINGS OF FACT AS TO PATIENT B

13. Between April 4, 1986 and August 9, 1986, Respondent rendered surgical services to Patient B at his medical office. (Pet. Ex. 4)

14. On or about May 6, 1986, Respondent billed Aetna Life and Casualty, Patient B's insurer, Five Hundred Dollars (\$500.00) for a nasal pharyngoscopy under general anesthesia; Nine Thousand Six Hundred Dollars (\$9,600.00) for a sub-mucous resection, bilateral turbinectomy and Caldwell Luc procedures; and Two Thousand Dollars (\$2,000.00) for an excision of a five (5) cm. tumor from the Patient's left face. (Pet. Exs. 4, 17)
15. Respondent's office records do not indicate that the patient had any complaint regarding a facial tumor. (Pet. Ex. 4), although Dr. Matz testified that it was unlikely for a patient not to present with a chief complaint of facial tumor with a lesion as large as this. (T. 85)
16. Respondent admitted that these procedures were not performed under general anesthesia. (T. 439)
17. According to Respondent's operative report, he was not assisted by any medical or nursing staff during these surgeries. (Pet. Ex. 4)
18. Dr. Matz testified that the performance of these procedures together would not be consistent with good surgical practice and that it would be medically impossible for Respondent to perform these surgeries without assistance. (T. 57, 69)
19. Respondent submitted to Aetna a pathology report on the letterhead of Universal Diagnostic Laboratories which indicated the removal of a schwannoma and removal of turbinates. This report bears the same specimen number, UDL 85/520 as that of the report submitted for Patient A. (Pet. Ex. 17)

20. A letter from the President of Universal Diagnostic Laboratories stated that these reports were not accurate. (Pet. Ex. 17) Universal Diagnostic Laboratories provided copies of the actual reports it had sent to the Respondent. The contents of these reports, which bear the same dates as the Respondent's own operative reports, do not support the Respondent's descriptions of the surgery performed. (Pet. Exs. 15, 17)
21. Respondent could not provide an explanation for these discrepancies. (T. 439)
22. Dr. Matz testified that the pathology reports supplied by Universal Diagnostic are consistent with blepharoplasty, which is a cosmetic procedure not reimbursable by insurance companies. (T. 61)
23. Respondent did not offer any explanation for the multiple instances of errors and inaccuracies in his records. (T. 450, 459, 464)

CONCLUSIONS AS TO PATIENT B

5. The Respondent knowingly and intentionally submitted a fraudulent operative report to the patient's insurance company. It is medically improbable that the Respondent would have performed these multiple surgical procedures simultaneously under local anesthesia in an office setting.
6. The Respondent knowingly and intentionally submitted a fraudulent pathology report, fabricated by Respondent, to the patient's insurance company.

7. The Respondent submitted fraudulent reports because he performed cosmetic procedures on Patient B for which the insurance company would not reimburse the practitioner.
8. By virtue of the submission of the fraudulent pathology and operative reports and Respondent's own admissions, these medical records failed to comport with the generally acceptable standards for medical records.

FINDINGS OF FACT AS TO PATIENT C

24. On or about May 1, 1985, the Respondent rendered surgical care to Patient C at Lutheran Medical Center, located at 150-55th Street, Brooklyn, New York. (Pet. Ex. 11)
25. On or about May 1, 1985, the Respondent billed Phoenix Mutual Life Insurance Company, Patient C's insurer, Two Thousand Dollars (\$2,000.00) for the excision of a 5x5 cm. melanoma of the face and closure with a rhomboid flap. (Pet. Ex. 7)
26. On or about July 15, 1985, Respondent forwarded to Phoenix Mutual Life Insurance Company a copy of a pathology report for the surgery performed on May 1, 1985. This report was a copy of the official Lutheran Medical Center pathology report which differed from the original report in two respects: the size of the facial tumor read "4.5 cm." rather than "1.5 cm." and the diagnosis read "melanoma of face, superficial spreading type, thickness is 1.5 mm." rather than "seborrheic keratosis". (T. 92-96, 118; Pet. Exs. 7, 11)
27. The pathology report indicated that the entire specimen was not embedded. Dr. Matz testified that a pathology report for a melanoma would normally indicate that the entire specimen was "embedded". (T. 116-117; Pet. Ex. 7)

28. Respondent also forwarded to Phoenix Mutual Life Insurance Company an operative report which claimed that Patient C had a pre-operative diagnosis of "melanoma right cheek"; that there was a pre-operative biopsy; that a melanoma was excised by Respondent; and that he closed the defect by designing a rhomboid flap. None of these "facts" are stated in the operative report contained in the patient's official hospital chart. (T. 92-103; Pet. Exs. 7, 11)
29. The operative report forwarded to Phoenix Mutual Life Insurance Company by Respondent was typed on the letterhead of Lutheran Medical Center. (T. 103-106; Pet. Ex. 7)
30. Respondent prepared three (3) separate operative reports for this patient, which are inconsistent with each other. (T. 106)
31. Respondent's office record contains obvious errors. For instance, the note dated April 3, 1985, appears to be the record of an initial office visit, but towards the end of the note, it is recorded that the patient was hospitalized from April 30, 1985 to May 5, 1985, a fact which Respondent could obviously not be aware of on April 3rd. (Pet. Ex. 6)

CONCLUSIONS AS TO PATIENT C

9. The Respondent knowingly and intentionally created false and inaccurate operative reports.
10. The Respondent knowingly and intentionally altered a pathology report.
11. Respondent's use of the hospital letterhead for the false operative report submitted to the insurance company was done with the intention of misleading the insurer into believing that it was a copy of the official report and, therefore, paying a claim to which the Respondent was not entitled.

12. By virtue of the submission of the fraudulent pathology and operative reports and Respondent's own admissions, these medical records failed to comport with the generally acceptable standards for medical records.

FINDINGS OF FACT AS TO PATIENT D

32. On or about December 1, 1985, Respondent performed a nasal pharyngoscopy on Patient D in the presence of active bleeding. Dr. Matz testified that although this procedure was not necessarily contraindicated, it would be difficult to see anything. (T. 141)
33. On or about December 2, 1985, the Respondent rendered surgical care to Patient D at Lutheran Medical Center. (Pet. Ex. 9)
34. On or about December 8, 1985, Respondent billed Pilot Insurance Company, Patient D's insurer, Three Thousand Dollars (\$3,000.00) for an open reduction of a left orbital floor fracture with implants. (Pet. Ex. 8)
35. Dr. Matz testified that this procedure would normally constitute an acute emergency, and would be the primary procedure discussed in an operative report. The hospital report makes no mention of this procedure. In addition, an xray taken in the hospital is inconsistent with such an injury. (T. 15-152; Pet. Ex. 9)
36. Respondent also billed Pilot Insurance Company for the performance of an iliac crest bone graft to the nasal dorsum. Dr. Matz testified that this is not usually done as an acute procedure in a patient with an open comminuted fracture of the nasal bone, and instead is usually performed as a secondary cosmetic procedure. (T. 151-152)

37. Respondent also billed for an open reduction of a maxillary process fracture. This procedure is not described in the official operative report, nor is it mentioned on the xray report in the patient's chart. (Pet. Ex. 9)

CONCLUSIONS AS TO PATIENT D

13. The Respondent knowingly and intentionally submitted false operative reports and billed for procedures he did not perform for the purposes of financial gain.
14. The Respondent is not guilty of negligence, since the Committee believes he did not perform the alleged procedures, with the exception of the pharyngoscopy, which was not contraindicated.
15. The Respondent is also therefore not guilty of excessive treatment of Patient D.
16. By virtue of the submission of the fraudulent operative reports, these medical records failed to comport with the generally acceptable standards for medical records.

FINDINGS OF FACT AS TO PATIENT E

38. Between on or about January 12, 1988 and on or about May 31, 1988, the Respondent treated Patient E at his office. His office records indicate that he first saw Patient E for wrist surgery in January, 1988. (Pet. Exs. 10, 16)

39. On or about January 20, 1988, Respondent submitted to Aetna Life and Casualty, Patient E's insurer, a claim for Seven Thousand Three Hundred Fifty Dollars (\$7,350.00) for an open reduction of a nasal fracture and a septal reconstruction allegedly performed on January 18, 1988, and a three (3) page document purporting to describe the patient's history, physical findings and details of surgery. (Pet. Ex. 16)
40. Respondent's office records do not mention this surgery, nor are there any post-surgical visits noted. (Pet. Ex. 10)
41. Aetna Life and Casualty contacted Patient E, who confirmed that Respondent never performed these surgeries. (T. 161; Pet. Ex. 16)
42. On or about October 5, 1988, Aetna Life and Casualty demanded reimbursement from Respondent of the Four Thousand Five Hundred Sixty Four Dollars (\$4,564.00) paid to him. Respondent returned the money in full without protest. (Pet. Ex. 16)

CONCLUSIONS AS TO PATIENT E

17. Respondent knowingly and intentionally billed the insurer for surgery he did not perform.
18. Respondent knowingly and intentionally created a false record and submitted it to the insurer for financial gain.
19. By virtue of the submission of the fraudulent operative reports, these medical records failed to comport with the generally acceptable standards for medical records.

FINDINGS OF FACT AS TO PATIENT F

43. Between on or about July 21, 1987 and on or about April 15, 1988, the Respondent treated Patient F for facial and abdominal keloids at Lutheran Medical Center, Brooklyn, New York and at his medical office. (Pet. Exs. 12, 13)
44. On or about July 28, 1987, the Respondent claimed to have excised facial and abdominal keloids and performed incisional and umbilical hernia repairs at Lutheran Medical Center. (Pet. Ex. 13)
45. Patient F testified that her primary physician, Dr. Padilla, performed complete physicals on her on an annual basis, and that he had never told her that she had any type of hernia. (T. 198-200)
46. After Respondent examined Patient F during her initial office visit, he never mentioned the need for hernia surgery. (T. 201)
47. A pre-operative physical examination was performed on Patient F at the hospital, and it did not note the presence of any hernias. (T. 202 Pet. Ex. 13)
48. The patient signed a consent form for the surgery performed on July 28, 1987. She testified that the Respondent was not present when she signed the form, and that it did not contain any reference to hernia surgery. (T. 205, 214; Pet. Ex. 13)
49. Dr. Vittal, the anesthesiologist for this surgery, testified that if he observed the hernia repair or was told about it by the surgeon, he would have noted it in the anesthesia record. It was not noted. Dr. Vittal also testified that if a "very large incisional hernia with multiple loops

of small bowel," was present as Respondent described it in his office records, he would have noticed it during the surgery. He also stated that the Respondent did not notify the anesthesiology department that he was going to perform a hernia repair on Patient F.

(T. 63-632, 636-637, 642-644; Pet. Ex. 13)

50. According to the hospital operative report, the patient received a series of steroid injections over a period of months. No mention is made of these injections in Respondent's office records, and the patient testified that she never received any. (T. 249-250, 339-340; Pet. Exs. 12, 13)

CONCLUSIONS OF LAW AS TO PATIENT F

20. The Respondent knowingly and intentionally dictated an inaccurate operative report and altered the patient's consent form to gain reimbursement for procedures he did not perform.
21. The Respondent knowingly and intentionally submitted false reports to the insurance company.
22. The Respondent is not guilty of negligence, excessive treatment, or failure to obtain informed consent since the Committee concluded that the hernia repair was not done.
23. By virtue of the creation of the fraudulent operative reports, these medical records failed to comport with the generally acceptable standards for medical records.

FINDINGS OF FACT AS TO PATIENT G

51. On or about May 15, 1992, Respondent treated Patient G in the emergency room at Lenox Hill Hospital, Park Avenue and 77th Street, New York, New York, for a cut lip and broken jaw she sustained after a bicycle accident. The patient was brought to the emergency room by ambulance. (Pet. Ex. 21)
52. After examining the patient, Respondent began to treat her lip by injecting anesthesia prior to suturing it. Patient G testified that the Respondent stated that he would not treat her lip unless she permitted him to perform all the necessary subsequent work. Patient G testified that she felt pressured and intimidated and, therefore, agreed to Respondent's proposal. (T. 271-272, 286)
53. Respondent denied Patient G's version of the events. (T. 727-728)

CONCLUSIONS OF LAW AS TO PATIENT G

24. Two members of the Hearing Committee did not find the witness's testimony, which was highly emotional, sufficiently credible to sustain the charge of willful harassment. One committee member disagreed.
25. The charge of lack of informed consent was not proven.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous, except where specified.)

**FIRST THROUGH SIXTH SPECIFICATION:
(Practicing fraudulently)**

SUSTAINED as to Paragraphs A and A1-6; B and B1-8; C and C1-4; D and D1,2,3,6; E and E1,2,4,5,6; F and F1 as to excision of keloids only, F2-5.

NOT SUSTAINED as to Paragraphs D4, D5; E3; F1 as to hernia repairs, and F4.

**SEVENTH THROUGH TWELFTH SPECIFICATIONS:
(Making a false report)**

SUSTAINED as to Paragraphs A and A1-6; B and B1-8; C and C1-4; D and D1,2,3,6; E and E1,2,4,5,6; F and F1 as to excision of keloids only, F2-5.

NOT SUSTAINED as to Paragraphs D4, D5; E3; F1 as to hernia repairs, and F4.

**THIRTEENTH SPECIFICATION:
(Practicing with negligence on more than one occasion)**

NOT SUSTAINED as to all charges.

**FOURTEENTH AND FIFTEENTH SPECIFICATION:
(Ordering excessive treatment)**

NOT SUSTAINED as to all charges.

**SIXTEENTH SPECIFICATION:
(Willful harassment)**

NOT SUSTAINED by a vote of 2-1 as to all charges.

SEVENTEENTH AND EIGHTEENTH SPECIFICATION:
(Failure to obtain informed consent)

NOT SUSTAINED as to all charges.

NINETEENTH THROUGH TWENTY-FOURTH SPECIFICATIONS:
(Failure to maintain records)

SUSTAINED as to Paragraphs A and A6; B and B8; C and C4; D and D6; E and E6; F and F5.

TWENTY-FIFTH SPECIFICATION:
(Moral unfitness)

NOT SUSTAINED as to all charges.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee has determined that the Respondent is a well trained physician with a good fund of knowledge and a good understanding of anatomy and surgical practice. Nonetheless, the Committee feels that he is an example of the excesses which are possible in a third party payor system where greed is a motivating factor. Although the Committee found evidence of unethical behavior on the part of the Respondent, it felt that this behavior did not rise to the level which makes him morally unfit to practice medicine.

The brief submitted on behalf of the Respondent acknowledges that he "failed to maintain a medical record for Patients A, B, C, D, E, and F which accurately reflects the patients' history, examination, laboratory tests and treatment provided; and also...willfully made or filed a false report with respect to Patients A, B, C, and D."

The Respondent's deliberate and conscientious attempt to defraud the insurance company and the outrageous and excessive bills he submitted do, however, call for a severe penalty. Because the Committee does not see the Respondent as a threat to the public health, it feels that a five-year period of suspension, stayed under the terms of probation, including a financial record review and Two Hundred (200) hours of community service, as is more fully set out in the Order, coupled with a monetary penalty of One Hundred Fifty Thousand Dollars (\$150,000.00) (Ten Thousand Dollars (\$10,000.00) for each of the twelve (12) sustained specifications of practicing fraudulently and making false reports, and Five Thousand Dollars (\$5,000.00) for each of the six (6) sustained specifications of failure to maintain records) are a more appropriate penalty than revocation.

ORDER

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

1. Respondent's license to practice medicine in the State of New York is hereby **SUSPENDED** for a period of five (5) years, with the suspension **STAYED** during a five (5) year period of probation; and
2. The terms of probation are as follows:
 - Respondent will personally meet with a member of the Office of Professional Medical Conduct Staff on a semi-annual basis, unless otherwise agreed to.
 - Respondent will conform fully:
 - a. to the professional standards of conduct imposed by law and by his profession;
 - b. with all civil and criminal laws, rules and regulations.
 - Respondent will notify the Office of Professional Medical Conduct of:
 - a. any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within thirty days of each action;

- b. any and all changes in personal and professional addresses and telephone numbers and facility affiliations, within thirty days of such changes. This will include any change in practice location, within or outside of the State of New York. The date of departure from the State of New York and the date of return, if any, must be reported in writing.

Failure to notify the Office of Professional Medical Conduct of any of the above will be considered a violation of probation.

- Respondent will maintain legible and complete medical records which accurately reflect a comprehensive history, physical examination findings, chief complaint, present illness, diagnosis and treatment. In cases of prescribing, dispensing or administering of controlled substances, the medical record will contain all information required by state rules and regulations regarding controlled substances.
- During the period of probation, the Director of the Office of Professional Medical Conduct or his/her designees, may review the professional performance of the Respondent. This review may include, but not be limited to, a random selection of the office records, including financial and billing records, and patient records or hospital charges, interviews or period visits with the Respondent at his office location or one of the offices of the Office of Professional Medical Conduct.
- The Respondent will make available for review by the Office of Professional Medical Conduct, or a physician selected by the Respondent and approved by the Office of Professional Medical Conduct, complete copies of any and all medical and office records selected by the Office of Professional Medical Conduct.
- Any deviation from accepted medical practice identified during any of the reviews will be discussed with the Respondent. Any pattern of substandard care identified during the probationary period may result in an independent medical review and could lead to additional investigation or charges.
- The Respondent shall perform Two Hundred (200) hours of community service. The service must be medical in nature, preferably plastic or reconstructive surgery, and delivered in a facility or with an organization equipped to provide medical services and serving a needy or medically underserved population in New York City. A written proposal for community service must be submitted in advance, for written approval by the Director or his/her designees. Community service performed prior to the effective date of this Order cannot be credited for compliance with this term.
- A violation of any aspect of the terms of probation shall be considered professional misconduct, pursuant to Section 230 of the Public Health Law and Section 6530 of the State Education Law.

3. A fine in the amount of One Hundred Fifth Thousand Dollars (\$150,000.00) is imposed upon the Respondent. Payment of the fine shall be made within thirty (30) days of the effective date of this **ORDER** to the New York State Department of Health, Bureau of Accounts Management, Revenue and Cash Unit, Corning Tower Building, Room 1245, Empire State Plaza, Albany, New York 12237¹.
4. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or upon seven days after mailing by certified or registered mail.

DATED: New York, New York

August 30, 1995


KENNETH KOWALD
Chairperson

JOHN D'ANNA, M.D.
STEVEN M. LAPIDUS, M.D.

¹Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York, This includes, but is not limited to, the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection and non-renewal of permits or licenses (Tax Law §171(27); State Finance Law §18; CPLR §5001; Executive Law §32).



APPENDIX I

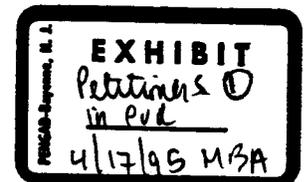
NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF
Jr. amended 6/16/95
JAMES E. LOWE, M.D. JBL

NOTICE
OF
HEARING

TO: JAMES E. LOWE, M.D.
103 East 75th Street
New York, New York



PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1995). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on , 1995, at 10:00 a.m. , at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, and at such other adjourned dates, times and places as the committee may direct.

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

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date.

Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1995), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1995). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
March 15, 1995


Chris Stern Hymn
Counsel

Inquiries should be directed to: **TERRENCE SHEEHAN**
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2615

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

-----X

IN THE MATTER : STATEMENT
OF : OF
JAMES E. LOWE, M.D. *Jr. Amended 6/16/95* : CHARGES
JBL

-----X

JAMES E. LOWE, M.D., the Respondent, was authorized to practice medicine in New York State on October 5, 1979, by the issuance of license number 140031 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. Between on or about April 10, 1986 and on or about April 26, 1986, Respondent rendered various surgical services to Patient A, a 59 year old woman, at his medical office located 133 East 73rd Street, New York, New York. (Patient A and all other patients are identified in the Appendix.)
1. On or about April 10, 1986, Respondent billed Aetna Life Insurance Co., Patient A's insurer, \$500.00 for a nasal pharyngoscopy under general anesthesia. In fact, Respondent did not perform this procedure. The bill submitted by Respondent was knowingly false.
 2. On or about April 14, 1986, Respondent billed the patient's insurer \$200.00 for a biopsy of her right eyelid. Respondent did not perform a biopsy of Patient

A's eyelid. The bill submitted by Respondent was knowingly false.

3. On or about April 14, 1986, Respondent billed the patient's insurer \$5,000.00 for an excision from the patient's right eyelid of a malignant basal cell carcinoma measuring 8cm. and for the surgical reconstruction of the eyelid. Respondent did not remove a carcinoma from Patient A's eyelid. He actually performed a blepharoplasty on both eyelids. A blepharoplasty is a cosmetic procedure which is not covered by Patient A's insurer. The bill submitted by Respondent to the insurer was knowingly false.
4. On or about July 30, 1986, the patient's insurer asked Respondent to provide a copy of the operative report and pathology report for the procedures performed on April 14, 1986. In response, Respondent forwarded an operative report which falsely stated that Respondent had excised a basal cell carcinoma from Patient A's right eyelid.
5. Respondent also forwarded a copy of a pathology report by Universal Diagnostic Laboratories, Inc., (Universal Diagnostic), 1414 Newkirk Avenue, Brooklyn, New York. The report contained a diagnosis of basal cell carcinoma of the right eyelid. The pathology report forwarded by Respondent, although on the letterhead of

Universal Diagnostic, had been fraudulently altered by Respondent to support his claim that he had removed a carcinoma. In fact, Respondent did not submit to Universal Diagnostic any specimen for pathological examination from Patient A's eyelid surgery; nor did Universal Diagnostic perform a pathology report for that procedure.

6. Respondent failed to maintain a medical record for Patient A which accurately reflects the patient's history, examination, laboratory tests, consent for surgery and treatment rendered.

B. Between on or about April 4, 1986 and on or about August 9, 1986, Respondent rendered various surgical services to Patient B at his medical office located at 133 East 73rd Street, New York, New York.

1. On or about May 6, 1986, Respondent billed Aetna, Patient B's insurer, \$500.00 for a nasal pharyngoscopy under general anesthesia. In fact, Respondent did not perform this procedure. The bill submitted by Respondent was knowingly false.
2. On or about May 6, 1986, Respondent billed the patient's insurer \$9600.00 for a submucous resection, bilateral turbinectomy and a Caldwell Luc procedure. Respondent did not perform these procedures. The bill

submitted by respondent was knowingly false.

3. On or about May 6, 1986, Respondent billed the patient's insurer \$2,000.00 for an excision of a tumor from the patient's left face. Respondent did not perform this procedure. The bill submitted by Respondent was knowingly false.
4. On or about July 2, 1986, the patient's insurer asked Respondent to provide a copy of the operative report and pathology report for the procedures performed on May 6, 1986.
5. In response, Respondent forwarded an operative report which falsely stated that Respondent had performed a nasal pharyngoscope under anesthesia; a submucous resection; a bilateral turbinectomy; a Caldwell Luc procedure and an excision of a tumor of the left face.
6. Respondent also forwarded a copy of a pathology report by Universal Diagnostic Laboratories, Inc. The pathology report forwarded by Respondent, although on the letterhead of Universal Diagnostic, had been fraudulently altered by Respondent to support his claim that he had removed a schwannoma and performed a turbinectomy.
7. The actual procedures performed by Respondent on May 6,

1986, were a blepharoplasty on both eyelids and the removal of keloids. Respondent knew that these procedures, being cosmetic in nature, would not have been covered by Patient B's insurer.

8. Respondent failed to maintain a medical record for Patient B which accurately reflects the patient's history, examination, laboratory tests, consent for surgery and treatment rendered.

C. On or about May 1, 1985, Respondent rendered surgical care to Patient C at Lutheran Medical Center, located at 150 55th Street, Brooklyn, New York.

1. On or about May 1, 1985, Respondent billed Phoenix Mutual Life Ins. Co., Patient C's insurance carrier, \$2,000.00 for the excision of a 5X5cm. melanoma of the face and closure with rhomboid flap. In fact, Respondent did not perform this procedure. The bill submitted by Respondent was knowingly false.
2. On or about July 15, 1985, respondent forwarded to Patient C's insurer a copy of a pathology report for the procedure performed on May 1, 1985. The pathology report forwarded by Respondent was a copy of the official Lutheran Medical Center pathology report which had been fraudulently altered by Respondent to support his claim that he had removed a melanoma.

3. On or about July 15, 1985, Respondent also forwarded to the patient's insurer an operative report which falsely stated that Respondent had excised a melanoma.
 4. Respondent failed to maintain a medical record for Patient C which accurately reflects the patients' history, examination, laboratory tests and treatment rendered.
- D. On or about December 2, 1985, Respondent rendered surgical care to Patient D at Lutheran Medical Center.
1. On or about December 8, 1985, Respondent billed Pilot Ins. Co., Patient D's insurer, \$3,000 for an open reduction of a left orbital floor fracture with implants. In fact, Respondent did not perform this procedure. The bill submitted by Respondent was knowingly false.
 2. On or about December 8, 1985, Respondent billed the patient's insurer \$500 for an open reduction of a maxillary process fracture. In fact, Respondent did not perform this procedure. The bill submitted by Respondent was knowingly false.
 3. On or about December 8, 1985, Respondent forwarded to the patient's insurer an operative report which falsely stated that Respondent had performed an open reduction of a left orbital floor fracture with implants and an

open reduction of a maxillary process fracture.

4. On or about December 2, 1985, Respondent performed a iliac crest bone graft to the nasal dorsum. This procedure was not indicated.
 5. On or about December 1, 1985, Respondent performed a nasal pharyngoscopy in the presence of acute bleeding. This procedure was not indicated.
 6. Respondent failed to maintain a medical record for Patient D which accurately reflects the patients' history, examination, consent for surgery, laboratory tests, x-rays and treatment rendered.
- E. Between on or about January 12, 1988 and on or about May 31, 1988, Respondent treated Patient E at his office at 103 East 75rd Street, New York, New York.
1. On or about January 20, 1988, Respondent submitted to Aetna Life and Casualty ("Aetna"), Patient E's insurer, a claim for \$7,350 for an open reduction of a nasal fracture and a septal reconstruction allegedly performed on January 18, 1988. In fact, Respondent never performed such surgery on Patient E. The claim submitted by Respondent to Aetna was knowingly false.
 2. On or about January 20, 1988, Respondent also submitted to Aetna a three page document purporting to describe

Patient E's nose injury, Respondent's findings on examination and the details of the surgery he performed. The document is false and was created by Respondent in order to induce Aetna to pay him monies to which Respondent knew he was not entitled.

3. On or about January 20, 1988, Respondent also submitted to Aetna a Trans World Airlines employee claim form. Patient E was an employee of TWA. On this form, Respondent, or an individual acting at the direction of Respondent, forged Patient E's signature.
 4. On or about March 9, 1988, Aetna paid \$4,564 for the surgery purportedly performed on January 18, 1988.
 5. On or about October 5, 1988, Aetna demanded reimbursement from Respondent of the \$4,564 paid to him. On or about November 30, 1988, Respondent repaid the money without protest.
 6. Respondent failed to maintain a medical record for Patient E which accurately reflects Patient E's history, examination, laboratory tests, consent for surgery and treatment rendered.
- F. Between on or about July 21, 1987 and on or about April 15, 1988, Respondent treated Patient F for facial and abdominal keloids at Lutheran Medical Center, Brooklyn, New York an

and at his medical office.

1. On or about July 28, 1987, Respondent excised facial and abdominal keloids and performed incisional and umbilical hernia repairs at Lutheran Medical Center.
 2. Respondent did not obtain Patient F's informed consent for the incisional and umbilical hernia repairs.
 3. On or about July 27, 1987, Patient F signed a consent form for excision of multiple keloids. Sometime after Patient F signed the consent form, Respondent, or someone acting on behalf of Respondent, fraudulently altered the consent form by adding the words "hernia repair" to the list of authorized procedures.
 4. The hernia repair procedures performed by Respondent were not medically necessary. Patient F did not have incisional and umbilical hernias. Respondent performed the procedures not in good faith and solely for financial gain.
 5. Respondent failed to maintain a medical record for Patient F which accurately reflects the patients' history, examination, consent form, laboratory tests, x-rays and treatment rendered.
- G. On or about May 15, 1992, Respondent treated Patient G in the emergency room at Lenox Hill Hospital, Park Avenue and

77th Street, New York, for injuries to the patients' lip and jaw caused by a fall from a bicycle.

1. Respondent was called in by the emergency room staff to see Patient G. After examining Patient G, the patient told Respondent that a certain physician was her plastic surgeon. While injecting the patients' lip with anesthesia, Respondent stated that he would not continue to treat her unless she permitted him to do all the required plastic surgery. Patient G felt pressured and coerced to consent.
2. Respondent repaired the laceration to the patient's lip. Respondent submitted a bill for \$3,900 to the patients' insurer for services rendered. Patient G went to her plastic surgeon for removal of the sutures and for surgery to her jaw.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH SPECIFICATIONS

PRACTICING FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently under N.Y. Educ. Law Section 6530(2) (McKinney Supp. 1995), in that Petitioner charges:

1. The facts in Paragraphs A and A.1 through A.6.
2. The facts in Paragraphs B and B.1 through B.8.
3. The facts in Paragraphs C and C.1 through C.4.
4. The facts in Paragraphs D and D.1 through D.6.
5. The facts in Paragraphs E and E.1 through E.6.
6. The facts in Paragraphs F and F.1 through F.5.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

MAKING A FALSE REPORT

Respondent is charged with committing professional misconduct within the meaning of N. Y. Educ. Law Section 6530(21) (McKinney Supp. 1995), by willfully making or filing a false report in that Petitioner charges:

7. The facts in Paragraphs A and A.1 through A.6.
8. The facts in Paragraphs B and B.1 through B.8.
9. The facts in Paragraphs C and C.1 through C.4.
10. The facts in Paragraphs D and D.1 through D.6.
11. The facts in Paragraphs E and E.1 through E.6.
12. The facts in Paragraphs F and F.1 through F.5.

THIRTEENTH SPECIFICATIONS

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1995), by practicing the profession with

negligence on more than one occasion, in that Petitioner charges two or more of the following:

13. The facts in Paragraphs D and D.4, D.5, and/or F and F.1 and F.4.

FOURTEENTH AND FIFTEENTH SPECIFICATIONS

ORDERING EXCESSIVE TREATMENT

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(35) (McKinney Supp. 1995) by ordering excessive tests, treatment or use of treatment facilities not warranted by the condition of the patient, in that Petitioner charges:

14. The facts in Paragraphs D and D.4, D.5.
15. The facts in Paragraphs F and F.4.

SIXTEENTH SPECIFICATION

WILLFUL HARASSMENT

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(31) (McKinney Supp. 1995) by willfully harassing, abusing or intimidating a patient either physically or verbally in that Petitioner charges:

16. The facts in Paragraphs G and G.1, G.2.

SEVENTEENTH AND EIGHTEENTH SPECIFICATIONS

FAILURE TO OBTAIN INFORMED CONSENT

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(26) (McKinney Supp. 1995) by performing professional services which have not been duly authorized by the patient or legal representatives in that Petitioner charges:

- 17. The facts in Paragraphs G and G.1 through G.3.
- 18. The facts in Paragraphs F and F.1 through F.5.

NINETEENTH THROUGH TWENTY-FOURTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1995) by his failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in that Petitioner charges:

- 19. The facts in Paragraphs A and A.6.
- 20. The facts in paragraphs B and B.8.
- 21. The facts in Paragraphs C and C.4.
- 22. The facts in Paragraphs D and D.6.
- 23. The Facts in Paragraphs E and E.6.
- 24. The facts in Paragraphs F and F.5.

TWENTY-FIFTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with practicing the profession in a manner which evidences moral unfitness to practice medicine under N.Y. Educ. Law Section 6530(20) (McKinney Supp. 1995), in that Petitioner charges:

25. The facts in Paragraphs A and A.1 through A.6, B and B.1 through B.7, C and C.1 through C.3, D and D.1 through D.5, E and E.1 through E.5, F and F.1 through F.5, and G and G.1 through G.3.

DATED: *February 9,* 1995
New York, New York



CHRIS STERN HYMAN
Counsel
Bureau of Professional
Medical Conduct