



*New York State Board for Professional Medical Conduct*

433 River Street, Suite 303 • Troy, New York 12180-2299 • (518) 402-0863

Nirav R. Shah, M.D., M.P.H.  
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NYS Department of Health  
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Office of Professional Medical Conduct

Public

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Chair  
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Vice Chair  
Katherine A. Hawkins, M.D., J.D.  
Executive Secretary

February 11, 2011

***CERTIFIED MAIL-RETURN RECEIPT REQUESTED***

Pravinchandra V. Mehta, M.D.

REDACTED

Re: License No. 129523

Dear Dr. Mehta:

Enclosed is a copy of Order BPMC #11-33 of the New York State Board for Professional Medical Conduct. This order and any penalty provided therein goes into effect February 18, 2011.

**If the penalty imposed by this Order is a surrender, revocation or suspension, you are required to deliver your license and registration within five (5) days of receipt of this Order to: Office of Professional Medical Conduct, c/o Physician Monitoring Unit, New York State Department of Health, 433 River Street, Suite 303, Troy, NY 12180-2299.**

If the document(s) are lost, misplaced or destroyed, you are required to submit to this office an affidavit to that effect. Enclosed for your convenience is an affidavit. Please complete and sign the affidavit before a notary public and return it to the Office of Professional Medical Conduct.

Sincerely,

REDACTED

Katherine A. Hawkins, M.D., J.D.  
Executive Secretary  
Board for Professional Medical Conduct

Enclosure

cc: Terence M. Connors, Esq.  
Connors & Vilardo, LLP  
1000 Liberty Building  
424 Main Street  
Buffalo, NY 14202

IN THE MATTER  
OF  
PRAVINCHANDRA MEHTA, M.D.

SURRENDER  
ORDER

BPMC No. #11-33

Upon the application of (Respondent) PRAVINCHANDRA MEHTA, M.D. to Surrender his license as a physician in the State of New York, which is made a part of this Surrender Order; it is

ORDERED, that the Surrender, and its terms, are adopted; and it is further

ORDERED, that Respondent's name be stricken from the roster of physicians in the State of New York; and it is further

ORDERED, that this Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Surrender Order, either by first class mail to Respondent at the address in the attached Surrender Application or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney, whichever is first.

SO ORDERED.

DATE: 2-11-2011

REDACTED

~~KENDRICK A. SEARS, M.D.~~  
Chair  
State Board for Professional Medical Conduct

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

IN THE MATTER  
OF  
PRAVINCHANDRA MEHTA, M.D.

SURRENDER  
of  
LICENSE

PRAVINCHANDRA MEHTA, M.D., represents that all of the following statements are true:

That on or about December 10, 1976, I was licensed to practice as a physician in the State of New York and issued License No. 129523 by the New York State Education Department.

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

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

A copy of the Amended Statement of Charges, marked as Exhibit "A", is attached to and part of this Surrender of License.

I am applying to the State Board for Professional Medical Conduct for permission to surrender my license as a physician in the State of New York on the grounds that I plead no contest to the Third Specification as to Patients A and B, in full satisfaction of the charges against me and in full satisfaction of any additional claims or allegations of professional misconduct subject to investigation by the Office of Professional Medical Conduct regarding any aspect of my practice of medicine as of the effective date of this Surrender.

I ask the Board to accept my Surrender of License, and I agree to be bound by all of the terms set forth in attached Exhibit "B".

I understand that, if the Board does not accept my Surrender of License, none of its terms shall bind me or constitute an admission of any of the acts of misconduct alleged; this application shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to the Public Health Law.

I agree that, if the Board accepts my Surrender of License, the Chair of the Board shall issue a Surrender Order in accordance with its terms. I agree that this Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Surrender Order by first class mail to me at the address in this Surrender of License, or to my attorney by certified mail, or upon facsimile transmission to me or my attorney, whichever is first. The Surrender Order, this agreement, and all attached exhibits shall be public documents, with only patient identities, if any, redacted. As public documents, they may be posted on the Department's website(s).

I ask the Board to accept this Surrender of License, which I submit of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's acceptance of this Surrender of License, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Surrender Order for which I apply, whether administratively or judicially, and I agree to be bound by the Surrender Order.

I understand and agree that the attorney for the Department, the Director of the Office of Professional Medical Conduct and the Chair of the State Board for Professional Medical Conduct each retain complete discretion either to enter into

the proposed agreement and Order, based upon my application, or to decline to do so. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

DATE: 2/11/2011

REDACTED

~~PRAVINCHANDRA MEHTA, M.D.~~  
Respondent

The undersigned agree to Respondent's attached Surrender of License and to its proposed penalty, terms and conditions.

CONNORS & VILARDO, LLP

DATE: 2/11/11

REDACTED

By: ~~TERRENCE M. CONNORS, ESQ.~~  
Attorney for Respondent

DATE: 2/11/11

REDACTED

~~JEFFREY J. CONKLIN, ESQ.~~  
Associate Counsel  
Bureau of Professional Medical Conduct

DATE: 2/11/11

REDACTED

~~KEITH W. SERVIS~~  
Director  
Office of Professional Medical Conduct

IN THE MATTER  
OF  
PRAVINCHANDRA MEHTA, M.D.

AMENDED  
STATEMENT  
OF  
CHARGES

PRAVINCHANDRAMIHTA, M.D., the Respondent, was authorized to practice medicine in New York State on or about December 10, 1976, by the issuance of license number 129523 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. Respondent provided medical care to Patient A at Niagara Falls Memorial Medical Center, located at 621 Tenth Street, Niagara Falls, New York, from on or about July 5, 2006, through on or about July 14, 2006. Patient A presented to the hospital with right lower extremity swelling and pain, and a history of severe, chronic rheumatoid arthritis, which had been treated with years of Prednisone therapy. Patient A's condition deteriorated, with worsening renal function, hypotension, and cardiac arrest. Respondent's care of Patient A failed to meet accepted standards of medical practice in that:
1. Respondent failed to timely and appropriately administer indicated parenteral steroids to patient A;
  2. Respondent failed to appreciate Patient A's symptomatology, including dehydration, renal failure and hypotension, and to timely and appropriately treat Patient A therefor;
  3. Respondent failed to timely and appropriately treat and manage Patient A's care upon the development of renal dysfunction and hypotension.

4. Respondent failed to consider adrenal insufficiency as a differential diagnosis;
5. Respondent failed to timely and appropriately treat or manage Patient A's endocrine condition;
6. Respondent failed to appreciate the necessity of administering parenteral steroid therapy for Patient A, who had no endogenous function of his adrenal to respond to medical stress;
7. Respondent failed to timely order indicated laboratory tests for Patient A; and
8. Respondent failed to keep and maintain legible hospital records for Patient A.

B. Respondent provided medical care to Patient B at Respondent's office, located at 550 Main Street, Niagara Falls, New York, and at Niagara Falls Memorial Medical Center from on or about July 14, 2000, through on or about August 8, 2007. Patient B presented to the hospital on June 20, 2005, with abdominal pain. Patient B was determined to have diabetes and ketosis, and was treated, inter alia, with hydration and insulin infusion within 12 hours of admission. Ultimately, Patient B was found to be unresponsive, and a neurological evaluation documented coma, likely related to metabolic encephalopathy. Respondent's care of Patient B failed to meet accepted standards of medical care in that:

1. Respondent failed to timely and appropriately treat Patient B for diabetic ketoacidosis, which should have included hourly electrolytes, saline hydration, Potassium repletion, and the administration of intravenous Dextrose when Patient B's glucose level dropped;
2. Respondent failed to timely and appropriately administer indicated

- parenteral Potassium for Patient B;
3. Respondent failed to timely and appropriately monitor Patient B's electrolytes, in that said patient was on parenteral insulin and intravenous fluids;
  4. Respondent failed to timely and appropriately administer indicated and adequate Dextrose for Patient B when said patient's glucose level dropped to a near normal level;
  5. Respondent failed to timely and appropriately administer sufficiently aggressive and indicated intravenous hydration during the first 12 hours of Patient B's admission;
  6. Respondent failed to timely and appropriately monitor Patient B's glucose levels, a patient who was on parenteral insulin,
  7. Respondent failed to timely and appropriately treat and manage Patient B's care;
  8. Respondent failed to keep and maintain legible office and hospital medical records for Patient B;
  9. Respondent failed to keep and maintain appropriate office medical records for Patient B;
  10. Respondent failed to advise Patient B of treatment goals for Patient B's Type 1 diabetes mellitus, and/or failed to document such treatment goals;
  11. Respondent failed to prescribe indicated medications for Patient B's Type 1 diabetes mellitus;
  12. Respondent failed to appropriately treat and manage Patient B's Type 1 diabetes mellitus;
  13. Respondent failed to advise Patient B of treatment goals for Patient B's blood pressure control, renal protection or cholesterol management, and/or failed to document such treatment goals; and

14. Respondent failed to advise Patient B of sick day rules to avoid the recurrence of ketoacidosis, and/or failed to document such advice.

C. Respondent provided medical care to Patient C at Respondent's office and at Niagara Falls Memorial Medical Center at various times from on or about October 6, 2005, through October 28, 2007. Patient C presented to the hospital on October 23, 2005, with confusion, significant hyponatremia, lethargy, weakness, garbled speech and a history of alcohol dependence. On admission, Patient C had a sodium level of 100. Respondent's care of Patient C failed to meet accepted standards of medical practice in that:

1. Respondent failed to timely and appropriately correct Patient C's sodium level;
2. Respondent failed to timely and appropriately treat Patient C's hyponatremia;
3. Respondent failed to take Patient C's blood pressure on October 6, 2005, and/or failed to document such reading;
4. Respondent failed to appropriately treat and manage Patient C's hypertension on October 6, 2005, and/or failed to document such treatment;
5. Respondent failed to appropriately monitor Patient C's laboratory test results, and to follow-up such test results and/or failed to document such monitoring; and
6. Respondent failed to keep and maintain legible hospital medical records for Patient C.

D. Respondent provided medical care to Patient D at Respondent's office at various times from on or about April 11, 2005, through February 28, 2007. Patient D was status post amputation of the left lower extremity for gangrene,

with a history of chronic obstructive pulmonary disease and congestive heart failure. Respondent's care of Patient D failed to meet accepted standards of medical practice in that:

1. Respondent failed to keep and maintain legible office medical records for Patient D;
2. Respondent failed to maintain an appropriate medication list on the occasions of Patient D's office visits;
3. Respondent failed to maintain an appropriate and complete allergy list for Patient D;
4. Respondent failed to maintain office medical records for Patient D which appropriately set forth a plan indicating what laboratory tests, x-rays, and consultations should be performed.
5. Respondent failed to keep and maintain appropriate office medical records for Patient D.
6. Respondent failed to make appropriate commentary in Patient D's office medical records regarding abnormal laboratory test results;
7. Respondent failed to order appropriate and indicated serial laboratory tests to monitor Patient D's electrolytes and lipids; and
8. Respondent failed to maintain an appropriate problem list for Patient D's various medical conditions.

E. Respondent provided medical care to Patient E at Respondent's office at various times from on or about October 17, 2003, through November 29, 2007. Patient E had been involved in a motor vehicle accident, with a history of cervical spine disease requiring a dissection. Respondent's care of Patient E failed to meet accepted standards of medical practice in that:

1. Respondent failed to maintain appropriate office medical records regarding Patient E's chronic obstructive pulmonary disease, and/or improperly included said condition on Patient E's problem list;
2. Respondent failed to maintain legible office medical records for Patient E;

3. Respondent failed to appropriately document Patient E's smoking history and allergies in said patient's office medical records;
4. Respondent failed to maintain an appropriate and accurate problem list for Patient E;
5. Respondent failed to obtain an indicated and appropriate pulmonary consultation for Patient E, and/or incorrectly documented that Patient E had emphysema; and
6. Respondent failed to obtain an appropriate and indicated pre-operative clearance for Patient E, and/or failed to properly document such pre-operative clearance.

F. Respondent provided medical care to Patient F at Respondent's office at various times from on or about October 17, 2005, through March 2, 2007. Patient F had a history of chronic obstructive pulmonary disease, asthma, depression and coronary artery disease. Respondent's care of Patient F failed to meet accepted standards of medical practice in that:

1. Respondent failed to maintain legible office medical records for Patient F;
2. Respondent failed to maintain an appropriate and accurate problem list for Patient F;
3. Respondent utilized non-standard abbreviations in the medical records for Patient F;
4. Respondent failed to determine an indicated and appropriate plan of action for Patient F's diabetic condition, and/or failed to properly document such plan;
5. Respondent's office medical records for Patient F failed to appropriately document the laboratory tests ordered for Patient F;
6. Respondent failed to appropriately follow-up on Patient F's abnormal laboratory test results, and/or failed to properly document such follow-up;

7. Respondent failed to appropriately treat Patient F's Type 2 diabetes.
8. Respondent failed to determine a plan of action for Patient F's elevated glucose levels;
9. Respondent failed to determine a treatment plan for Patient F when he was given intravenous Depo-Medrol;
10. Respondent failed to document the potential risks to Patient F regarding worsening glycemic control or an appropriate treatment plan in the event steroids affected Patient F's blood sugar levels; and
11. Respondent failed to maintain appropriate office medical records for Patient F regarding whether Patient F did home glucose monitoring or adjustment of medications for his diabetic condition.

G. Respondent provided medical care to Patient G at Respondent's office at various times from on or about February 2, 2007, through August 8, 2007. Patient G had a history of degenerative joint disease of the cervical and lumbar spine, and bipolar disorder. Respondent's care of Patient G failed to meet accepted standards of medical practice in that:

1. Respondent failed to maintain legible office medical records for Patient G;
2. Respondent failed to appropriately follow-up on Patient G's abnormal laboratory test results, and/or failed to properly document such follow-up;
3. Respondent failed to determine an appropriate treatment plan for Patient G's diabetes mellitus, and/or failed to properly document such treatment plan;
4. Respondent failed to appropriately treat Patient G's diabetes mellitus; and
5. Respondent failed to maintain an appropriate and accurate medication sheet for Patient G.

## SPECIFICATION OF CHARGES

### FIRST SPECIFICATION

#### GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. The facts in Paragraphs A and A1, A and A2, A and A3, A and A4, A and A5, A and A6, and A and A7; B and B1, B and B2, B and B3, B and B4, B and B5, B and B6, and B and B7; and C and C1, and/or C and C2.

### SECOND SPECIFICATION

#### GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

2. The facts in Paragraphs A and A1, A and A2, A and A3, A and A4, A and A5, A and A6, and A and A7; B and B1, B and B2, B and B3, B and B4, B and B5, B and B6, and B and B7; and C and C1, and/or C C2.

### THIRD 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 two or more of the following:

3. The facts in Paragraphs A and A1, A and A2, A and A3, A and A4, A and A5, A and A6, and A and A7; B and B1, B and B2, B and B3, B and B4, B and B5, B and B6, B and B7, B and B10, B and B11, B and B12, B and B13, and B and B14; C and C1, C and C2, C and C3, C and C4, and C and C5; D and D6, and D and D7; E and E5, and E and E6; F and F4, F

and F6, F and F7, F and F8, F and F9, and F and F10; G and G2, G and G3, and/or G and G4.

#### FOURTH 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 two or more of the following:

4. The facts in Paragraphs A and A1, A and A2, A and A3, A and A4, A and A5, A and A6, and A and A7; B and B1, B and B2, B and B3, B and B4, B and B5, B and B6, B and B7, B and B10, B and B11, B and B12, B and B13, and B and B14; C and C1, C and C2, C and C3, C and C4, and C and C5; D and D6, and D and D7; E and E5, and E and E6; F and F4, F and F6, F and F7, F and F8, F and F9, and F and F10; and G and G2, G and G3, and/or G and G4.

#### FIFTH SPECIFICATION

##### 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 care and treatment of the patient, as alleged in the following:

5. The facts of A and A8; B and B8, B and B9, B and B10, B and B13, and B and B14; C and C6; D and D1, D and D2, D and D3, D and D4, D and D5, D and D6, and D and D8; E and E1, E and E2, E and E3, E and E4, E and E5, and E and E6; F and F1, F and F2, F and F3, F and F4, F and F5, F and F6, F and F10, and F and F11; and G and G1, G and G2, G and G3, and/or G and G5.

DATED: December 1, 2010  
Albany, New York

REDACTED

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Peter D. Van Buren  
Deputy Counsel  
Bureau of Professional  
Medical Conduct

## EXHIBIT "B"

### Requirements for Closing a Medical Practice Following a Revocation, Surrender, Limitation or Suspension of a Medical License

1. Licensee shall immediately cease and desist from engaging in the practice of medicine in New York State, or under Licensee's New York license, in accordance with the terms of the Order. In addition, Licensee shall refrain from providing an opinion as to professional practice or its application and from representing that Licensee is eligible to practice medicine.
2. Within 5 days of the Order's effective date, Licensee shall deliver Licensee's original license to practice medicine in New York State and current biennial registration to the Office of Professional Medical Conduct (OPMC) at Hedley Park Place, 433 River Street 4th Floor, Troy, NY 12180-2299.
3. Within 15 days of the Order's effective date, Licensee shall notify all patients of the cessation or limitation of Licensee's medical practice, and shall refer all patients to another licensed practicing physician for continued care, as appropriate. Licensee shall notify, in writing, each health care plan with which the Licensee contracts or is employed, and each hospital where Licensee has privileges, that Licensee has ceased medical practice. Within 45 days of the Order's effective date, Licensee shall provide OPMC with written documentation that all patients and hospitals have been notified of the cessation of Licensee's medical practice.
4. Licensee shall make arrangements for the transfer and maintenance of all patient medical records. Within 30 days of the Order's effective date, Licensee shall notify OPMC of these arrangements, including the name, address, and telephone number of an appropriate and acceptable contact persons who shall have access to these records. Original records shall be retained for at least 6 years after the last date of service rendered to a patient or, in the case of a minor, for at least 6 years after the last date of service or 3 years after the patient reaches the age of majority, whichever time period is longer. Records shall be maintained in a safe and secure place that is reasonably accessible to former patients. The arrangements shall include provisions to ensure that the information in the record is kept confidential and is available only to authorized persons. When a patient or a patient's representative requests a copy of the patient's medical record, or requests that the original medical record be sent to another health care provider, a copy of the record shall be promptly provided or forwarded at a reasonable cost to the patient (not to exceed 75 cents per page.) Radiographic, sonographic and similar materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of an inability to pay.
5. In the event that Licensee holds a Drug Enforcement Administration (DEA) certificate for New York State, Licensee shall, within fifteen (15) days of the Order's effective date, advise the DEA, in writing, of the licensure action and shall surrender his/her DEA controlled substance privileges for New York State to the DEA. Licensee shall promptly surrender any unused DEA #222 U.S. Official Order Forms Schedules 1 and 2 for New York State to the DEA. All submissions to the DEA shall be addressed to Diversion Program Manager, New York Field Division, U.S. Drug Enforcement Administration, 99 Tenth Avenue, New York, NY 10011.

6. Within 15 days of the Order's effective date, Licensee shall return any unused New York State official prescription forms to the Bureau of Narcotic Enforcement of the New York State Department of Health. Licensee shall destroy all prescription pads bearing Licensee's name. If no other licensee is providing services at Licensee's practice location, Licensee shall properly dispose of all medications.
7. Within 15 days of the Order's effective date, Licensee shall remove from the public domain any representation that Licensee is eligible to practice medicine, including all related signs, advertisements, professional listings (whether in telephone directories, internet or otherwise), professional stationery or billings. Licensee shall not share, occupy, or use office space in which another licensee provides health care services.
8. Licensee shall not charge, receive or share any fee or distribution of dividends for professional services rendered by Licensee or others while Licensee is barred from engaging in the practice of medicine. Licensee may be compensated for the reasonable value of services lawfully rendered, and disbursements incurred on a patient's behalf, prior to the Order's effective date.
9. If Licensee is a shareholder in any professional service corporation organized to engage in the practice of medicine, Licensee shall divest all financial interest in the professional services corporation, in accordance with New York Business Corporation Law. Such divestiture shall occur within 90 days. If Licensee is the sole shareholder in a professional services corporation, the corporation must be dissolved or sold within 90 days of the Order's effective date.
10. Failure to comply with the above directives may result in a civil penalty or criminal penalties as may be authorized by governing law. Under N.Y. Educ. Law § 6512, it is a Class E Felony, punishable by imprisonment of up to 4 years, to practice the profession of medicine when a professional license has been suspended, revoked or annulled. Such punishment is in addition to the penalties for professional misconduct set forth in N.Y. Pub. Health Law § 230-a, which include fines of up to \$10,000 for each specification of charges of which the Licensee is found guilty, and may include revocation of a suspended license.