



*New York State Board for Professional Medical Conduct*

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

Dennis P. Whalen  
*Executive Deputy Commissioner of Health*  
Anne F. Saile, Director  
*Office of Professional Medical Conduct*  
William J. Comiskey, Chief Counsel  
*Bureau of Professional Medical Conduct*

William P. Dillon, M.D.  
*Chair*  
Denise M. Bolan, R.P.A.  
*Vice Chair*  
Ansel R. Marks, M.D., J.D.  
*Executive Secretary*

December 10, 1998

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Dimitrios Kontos, M.D.

REDACTED

RE: License No. 095829

Dear Dr. Kontos:

Enclosed please find Order #BPMC 98-297 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect **December 10, 1998.**

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct  
New York State Department of Health  
Hedley Park Place, Suite 303  
433 River Street  
Troy, New York 12180

If the penalty imposed by the Order is a fine, please write the check payable to the New York State Department of Health. Noting the BPMC Order number on your remittance will assist in proper crediting. Payments should be directed to the following address:

Bureau of Accounts Management  
New York State Department of Health  
Corning Tower, Room 1315  
Empire State Plaza  
Albany, New York 12237

Sincerely,

REDACTED

Ansel R. Marks, M.D., J.D.  
Executive Secretary  
Board for Professional Medical Conduct

Enclosure

cc: Amy Kulb, Esq.  
Jacobson & Goldberg  
591 Stewart Avenue  
Garden City, New York 11530

Claudia Morales Bloch, Esq.

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

IN THE MATTER  
OF  
DIMITRIOS D. KONTOS, M.D.

SURRENDER  
OF  
LICENSE

BPMC #98-297

STATE OF NEW YORK )  
COUNTY OF NASSAU ) SS.:

DIMITRIOS D. KONTOS, M.D., being duly sworn, deposes and says:

On or about May 18, 1966, I was licensed to practice medicine as a physician in the State of New York having been issued License No. 095829 by the New York State Education Department.

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

I understand that I have been charged with forty-six (46) specifications of professional misconduct as set forth in the Statement of Charges, annexed hereto, made a part hereof, and marked as Exhibit "A".

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 admit guilt to the first specification (a criminal conviction under New York state law) in full satisfaction of the Statement of Charges.

In addition to surrendering my license as a physician in the State of New York I hereby agree to the penalty of a fine in the amount of \$20,000.00.

12

Unless otherwise specified herein, the fine is payable in full within thirty (30) days of the effective date of this Order. Payments must be submitted to:

Bureau of Accounts Management  
New York State Department of Health  
Empire State Plaza  
Corning Tower, Room 1245  
Albany, New York 12237

I hereby make this application to the State Board for Professional Medical Conduct and request that it be granted.

I understand that, in the event that the application is not granted by the State Board for Professional Medical Conduct, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged and charged against me, such application shall not be used against me in any way, and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the State Board for Professional Medical Conduct shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by a Committee on Professional Medical Conduct pursuant to the provisions of the Public Health Law.

I agree that, in the event the State Board for Professional Medical Conduct grants my application, an order shall be issued striking my name from the roster of physicians in the State of New York without further notice to me.

13

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive any right I may have to contest the Surrender Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted.

1  
REDACTED

~~DIMITRIOS D. KONTOS, M.D.~~  
RESPONDENT

Sworn to before me this  
3<sup>rd</sup> day of December, 1998

REDACTED

~~NOTARY PUBLIC~~

AMY T. KULB  
NOTARY PUBLIC, State of New York  
No 02KU6034728  
Qualified in Nassau County  
Commission Expires October 17, 2000

The undersigned agree to the attached application of the Respondent to surr  er his license.

Date: 12/3/98

REDACTED

AMY KILB, Esq.  
Attorney for Respondent

Date: 12/4/98

REDACTED

CLAUDIA MORALES BLOCH  
Associate Counsel  
Bureau of Professional  
Medical Conduct

Date: December 7, 1998

REDACTED

ANNE F. SAILE  
Director  
Office of Professional Medical Conduct

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

IN THE MATTER  
OF  
DIMITRIOS D. KONTOS, M.D.

SURRENDER  
ORDER

Upon the proposed agreement of DIMITRIOS D. KONTOS, M.D.  
(Respondent) to Surrender his license as a physician in the State of New York,  
which proposed agreement is made a part hereof, it is agreed to and

ORDERED, that the application and the provisions thereof are hereby  
adopted, including the payment of a fine; it is further

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

ORDERED, that this order shall take effect as of the date of the personal  
service of this order upon Respondent, upon receipt by Respondent of this order via  
certified mail, or seven days after mailing of this order via certified mail, whichever is  
earliest.

SO ORDERED.

DATED: 12/8/98

REDACTED

WILLIAM P. DILLON, M.D.  
Chairperson  
State Board for Professional  
Medical Conduct

IN THE MATTER  
OF  
DIMITRIOS D. KONTOS, M.D.

STATEMENT  
OF  
CHARGES

DIMITRIOS D. KONTOS, M.D., the Respondent, was authorized to practice medicine in New York State on or about May 18, 1966, by the issuance of license number 095829 by the New York State Education Department. The names of Patients A through Y are identified in an Appendix annexed hereto.

**FACTUAL ALLEGATIONS**

- A. On or about October 28, 1997, Respondent was convicted in the Criminal Court of the State of New York, upon a plea of guilty, of attempted tampering with physical evidence under Penal Law Secs. 110 and 215.40, in that Respondent knowingly attempted to produce a falsified patient chart for Patient A in response to a grand jury subpoena duces tecum. The chart contained an entry that Respondent had seen the patient on September 22, 1993 when in truth and in fact he had not.
1. On or about September 23, 1993 and on or about September 29, 1993, Respondent knowingly falsely billed the Medical Assistance Program (hereinafter referred to as "the Program") for office visits by and services rendered to Patient A on these dates which, in fact, never occurred. Respondent never saw Patient A.

**"EXHIBIT A"**

17

2. Respondent knowingly falsely wrote prescription(s) for durable medical equipment, to wit: orthotic devices, in Patient A's name, for the sole purpose of referring the prescription(s) to Negat Acanovski, a Medicaid provider known by the Program as "Quality Orthopedics" (hereinafter referred to as "Q.O."). Respondent knew or should have known that "Q.O." would use said false prescription(s) to submit false bills to the Program for various orthotic devices, with a total cost to the Program of approximately \$10,342.00;
  3. Respondent failed to obtain a history from Patient A;
  4. Respondent failed to perform a physical examination of Patient A;
  5. Respondent knowingly prescribed various orthotic devices for Patient A inappropriately and without legitimate medical purpose;
  6. Respondent failed to maintain a record for Patient A which accurately reflects the patient's history, examination, diagnosis, test, and treatment rendered.
  7. Respondent created a record for Patient A which is false and inaccurate and does not reflect legitimate patient care and treatment.
- B. Respondent provided the Office of Professional Medical Conduct (hereinafter referred to as "OPMC") with a copy of an office record which he knowingly

falsely certified to be a "complete, true and exact copy[ies] of the medical record for Patient B kept on file during the regular course of business and made at the time of such event as recorded or written." Said office record contains two entries made by Respondent dated June 27, 1994 and January 26, 1995:

1. On each documented occasion referred to in paragraph B, supra, Respondent failed to:
  - a. Obtain and note an adequate history;
  - b. Perform and note an adequate physical examination;
  - c. Obtain and/or order an x-ray and/or other diagnostic modalities.
2. On each documented occasion referred to in paragraph B, Respondent noted a diagnosis for Patient B which was medically unsubstantiated by history or physical examination.
3. On each documented occasion referred to in paragraph B, Respondent failed to properly evaluate the patient and arrive at an appropriate diagnosis to address the patient's complaint(s).
4. At various undocumented times, Respondent knowingly prescribed various orthotic devices for Patient B inappropriately and without legitimate medical purpose.

5. On each documented occasion referred to in paragraph B, Respondent failed to evaluate and note the specifics of the orthotic devices prescribed.
6. Respondent falsely prescribed orthotic devices for Patient B when he knew or should have known that "Q.O." would use said false prescriptions to submit false bills to the Program for the devices, with a total cost to the Program of approximately \$6,767.00.
7. Respondent failed to perform and note a follow-up examination and evaluation of the patient's medical condition and of the orthotic device(s) he prescribed.
8. Respondent knowingly falsely billed the Program for medical services which were never rendered, to wit office visits for:
  - a. November 19, 1993;
  - b. November 29, 1993;
  - c. February 16, 1994;
  - d. February 24, 1994;
  - e. March 30, 1994;
  - f. June 8, 1994;
  - g. June 21, 1994;
  - h. August 11, 1994;
  - i. August 19, 1994;
  - j. August 30, 1994;
  - k. December 10, 1994;

9. Respondent failed to maintain a record for Patient B which accurately reflects the patient's history, examination, diagnosis, test, and treatment rendered.

10. Respondent created a record for Patient B which is false and inaccurate and does not reflect legitimate patient care and treatment.

C. Respondent provided OPMC with a copy of an office record which he knowingly falsely certified to be a "complete, true and exact copy[ies] of the medical record for Patient C kept on file during the regular course of business and made at the time of such event as recorded or written." Said office record contains one entry made by Respondent for August 11, 1994:

1. On the documented occasion referred to in paragraph C, supra, Respondent failed to:

a. Obtain and note an adequate history;

b. Perform and note an adequate physical examination;

c. Obtain and/or order an x-ray and/or other diagnostic modalities.

2. On the documented occasion referred to in paragraph C, Respondent noted a diagnosis for Patient C which was medically

unsubstantiated by history or physical examination.

3. Respondent failed to properly evaluate the patient and arrive at an appropriate diagnosis to address the patient's complaint(s).
4. At various undocumented times, Respondent knowingly prescribed various orthotic devices for Patient C inappropriately and without legitimate medical purpose.
5. Respondent failed to evaluate and note the specifics of the orthotic devices prescribed.
6. Respondent falsely prescribed orthotic devices for Patient C when he knew or should have known that "Q.O." would use said false prescriptions to submit false bills to the Program for the devices, with a total cost to the Program of approximately \$5,006.00.
7. Respondent failed to perform and note a follow-up examination and evaluation of the orthotic device(s) he prescribed.
8. Respondent failed to maintain a record for Patient C which accurately reflects the patient's history, examination, diagnosis, test, and treatment rendered.
9. Respondent created a record for Patient C which is false and inaccurate and does not reflect legitimate patient care and treatment.

D. Respondent provided OPMC with a copy of an office record which he knowingly falsely certified to be a "complete, true and exact copy[ies] of the medical record for Patient D kept on file during the regular course of business and made at the time of such event as recorded or written." Said office record contains entries made by Respondent for April 21, 1994 and April 29, 1994:

1. On each documented occasion referred to in paragraph D, supra, Respondent failed to:

a. Obtain and note an adequate history;

b. Perform and note an adequate physical examination;

2. On April 21, 1994, Respondent failed to obtain and/or order an x-ray and/or other diagnostic modalities.

3. On April 21, 1994, Respondent noted a diagnosis for Patient D which was medically unsubstantiated by history or physical examination.

4. On April 21, 1994, Respondent failed to properly evaluate the patient and arrive at an appropriate diagnosis to address the patient's complaint(s).

5. At various undocumented times, Respondent knowingly prescribed various orthotic devices for Patient D inappropriately

and without legitimate medical purpose.

6. Respondent failed to evaluate and note the specifics of the orthotic devices prescribed.
  7. Respondent falsely prescribed orthotic devices for Patient D when he knew or should have known that "Q.O." would use said false prescriptions to submit false bills to the Program for the devices, with a total cost to the Program of approximately \$4,644.00.
  8. Respondent failed to perform and note a follow-up examination and evaluation of the orthotic device(s) he prescribed.
  9. Respondent, failed to maintain a record for Patient D which accurately reflects the patient's history, examination, diagnosis, test, and treatment rendered.
  10. Respondent created a record for Patient D which is false and inaccurate and does not reflect legitimate patient care and treatment.
- E. Respondent provided OPMC with a copy of an office record which he knowingly falsely certified to be a "complete, true and exact copy[ies] of the medical record for Patient E kept on file during the regular course of business and made at the time of such event as recorded or written." Said office record contains entries made by Respondent for July 11, 1994 and July 12, 1994:

1. On each documented occasion referred to in paragraph E, supra Respondent failed to:
  - a. Obtain and note an adequate history;
  - b. Perform and note an adequate physical examination;
2. On July 11, 1994, Respondent failed to obtain and/or order an x-ray and/or other diagnostic modalities.
3. On each documented occasion referred to in paragraph E, Respondent noted a diagnosis for Patient E which was medically unsubstantiated by history or physical examination.
4. On each documented occasion referred to in paragraph E, Respondent failed to properly evaluate the patient and arrive at an appropriate diagnosis to address the patient's complaint(s).
5. At various undocumented times, Respondent knowingly prescribed various orthotic devices for Patient E inappropriately and without legitimate medical purpose.
6. Respondent failed to evaluate and note the specifics of the orthotic devices prescribed.
7. Respondent falsely prescribed orthotic devices for Patient E when he knew or should have known that "Q.O." would use said false

prescriptions to submit false bills to the Program for the devices, with a total cost to the Program of approximately \$5,006.00.

8. Respondent failed to perform and note a follow-up examination and evaluation of the orthotic device(s) he prescribed.
  9. Respondent knowingly falsely billed the Program for medical services which were never rendered, to wit an office visit for July 1, 1994.
  10. Respondent failed to maintain a record for Patient E which accurately reflects the patient's history, examination, diagnosis, test, and treatment rendered.
  11. Respondent created a record for Patient E which is false and inaccurate and does not reflect legitimate patient care and treatment.
- F. Respondent provided OPMC with a copy of an office record which he knowingly falsely certified to be a "complete, true and exact copy[ies] of the medical record for Patient F kept on file during the regular course of business and made at the time of such event as recorded or written." Said office record contains one entry made by Respondent for April 28, 1994:
1. On the documented occasion referred to in paragraph F, supra, Respondent failed to:

- a. Obtain and note an adequate history;
  - b. Perform and note an adequate physical examination;
  - c. Conduct and note an evaluation of the patient's complaint and/or condition.
2. At various undocumented times, Respondent knowingly prescribed various orthotic and prosthetic devices for Patient F inappropriately and without legitimate medical purpose.
  3. Respondent failed to evaluate and note the specifics of the prosthetic devices prescribed.
  4. At various undocumented times, Respondent falsely prescribed orthotic devices for Patient F when he knew or should have known that "Q.O." would use said false prescriptions to submit false bills to the Program for the devices, with a total cost to the Program of approximately \$12,178.00.
  5. Respondent failed to perform and note a follow-up examination and evaluation of the orthotic device(s) and prosthetic he prescribed.
  6. Respondent knowingly falsely billed the Program for medical services which were never rendered, to wit office visits for:

- a. August 27, 1993;
- b. September 3, 1993;
- c. October 14, 1993;
- d. December 28, 1993;
- e. January 20, 1994;
- f. January 27, 1994;
- g. March 21, 1994.

7. At various undocumented times, Respondent knowingly prescribed medications to Patient F inappropriately and without legitimate medical purpose, to wit, Respondent's prescriptions of the following drugs for Patient F were filled:

a. On or about October 15, 1993:

- i. Xanax
- ii. Procardia
- iii. Zantac
- iv. Aspirin

b. On or about October 26, 1993, Hydergine Tab. (1mg. oral)

c. On or about March 25, 1994:

- i. Procardia
- ii. Hydergine Tab

- iii. Provent Rep Tab (4mg)
- iv. Zantac
- v. Aspirin

d. On or about April 20, 1994:

- i. Procardia 60 mg
- ii. Proventil Aerosol
- iii. Zantac 300 mg.
- iv. Ergoloid Mes. Tab

8. Respondent failed to maintain a record for Patient F which accurately reflects the patient's history, examination, diagnosis, test, and treatment rendered.

9. Respondent created a record for Patient F which is false and inaccurate and does not reflect legitimate patient care and treatment.

G. From in or about January, 1993 through on or about October 27, 1997, Respondent knowingly participated in an ongoing illegitimate referral arrangement with Negat Acanovski, acting as "Q.O.". During this period of time, Mr. Acanovski brought Medicaid or Medicare recipients to Respondent, purportedly, as patients. Respondent knowingly wrote prescriptions for durable medical equipment, to wit, various orthotic and prosthetic devices, as dictated by Mr. Acanovski for these recipients and, then, referred these patients back to "Q.O.", who billed the Program. Respondent knowingly

prescribed various orthotic and prosthetic devices to these patients inappropriately and without knowing the medical necessity for them. Respondent never had a follow-up visit, and/or any further contact with these patients after having prescribed the orthotic and/or prosthetic devices dictated by Mr. Acanovski. During this period of time, in addition to the foregoing, Respondent knowingly falsely billed the Program for having seen these patients when, in fact he had not rendered any legitimate medical care and/o treatment to them, to wit: Patients A through Y.

- H. Respondent provided OPMC with a copy of office records for Patients G through Y which he knowingly falsely certified to be a "complete, true and exact copy of the medical record for [the Patient] kept on file during the regular course of business and made at the time of such event as recorded or written."

### **SPECIFICATION OF CHARGES**

#### **FIRST SPECIFICATION**

#### **CRIMINAL CONVICTION (N.Y.S.)**

Respondent is charged with committing professional misconduct as defined N.Y. Educ. Law §6530(9)(a)(i)(McKinney Supp. 1998) by having been convicted of committing an act constituting a crime under New York state law as alleged in the facts of the following:

1. The facts in paragraph A.

**SECOND THROUGH SIXTEENTH SPECIFICATIONS**

**FRAUDULENT PRACTICE**

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1998) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

2. The facts in paragraphs A(1), A(2), A(5), A(6), A(7).
3. The facts in paragraphs B, B(2), B(4), B(5), B(6), B(9), and (10).
4. The facts in paragraphs B(8)(a) through B(8)(k).
5. The facts in paragraphs C, C(2), C(4), C(6), C(8), and C(9).
6. The facts in paragraphs D, D(3), D(5), D(6), D(7), D(9) and D(10).
7. The facts in paragraphs E, E(3), E(5), E(7), E(10) and E(11).
8. The facts in paragraphs E(9).
9. The facts in paragraphs F, F(2), F(4), F(8) and F(9).
10. The facts in paragraph F(6)(a) through F(6)(g).
11. The facts in paragraph F(7)(a)(i) through F(7)(a)(iv).
12. The facts in paragraph F(7)(b).
13. The facts in paragraph F(7)(c)(i) (through F(7)(c)(v).
14. The facts in paragraph F(7)(d)(i) through F(7)(d)(iv).
15. The facts in paragraph G.
16. The facts in paragraph H.

**SEVENTEENTH SPECIFICATION**

**NEGLIGENCE ON MORE THAN ONE OCCASION**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1998) 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:

17. The facts in paragraphs A(1) through A(7), B, B(1)(a) through B(1)(c), B(2) through B(7), B(8)(a) through B(8)(k), B(9), B(10), C, C(1)(a) through C(1)(c), C(2) through C(9), D, D(1)(a), D(1)(b), D(2) through D(10), E, E(1)(a), E(1)(b), E(2) through E(11), F, F(1)(a) through F(1)(c), F(2) through F(5), F(6)(a) through F(6)(g), F(7)(a)(i) through F(7)(a)(iv), F(7)(b), F(7)(c)(i) through F(7)(c)(v), F(7)(d)(i) through F(7)(d)(iv), F(8), F(9), and G.

#### **EIGHTEENTH SPECIFICATION**

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

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1998) 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:

18. The facts in paragraphs A(1) through A(7), B, B(1)(a) through B(1)(c), B(2) through B(7), B(8)(a) through B(8)(k), B(9), B(10), C, C(1)(a) through C(1)(c), C(2) through C(9), D, D(1)(a), D(1)(b), D(2) through D(10), E, E(1)(a), E(1)(b), E(2) through E(11), F, F(1)(a) through F(1)(c), F(2) through F(5), F(6)(a) through F(6)(g), F(7)(a)(i) through F(7)(a)(iv), F(7)(b), F(7)(c)(i) through F(7)(c)(v), F(7)(d)(i) through F(7)(d)(iv), F(8), F(9), and G.

**NINETEENTH THROUGH TWENTY-FIFTH SPECIFICATION**  
**GROSS NEGLIGENCE**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1998) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

19. The facts in paragraphs A(1) through A(7).
20. The facts in paragraphs B, B(1)(a) through B(1)(c), B(2) through B(7), B(8)(a) through B(8)(k), B(9), and B(10).
21. The facts in paragraphs C, C(1)(a) through C(1)(c), and C(2) through C(9).
22. The facts in paragraphs D, D(1)(a), D(1)(b), and D(2) through D(10).
23. The facts in paragraphs E, E(1)(a), E(1)(b), and E(2) through E(11).
24. The facts in paragraphs F, F(1)(a) through F(1)(c), F(2) through F(5), F(6)(a) through F(6)(g), F(7)(a)(i) through F(7)(a)(iv), F(7)(b), F(7)(c)(i) through F(7)(c)(v), F(7)(d)(i) through F(7)(d)(iv), F(8), and F(9).
25. The facts in paragraph G.

**TWENTY-SIXTH THROUGH THIRTY-SECOND SPECIFICATION**  
**GROSS INCOMPETENCE**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1998) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

26. The facts in paragraphs A(1) through A(7).
27. The facts in paragraphs B, B(1)(a) through B(1)(c), B(2) through B(7), B(8)(a) through B(8)(k), B(9), and B(10).
28. The facts in paragraphs C, C(1)(a) through C(1)(c), and C(2) through C(9).
29. The facts in paragraphs D, D(1)(a), D(1)(b), and D(2) through D(10).
30. The facts in paragraphs E, E(1)(a), E(1)(b), and E(2) through E(11).
31. The facts in paragraphs F, F(1)(a) through F(1)(c), F(2) through F(5), F(6)(a) through F(6)(g), and F(7)(a)(i) through F(7)(a)(iv), F(7)(b), F(7)(c)(i) through F(7)(c)(v), F(7)(d)(i) through F(7)(d)(iv), F(8), and F(9).
32. The facts in paragraph G.

**THIRTY-THIRD THROUGH THIRTY-NINTH SPECIFICATION**  
**EXCESSIVE TESTS/TREATMENT**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 1998) by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient as alleged in the facts of:

33. The facts in paragraphs A(2) and A(5).
34. The facts in paragraphs B(4) and B(6).
35. The facts in paragraphs C(4) and C(6).
36. The facts in paragraphs D(5) and D(7).
37. The facts in paragraphs E(5) and E(7).

38. The facts in paragraphs F(2), F(4), F(7)(a)(i) through F(7)(a)(iv), F(7)(b), F(7)(c)(i) through F(7)(c)(v), and F(7)(d)(i) through F(7)(d)(iv).
39. The facts in paragraph G.

**FORTIETH THROUGH FORTY-SIXTH SPECIFICATION**  
**FAILURE TO MAINTAIN RECORDS**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §(32)(McKinney Supp. 1998) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

40. The facts in paragraphs A, A(6) and A(7).
41. The facts in paragraphs B, B(1)(a), B(1)(b), B(5), B(7), B(9), and B(10).
42. The facts in paragraphs C, C(1)(a), C(1)(b), C(5), C(7), C(8), and C(9).
43. The facts in paragraphs D, D(1)(a), D(1)(b), D(6), D(8), D(9), and D(10).
44. The facts in paragraphs E, E(1)(a), E(1)(b), E(6), E(8), E(10), and E(11).
45. The facts in paragraphs F, F(1)(a), F(1)(b), F(1)(c), F(3), F(5), F(8) and F(9).
46. The facts in paragraph H.

DATED: November 2, 1998  
New York, New York

REDACTED

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**ROY NEMERSON**  
Deputy Counsel  
Bureau of Professional  
Medical Conduct