

**NEW YORK**  
state department of  
**HEALTH**

Public

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

Sue Kelly  
Executive Deputy Commissioner

March 13, 2013

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Harshad Bhatt, M.D.  
94-54 Lefferts Boulevard  
Richmond Hill, New York 11419

Harshad Bhatt, M.D.  
REDACTED

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New York, New York 10007

Marybeth Hefner  
NYS Department of Health  
Bureau of Accounts Management  
ESP-Corning Tower-Room 1717  
Albany, New York 12237

**RE: In the Matter of Harshad Bhatt, M.D.**  
**a.k.a. Harshadrai Chimandral Bhatt, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 13-72) 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 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  
Office of Professional Medical Conduct  
Riverview Center  
150 Broadway - Suite 355  
Albany, New York 12204

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), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "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., Chief Administrative Law Judge  
New York State Department of Health  
Bureau of Adjudication  
Riverview Center  
150 Broadway – Suite 510  
Albany, New York 12204

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

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

Sincerely,

REDACTED

James F. Horan  
Chief Administrative Law Judge  
Bureau of Adjudication

JFH:cah  
Enclosure

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

IN THE MATTER

OF

HARSHAD BHATT, M.D., A.K.A.  
HARSHADRAI CHIMANDRAL BHATT, M.D.

DETERMINATION

AND

ORDER

BPMC #13-72

COPY

A Notice of Hearing dated April 20, 2012 and an Amended Statement of Charges, dated May 25, 2012, were served on Harshad Bhatt, M.D., A.K.A. Harshadrai Chimandral Bhatt, M.D., and hearings were held pursuant to N.Y. Public Health Law §230 and New York State Admin. Proc. Act §§ 301-307 and 401 on June 20, November 26 and December 27, 2012 at the Offices of the New York State Department of Health, 90 Church Street, New York, New York ("the Petitioner"). **Michael R. Golding, M.D., Jerry Waisman, M.D., and James J. Ducey**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter. **David A. Lenihan, Esq.**, Administrative Law Judge, served as the Administrative Officer. The Petitioner appeared by **James E. Dering, Esq.**, General Counsel, by **Gerard A. Cabrera, Esq.**, Associate Counsel, New York State Department of Health, of Counsel and **Daniel Guenzburger, Esq.** Associate Counsel, New York State Department of Health, of Counsel. The Respondent appeared with counsel, **Lawrence F. Kobak, Esq.** of the firm of **Kern, Augustine, Conroy & Schoppmann, P.C.** of Westbury, New York. Evidence was received, including witnesses who were sworn or affirmed, and transcripts of these proceedings were made.

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

### PROCEDURAL HISTORY

Date of Service of Notice Of Hearing and Statement of Charges:	April 20, 2012
Answer Filed:	April 27, 2012
Pre-Hearing Conference:	May 18, 2012
Hearing Dates:	June 20, 2012 November 26, 2012 December 27, 2012
Witnesses for Petitioner:	Barry Kraushaar, M.D.
Witnesses for Respondent:	Steven B. Zelicof, M.D., Ph.D. Pradeep Albert, M.D. Ms. Lata Patel Harshad Bhatt, M.D.
Deliberations Date:	February 11, 2013

It is noted that the initial hearing panel included Dr. William M. Bisordi. Dr. Bisordi was unable to continue due to illness. He was replaced by Dr. Jerry Waisman after the first hearing date. Dr. Waisman read the transcript of the first hearing date prior to deliberations.

It is also noted that there was a delay in the hearing of this matter occasioned by the damage from Hurricane Sandy. This matter was originally scheduled with hearing dates in early November. The Department of Health offices at 90 Church Street were closed and unavailable at that time. The Administrative Officer made arrangements for an alternate hearing site at the Department of Health offices in New Rochelle. However, the Respondent's attorney, Mr. Kobak, had suffered considerable damage to his home and car on Long Beach, Long Island and was unable to travel until later in the month.

### STATEMENT OF THE CASE

Petitioner charged Respondent, a physician practicing orthopedic surgery, with twelve specifications of professional misconduct. The first specification charged Respondent 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. The second specification charged Respondent 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.

In the third through sixth specifications Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently.

In the seventh through tenth specifications Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) by willfully

making or filing a false report. The eleventh specification charged the Respondent 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. Finally, the twelfth specification charged the Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice medicine.

A copy of the Amended Statement of Charges is attached to this Determination and Order as Appendix I.

#### **FINDINGS OF FACT**

The following Findings of Fact were made after a review of the entire record in this matter. Numbers below in parentheses refer to transcript page numbers or exhibits, denoted by the prefixes "T." or "Ex." These citations refer to evidence found to be 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.

1. Respondent, Harshad C. Bhatt, M.D., an orthopedist, was authorized to practice medicine in New York State on or about March 11, 1983 by the issuance of license number 153340 by the New York State Education Department. (Dept. Ex. 1 and 2)

2. Respondent is not a Board-Certified orthopedic surgeon (T. 468), nor is he a member of the American College of Surgeons. (T. 487-89) He has been performing arthroscopies since the late 80's or early 90's. (T. 440)
3. Respondent treated Patients A-H at Boulevard Surgical Center ("Boulevard") in Long Island City, New York. (Dept. Exhibits 3 - 6; Resp. Exhibit A)
4. The Department's medical expert, Dr. Barry Kraushaar, M.D. is a graduate of Albert Einstein College of Medicine, and was licensed in New York in 1993, after completing his orthopedic residency and completing a sports medicine fellowship. His training included reading MRI films and digital imaging studies, and radiology rotations. His board certification exams included testing of his skill in radiologic interpretation. He is double-board certified in orthopedic surgery and sports medicine. (T. 27-29, 56; 187-188)
5. Dr. Kraushaar based his opinions upon his review of "a massive amount" of data, including medical charts, MRI studies, and photographic quality prints of digitally scanned intraoperative photos provided by the insurance carrier. (T. 31, lines 18-24; Dept. Ex. 9, 10, 11, 13, and 14)
6. Respondent's expert witness, Steven B. Zelicof, M.D., Ph.D., a highly qualified orthopedic surgeon, testified on direct examination that, when rendering an expert opinion, "Every bit of information I can get would be useful...I would want to have as much information as possible." (T. 271, 272 lines 5-8). Nevertheless, Doctor Zelicof reviewed only various "copies" and a written "case summary" for review. He could not

identify its author but presumed the case summary was prepared by Respondent's attorney. (T. 276-77; 333-335)

7. Most critically, Doctor Zelicof failed to review actual prints of the intraoperative photos for Patients F, G and H, the only "objective" documentation for many of the procedures claimed to have been performed by Respondent. The Respondent's orthopedic expert never reviewed the intraoperative photos. (T. 276-77; 333-335)

8. Dr. Pradeep Albert, a board certified radiologist who served as Respondent's radiology expert, reviewed only the MRI studies. (T. 356)

#### FAILURE TO MAINTAIN RECORDS -- PATIENTS B-E

9. As alleged in Paragraphs B, B1, B1 (a) - B1(d) of the Amended Statement of Charges, the Respondent failed to maintain a medical record that accurately reflected the evaluation and treatment for Patients B, C, D and E all of whom had right knee arthroscopies on March 19, 2008, with operative reports dictated on March 26, 2008. (Dept. Ex. 1; Resp. Ex. A, pp. 1-9)

10. The Department's expert, Dr. Kraushaar testified that operative reports are the primary form of documentation for an arthroscopy. The preparation and accuracy of operative reports are the responsibility of the surgeon and they must contain certain elements in order to reflect the care and treatment of the patient. These elements include patient demographics, pre- and post-operative diagnoses, a section describing

the specific surgical procedures, and a narrative portion describing findings at surgery. (T. 34-36; 66)

11. Respondent's expert, Dr. Steven Zelicof, concurred with Dr. Kraushaar and testified that it was the surgeon's ultimate responsibility for documentation of the surgical procedure. (T. 278-79) Dr. Zelicof testified that surgeons must have a system in place to ensure the integrity of the record before signing the operative report. This system should include reading the operative report before signing it, using notes, photographs, and "a whole host of things..." (T. 282-284; T. 284, lines 8-9)

12. Dr. Zelicof also testified that it is optimal to dictate the report immediately after the procedure and if not immediately after, then 48 to 72 hours afterwards. (T 282-284; T. 322) Respondent conceded that he dictated the reports for Patients B-E an entire seven days after performing the procedures. (T. 450, 460)

13. Respondent's operative reports failed what Dr. Kraushaar termed the "transparency test"; meaning, held up to the light against each other, the blocks of text line up perfectly. Dr. Kraushaar testified that in his entire 16 year career he had never seen anything like it. (T. 38-44; T. 68, line 14-15; Resp. Ex. A, p 1-9)

14. Answering the Chairperson's question, Dr. Kraushaar testified it was a "statistical impossibility" that each patient's documentation would have identical notations for Pre-operative Diagnoses, Post-operative Diagnoses, Operation Performed, Operative Technique including identical knee flexion and extension, and Identical OCD lesions of 2.7 centimeters. (T. 38-44; T. 68, line 14-15; Resp. Ex. A, p 1-9)

15. Dr. Zelicof found it "unusual" and "weird" for Patients B-E to have identical measurements of flexion of 115 degrees and extension to minus five degrees, and for each patient to have an OCD lesion 2.7 centimeters in size. He testified that lesion size and flexion and extension are not something that he would "template." (T. 289-293)

16. Respondent admitted that he dictated Patients B, C, D, and E's operative reports seven days after the fact, on March 26, 2008, without reference to the medical record, but relied on "index cards" upon which he scribbled notes, and which had preprinted information provided by the surgi-center. (Resp. Ex. A, pp. 1-9; Resp. Ex. I, J, K, L; T. 477)

17. In fact, the Respondent did not even consult his own handwritten notes on the "index cards" and conceded that for Patient C he wrote in his own hand "abrasion arthroplasty", but dictated "abrasion chondroplasty" in his operative report. (Resp. Ex. A, pp. 4-5; Resp. Ex. L, p. 2; T. 475)

18. Contrary to Respondent's procedure, his orthopedic expert testified that before signing an operative report the surgeon should review it. (T. 283, 322) Respondent admitted his system did not include reading or checking the narrative body of operative reports before signing off on them. (T. 464)

19. Respondent was simply not credible when he testified that each overwhelmingly identical operative report was separately dictated by him verbatim for Patients B-E at Boulevard and were not "templated." (Resp. Ex. A, pp. 1-9; T. 463)

20. Respondent failed to take responsibility for the false operative reports. He blamed the dictation service for errors when it was his own professional responsibility to prevent them. (T. 461-465)

## PATIENT A

### FAILURE TO MAINTAIN RECORDS, FALSE REPORT AND FRAUD

21. As alleged in Paragraphs A, A1, and A2 of the Amended Statement of Charges, the Respondent knowingly and falsely and, with the intent to deceive, represented in an operative report and insurance claim form that he performed arthroscopic knee surgery on Patient A. In addition, Respondent failed to maintain a medical record that accurately reflected Patient A's evaluation and treatment. (Dept. Ex. 1)

22. Patient A was rescheduled for left knee arthroscopy on the same day as Patients B, C, D and E, March 19, 2008 (T. 45). Respondent conceded that the surgery was again cancelled because Patient A's blood pressure was too high. (Dept. Ex. 3b, p. 28)

23. Respondent dictated an operative report on March 26, 2008 and signed the insurance claim form on March 28 2008. The claim was received by Progressive on April 7, 2008. (T. 46; Dept. Ex. 3a pp. 18-20, 31-32; Resp. Ex. A, p. 22)

24. Respondent testified that he kept notes of each surgery on "index cards" and that he would refer to these notes when dictating an operative report. With regard to Patient A, he admitted he did not have a note on an index card. (T. 461, 477)

25. Respondent received multiple telephone calls from the Boulevard Surgi-center administrative personnel requesting that he submit operative reports for surgeries he

performed at Boulevard on March 19, 2008. The surgi-center could not bill for the facility fee without an operative report. (T. 448, 457)

26. On March 26, 2008 Respondent dictated an operative report for Patient A. Respondent dictated the report without reference to any records or notes, and for which he had no meaningful knowledge. Furthermore, this report contained exquisite detail including a debridement of a Grade III chondromalacia on the medial patellar articular surface, and an abrasion chondroplasty of a Grade IV osteochondritis dessicans [*sic*] lesion of the left femoral condyle. (Resp. Ex. A, pp. 10-11; T. 471)

27. Dr. Kraushaar testified: "I'm sorry, but in my 16 years of practice and six years of training, twenty-two years in total, I've never seen that happen ... [Y]ou could not issue an operative report on something that was not actually seen and done." (T. 65, lines 13-15; T. 66 lines 2-4) When asked, Dr. Zellcof, a self-described "black and white kind of guy," testified that it would be wrong to prepare an insurance claim form and operative report for a surgery that was never done. (T. 295, lines 13-14, T. 296)

28. When Respondent dictated the operative report for Patient A and then instructed his administrative staff to submit an insurance claim, he clearly had no idea as to whether he had operated on Patient A and what if any procedures he had performed. With respect to Patient A, Respondent knowingly and falsely represented, with the intent to deceive, that he operated on Patient A and knowingly and falsely represented to Patient A's no-fault insurance provider that he had performed reimbursable medical procedures.

## PATIENTS F and H

### NEGLIGENCE, INCOMPETENCE, FRAUD, FALSE REPORT--PATIENTS F and H

29. As alleged in Paragraphs C, C1, C1(c) and C3 in the Amended Statement of Charges, the Respondent inappropriately diagnosed Patient F with adhesions in the anterior capsule and subscapularis tendon and fraudulently billed an insurance carrier for lysis and resection of these adhesions. (Dept. Ex. 1)

30. Respondent treated Patient F, a 31-year-old female, who suffered various injuries related to an automobile accident on October 22, 2008. Respondent first evaluated her on November 25, 2008 and performed a left shoulder arthroscopy on December 10, 2008. (Dept. Ex. 4a, pp. 1-20)

31. Dr. Kraushaar described adhesions as scar tissue inside the shoulder joint restricting movement. Its treatment is known as lysis, which is the term for cutting through the scar tissues. (T. 85-86)

32. Dr. Kraushaar based his testimony on his review of the medical records, prints of scanned intraoperative photos, as well as the MRI report for Patient F. Neither film nor digital MRI images could be located at the time he wrote his report and testified. (Dept. Ex. 4a, 4b; Dept. Ex. 9, T. 75)

33. Progressive Insurance returned the original intraoperative photos to Respondent as per his request on November 30, 2009. (Dept. Ex. 9, p. 3; T. 513)

34. Dr. Kraushaar testified that intra operative photographs of diagnoses and treatments customarily are taken by the surgeon in a sequential fashion during arthroscopies "because you can't always describe things so photographs complete the documentation." (T. 37; T. 126, lines 16-23)

35. Dr. Zelicof further added reasons to take photos include illustrative purposes, for future treating physicians, for the patient's family, and to document significant conditions uncovered during the surgery. (T. 281) He himself takes photographs, depending on the patient, sometimes as many as 8-10. (T. 317)

36. Dr. Kraushaar testified that he found no evidence of adhesions or lysis after reviewing the "good photos of the inside of the joint." (T. 96-98)

37. Respondent's radiology expert, Dr. Pradeep Albert, MD, confirmed he could not diagnose adhesions of the subscapularis tendon based on the digital MRI images. (T. 352), and Respondent himself agreed that adhesions were not present on the photographs in evidence, photos he took himself. (T. 513-514)

38. Respondent billed for lysis of adhesions, and charged \$1,873.54 for it. (T. 97-98) (Dept. Ex. 9, pp. 1-2)

39. With the intent to deceive, Respondent knowingly and falsely represented on a no-fault insurance claim that that Patient F had adhesions and that he performed a lysis of adhesions.

## PATIENT G

40. As alleged in Paragraphs D, D1, D1(a) and D1( c) of the Amended Statement of Charges, the Respondent inappropriately diagnosed Patient G with osteochondritis dissecans (OCD) of the right femoral condyle and a torn anterior horn of the lateral meniscus. (Dept. Ex. 1)

41. Respondent treated Patient G, a 43 year-old male for injuries related to an automobile accident, which occurred on September 24, 2008. Respondent first evaluated Patient G on or about November 3, and then performed arthroscopic surgery of the right knee on November 18, 2008. (Dept. Ex. 5a, pp. 3-7; pp. 35-37)

42. Dr. Kraushaar testified that osteochondritis dissecans (OCD) is a condition in which there is a missing piece on the surface of the bone and the cartilage in the joint. "The surface of the bone, surface of the femur, if it had osteochondritis dissecans, would have a big bruise in the middle of it. It might even show breakage of bone and cartilage off of the surface." (T. 138-139; T. 145, lines 12-17)

43. Dr. Kraushaar testified using MRI films before the Hearing Committee. He stated that MRIs are "very effective" in diagnosing OCD. (T. 141, lines 17-18) "... [T]he surface would have a dark appearance to it and possibly a white line." (T. 145, lines 23-25) "If there was OCD on this femur, it would be obvious to the radiologist and to the orthopedist, and even to the non-doctor"[...] "It's not subtle," Dr. Kraushaar concluded, "OCD does not exist on these images, in my opinion, and in the radiologist's opinion too." (T. 141-142; 144-146 including T. 146, lines 9-16; Dept. Ex. 13 MRI Series 4, Images 9-12)

44. Dr. Albert testified that the MRI did not support a finding of OCD. (T. 375)

45. Dr. Kraushaar testified using photographic quality prints of the digitally scanned intraoperative photos (Dept. Ex. 10) and testified to a degree of medical certainty that there was nothing to support findings of OCD. As set forth in Finding # 7, Respondent's attorney never showed his orthopedic expert Intraoperative photos. (T. 153-155; 276-77; 333-335)

46. The existence of OCD In Patient G is also brought into question by the fact that Respondent never mentioned OCD in the sequential findings section, "Operative Technique," of the operative report. In the section entitled "Operative Technique" the surgeon is required to describe the significant findings the surgeon has observed during the operation. (T. 139-140; 142; Dept. Ex. 5a 35-37)

47. Respondent conceded that he never documented OCD at all in the "Operative Technique" and, in fact, he dictated an entirely different condition, "a chondromalacia of the patella," which he treated with "debridement." Even more surprising, Respondent dictated a different procedure than debridement -- "abrasion chondroplasty of the femoral condyle" -- in "Operation Performed". (Dept. Ex. 5a, pp. 35-36; T. 528-529)

48. Respondent dictated a dizzying array of verbiage: OCD as a "Postoperative Diagnosis;" "chondromalacia of the patella" as the condition treated in "Operative Technique;" "debridement" as the treatment for the chondromalacia; "abrasion chondroplasty" in the "Operation Performed", and "abrasion arthroplasty" in the insurance claim form, none of which were supported by the evidence. Dr. Kraushaar testified that the intraoperative photos did not illustrate treatment in line with OCD, nor

did he see abrasion chondroplasty as documented, nor did he see evidence of abrasion arthroplasty being performed for which Respondent billed. (T. 148-149; 153, 155-157)

49. With the intent to deceive, Respondent, knowingly and falsely represented on a no-fault insurance claim that Patient G had non-existent OCD and that he treated the right femoral condyle with abrasion arthroplasty. Respondent billed the no-fault insurance provider \$1,779 for an abrasion arthroplasty he did not perform. (Dept. Ex. 5a, p. 61)

50. As alleged in Paragraph D1(c), The Respondent inappropriately diagnosed a torn anterior horn of the lateral meniscus in Patient G. (Dept. Ex. 1)

51. The meniscus of the knee is the cushion between the bones, and is made of rubbery cartilage. A tear in the anterior horn means a tear in the front of the lateral meniscus cartilage, in other words "the part of the knee that you would kneel on if you were kneeling." (T. 142-143, lines 16-17)

52. Dr. Kraushaar indicated that there was no evidence of a tear in the anterior horn of the lateral meniscus in either the MRI report or MRI images that he reviewed. Dr. Kraushaar stated: "I don't see a tear of what we call the anterior horn of the lateral meniscus on these images and neither did the radiologist." (T. 143-144; 146-147 lines 12-15; 152, 153-154; Dept. Ex. 13 MRI Series 4, Image 5-9)

53. Likewise, the intraoperative photos showed no evidence of an anterior lateral meniscus tear. Rather, there was evidence of only a torn medial meniscus cartilage. (Dept. Ex. 10, T. 146-147, 156)

54. Dr. Albert testified that the MRI could not conclusively show a tear in the anterior horn of the lateral meniscus. (T. 375, 376, 378; Resp. Ex. F)

#### PATIENT H

55. As alleged in Paragraphs E, E1, E1 (a) and (b) of the Amended Statement of Charges, the Respondent inappropriately diagnosed hypertrophic synovitis and adhesions in the anterior capsule of the right shoulder in Patient H. (Dept. Ex. 1)

56. Respondent treated Patient H, a 43 year-old female for injuries related to an automobile accident on August 19, 2008. She was first evaluated on August 22, 2008, and Respondent performed arthroscopic surgery of her right shoulder on October 22, 2008. (Dept. Ex. 1; Dept. Ex. 6a, pp. 3-17, 39-41)

57. According to Dr. Kraushaar, Hypertrophic synovitis is Inflammation of the normal synovium inside the joint and should appear very red, and "look like red grapes almost, bubbly and fluffy." (T. 81-82, lines 6-8)

58. Dr. Kraushaar testified that despite a finding of hypertrophic synovitis dictated in the "Operation Performed" section of the operative report, it was absent as a finding in the "Postoperative Diagnosis" (T. 199; Dept. Ex. 6a, p. 39)

59. Dr. Kraushaar did not find any evidence of hypertrophic synovitis in the MRI report. (T. 200; Dept. Ex. 6a, 44-45)

60. The pathology report from an independent lab showed no evidence of synovitis in the biopsy sample taken by the Respondent himself. In fact, the report stated a finding

of "benign synovium and cartilage" and "no evidence of neoplasia." In other words, the biopsy showed no pathology. (T. 201, lines 10-21)

61. Dr. Kraushaar testified that the MRI images themselves showed no evidence of inflammation inside the joint and therefore no evidence of synovitis, stating they showed an "essentially normal or close to normal looking shoulder." (Dept. Ex. 14; T. 202, lines 11-12; T. 204-205)

62. Dr. Kraushaar found that the prints of digitally scanned intraoperative photos provided by the insurance carrier for Patient H were very well-taken, and did not display synovitis. "If there were inflammation, you would be seeing red, but on this page in this part of the surgery there's no red because there's no synovitis inside the joint, and that's what the pathologist felt too." (T. 206, lines 17-22; Dept. Ex. 11)

63. Dr. Kraushaar testified that the intraoperative photos also lacked evidence of adhesions, saying, "I don't see any adhesions on the subscapularis tendon despite Dr. Bhatt saying he did a lysis of adhesions. Dividing adhesions, once again, would be a pretty obvious process and he would have taken pictures of it, if he did it, but I don't see the process being performed here on these images, so I don't see synovectomy and I don't see lysis of adhesions." (T. 207, lines 8-16)

64. Contrary to Dr. Kraushaar's expert testimony, the Respondent looked at the same photographs and testified he could see "beautiful" and "fantastic" adhesions. Nevertheless, the Respondent elected not to show his orthopedic expert the photos and have him provide this Hearing Panel with his expert opinion in support of Respondent's position. (T. 537)

65. As alleged in Paragraph E2 of the Amended Statement of Charges, the Respondent falsely and with intent to deceive represented on a no-fault Insurance claim that he performed lysis of Patient H's adhesions. Dr. Kraushaar testified he reviewed Patient H's insurance claim form and that the Respondent billed \$1,873.54 for the procedure. (Dept. Ex. 6a, p. 49; T. 208-209)

### CONCLUSIONS OF LAW

Pursuant to the Findings of Fact as set forth above, the Hearing Committee unanimously concluded that the twelve Specifications of Misconduct set forth in the Statement of Charges were all sustained.

These specifications of professional misconduct are listed in New York Education Law §6530. This statute sets forth numerous forms of conduct, which constitute professional misconduct, but does not provide definitions of the various types of misconduct. The definitions utilized herein are set forth in a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law," sets forth suggested definitions of negligence, incompetence, and fraud.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Fraud - fraudulent practice involves the intentional misrepresentation or concealment of a known fact within the practice of the profession. Fraudulent practice can be exhibited in many different ways. For example, such practices can include knowingly submitting false bills for services or submitting false or exaggerated medical reports. Fraudulent practice may also include giving false statements on an application for hospital privileges or prescribing controlled substances for other than a good faith medical purpose.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee concluded that all the specifications set forth in the Amended Statement of Charges were sustained. The rationale for this reasoning is set forth in the discussion below. It is noted that all these conclusions resulted from a unanimous vote of the Hearing Committee.

### **DISCUSSION**

In its deliberations, the Hearing Committee carefully reviewed the Exhibits admitted into evidence, the transcripts of the three (3) Hearing days, the Department's Proposed Findings of Fact, Conclusions of Law, and Sanction as well as the Respondent's Proposed Findings of Fact and Conclusions of Law. In addition, after concluding that there was misconduct, the Hearing Committee was given the Department's Penalty Phase Memorandum and supporting documents. This

documentation included copies of a prior finding of professional misconduct by the Department and the Decision of the ARB which sustained the finding of misconduct. It is noted that the ARB overturned the penalty of suspension and revoked the Respondent's license. The panel was also given for review the Education Department's Regent's Report of the Committee on the Professions Application for Restoration of Physician License. During the course of its deliberations on these charges, the Hearing Committee considered the following instructions from the ALJ:

1. The Committee's determination is limited to the Allegations and Charges set forth in the Amended Statement of Charges. (Appendix I)

2. The burden of proof in this proceeding rests on the Department. The Department must establish by a fair preponderance of the evidence that the allegations made are true. Credible evidence means the testimony or exhibits found worthy to be believed. Preponderance of the evidence means that the allegations presented are more likely than not to have occurred (more likely true than not true). The evidence that supports the claim must appeal to the Hearing Committee as more nearly representing what took place than the evidence opposed to its claim.

3. The specifications of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence. The Hearing Committee understands that the Department must establish each and every element of the charges by a preponderance of the evidence. As to the veracity of the opposing witnesses, it is for the Hearing Committee to pass on the credibility of the witnesses and to base its inference on what it accepts as the truth.

4. Where a witness's credibility is at issue, the Committee may properly

credit one portion of the witness' testimony and, at the same time, reject another. The Hearing Committee understands that, as the trier of fact, they may accept so much of a witness' testimony as is deemed true and disregard what they find and determine to be false. In the alternative, the Hearing Committee may determine that if the testimony of a witness on a material issue is willfully false and given with an intention to deceive, then the Hearing Committee may disregard all of the witness' testimony.

5. The Hearing Committee followed ordinary English usage and vernacular for all other terms and allegations. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony.

With regard to the testimony presented, the Hearing Committee evaluated all the witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility. The Hearing Committee considered whether the testimony presented by each witness was supported or contradicted by other independent objective evidence. The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony. The Department presented an expert witness, Doctor Barry Kraushaar, whom the panel found to be both credible and persuasive. On the contrary, the Respondent's witnesses, and, in particular, the Respondent himself, were found to be not credible and thus unpersuasive. Similarly, the witnesses from the Respondent's staff were found to be less than candid and unbelievable.

The Hearing Committee sustained all twelve specifications of misconduct after discussing each one in detail and reviewing the factual allegations point by point. The

first specification charged Respondent 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. The panel unanimously sustained this specification of negligence as they concluded that the credible testimony about the Respondent's practice overwhelmingly established a persistent pattern of negligence in the manner in which the Respondent's practice was conducted.

The panel noted that the Respondent did not compose a contemporaneous operative report after his operations but waited up to a week to dictate his reports from scribbled notes. It was obvious to the panel that this haphazard approach to the practice of medicine led to and was one of the precipitating causes of the multiple errors that are strewn across this record. The panel found that the Respondent's practice and method of taking patient histories and reports were clearly negligent.

The second specification charged Respondent 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. A review of the record herein shows the Respondent generated five completely false and fabricated operative reports that were aptly described by the Department's expert witness as "weird" and a "statistical impossibility." (See T. 38-44) The panel found that these sloppy and erratic reports were not due to some clerical error by a subordinate. The panel concluded that these outrageous reports were due to the Respondent's incompetence. It was the Respondent's responsibility to prepare cogent and accurate operative reports that would enable a subsequent treating physician to understand what transpired in the operation. Respondent's failure to prepare such a report is clear evidence of his incompetence.

in the third through sixth specifications, Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently.

The law provides that in order for a hearing committee to sustain a charge that a licensee practiced medicine fraudulently, the hearing committee must find that (1) a licensee made a false representation, whether by words, conduct or by concealing that which the licensee should have disclosed; (2) the licensee knew the representation was false; and (3) the licensee intended to mislead through the false representation, Sherman v. Board of Regents, 24 AD.2d 315, 266 N.Y.S.2d 39 (Third Dept. 1966), *aff'd*, 19 N.Y.2d 679, 278 N.Y.S.2d 870 (1967). The case law provides that a committee may infer the licensee's knowledge and intent properly from facts that such committee finds, but the committee must state specifically the inferences it draws regarding knowledge and intent, Choudhry v. Sobol, 170 A.D.2d 893, 566 N.Y.S.2d 723 (Third Dept. 1991).

The panel inferred from the facts and testimony in this case that the Respondent must have known that he could not possibly write medically acceptable operative reports given his procedures. The Committee based its conclusion on the following facts that were established by overwhelming evidence at the hearing. First, on March 19, 2008, the date in question for the putative surgery on Patient A, the Respondent scheduled arthroscopic procedures on 14 patients. Second, Respondent dictated the reports for Patients A-E on March 26, 2008, 7 days after he supposedly performed the procedures. Third, Respondent did not take meaningful notes upon which he could rely to prepare an operative report at a later date. Respondent's notes for Patients B through E, offered by Respondent as Respondent's Exhibits I, J, K, and L, is a simple

list of diagnoses and procedures. While such a list would be useful for instructing Respondent's office staff on how to prepare insurance claims, the notes lack sufficient information for preparing a medically acceptable operative report. Finally, Respondent admitted at the hearing that he would sign the operative reports without reviewing the report or even comparing the report to his inadequate handwritten notes. The Respondent frankly admitted that he did an operative report for one patient while thinking about another, without checking the record to verify the actual surgery. The Respondent admitted that the surgery in question for Patient A was never done and that the whole report was a fabrication. (See T. 471)

Furthermore, the panel found that fraud could also be inferred from the operative reports for patients F and H. The Department's attorney has also demonstrated through both pre-operative diagnostic studies and post-operative studies that Doctor Bhatt's operative reports for Patients F and H were prepared in an equally haphazard and unreliable manner. Patients F and H had various arthroscopic procedures relating to their knees or shoulders.

While there is no question that Respondent actually operated on patients F and H, the panel found that Doctor Bhatt inaccurately represented that he performed more procedures and/or more complex procedures than what actually occurred. Respondent's operative reports and insurance claims are inconsistent with pre-operative, intraoperative and postoperative diagnostic studies, including preoperative MRIs, intraoperative photos, and in one case a pathological evaluation. Respondent's repeated claim that he saw the condition through the arthroscope but neglected to take an intraoperative photograph of the condition and/or of his treatment of the condition is

simply not credible. Accordingly, the record and the hearing testimony convinced the panel that the Respondent practiced the profession fraudulently.

In the seventh through tenth specifications Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) by willfully making or filing a false report. To make a finding of a Respondent willfully filing a false report, a committee must establish that a licensee made or filed a false statement willfully, which requires a knowing or deliberate act, Matter of Brestin v. Comm. of Educ., 116 A.D.2d 357, 501 N.Y.S.2d 923 (Third Dept. 1986). Merely making or filing a false report, without intent or knowledge about the falsity fails to constitute professional misconduct, Matter of Brestin v. Comm. of Educ. (supra). The law provides, however, that a committee may reject a licensee's explanation for erroneous reports (such as errors resulting from inadvertence or carelessness) and draw the inference that the licensee intended or was aware of the misrepresentation with other evidence as the basis. (See Matter of Brestin)

The panel was convinced of the Respondent's fraudulent practice and this point was clearly established by the record and testimony herein. The essence of this fraudulent practice was the false and fabricated reports. The panel inferred that these reports were intentionally and knowingly filed by the Respondent. Accordingly, specifications seven through ten were sustained.

The eleventh specification charged the Respondent 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. The panel chair, Doctor Golding, questioned the Respondent about a patient's medical history and

ascertained that the Respondent did not note the patient's temperature, pulse or blood pressure in his record. Furthermore, the Respondent's record did not include the chief complaint and present illness. (See the questioning by Dr. Golding at T. 490 *et seq.*) On review of all the medical records in this case, the panel was unanimous in finding that the Respondent failed to maintain a record for each patient, which accurately reflects the care and treatment of the patient in question.

Finally, the twelfth specification charged the Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice medicine. On the issue of moral unfitness to practice medicine, the panel recognized that the evidence clearly established the case for negligence, incompetence and shoddy practice in the taking and keeping of medical records. Ordinarily, such practices, although reprehensible, do not rise to the level of moral unfitness.

This case however, is different. The record herein shows an extraordinary level of impropriety and a shockingly cavalier disregard for the most basic of medical practice procedures. Not only did the Respondent wait a week to write up his operative report but he also signed his reports without even looking at them. From these practices and the Respondent's failure to read his reports before signing them, the panel concluded that the Respondent did not take appropriate responsibility for his actions. The panel reviewed the Respondent's office system and determined that his systems were bound to fail. While the Respondent testified that his billing for an unperformed surgery was a simple clerical error, the panel disagreed and found such a billing to be an inevitable consequence of the Respondent's procedures. The panel concluded that the

Respondent should have known that his procedures would lead to failure and in that disregard for proper and reasonable procedure, the panel found moral unfitness. The panel found that it was wrong for the Respondent to conduct his practice the way he did and therefore they unanimously sustained the twelfth specification.

### VOTE OF THE HEARING COMMITTEE

#### FIRST SPECIFICATION

The first specification charged Respondent 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.

The panel found that the Department clearly and overwhelmingly established the case for negligence on more than one occasion. The most glaring example of negligence was the Respondent's practice of not preparing his operative report until a week after the surgery and then doing so by dictation from memory and imperfect notations. To compound this carelessness, the Respondent did not even read the reports before signing them.

The Committee therefore concludes, unanimously, that the First Specification was SUSTAINED.

**Vote: SUSTAINED (3-0)**

## SECOND SPECIFICATION

The second specification charged Respondent 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.

The panel found that the above evidence for negligence also supports the specification of incompetence. The panel looked to the medical records and testimony and found no evidence of rehabilitation efforts or follow up treatment by this Doctor for his orthopedic patients.

The Committee therefore concludes, unanimously, that the Second Specification of incompetence on more than one occasion was SUSTAINED.

**Vote: SUSTAINED (3-0)**

## THIRD THROUGH SIXTH SPECIFICATIONS

In the third through sixth specifications Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently.

The panel had some concerns with the discussion of fraud. They realized they could not get inside the Respondent's mind and see clearly what his real intentions were. The panel could only judge the Respondent by his overt actions and infer from these actions and conduct what the Respondent's real intentions were.

It is noted that the charge of practicing the profession fraudulently involves the intentional misrepresentation or concealment of a known fact, made in some connection

with the practice of medicine and made with the intent to deceive. An individual's knowledge that he or she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts. Fraud is also a statement or representation with reckless disregard as to the truth of the statement or representation.

The courts have confirmed findings of fraudulent medical practice in several situations. Submitting false bills or claims for services rendered, with knowledge that they were false, supports a charge of fraudulent practice, as does the submission of false and exaggerated medical reports and bills. See Holmstrand v. Board of Regents, 71 A.D.2d 725, 419 N.Y.S.2d 223 (3<sup>rd</sup> Dept. 1979). While the mere making or filing of a false report, without intent or knowledge of the falsity, does not constitute fraudulent practice, the hearing committee is free to reject, as not credible, a licensee's mitigating explanations. See Kenna v. Ambach, 61 A.D.2d 1091, 403 N.Y.S.2d 351 (3<sup>rd</sup> Dept. 1978). The law also provides that the hearing committee must base its inferences on that which it accepts as the truth. Klein v. Sobol, 167 A.D.2d 625, 562 N.Y.S.2d 856 (3<sup>rd</sup> Dept. 1990) appeal denied 77 N.Y.2d 809 (1991).

In addition, the law provides that there need not be actual injury caused by the misrepresentation in order for the misrepresentation to constitute fraudulent practice of medicine. The unambiguous and unrefuted testimony in this case established that the Respondent created fraudulent records. There is no credible evidence to the contrary. Based on the preponderance of the credible evidence, the Hearing Committee concluded that the Respondent practiced the profession fraudulently by fabricating false and inaccurate medical records.

In reviewing the entire record, the panel concluded that the Respondent acted fraudulently. Not only did he bill for a surgery that was never performed. There were several additional examples of fraud established in this case. For example, the panel found that the Respondent knowingly and falsely billed a no-fault insurance carrier \$1,873.54 for a lysis of adhesions on Patient F. The panel agreed with the Department's expert and concluded that there were no adhesions and thus found fraud on the part of the Respondent. This fraud consisted of the willful intent to deceive the insurance carrier.

As for the third specification, the panel inferred the commission of fraud from the submission of a bill for surgery on patient A that was never performed. The record shows that the Respondent submitted a bill on March 28, 2008 for knee surgery supposedly performed on Patient A on March 19, 2008. This surgery was not performed and the hearing panel inferred fraudulent intent from this deception.

As for the fourth specification, the panel inferred fraud from the submission of a bill for surgery on Patient F that was never performed. The Respondent falsely represented to the insurance carrier that he performed a lysis and resection that was never in fact performed. From this exaggeration of what he actually did, the panel concluded that there was fraudulent intent, noting that the errors in this case were always in the Respondent's favor and he did not ever bill for less than he was entitled to.

As for the fifth specification, the panel inferred fraud from the submission of a bill for surgery on Patient G that was never performed. The record and testimony herein show that the Respondent billed an insurance carrier for an abrasion arthroplasty

for Patient G which he did not do. The documentation in this case shows that the Respondent billed an insurance carrier \$1,779.00 for an abrasion arthroplasty. The Respondent maintained that this procedure was needed to deal with a condition called osteochondritis dessicans. The panel accepted the testimony of Doctor Kraushaar that this condition did not exist. The panel did not believe the Respondent when he claimed he saw this condition during surgery.

Accordingly, the panel once again inferred that there was fraudulent intent, noting again that the errors in this case were always in the Respondent's favor and he did not ever bill for less than what was entitled.

As for the sixth specification, the panel inferred fraud from the submission of a bill for surgery on Patient H that was never performed. The record and testimony herein show that the Respondent billed an insurance carrier for lysis and resection of adhesions for Patient H which the Respondent did not do.

On review of the all the facts and testimony in this case the Committee therefore concludes, unanimously, that the Third through Sixth Specifications are

**SUSTAINED.**

**Vote: SUSTAINED (3-0)**

#### **SEVENTH through TENTH Specifications**

In the seventh through tenth specifications Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) by willfully making or filing a false report.

Specifically, the panel concluded that there was a deliberate and false filing with regard to the following:

Specification Seven: The Respondent billed for a surgery on Patient A that was never performed. Again, the Respondent billed for doing surgery on March 19, 2008. The credible and persuasive evidence established that he did not do this surgery.

Specification Eight: The Respondent billed for a surgery on Patient F that was never performed. The Respondent claimed to have performed a lysis and resection on this patient's shoulder. The credible evidence convinced the panel that the Respondent did not do this procedure.

Specification Nine: The Respondent billed for a surgery on Patient G that was never performed. As was seen above in Specification Four, the record shows that the Respondent billed an insurance carrier for an abrasion arthroplasty for Patient G which he did not do. The believable evidence in this case established that the Respondent billed an insurance carrier \$1,779.00 for an abrasion arthroplasty. The Respondent maintained that this procedure was needed to deal with a condition called osteochondritis dessicans. With the same reasoning they used in Specification Four, the panel accepted the testimony of the Department's expert witness that this condition did not exist. The panel did not believe the Respondent when he claimed he saw this condition during surgery but did not take a photo to prove it.

Specification Ten: The Respondent billed for a surgery on Patient H that was never performed. The panel followed their reasoning in the Sixth Specification and therefore concluded that there was a false report in the submission of a bill for surgery on Patient H that was never performed. The record and testimony herein show that the

Respondent billed an insurance carrier for lysis and resection of adhesions for Patient H which the Respondent did not do.

On review of the all the facts and testimony in this case, the Committee therefore concludes, unanimously, that the Seventh through Tenth Specifications are

**SUSTAINED.**

**Vote: SUSTAINED (3-0)**

### **ELEVENTH SPECIFICATION**

The eleventh specification charged the Respondent 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.

The most glaring example of this misconduct was the billing for Patient A. This surgery never happened and yet the Respondent signed off on a report to get payment from an insurance company. The panel did not believe the Respondent's testimony about the failure of his staff and dictation errors. This record was clearly inaccurate and evidence of misconduct.

Similarly, the operative reports for patients B, C, and D were inaccurate and do not reflect the actual care that was given these patients. In each case, a more costly procedure was described for the purpose of getting a larger payment from the insurance carrier. The panel inferred this conclusion from their review of the testimony and the records presented at the hearing.

On review of all the facts presented, the Committee therefore concluded, unanimously, that the Eleventh Specification was SUSTAINED.

**Vote: SUSTAINED (3-0)**

### TWELFTH SPECIFICATION

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

As set forth in the discussion section of this determination, this case presents a pattern of careless and deceptive behavior that goes far beyond mere clerical errors. The record herein shows an extraordinary level of impropriety and a shockingly cavalier disregard for the most basic of medical practice procedures, which have been designed and intended to protect the patient. For personal gain, the Respondent altered his reports to reflect procedures that were not performed.

The record shows that the Respondent waited a week to write up his operative report and also signed his reports without even looking at them. From these practices and the Respondent's failure to read his reports before signing them, the panel concluded that the Respondent did not take appropriate responsibility for his actions. The panel reviewed the Respondent's office system and determined that it was bound to fail.

Ordinarily, such sloppiness and careless recordkeeping does not amount to

immorality. In this case, however, the Respondent's practices were so glaringly deficient that they show him to lack the most basic moral fitness and probity required of a physician. The panel found that it was morally wrong for the Respondent to conduct his practice the way he did and therefore they unanimously sustained the twelfth specification.

The Committee therefore concludes, unanimously, that the Twelfth Specification was **SUSTAINED**.

**Vote: SUSTAINED (3-0)**

#### **HEARING COMMITTEE DETERMINATION AS TO PENALTY**

The discussion about penalty was done in two stages. Only after the panel had voted on the specifications and had sustained the charges of misconduct did the discussion move to the second stage, the one which included the Respondent's prior acts of medical misconduct, acts that were not alluded to in the Department's case in chief.

When the panel finished voting on all the specifications, they were given copies of the Department's Penalty Phase Memorandum. Only then did the panel learn that the Respondent had been before the State Board for Professional Medical Conduct in the past.

These documents presented by the Department show that the Respondent has a

criminal conviction and a prior State Board of Professional Medical Conduct discipline that should be considered by the Hearing Committee in determining an appropriate sanction.

According to the Department's attorney, the Respondent's prior criminal/discipline history provides significant additional reasons for revoking his medical license. The panel was dismayed to learn that the prior criminal conviction in New York State Supreme Court, Queens County and State Board for Professional Medical Conduct discipline were so similar to the present misconduct. According to the records submitted by the Department, the Respondent was charged in an 111 count indictment with submitting false Medicare claims. In particular, the Respondent was charged and pled guilty to submitting a bill for a hip operation on a patient that he never performed. At that time, the Respondent was paid \$14,073.78 on his claim for \$34,037.77 for a surgery that he never performed. The panel noted with considerable concern that the issues in the prior matter, which involved fraudulent insurance billing, closely mirror the issues in the instant case.

In the documentation it submitted, the Department contended that Respondent misled the Hearing Panel when he testified that he had never had a problem with billing for a surgery that had not been performed. During his testimony Respondent was asked, "Have you ever had a problem like this as far as billing for a surgery that was not performed prior to this incident?" Dr. Bhatt answered, "No, sir" (T. 459-460), when in fact, Respondent had been criminally convicted for submitting a false Medicare claim. According to the Department, the Respondent's misleading testimony in this Hearing is an additional reason to impose license revocation. The panel did not consider this

additional circumstance as they had more than enough reason to find for revocation from the evidence presented by the Department in its case in chief.

In its deliberations, the panel reviewed the records submitted by the Department which show that, in 1994, the Respondent, Doctor Harshad C. Bhatt, was convicted in the Supreme Court of the State of New York, Queens County, for Insurance Fraud in the Fourth Degree, a Class E Felony. In that case, the Respondent was charged with submitting 27 false claims and pled guilty to submitting a false Medicare claim form to an insurance carrier for \$34,037.77 for a surgery that was never performed. He was sentenced to five years' probation, a \$10,000 fine, and restitution to the U.S. Government for \$36,451.54, and a \$5 crime victim fee. (See, Report of the Committee of the Professions, p.2)

Because of this criminal conviction, the Respondent was brought before a panel of the State Board for Professional Medical Conduct in a Direct Referral proceeding, presided over by ALJ Larry G. Storch. Following this proceeding and based on the above conviction, the Respondent's New York State medical license was Suspended for three years in January of 1996.

The Direct Referral Committee found that the Respondent was genuinely remorseful for his past misdeeds and acknowledged his work in underserved areas and so did not revoke his license.

This Suspension was stayed and the Respondent was placed on probation for five years. The Department appealed this determination to the Administrative Review Board for Professional Medical Conduct (ARB) and the ARB revoked the Respondent's medical license in May of 1996.

The ARB overturned the Hearing Committee's determination because they found that a mere stayed suspension was not consistent with the findings of fraudulent activity. The ARB found that a stayed suspension was not an appropriate penalty for misconduct in which a Respondent had used his medical license to commit fraud. Therefore, the ARB revoked the Respondent's medical license.

Thereafter, the Respondent petitioned for restoration of his license in 1998. In 2001, the Respondent's petition was granted to the extent of staying the revocation and placing the Respondent on four years' probation. It is noted that one Peer Committee Member dissented from this lenient course of action, believing that Dr. Bhatt had not met the criteria for restoration. (See Report of the Committee on the Professions, p.2)

The record of the proceedings of the Report of the Committee on the Professions goes on to show that, in order to reassure the Board of Regents that he would never have another insurance billing problem, Respondent made a number of promises about what his future practice would be like. The evidence in this Hearing shows how far his actual practice has deviated from the promises Respondent made when applying for restoration of his license. The report of the restoration committee summarized the Respondent's testimony as follows:

"Applicant states that if he is allowed to return to the practice of medicine, he would be the most careful practitioner ever. He would have focus, limit his practice and not over-stretch himself. He would have a proper office and run it in the most practical and ethical way. He would employ billing persons and have in place strict accounting procedures." (Report of the Peer Committee, p.12)

In the papers submitted for the penalty phase, the Department's attorney requested that the Hearing Committee remember the Respondent's pledge when considering an appropriate penalty. The Department's attorney pointed out that Doctor Bhatt was given his second chance to demonstrate to the profession and to the public that he would be "the most careful practitioner ever" when his license was restored. As this proceeding has clearly demonstrated, the Respondent misled the Hearing Committee and broke his promise to the Board of Regents to "practice without taint or tarnish, and walk on the path of truth." (Report of the Committee of the Professions, p. 4)

The Hearing Committee took a recess to read all the materials submitted for the penalty phase and also had an opportunity to review the papers in the prior disciplinary action against Respondent. The panel noted that the restoration committee allowed Respondent to escape with his "professional life" and gave him a second chance. After reviewing the entire record, it is abundantly clear that the only appropriate sanction now is revocation. The panel noted that anything short of revocation would allow Respondent to continue his wrongful and potentially harmful practice.

The Respondent has clearly not learned from his past misconduct and criminal conviction; he is still engaging in fraudulent and deceptive behavior. As the Hearing Committee eloquently stated in The Matter of Peter Muncan, BPMC 01-221, "[O]ne can be taught the theories of the ethics but not the application of morality and truthfulness. Respondent was viewed as a professional who will do anything to protect himself rather than his patient." The exact same statements hold for the Respondent in the instant matter. The record herein shows that the Respondent has not learned from

past mistakes; he still is not able to take responsibility for his actions and is willing to commit fraud without compunction or remorse.

The attorney for the Respondent has argued that the prior behavior of Doctor Bhatt was long ago in the past and that he should not now have to be punished for his prior misdeeds of almost two decades ago. The panel disagreed and found that the present behavior is but a reprise of his prior misconduct. It is noted that the panel may well have decided that the present misconduct, in and of itself, shows a cavalier and wanton disregard for proper practice and billing procedure and would, standing alone, be sufficient ground for revocation. Moreover, when the prior misconduct was added to the present fraudulent action and behavior, the panel was left with no choice but to order revocation.

The panel did not reach this conclusion lightly and gave full consideration to all other available penalties. The panel fully appreciates the gravity of their decision. Nevertheless, the facts herein cry out for revocation and the imposition of a financial penalty. At the conclusion of their deliberations, the panel took another vote and decided unanimously on revocation and a substantial fine as the appropriate penalty.

Attorney Kobak, the Respondent's attorney, argued that a revocation and a financial penalty would not be appropriate as the prior misconduct occurred 18 years ago. In addition, Attorney Kobak pointed out that there was no credible evidence that the Respondent had any financial gain from the present misconduct. The panel disagreed and noted that all the billing errors in this case redounded to the Respondent's benefit. Not one bill was shown where the bill submitted was for an amount less than the Respondent was entitled to.

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, after due deliberation, unanimously determined that all twelve specifications raised against Respondent were sustained and that, under the circumstances of this case, the only appropriate and just penalty is revocation of the Respondent's license to practice medicine. In addition, the panel found that a substantial fine should be levied. The Committee was unanimous in its vote that the maximum possible fine should be imposed.

The Committee has a responsibility to protect the patients of the State. The issue before this Committee is to choose a penalty that offers the best protection to the people of the State. The Committee finds that the Respondent has committed sufficiently egregious misconduct that is worthy of the revocation of his medical license.

The panel recognized that the Respondent's conduct and office practice was, at least in part, motivated by greed. The panel was convinced that the desire for wrongful financial gain was the reason behind the Respondent's wrongful billing practices. Taking this desire for financial gain into account the panel determined that the Respondent should be punished financially for his actions and determined that a fine of \$120,000 would be appropriate under the circumstances of this case. The panel sustained all twelve specifications of misconduct and the maximum fine for each specification is \$10,000.00. The panel agreed, unanimously, that the maximum fine should be imposed in this case since it is not the first time that such an issue of financial integrity has come before the board.

The Committee concluded that the only way to ensure the safety of the public is to revoke Respondent's medical license. Anything other than that sanction would risk a

recurrence of this behavior. The public should not bear that risk.

### ORDER

#### IT IS HEREBY ORDERED THAT:

1. All twelve Specifications of professional misconduct, as set forth in the Amended Statement of Charges, are SUSTAINED;
2. The Respondent's license to practice medicine is hereby REVOKED;
3. A fine of \$120,000.00 is imposed on the Respondent, Dr. Harshad Bhatt, M.D. The fine is payable in full within 90 days of the effective date of this Order. Payment must be submitted to the New York State Department of Health, Bureau of Accounts Management, Empire State Plaza, Coming Tower, Room 2784, Albany, New York 12237. Failure to pay the fine on time will subject the Respondent to all provisions of law relating to debt collection by New York State, including 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 and licenses (Tax Law Section 171[27], State Finance Law Section 18, CPLR Section 5001, Executive Law Section 32).
4. This Determination and Order shall be effective upon service on the Respondent. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall

be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

**DATED: New York, New York**

12 March, 2013

**REDACTED**

**Michael R. Golding, M.D., Chair**

**Jerry Waisman, M.D.**

**James J. Ducey**

**TO:**

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94-54 Lefferts Blvd.  
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Harshad Bhatt, M.D.  
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## APPENDIX I

IN THE MATTER  
OF  
HARSHAD BHATT, M.D, A.K.A.  
HARSHADRAI CHIMANDRAL BHATT, M.D.

AMENDED  
STATEMENT  
OF  
CHARGES

Harshad Bhatt, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 11, 1983, by the issuance of license number 153340 by the New York State Education Department.

**FACTUAL ALLEGATIONS**

- A. Respondent, an orthopaedist, treated Patients A-I, at Boulevard Surgical Center, 46-04 31<sup>st</sup> Avenue, Long Island City, N.Y. 11103; A.P. Orthopedic and Rehabilitation, P.C., 94-54 Lefferts Boulevard, Richmond Hill, N.Y. 11419; Liberty Orthopedics, P.L.L.C., 388 Fulton Avenue, Hempstead, N.Y. 11550; and Hempstead Medical Care, P.C., 95 Clinton Street, Hempstead, N.Y. 11550. Patients A-I are identified in the Appendix.

On or about and between January 25, 2008 and March 19, 2008, the Respondent treated Patient A, a 46-year old male, for various injuries related to an automobile accident dated January 8, 2008. Respondent scheduled Patient A for arthroscopic knee surgery on March 12, 2008. The surgery was cancelled due to Patient A's elevated blood pressure. The surgery was rescheduled for March 19, 2008. The second surgery date was also cancelled due to Patient A's elevated blood pressure. On or about March 26, 2008, Respondent dictated an operative report in which he represented that he



Dept EXH 15

operated on Patient A on March 19, 2008. On or about March 28, 2008, Respondent submitted an insurance claim for various surgical procedures purportedly performed on March 19, 2008. With regard to Patient A:

1. Respondent knowingly and falsely represented in the operative report and on an insurance claim form submitted to Progressive Insurance, that he performed various surgical procedures on March 19, 2008, when, in fact, he knew that he had not performed the procedures. Respondent intended to deceive.
2. Respondent failed to maintain a medical record that accurately reflected the care and treatment of this patient.

B. In operative reports dictated on March 26, 2008, the same day Respondent dictated the operative report for Patient A, Respondent represented that he performed arthroscopic knee surgery on four other patients, B, C, D, and E.

1. Respondent failed to maintain a medical record that accurately reflected his evaluation and treatment for:
  - a. Patient B.
  - b. Patient C.
  - c. Patient D.
  - d. Patient E.

C. On or about and between November 25, 2008 and June 30, 2009, Respondent treated Patient F, a 31-year-old female, for various injuries related to an automobile accident dated October 22, 2008. Respondent performed arthroscopic shoulder surgery on December 10, 2008.

1. Respondent deviated from minimally acceptable standards of care in that he inappropriately diagnosed:

- a. a superior Type 2 labral tear;
  - b. hypertrophic synovitis in the glenohumeral joint;
  - c. adhesions of the anterior capsule and subscapularis tendon.
2. Respondent deviated from minimally acceptable standards of care in that he inappropriately performed:
    - a. a repair of the labrum;
    - b. debridement of glenohumeral synovitis.
  3. In the operative report and on an insurance claim for Patient F, Respondent knowingly and falsely represented, with the intent to deceive, that he performed lysis and resection of the adhesions of the shoulder billed under CPT Code 29825.

D. On or about and between November 3, 2008 and December 1, 2008, Respondent treated Patient G, a 43-year-old male, for various injuries related to an automobile accident dated September 24, 2008. Respondent performed arthroscopic surgery on November 18, 2008.

1. Respondent deviated from minimally acceptable standards of care in that he inappropriately diagnosed:
  - a. osteochondritis dissecans of the right femoral condyle;
  - b. an ACL tear, (WITHDRAWN)
  - c. a torn anterior horn of the lateral meniscus.
2. In the operative report and/or on an insurance claim for Patient G, Respondent knowingly and falsely represented, with the intent to deceive, that he performed the following procedures:
  - a. abrasion arthroplasty billed under CPT code 29879;

- b. medial and lateral meniscectomy billed under CPT Code 29880. (WITHDRAWN)

E. On or about and between August 22, 2008 and December 15, 2008, Respondent treated Patient H, a 43-year-old female, for various injuries related to an automobile accident dated on August 19, 2008. Respondent performed arthroscopic surgery on October 22, 2008.

- 1. Respondent deviated from minimally acceptable standards of care in that he inappropriately diagnosed:
  - a. hypertrophic synovitis;
  - b. adhesions in the anterior capsule of the shoulder.
- 2. In the operative report and on an insurance claim for Patient H, Respondent knowingly and falsely represented, with the intent to deceive, that he performed lysis and resection of adhesions billed under CPT Code 29825.

F. On or about and between January 8, 2009 and April 9, 2009, Respondent treated Patient I, a 60-year-old male, for various injuries related to an automobile accident that dated October 30, 2008. Respondent performed arthroscopic surgery on February 11, 2009.

- 1. Respondent deviated from minimally acceptable standards of care in that he inappropriately diagnosed:
  - a. grade four chondromalacia of the patella when the severity of the chondromalacia was significantly less;
  - b. subluxation of the patella;
  - c. a tear in the anterior horn of the lateral meniscus.
- 2. Respondent deviated from minimally acceptable standards of

- care in that he inappropriately performed a partial lateral meniscectomy.
3. Respondent failed to obtain and/or note an adequate patient history.

### **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) 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 C, C1a-c, C2a-b; D, D1a-c; E, E1a-b; and F, F1a-c, F2, and F3.

#### **SECOND SPECIFICATION**

##### **INCOMPETENCE ON MORE THAN ONE OCCASION**

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

2. Paragraphs C, C1a-c, C2a-b; D, D1a-c; E, E1a-b; and F, F1a-c, F2, and F3.

#### **THIRD THROUGH SIXTH SPECIFICATION**

##### **FRAUDULENT PRACTICE**

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

alleged in the facts of:

3. Paragraphs A and A1;
4. Paragraphs C and C3;
5. Paragraphs D, D2, and D2a, D2b;
6. Paragraphs E and E2.

### **SEVENTH THROUGH TENTH SPECIFICATION**

#### **FALSE REPORT**

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

7. Paragraphs A and A1;
8. Paragraphs C and C3;
9. Paragraphs D, D2 and D2a, D2b;
10. Paragraphs E and E2.

### **ELEVENTH 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 that accurately reflects the care and treatment of the patient, as alleged in the facts of:

11. Paragraphs A and A2; B, B1, B1(a), B1(b), B1(c), B1(d); F and F3.

### **TWELFTH SPECIFICATION**

#### **MORAL UNFITNESS**

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

12. Paragraphs A - F and their subparagraphs.

DATE: May 25, 2012  
New York, New York

REDACTED

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Roy Nemerson  
Deputy Counsel  
Bureau of Professional Medical Conduct