STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

May 14, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrence Sheehan, Esq.
Patricia Moro, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Barbara A. Ryan, Esq.
Aaronson, Rappaport, Feinstein
& Deutsch, LLP
757 Third Avenue
New York, New York 10017

Arthur Brown, M.D.
1928 Kings Highway
Brooklyn, New York 11229

RE: In the Matter of Arthur Brown, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 98-97) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), 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 penalties **other than suspension or revocation** until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:lcc
Enclosure

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

COPY

IN THE MATTER OF ARTHUR BROWN, M.D.	DETERMINATION AND ORDER BPMC-98-97

BENJAMIN WAINFELD, M.D., Chairman, FLORENCE KAVALER, M.D. and **MS. EUGENIA HERBST,** 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 Section 230(10)(e) of the Public Health Law. **MICHAEL P. McDERMOTT, 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 PROCEEDINGS

Notice of Hearing and Statement of Charges:	November 5, 1997
Pre-Hearing Conference:	November 24, 1997
Hearing Dates:	December 1, 1997 January 13, 1998 January 27, 1998 February 3, 1998 February 12, 1998 March 18, 1998 March 19, 1998
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York

Dates of Deliberations:	April 14, 1998 April 28, 1998
Petitioner appeared by:	Henry M. Greenberg, Esq. General Counsel NYS Department of Health By: Terrence Sheehan, Esq. and Patricia Moro, Esq., of Counsel
Respondent appeared by:	Aaronson, Rappaport, Feinstein & Deutsch, LLP 757 Third Avenue New York, New York 10017 By: Barbara A. Ryan, Esq.

WITNESSES

For the Petitioner:	Steven Tamarin, M.D.
For the Respondent:	1) Arthur Brown, M.D., the Respondent 2) Patient D 3) Rabbi David Spiegel 4) Joshua Mark Feibusch, M.D.

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with Negligence on More Than One Occasion, Incompetence on More Than One Occasion, Fraudulent Practice, Making a False Report, Unnecessary Tests or Treatment, Failure to Maintain Records and Moral Unfitness.

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 parenthesis refer to transcript page numbers or exhibits. 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. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS

1. Arthur Brown, M.D., the Respondent, was authorized to practice medicine in New York State on December 1, 1978 by the issuance of license number 136892 by the New York State Education Department.

FINDINGS AS TO PATIENT A

2. Patient A, a 52 year old female, was seen by the Respondent on 84 occasions during the period May 14, 1992 through October 13, 1994. There were 30 visits in a 7 month period in 1992; 39 visits in 1993 and 15 visits in a 10 month period in 1994 (Pet's. Ex. 2).

3. Patient A 's medical records indicate that only 24 of these visits were medically justified based on the recorded complaint, examination and diagnosis. These were the visits of 5/14/92, 5/28/92, 6/23/92, 7/23/92, 8/6/92, 9/10/92, 10/10/92, 12/17/92, 12/29/92, 1/14/93, 3/11/93, 3/18/93, 5/13/93, 5/27/93, 7/10/93, 7/15/93, 11/11/93, 1/13/94, 2/7/94, 2/17/94, 2/24/94, 4/26/94, 7/12/94, and 10/6/94.

   Although these visits were medically justified, there remain questions regarding the treatment options used (Pet's. Ex. 2).

4. The remaining 60 visits by Patient A were not medically justified based on the lack of adequate documentation to support the medical necessity of the visits; and the frequency of follow-up visits on the same presenting complaint or diagnosis (Pet's. Ex. 2).

5. The record of this case does not contain copies of any bills submitted by the Respondent to any insurance carrier on behalf of Patient A.

6. On June 23, 1992, the Respondent treated Patient A for a severe abscess and cellulitis of the middle left finger. In addition to incision and drainage, he treated the condition with one injection of Gentamicin and one injection of Penicillin. This was inappropriate. The choice of Gentamicin was not appropriate because of its known toxicity, and as used in this case, the dosage was inadequate. The dosage and form of Penicillin used was inappropriate for staph infection (Pet's. Ex. 2 and Pet's. Ex. 13, p. 2; Tr. 37-39).

7. The Respondent repeatedly referred Patient A to several specialists including a gastroenterologist, neurologist, pulmonologist, gynecologist and a cardiologist.
The referrals to a pulmonologist, gynecologist and cardiologist were medically justified. However, the record does not support the referrals to a gastroenterologist and neurologist (Pet's. Ex. 2).

8. There is no evidence in the record to support the allegation that the referrals made by the Respondent for Patient A were fraudulent (Pet's. Ex. 2).

9. The medical record does not support the need for almost weekly psychological counseling by the Respondent for Patient A. There is no documentation of psychiatric history, psychological testing, mental status evaluation, treatment plan or goals of therapy (Pet's. Ex. 2).

10. The Respondent treated Patient A's carpal tunnel syndrome with intra-articular injections into the joint space of the wrist. This treatment was appropriate (Pet's. Ex. 2, pp. 68, 70; Tr. 90-94).

11. On February 17, 1994 and again on February 24, 1994, the Respondent treated Patient A's otitis media with an intra muscular injection of penicillin and a prescription for amoxicillin. This was an appropriate treatment for the patient's condition (Pet's. Ex. 2, p. 50; Tr. 619).

12. The Respondent failed to maintain a medical record for Patient A which accurately reflects the care and treatment of the patient (Pet's. Ex. 2).

CONCLUSIONS AS TO PATIENT A

The Respondent's medical record for Patient A does not meet acceptable standards. There is inadequate documentation of complaint, history, review of systems, physical examination, diagnosis and treatment plan.

There was a pattern of frequency of visits which was not justified by the patient's medical record.

The Respondent's treatment of a severe abcess and cellulitis in Patient A's middle left finger did not meet accepted standards of medical care.

The need for the Respondent's almost weekly psychological counseling of Patient A is not supported by the medical record.

FINDINGS AS TO PATIENT B

13. Patient B, a 19 year old female, was seen by the Respondent on 22 occasions during the period November 24, 1993 through October 5, 1994.

14. Patient B's medical records indicate that only 6 of these visits were medically justified based on the recorded complaint, examination and diagnosis. These were the visits of 11/24/93, 11/29/93, 21/1/93, 1/17/94, 5/11/94 and 8/17/94 (Pet's. Ex. 3).

15. The remaining 16 visits by Patient B were not medically justified based on the lack of adequate documentation to support the medical necessity of the visits, and the frequency of the follow-up visits on the same presenting complaint or diagnosis (Pet's. Ex. 3).

16. The record of this case contains copies of three bills which were submitted by the Respondent to an insurance carrier on behalf of Patient B. The Respondent knew that these bills were excessive because the billing codes are not supported by data in the medical records on 11/24/93, 12/13/93 and 1/17/94 (Pet's. Exs. 3 and 7).

17. On four different visits, 11/24/93, 12/1/93, 5/11/94 and 6/22/94, the Respondent performed Spirometry tests on Patient B. Each test was inadequately administered because the Respondent failed to repeat the test 3 times on each visit (Tr. 237). The medical record indicates only one test result on each occasion (Pet's. Ex. 3, pp. 10-11).

18. The Respondent's treatment of Patient B's asthma was inadequate. He prescribed Theodur instead of inhaled steroids, and he prescribed the Theodur in an incorrect dosage. He also ordered a Proventil Pump on an incorrect regimen (Pet's. Ex. 13, pp. 11-12; Tr. 229-231).

19. The Respondent failed to treat Patient B's bronchitis appropriately. He repeatedly employed Penicillin and Lincocin, neither of which was adequate for the patient's condition. Penicillin is a narrow spectrum antibiotic which is effective for only 60% of the possible organisms responsible for bronchitis, while Lincocin is a dangerous toxic drug with no applicability for a mild infection such as that afflicting Patient B (Pet's. Ex. 13, p. 12; Tr. 231-233).

20. The Respondent performed numerous tests for Patient B which were not medically indicated. These included FSH, LH, HCG, Ferritin and HCV toxo tests. The Respondent repeated these unnecessary tests at least twice and some of them were performed in the office lab owned by the Respondent (Pet's. Ex. 13, pp. 12-13; Tr. 232, 943).

21. The Respondent failed to maintain a medical record for Patient B which accurately reflected the care and treatment of the patient (Pet's. Ex. 3).

CONCLUSIONS AS TO PATIENT B

The Respondent's medical record for Patient B does not meet acceptable medical standards. There is inadequate documentation of complaint, history, review of systems, physical examination, diagnosis and treatment plan.

There was a pattern of frequency of visits which was not justified by the patient's medical record.

The Respondent's testing and treatment for Patient B's asthma condition did not meet accepted standards of medical practice.

The Respondent failed to treat Patient B's bronchitis appropriately.

The Respondent performed numerous tests for Patient B which were not medically indicated.

The Respondent submitted 3 bills to the insurance carrier on behalf of Patient B knowing that the billing codes were excessive because they were not supported by data in the patient's medical record.

FINDINGS AS TO PATIENT C

22. Patient C, a 42 year old male, was seen by the Respondent on 38 occasions during the period July 29, 1992 through April 5, 1993. There were 22 visits in a 5 month period in 1992 and 16 visits in a 4 month period in 1993 (Pet's. Ex. 4).

23. Patient C's medical records indicate that only 8 of these visits were medically justified based on the recorded complaint, examination and diagnosis. These were the visits of 7/29/92, 9/30/92, 11/15/92, 11/23/92, 12/2/92, 12/7/92, 12/20/92 and 3/31/93 (Pet's. Ex. 4).

24. The remaining 30 visits by Patient C were not medically justified based on the lack of adequate documentation to support the medical necessity of the visits, and the frequency of the follow-up visits on the same presenting complaint or diagnosis (Pet's. Ex. 4).

25. The Respondent incorrectly diagnosed Patient C as having Epstein-Barr virus, and inappropriately administered IV infusions of saline, Vitamin C and Vitamin B-complex on 29 occasions over a 9 month period. This treatment was inappropriate and medically unproven (Pet's. Ex. 4, p. 27 and Pet's. Ex. 13, p. 19; Tr. 340-342).

26. Patient C's successive creatinine levels showed the possibility of renal failure mandating further work-up by the Respondent despite the refusal by the patient to see a nephrologist. The Respondent failed to work-up or treat this possible serious condition (Pet's. Ex. 4 and Pet's. Ex. 13, p. 18-19).

27. On November 3, 1992, the Respondent administered IV Lincomycin and prescribed oral Keflex for Patient C's pulmonary condition. The use of Lincomycin was inappropriate in this case (Pet's. Ex. 4, p. 12; Tr. 342-343).

28. The record in this case does not contain copies of any bills submitted by the Respondent to any insurance carrier on behalf of Patient C.

29. The Respondent failed to maintain a medical record for Patient C which accurately reflects the care and treatment of the patient (Pet's. Ex. 4).

CONCLUSIONS AS TO PATIENT C

The Respondent's medical record for Patient C does not meet acceptable medical standards. There is inadequate documentation of complaint, history, review of systems, physical examination, diagnosis and treatment plan.

There was a pattern of frequency of visits which was not justified by the patient's medical record.

The quality of care provided by the Respondent in his treatment of Patient C did not me accepted standards of medical care.

FINDINGS AS TO PATIENT D

30. Patient D, a 45 year old female, was seen by the Respondent on 106 occasi period May 4, 1992 through August 29, 1994. There were 35 visits in an 8 1992; 48 visits in 1993; and 23 visits in an 8 month period in 1994 (P

31. Patient D's medical record indicates that only 36 of these visits were medically justified based on the recorded complaint, examination and diagnosis. These were the visits of 5/6/92, 5/7/92, 5/18/92, 5/27/92, 6/15/92, 6/22/92, 7/20/92, 7/27/92, 8/24/92, 9/14/92, 11/9/92, 11/18/92, 11/30/92, 12/28/92, 3/10/93, 3/17/93, 3/24/93, 4/21/93, 4/30/93, 5/5/93, 6/23/93, 6/27/93, 6/30/93, 7/14/93, 7/19/93, 7/21/93, 9/8/93, 11/3/93, 11/25/93, 1/17/94, 3/21/94, 3/30/94, 4/11/94, 6/20/94, 7/13/94 and 8/17/94 (Pet's. Ex. 5).

32. The remaining 70 visits by Patient D were not medically justified based on the lack of adequate documentation to support the medical necessity of the visits, and the frequency of the follow-up visits on the same presenting complaint or diagnosis (Pet's. Ex. 5).

33. Patient D is an insulin dependent diabetic and the Respondent failed to manage her diabetes. The Respondent failed to order appropriate tests and to adequately adjust the patient's insulin dosage in relation to her blood sugar levels (Pet's. Ex. 5 and Pet's. Ex. 13, p. 20; Tr. 404-417).

34. The Respondent's treatment of Patient D's cellulitis with a single dose of Lincomycin was inappropriate (Pet's. Ex. 5, p. 45 and Pet's. Ex. 13, p. 24; Tr. 411-412).

35. The record in this case does not contain copies of any bills submitted by the Respondent to any insurance carrier on behalf of Patient D.

36. The Respondent failed to maintain a medical record for Patient D which accurately reflects the care and treatment of the patient (Pet's. Ex. 5).

CONCLUSIONS AS TO PATIENT D

The Respondent's medical record for Patient D does not meet acceptable medical standards. There is inadequate documentation of complaint, history, review of systems, physical examination, diagnosis and treatment plan.

There was a pattern of frequency of visits which was not justified by the patient's medical record.

The quality of medical care provided by the Respondent in his management of Patient D's diabetes does not meet accepted standards of medical care.

FINDINGS AS TO PATIENT E

37. Patient E's medical record (Petitioner's Ex. 6) is incomplete. There is a note on the certification cover sheet which reads "This chart is incomplete as the Medical Dept. in Albany has already taken the first part of the chart thru approx 3/93" (Pet's. Ex. 6).

38. The medical records available for the Hearing Committee's review are incomplete in that there are laboratory test result reports in 1992 without corresponding medical record entries for those dates; and there are billing records (Metra Health Service Corp.) for 1992 and 1993 which also do not have corresponding medical record entries (Pet's. Ex. 6 and Pet's. Ex. 10).

39. There are 20 Metra Health Service Corp bills for office visits for Patient E in the record. Of these 20 bills only 7 have corresponding entries in the medical record. They are 3/31/93, 4/14/93, 4/28/93, 5/12/93, 5/26/93, 6/9/93 and 7/7/93.

The Respondent knew that the bills for these dates were excessive because the billing codes are not supported by the data in the medical record (Pet's. Ex. 6 and Pet's. Ex. 10; Tr. 488-489).

40. There is no evidence whatsoever in the record to support the remaining 13 Metra Health Service Corp. bills which the Respondent knowingly submitted to the insurance carrier (Pet's. Ex. 6 and Pet's. Ex. 10).

41. The Respondent failed to perform the necessary neurological and physical examinations and other tests to confirm or rule out the diagnosis of Parkinson's disease as reflected in the medical record (Pet's. Ex. 6; Tr. 491-493).

42. The Respondent failed to maintain a medical record for Patient E which accurately reflects the care and treatment of the patient (Pet's. Ex. 6).

CONCLUSIONS AS TO PATIENT E

The Respondent's medical record for Patient E does not meet accepted medical standards. There is inadequate documentation of complaint, history, review of systems, physical examination, diagnosis and treatment plan.

The Respondent failed to adequately perform the necessary examinations and tests indicated by the patient's complaint which was tremor.

The Respondent submitted 7 bills to the insurance carrier on behalf of Patient E knowing that the billing codes were excessive because they were not supported by data in the patient's medical record.

There is no evidence whatsoever in the record to support the additional 13 bills which the Respondent knowingly submitted to the insurance carrier on behalf of Patient E.

VOTE OF THE HEARING COMMITTEE

(All Votes Were Unanimous Unless Otherwise Specified)

FIRST SPECIFICATION: (NEGLIGENCE ON MORE THAN ONE OCCASION)

SUSTAINED as to those charges specified in paragraphs A(1), A(3), A(6), A(7), A(12); B(1), B(3), B(4), B(5), B(6), B(9); C(1), C(3), C(4), C(5), C(6), C(8); D(2), D(4); E(1), E(3) of the Statement of Charges.

NOT SUSTAINED as to those charges specified in paragraphs A(8), A(9), A(10) of the Statement of Charges.

The Hearing Committee **SUSTAINED** the charges as specified in paragraph A(4) of the Statement of Charges relating to the Respondent's referrals of Patient A to a gastroenterologist and neurologist, but did **NOT SUSTAIN** that portion of the charges relating to the Respondent's referrals of Patient A to a pulmonologist, gynecologist and cardiologist.

The Hearing Committee **SUSTAINED** the charges as specified in paragraphs D(1)(a)(b) and (c) of the Statement of Charges but did **NOT SUSTAIN** the charge as specified in Paragraph D(1)(d).

SECOND SPECIFICATION: (INCOMPETENCE ON MORE THAN ONE OCCASION)

SUSTAINED as to those charges specified in paragraphs A(3), A(6), A(7); B(3), B(4), B(5); C(3), C(4), C(5), C(6); D(2) and E(1) of the Statement of Charges.

NOT SUSTAINED as to those charges specified in paragraphs A(1), A(4), A(8), A(9), A(10), A(12); B(1), B(6), B(9); C(1); D(4) and E(3) of the Statement of Charges.

The Hearing Committee **SUSTAINED** the charges as specified in paragraphs D(1)(a)(b) and (c) of the Statement of Charges but did **NOT SUSTAIN** the charge as specified in paragraph D(1)(d).

THIRD THROUGH SEVENTH SPECIFICATIONS: (FRAUDULENT PRACTICE)

SUSTAINED as to those charges specified in paragraphs B(2), B(6), B(7), B(8) and E(2) of the Statement of Charges.

NOT SUSTAINED as to those charges specified in paragraphs A(1) (Vote 2-1), A(2), A(4), (Vote 2-1), A(11); B(1) (Vote 2-1); C(1)(Vote 2-1), C(2), C(7) and D(3) of the State Charges.

EIGHTH THROUGH TWELFTH SPECIFICATIONS: (MAKING A FALSE REPORT)

SUSTAINED as to those charges specified in paragraphs B(2), B(8) and E(2) of the Statement of Charges.

NOT SUSTAINED as to those charges specified in paragraphs A(1), A(2), A(4), A(5), A(11); B(1), B(6), B(7); C(1), C(2), C(7) and D(3) of the Statement of Charges.

THIRTEENTH THROUGH FIFTEENTH SPECIFICATIONS:

(UNNECESSARY TESTS OR TREATMENT)

SUSTAINED as to those charges specified in paragraphs A(6) and B(6) of the Statement of Charges.

NOT SUSTAINED As to the charges specified in Paragraphs A(1); B(1) and C(1) of the Statement of Charges.

SIXTEENTH THROUGH TWENTIETH SPECIFICATIONS:

(FAILURE TO MAINTAIN A RECORD)

SUSTAINED as to those charges specified in paragraphs A(12); B(9); C(8); D(4) and E(3) of the Statement of Charges.

TWENTY FIRST SPECIFICATION: (MORAL UNFITNESS)

SUSTAINED as to those charges specified in paragraphs B(2), B(6), B(7), B(8) and E(2) of the Statement of Charges.

NOT SUSTAINED as to those charges specified in paragraphs A(1), A(2), A(4), A(5), A(11); B(1); C(1), C(2), C(7) and D(3) of the Statement of Charges.

DETERMINATION OF THE HEARING COMMITTEE

After a review of the entire record in this case, the Hearing Committee concludes as follows:

1. The Respondent's medical records are inadequate.
2. There was a pattern of unusually frequent patient visits which were not supported by the medical records.
3. There was an inadequate quality of care and inappropriate choices of therapy and prescriptions.
4. There was excessive testing not supported by the medical record.
5. The Respondent's office procedures were inappropriate in that unidentified office staff were permitted to write in the medical record concerning testing, diagnosis and treatment.
6. The Respondent knew that billing codes on bills which he submitted to the insurance carriers on behalf of patients were excessive because they were not supported by data in the medical records.
7. The Respondent's testimony was evasive and he frequently attempted to shift blame to other office staff who he would not identify.

The Hearing Committee has voted to **SUSTAIN**

23 charges of Negligence.

13 charges of Incompetence

5 charges of Fraudulent Practice

3 charges of Making a False Report

2 charges of Unnecessary Tests or Treatment

5 charges of Failure to Maintain Records

5 charges of Moral Unfitness

The Hearing Committee is aware of the Respondent's prior conviction of Petit Larceny relating to the Medicaid Program; and of his being placed on a period of probation by the Office of Professional Medical Conduct.

Based on the entire record of this case, the Hearing Committee determines unanimously (3-0) that the Respondent's license to practice medicine in New York State should be **REVOKED**.

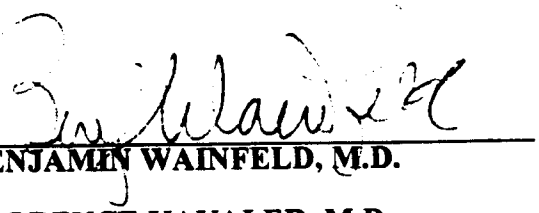
ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondent's license o practice medicine in New York State is hereby **REVOKED.**

2. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or certified or registered mail.

DATED: New York, New York
_____ 1998



BENJAMIN WAINFELD, M.D.

FLORENCE KAVALER, M.D.
MS. EUGENIA HERBST

TO: Terrence Sheehan, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

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APPENDIX A

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

IN THE MATTER OF ARTHUR BROWN, M.D.	STATEMENT OF CHARGES

ARTHUR BROWN, M.D., the Respondent, was authorized to practice medicine in New York State on or about December 1, 1978, by the issuance of license number 136892 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Between on or about 1991 and on or about September, 1994, Respondent treated Patient A at his private medical office located at 1670 Bay Blvd., Atlantic Beach, New York. (The names of patients are contained in the attached Appendix).

1. Between 1991 and September, 1994, Respondent saw Patient A on almost a weekly basis. Most of these visits were unnecessary and without medical value.
2. This pattern of unnecessary visits was followed by Respondent in order to bill Patient A's insurance carrier and receive reimbursement to which Respondent knew he was not entitled.
3. Respondent prescribed Gentamicin and penicillin for a left middle finger abscess and cellulitis. Gentamicin was not indicated and both drugs were given in improper doses.
4. Respondent repeatedly referred Patient A to various specialists, including a gastroenterologist, neurologist, pulmonologist, gynecologist and cardiologist. In none of these instances is

the referral medically warranted.

5. In every instance where there is an attempted referral of the patient to a specialist, the chart notes that the patient refused the referral. In fact, these entries regarding referrals do not reflect actual attempted referrals. They are fraudulent entries designed to create a 'paper defense" to allegations of incompetent or out of specialty treatment.

6. Respondent provided almost weekly psychological counseling to Patient A for stress, headaches and other psychological conditions. Respondent was not qualified to provide this treatment and the treatment was of no medical value.

7. Respondent failed to take even a rudimentary psychological history, reach a valid diagnosis or consider psychopharmacologic therapy.

8. On three occasions Respondent treated the patient's carpal tunnel syndrome by injecting her with steroids. These injections were not indicated and were potentially harmful.

9. Respondent improperly failed to prescribe splints and physical therapy for the patient's carpal tunnel syndrome.

10. On two occasions Respondent treated otitis media with penicillin, 600,000 units, which is not indicated.

11. Respondent routinely billed Patient A's insurance carrier at inflated billing codes and thereby attempted to obtain reimbursement at rates to which Respondent knew he was not entitled.

12. Respondent failed to maintain a medical record for Patient A which accurately reflects the care and treatment he provided,

including, patient complaints, history, physical examination, diagnoses, rationales for tests and a treatment plan.

B. Between on or about November, 1993 and on or about October, 1994, Respondent treated Patient B at his medical office.

1. Between November, 1993 and October, 1994, Respondent saw Patient B on almost a weekly basis. Most of these visits were unnecessary and without medical value.
2. This pattern of unnecessary patient visits was followed by Respondent in order to bill Patient B's insurance carrier and receive reimbursement to which Respondent knew he was not entitled.
3. Respondent treated Patient B for bronchial asthma. The spirometry which Respondent administered, and on which he based his subsequent treatment, was inadequately administered. Respondent administered only one trial instead of the customary three and he failed to note the quality of the patient's effort in the portion of the test that is very effort-dependent.
4. Respondent improperly treated the patient's asthma. Specifically, he prescribed Theodur, instead of inhaled steroids, and he ordered Theodur in an incorrect dosage. He also ordered a proventil pump on an incorrect regimen.
5. Respondent failed to order an appropriate antibiotic in an appropriate dose for Patient B's bronchitis.
6. Respondent frequently ordered unnecessary lab tests or ordered unnecessary repeats of tests including, LH, HCV toxo, TSH sedrate, SMA28, FSH, LHHCJ, ESR, H. Pylori, CBC, and ferritin

tests.

7. Respondent owned the lab which performed these unnecessary tests or Respondent did the tests himself. These tests were ordered by Respondent in order to receive payments to which Respondent knew he was not entitled.

8. Respondent routinely billed Patient B's insurance carrier at inflated billing codes and thereby attempted to obtain reimbursement at rates to which Respondent knew he was not entitled.

9. Respondent failed to maintain a medical record for Patient B which accurately reflects the care and treatment he provided, including, patient complaints, history, physical examination, diagnoses, rationales for tests and a treatment plan.

C. Between on or about July, 1992 and on or about March, 1993, Respondent treated Patient C at his medical office.

1. Between July, 1992 and March, 1993 Respondent saw Patient C on almost a weekly basis. Most of these visits were unnecessary and without medical value.

2. This pattern of unnecessary visits was followed by Respondent in order to bill Patient C's insurance carrier and receive reimbursement to which Respondent knew he was not entitled.

3. Respondent made a diagnosis of Epstein Barr virus in Patient C. This diagnosis is incorrect.

4. Respondent or his staff administered weekly IV infusions of saline, vitamin C and B-complex for the patient's Epstein Barr. This treatment is unproven and was not indicated.

5. Successive creatinine levels showed chronic renal failure. Respondent failed to work-up or treat this serious condition in any way, aside from noting that the patient refused a renal consultation.

6. Respondent prescribed IV Lincomycin and oral Keflex for a pulmonary infection. These medications were not indicated.

7. Respondent routinely billed Patient C's insurance carrier at inflated billing codes and thereby attempted to obtain reimbursement at rates to which Respondent knew he was not entitled.

8. Respondent failed to maintain a medical record for Patient C which accurately reflects the care and treatment he provided, including, patient complaints, history, physical examination, diagnoses, rationales for tests and a treatment plan.

D. Between on or about May, 1992 and on or about September, 1994, Respondent treated Patient D at his medical office.

1. Patient D is an Insulin-dependent diabetic. Respondent failed to properly manage the patient's diabetes. Specifically,

   a. Respondent failed to order glycohemoglobin, hemoglobin AIC and C peptide tests.

   b. When the patient's blood sugar was over 400, Respondent failed to obtain urinary ketones or electrolytes to rule out diabetic ketoacidosis.

   c. Respondent did not adjust the patient's morning and evening Insulin doses to adequate levels.

   d. Respondent repeatedly injected high doses of

corticosterioids as an initial treatment for minor joint pain. This in unnecessary treatment in general and especially ill-advised in a diabetic patient.

2. Patient D developed cellutitis with pus of a hand wound. Initially Respondent treated the condition with penicillin, which is inappropriate. Several days later for the same condition he gave a single 300 mg. dose of Lincomycin, which is inadequate.

3. Respondent routinely billed Patient D's insurance carrier at inflated billing codes and thereby attempted to obtain reimbursement at rates to which Respondent knew he was not entitled.

4. Respondent failed to maintain a medical record for Patient D which accurately reflects the care and treatment he provided, including, patient complaints, history, physical examination, diagnoses, rationales for tests and a treatment plan.

E. Between in or about 1992 and on or about July, 1993, Respondent treated Patient E at his medical office.

1. In or about April, 1993, Respondent made a diagnosis of Parkinson's disease in this 42 year-old woman. This diagnosis is not substantiated. Respondent improperly failed to perform a neurologic exam to support this diagnosis. He also failed to mention common physical manifestations of Parkinson's, including, rigidity, cogwheeling, impaired gait and masklike facies.

2. Respondent routinely billed Patient E's insurance carrier at inflated billing codes and thereby attempted to obtain reimbursement at rates to which Respondent knew he was not

entitled.

3. Respondent failed to maintain a medical record for Patient E which accurately reflects the care and treatment he provided, including, patient complaints, history, physical examination, diagnoses, rationales for tests and a treatment plan.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1997) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. Paragraphs A and A(1), A(3), A(4), A(6)-A(10) and A(12), B and B(1), B(3)-B(6) and B(9), C and C(1) , C(3)-C(6) and C(8), D and D(1), D(2) and D(4) and (E) andE(1) and E(3).

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1997) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. Paragraphs A and A(1), A(3), A(4), A(6)-A(10) and A(12), B and B(1), B(3)-B(6) and B(9), C and C(1) , C(3)-C(6) and C(8), D and

D(1), D(2) and D(4) and (E) andE(1) and E(3).

THIRD THROUGH SEVENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1997) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. Paragraphs A and A(1), A(2), A(4), A(5) and A(11).
4. Paragraphs B and B(1), B(2), B(6)-B(8).
5. Paragraphs C and C(1), C(2) and C(7).
6. Paragraphs D and D(3).
7. Paragraphs E and E(2).

EIGHTH THROUGH TWELFTH SPECIFICATIONS

MAKING A FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21)(McKinney Supp. 1997) by wilfully making or filing a false report, as alleged in the facts of:

8. Paragraphs A and A(1), A(2), A(4), A(5) and A(11).
9. Paragraphs B and B(1), B(2), B(6)-B(8).
10. Paragraphs C and C(1), C(2) and C(7).
11. Paragraphs D and D(3).
12. Paragraphs E and E(2).

THIRTEENTH THROUGH FIFTEENTH SPECIFICATIONS

UNNECESSARY TESTS OR TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 1997) by ordering excessive tests, and treatment as alleged in the facts of:

13. Paragraphs A and A(1), A(6).
14. Paragraphs B and B(1), B(6).
15. Paragraphs C and C(1).

SIXTEENTH THROUGH TWENTIETH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §(32)(McKinney Supp. 1997) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

16. Paragraphs A and A(12).
17. Paragraphs B and B(9).
18. Paragraphs C and C(8).
19. Paragraphs D and D(4).
20. Paragraphs E and E(3).

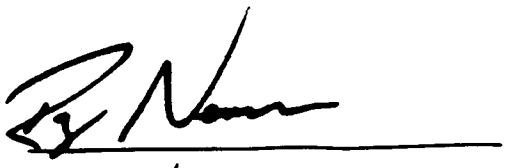
TWENTY-FIRST SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20)(McKinney Supp. 1997) 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:

21. Paragraphs A and A(1), A(2), A(4), A(5) and A(11), B and B(1), B(2) and B(6) - B(8), C and C(1), C(2) and C(7), D and D(3) and E and E(2).

DATED: November 5, 1997
New York, New York



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