

Public



STATE OF NEW YORK  
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.  
Commissioner

James W. Clyne, Jr.  
Executive Deputy Commissioner

December 20, 2010

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Harry Josifidis, M.D.  
27-47 Crescent Street #206  
Astoria, New York 11102

Nathan L. Dembin, Esq.  
1123 Broadway – Suite 1117  
New York, New York 10010

Diane Abeloff, Esq.  
NYS Department of Health  
90 Church Street – 4<sup>th</sup> Floor  
New York, New York 10007

**RE: In the Matter of Harry Josifidis, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 10-272) 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  
Hedley Park Place  
433 River Street - Fourth Floor  
Troy, New York 12180

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

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (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., Administrative Law Judge  
New York State Department of Health  
Bureau of Adjudication  
Hedley Park Place  
433 River Street, Fifth Floor  
Troy, New York 12180

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

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

Sincerely,

REDACTED

James F. Horan, Acting Director  
Bureau of Adjudication

JFH:cah  
Enclosure

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

COPY

IN THE MATTER  
OF  
HARRY JOSIFIDIS, M.D.

DETERMINATION  
AND  
ORDER

BPMC #10-272

A Notice of Hearing and Statement of Charges were served on HARRY JOSIFIDIS, M.D., Respondent, on March 1, 2010. Hearings were held pursuant to N.Y. Public Health Law §230 and New York State Admin. Proc. Act §§ 301-307 and 401 on May 4, 2010, June 23, July 12, August 4, and August 11, 2010. All hearings were held at the Offices of the New York State Department of Health, 90 Church Street, New York, New York ("the Petitioner"). **James R. Dickson, M.D., Chair, Elisa J. Wu, M.D., and Jacqueline H. Grogan, Ed. D.**, 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 **Thomas G. Conway, Esq.**, General Counsel, by **Dianne Abeloff, Esq.**, Associate Counsel, New York State Department of Health, of Counsel. The Respondent appeared with counsel, **Nathan L. Dembin, Esq.** Evidence was received, witnesses 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:	March 1, 2010
Answer Filed:	October 23, 2009
Pre-Hearing Conference:	April 8, 2010
Hearing Dates:	May 4, 2010 June 23, 2010 July 12, 2010 August 4, 2010 August 11, 2010
Witnesses for Petitioner:	Cornel Dumitriu, M.D. Patient "Q" Patient "Q"'s Mother
Witnesses for Respondent:	Harry Josifidis, M.D. George Delis
Deliberations Date:	October 18, 2010

## STATEMENT OF THE CASE

Petitioner charged Respondent, a physician practicing addiction medicine, with fifteen (15) specifications of professional misconduct. The first through third specifications charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530(2) by falsely submitting bills to insurance companies under the name of another physician for services rendered by Respondent.

The fourth and fifth specifications charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(25) by delegating professional responsibilities to an unlicensed person.

In the sixth and seventh specifications Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(11) by permitting, aiding or abetting an unlicensed person to perform activities requiring a license.

In the eighth specification Respondent was 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.

In the ninth through eleventh specifications Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient.

Finally, in the twelfth through fifteenth specifications, Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) by engaging in conduct in the practice of medicine that evidences moral unfitness to practice.

It is noted that this matter had originally convened with another panel and there was discussion of a settlement at the hearing held May 4, 2010. At that time, the Respondent was represented by Attorney Michael S. Kelton of New York City. The discussions at that time did not result in a final settlement, and a new panel was convened to hear the matter. Attorney Kelton represented the Respondent at the first hearing date before the present panel on June 23, 2010. Subsequently the Respondent obtained new counsel and the hearing continued with new counsel, Nathan L. Dembin, Esq. on July 12, 2010.

A copy of the 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 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 was authorized to practice medicine in New York State on July 10, 1986 by the issuance of license number 166922 by the New York State Education Department. His office is currently located at 27- 47 Crescent Street, # 206, Astoria, New York 11102. (Ex. 1)
2. In 2001 through 2004, Respondent, due to a suspension of his New York State medical license, needed to have a physician supervise his operative procedures. Dr. Dumitriu knew Respondent from his residency training days at St. Luke's – Roosevelt Hospital in New York City and Dr. Dumitriu agreed to supervise Respondent. (T.36, 37, 40)
3. In 2002 Respondent approached Dr. Dumitriu seeking help from him to devise a way to be paid for his treatment of "in network" patients whose treatment could no longer be submitted under Respondent's own name. (T.41, 42,50,84,110, 166)
4. Initially, Dr. Dumitriu asked a recent graduate to join the Respondent as a younger associate. That plan did not work out, so it was agreed that Dr. Dumitriu would be the provider on the record, so that the Respondent could continue to see his own patients. (T. 42)
5. Dr. Dumitriu knew Respondent during his training years and he believed that the

Respondent was a competent urologist. Dr. Dumitriu knew about Respondent's disciplinary problems, but believed that Respondent deserved a chance to straighten himself out. Dr. Dumitriu also felt that the State Board for Professional Medical Conduct also felt that Respondent deserved another chance and that is why Respondent was allowed to return to practice. (T.51, 53, 160)

5. Dr. Dumitriu was transitioning from private practice to a hospital-based practice and was therefore divesting himself of his private practice to dedicate himself to a hospitalist-type practice. (T.34) After consultation with Respondent, Dr. Dumitriu drafted the December 2002 "Agreement" (Department's Exhibit 2) This document required both Respondent and Dr. Dumitriu to treat the patients and the services would all be billed under Dr. Dumitriu's name with his Bronx address, although all patients were seen in Respondent's Astoria office. (T.44, 48, 49; Dept's Ex. 2)
7. Dr. Dumitriu's plan was to get to know Respondent's patient population. He might not treat the patient at each visit, but his aim was to be familiar with the entire population. He thought that constituted sufficient supervision to satisfy the insurance companies (T. 44)
8. Dr. Dumitriu never had an attorney review the "Agreement". He also never asked Respondent if he had checked with insurance companies about the legality of providing services under another physician's name given that Respondent had been terminated from directly providing those services. (Dep't Ex 2, T. 46, 47 )
9. The "Agreement" worked for a short period of time; however, the Respondent's non-compliance began to spiral out of Dr. Dumitriu's control. The plan was no longer manageable. Respondent would see patients that Dr. Dumitriu knew nothing about, or he would not inform the patients about Dr. Dumitriu. Dr. Dumitriu would try to correct the Respondent and the

Respondent would comply for a period of time and then would revert to doing what he (Respondent) wanted to do, often in violation of the Agreement. Dr. Dumitriu would complain to Respondent, but the whole cycle would begin again. (T.55 -58, 50, 58, 78, 138, 140; see Dep't Ex. 4A, 6A, 11A, 17A)

10. Dr. Dumitriu ended up spending two full days a week in Respondent's office and reviewing paperwork at home on the other days to stay on top of Respondent's practice. (T. 48, 91)

11. Dr. Dumitriu profited from this "Agreement" but Respondent was the physician who profited the most. Without this "Agreement" Respondent could not bill the insurance companies directly for "in network" patients. (T. 141, 144, 386-388 )

12. Respondent's staff sent in all of the bills to the insurance company whether Dr. Dumitriu saw the patient in Respondent's office or whether only Respondent saw the patient. They did not send in bills of patients that Dr. Dumitriu saw in his own practice in the Bronx. Dr. Dumitriu's staff oversaw that practice. (T. 282, 284)

13. Respondent's staff created the bills and faxed the bills to Dr. Dumitriu for review. He would fax them back with his comments; however, he never saw the bills that were actually submitted to the insurance companies by Respondent's staff. He would then receive the checks from the insurance companies, but he did not have a complete list of the patients seen in Respondent's office or their records. He was unable to compare the Explanation of Benefits (EOB) with the records. (T.58, 398)

14. Respondent instructed his office staff about billing procedures. On some occasions the staff was instructed to bill for uroflows citing different days than when they were actually performed. (T. 262)

15. Respondent testified that patients may have difficulty urinating on the day of the examination and need to return to the office the following day to urinate for the uroflow test. None of the numerous patients for whom the uroflows were billed on different days than when the examination was performed contained information in the chart for the days the uroflows were actually billed to support this contention. (T. 481; Dep't Ex. 3A, 4A, 5A, 6A, 9A, 10A, 12A, 13A, 15A, 18A, 19A, 20A, 21A, 22A, 23A, 24A)

16. Patient Q was Respondent's patient for one visit in 2003. She never was treated by him again despite 54 prescriptions called in from Respondent's office in the name of Patient Q from February 15, 2006 through September 23, 2008. The pharmacy recorded Amrit's name as the individual from Respondent's office who called in many of those prescriptions. Patient Q never gave permission to anyone in Respondent's office to call prescriptions into the pharmacy in her name. (T.204, 271; Dep't Ex. 27)

17. Respondent fired Maria Pyrros in August 2004; therefore, she was not working in his office from 2006-2008. (T.298)

18. Respondent permitted his unlicensed office manager to prescribe medications to Patients R-U without examining or obtaining necessary information prior to the issuance of the prescriptions. (Dep't Ex. 28, T.537-541)

19. Respondent is the individual responsible for the practices in his office. (T. 481)

20. Respondent failed to maintain a medical record for Patients R-U, individuals for whom he issued prescriptions. (Dep't Ex. 28)

## CONCLUSIONS OF LAW

Pursuant to the Findings of Fact as set forth above, the Hearing Committee unanimously concludes that the Factual Allegations and Specifications as set forth in the Statement of Charges, are resolved as follows:

1. Factual Allegation A of professional misconduct, as set forth in the Statement of Charges, is **SUSTAINED**;
2. Factual Allegations B, C, and D of professional misconduct as set forth in the Statement of Charges are **NOT SUSTAINED**;
3. Factual Allegation E of professional misconduct, as set forth in the Statement of Charges, is **SUSTAINED**;

Accordingly, **SPECIFICATIONS ONE** and **ELEVEN** are **SUSTAINED** the remaining **SPECIFICATIONS** are **NOT 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," dated January 9, 1996, sets forth suggested definitions of professional misconduct.

In arriving at its Conclusions of Law, the Hearing Committee carefully reviewed the Exhibits admitted into evidence, the transcripts of the five (5) 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. 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 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 and, 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' 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.

### EVALUATION OF 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 recognized its responsibility to pass on the credibility of the witnesses and base its position on what it accepts as the truth. Where a witness' credibility is at issue, the Committee may properly credit one portion of the witness' testimony and, at the same time reject another portion. The Hearing Committee may accept as much of a witness' testimony as is deemed true and disregard what they find and determine to be false. In the alternative, the 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 Committee may disregard all of the witness' testimony.

The central witnesses in this case were Dr. Dumitriu for the Department and Dr. Josifidis for himself. The panel found that the testimony of Dr. Dumitriu was not fully

persuasive due to the fact that he was complicit in the agreement to defraud the insurance companies. However, the panel concluded that there was sufficient credible evidence in Dr. Dumitriu's testimony, when coupled with the documentation in the record, to establish the fraud that the Respondent had committed. The panel concluded that Dr. Josifidis was not credible. He was consistently evasive and, on several occasions, he distorted the truth. The Committee carefully reviewed all the testimony in this case and determined that the Respondent's testimony was patently not credible. The panel did not believe the Respondent's claim that he relied on Dr. Dumitriu's representations that he, Dr. Josifidis, was permitted to bill under another physician's name as if that other physician provided the services. This position is not credible. Respondent approached Dr. Dumitriu about working out an "arrangement," which would allow Respondent indirectly to receive payment from insurance companies since he could not bill the insurance companies directly. This action indicated that Respondent had the intent to collect money from the insurance companies under the name of another doctor who did not do the actual work. The panel concluded that this was fraudulent.

Respondent testified that he entered into this "Agreement" with Dr. Dumitriu to ensure continued coverage of his long-term patients, particularly the Greek-speaking patients. Again this representation fails to make sense. If Dr. Josifidis was so concerned about his patients, he could have treated the patients and not charged the insurance company. He could have provided the services for free, or his patients could have submitted the bill as a visit to an out of network provider. He did not like the latter idea either since his patients would not want to pay the substantial out of pocket expense to see an out of network provider.

The most compelling indication that Respondent intended to defraud the insurance companies and not just provide services for his Greek patients, is the financial structure of the

"Agreement" . Respondent treated the majority of the patients on his own without any help from Dr. Dumitriu; however, he received only 50% of the reimbursement. Respondent had to pay for the rent of his office, equipment, office staff, etc. The only feasible explanation for entering this lopsided agreement is that without the agreement he would have received no money at all.

Respondent's testimony concerning his lack of knowledge of procedures in his office is also not credible. According to Respondent, he did not know anything about billing, he was unaware that someone in his office was repeatedly calling in prescriptions and he claimed that a former employee hacked into his office computer system for the purpose of changing the dates of uroflows. He also testified that his employees, on their own, completely without his knowledge, billed the wrong dates for uroflows. Most of his testimony in these areas was convoluted and evasive. He stretched the limits of credulity.

Patient Q's testimony was credible. Her answers to many of Mr. Dembin's questions made clear that she did not understand his questions; however, the essential point was crystal clear. She did not give anyone permission to use her name on any of the prescriptions for the years 2006 through 2008. She had no motivation to misrepresent that fact. She received no benefit from these prescriptions.

Patient Q's mother's testimony as to what occurred in Respondent's office was also credible. Although she was angry about the manner in which Respondent terminated her employment she still testified positively about their prior relationship. She also was annoyed that Respondent did not pay her the vacation pay that she was owed, but that issue was resolved years before this disciplinary action began. Her statements about the manner in which the prescriptions were issued was speculative since she no longer worked in

Respondent's office. Patient Q's mother has not worked for Respondent for 6 years; she has worked for another physician for years. She has no motivation to fabricate testimony about procedures in Respondent's office.

### VOTE OF THE HEARING COMMITTEE

#### FACTUAL ALLEGATIONS

**A.** Respondent knowingly and with intent to mislead insurance companies caused bills for Patients A- P to be submitted to these insurance companies falsely under another physician's name as the provider when the services were rendered by Respondent who was ineligible to bill those insurance companies.

The panel sustained this allegation and found that the Respondent intentionally misled insurance companies in paying for treatment that Respondent rendered under the name of Dr. Dumitriu.

**B.** Respondent knowingly and with intent to mislead submitted bills to various insurance companies for uroflow procedures he falsely claimed to have performed on a date separate from the office visit for said Patients.

On review of all the testimony and documentation in this case, the panel did not find that this allegation was sustained.

**C.** From on or about February 15, 2006, to on or about September 23, 2008, Respondent permitted his unlicensed office manager to prescribe medications in Patient Q's name, purportedly but not in fact for the treatment of Patient Q, on approximately 54 occasions without Patient Q's knowledge and/or permission.

On review of all the testimony and documentation in this case, the panel did not find that this allegation was sustained.

**D.** Respondent permitted his unlicensed office manager to prescribe medications to Patients R-U without examining or obtaining necessary information prior to the issuance of the prescriptions.

On review of all the testimony and documentation in this case, the panel did not find that this allegation was sustained.

**E.** Respondent failed to maintain a medical record for Patients R-U, individuals for whom he issued prescriptions.

On review of all the testimony and documentation in this case, the panel found that this allegation was sustained for one patient.

#### **FIRST SPECIFICATION - FRAUDULENT PRACTICE**

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6630(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

Respondent knowingly and with intent to mislead insurance companies caused bills for Patients A- P to be submitted to these insurance companies falsely under another physician's name as the provider when the services were rendered by Respondent who was ineligible to bill those insurance companies.

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

#### **Discussion:**

The panel reviewed all the documentation and testimony in this case and found

that this allegation of fraud was clearly sustained by the evidence. The panel found that Dr. Josifidis made a false representation by stating to the Insurance Companies that his work was the work of Dr. Dumitriu. Furthermore, the panel concluded that that Dr. Josifidis knew that the representation was false, and that he intended to mislead through this false representation.

The Committee found that the Respondent's testimony concerning his lack of knowledge of procedures in his office was incredible. According to Respondent, he did not know anything about billing. The Committee found that Dr. Josifidis's testimony in this area was convoluted and evasive and stretched the limits of credulity. The panel concluded that it was fraudulent for the Respondent to receive payment indirectly from insurance companies for services he could not bill directly.

#### **SECOND SPECIFICATION - FRAUDULENT PRACTICE**

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6630(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

Respondent knowingly and with intent to mislead submitted bills to various insurance companies for uroflow procedures he falsely claimed to have performed on a date separate from the office visit for said Patients, (see Appendix B for a list of patients, dates of service and billing date)

**VOTE: NOT SUSTAINED (3-0)**

**Discussion:**

The panel reviewed all the documentation and testimony in this case and found that this allegation of fraud was not sustained by a preponderance of the evidence. The panel found that all the necessary elements of the charge of fraud were not established and thus could not sustain this charge.

**THIRD SPECIFICATION - FRAUDULENT PRACTICE**

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6630(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

From on or about February 15, 2006, to on or about September 23, 2008, Respondent permitted his unlicensed office manager to prescribe medications in Patient Q's name, purportedly but not in fact for the treatment of Patient Q, on approximately 54 occasions without Patient Q's knowledge and/or permission.

**VOTE: NOT SUSTAINED (3-0)**

**Discussion:**

The panel reviewed all the documentation and testimony in this case and found that this allegation of fraud was not sustained by the evidence. The panel found that all the necessary elements of the charge of fraud were not established by a preponderance of the evidence.

**FOURTH AND FIFTH SPECIFICATIONS**

**DELEGATING RESPONSIBILITIES TO UNLICENSED PERSON**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(25) by delegating professional responsibilities to a person when the licensee delegating such responsibilities knew or had reason to know that such person is not qualified, by training, by experience, or by licensure, to perform them.

Respondent was charged with permitting his unlicensed manager to prescribe medications in Patient Q's name, purportedly but not in fact for the treatment of Patient Q, on approximately 54 occasions without Patient Q's knowledge and/or permission. In addition, the charge detailed that the manager prescribed medications to Patients R-U without examining or obtaining necessary information prior to the issuance of the prescriptions.

**VOTE: NOT SUSTAINED (3-0)**

**Discussion:**

The panel reviewed all the documentation and testimony in this case and found that this allegation was not sustained by a preponderance of the evidence. The panel found that all the necessary elements of the charge were not established.

**SIXTH AND SEVENTH SPECIFICATIONS**  
**PERMITTING, AIDING OR ABETTING AN UNLICENSED PERSON**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(11) by permitting, aiding or abetting an unlicensed person to perform activities requiring a license as alleged in the facts of the following:

C. From on or about February 15, 2006, to on or about September 23, 2008,

Respondent permitted his unlicensed office manager to prescribe medications in Patient Q's name, purportedly but not in fact for the treatment of Patient Q, on approximately 54 occasions without Patient Q's knowledge and/or permission.

D. Respondent permitted his unlicensed office manager to prescribe medications to Patients R-U without examining or obtaining necessary information prior to the issuance of the prescriptions.

**VOTE: NOT SUSTAINED (3-0)**

**Discussion:**

The panel reviewed all the documentation and testimony in this case and found that this allegation was not sustained by a preponderance of the evidence. The panel found that all the necessary elements of this charge were not established.

**EIGHTH 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:

C. From on or about February 15, 2006, to on or about September 23, 2008, Respondent permitted his unlicensed office manager to prescribe medications in Patient Q's name, purportedly but not in fact for the treatment of Patient Q, on approximately 54 occasions without Patient Q's knowledge and/or permission.

D. Respondent permitted his unlicensed office manager to prescribe medications to Patients R-U without examining or obtaining necessary information prior to the issuance of the prescriptions.

E. Respondent failed to maintain a medical record for Patients R-U, individuals for whom he issued prescriptions.

**VOTE: NOT SUSTAINED (3-0)**

**Discussion:**

The panel reviewed all the documentation and testimony in this case and found that this allegation was not sustained by a preponderance of the evidence. The panel found that all the necessary elements of the charge were not established.

**NINTH THROUGH ELEVENTH SPECIFICATIONS**

**FAILURE TO MAINTAIN RECORDS**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of Allegations B, C and E.

**VOTE: SUSTAINED (3-0) as to Specification 11.**

**Discussion:**

The panel reviewed all the documentation and testimony in this case and found that this allegation of failing to keep records was clearly sustained for one patient, Patient R.

**TWELFTH THROUGH FIFTEENTH SPECIFICATIONS**

**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 medicine as alleged in Factual Allegations A, B, C, and D.

**VOTE: NOT SUSTAINED (3-0)**

**Discussion:**

The panel reviewed all the documentation and testimony in this case and found that this allegation of moral unfitness was not sustained by the evidence. The panel found that all the necessary elements of the charge of moral unfitness were not established.

**HEARING COMMITTEE DETERMINATION AS TO PENALTY**

The panel first reviewed the specifications and took its vote. After sustaining the charges of fraud and failing to keep records, the ALJ then informed the panel of the

Respondent's prior disciplinary action that was taken by the Administrative Review Board for Professional Medical Conduct in 2001. The record of this disciplinary action had been offered into evidence in the Prehearing Conference. The ALJ ruled that this evidence would be prejudicial, and determined that it should be held back until such time that charges against the Respondent were sustained.

Accordingly, only after the above votes did the Hearing Committee have an opportunity to review the prior disciplinary action against Respondent. In its decision, (Dept. Ex. 29 for Identification) The ARB allowed Respondent to escape with his "professional life." The ARB found that, " Respondent subjected several vulnerable people to surgical risk, without adequate reason, and denied those persons individualized care to which all patients are entitled. We hold that the Respondent's repeated egregious conduct warrants a severe sanction that will include actual time on suspension with probation to follow. To assure that the sanction we impose will deter the Respondent from future misconduct, we place the Respondent under supervision during that probation."

After reading this ARB determination and taking into account the present finding of fraud, the panel determined that the only appropriate sanction would be revocation. The panel concluded that anything short of revocation would allow Respondent to evade the designed sanction.

It was noted that the Respondent, in his prior disciplinary action, also shifted the blame onto his co-Respondent, Dr. Peress, the same as he tried to do in the instant case with Dr. Dumitriu. Dr. Josifidis has not learned from past mistakes and the panel concluded that he still is not able to take responsibility for his actions.

As the Hearing Committee eloquently stated in The Matter of Petar 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. His needs were superior to everyone else's. He defrauded the insurance company; he took advantage of Dr. Dumitriu's misguided attempts to rehabilitate him.

After the present finding of fraud the panel determined that the only appropriate sanction is Revocation of Respondent's license to practice medicine. 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 Committee concludes that the Respondent's conduct in this matter has so violated the public trust that revocation is the only appropriate penalty under the circumstances of this case.

In reaching this conclusion, the Committee considered the full range of penalties available in a case such as this. The Committee concluded that the only way to ensure the safety of the public is to revoke Respondent's medical license. Any other penalty would risk a recurrence of this behavior. The public should not bear that risk.

### ORDER

#### **IT IS HEREBY ORDERED THAT:**

1. The First and Eleventh Specifications of professional misconduct, as set forth in the Statement of Charges, are **SUSTAINED**;

2. The remaining Specifications of professional misconduct, as set forth in the Statement of Charges, are **NOT SUSTAINED**;
3. The Respondent's license to practice medicine is hereby **REVOKED**;
4. The Respondent is fined a total of twenty thousand dollars (\$20,000.00), \$10,000 for each of the two sustained specifications.

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: Rye, New York**

**December, 6, 2010**

REDACTED

**James R. Dickson, M.D., CHAIR,**

**Elisa J. Wu, M.D.**

**Jacqueline H. Grogan, Ed. D.**

TO:

Harry Josifidis, M.D.  
27-47 Crescent Street #206  
Astoria, N.Y. 11102

Nathan L. Dembin, Esq.  
Attorney for Dr. Josifidis  
1123 Broadway, Suite 1117  
New York, N.Y. 10010

Diane Abeloff, Esq.  
Associate Counsel  
New York State Department of Health  
90 Church Street  
New York, N.Y. 10007

## APPENDIX I

These charges are only allegations which may be contested by the licensee in an administrative hearing.

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

IN THE MATTER  
OF  
HARRY JOSIFIDIS, M.D.

STATEMENT  
OF  
CHARGES

Harry Josifidis, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 10, 1986, by the issuance of license number 166922 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. Respondent knowingly and with intent to mislead insurance companies caused bills for Patients A- P (identity of Patients is contained in Appendix A) to be submitted to these insurance companies falsely under another physician's name as the provider when the services were rendered by Respondent who was ineligible to bill those insurance companies.
- B. Respondent knowingly and with intent to mislead submitted bills to various insurance companies for uroflow procedures he falsely claimed to have performed on a date separate from the office visit for said Patients. (see Appendix B for a list of patients, dates of service and billing date)
- C. From in or about February 15, 2006, to on or about September 23, 2008, Respondent permitted his unlicensed office manager to prescribe medications in Patient Q's name, purportedly but not in fact for the treatment of Patient Q, on approximately 54 occasions without Patient R's

*Q*  
*Answered*  
*Staten*

knowledge and/or permission.

- D. Respondent permitted his unlicensed office manager to prescribe medications to Patients R-U without examining or obtaining necessary information prior to the issuance of the prescriptions.
- E. Respondent failed to maintain a medical record for Patients R-U, individuals for whom he issued prescriptions.

### **SPECIFICATION OF CHARGES**

#### **FIRST THROUGH THIRD SPECIFICATION FRAUDULENT PRACTICE**

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

- 1. Paragraph A
- 2. Paragraph B
- 3. Paragraph C

#### **FOURTH THROUGH FIFTH SPECIFICATION DELEGATING RESPONSIBILITIES TO UNLICENSED PERSON**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(25) by delegating professional responsibilities to a person when the licensee delegating such responsibilities knew or had reason to know that such person is not qualified, by training, by experience, or by licensure, to perform them; as alleged in the facts of:

- 4. Paragraph C
- 5. Paragraph D

**SIXTH THROUGH SEVENTH SPECIFICATION**  
**PERMITTING, AIDING OR ABETTING**  
**AN UNLICENSED PERSON**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(11) by permitting, aiding or abetting an unlicensed person to perform activities requiring a license as alleged in the facts of the following:

6. Paragraph C
7. Paragraph D

**EIGHTH 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:

8. Paragraphs C, D and/or E.

**NINTH THROUGH 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 for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

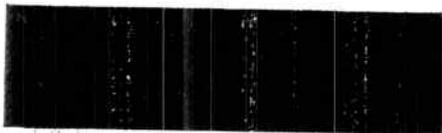
9. Paragraph B
10. Paragraph C
11. Paragraph E

**TWELFTH THROUGH FIFTEENTH 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 the following:

12. Paragraph A
13. Paragraph B
14. Paragraph C
15. Paragraph D

DATE: February 22, 2010  
New York, New York



ROY NEMERSON  
Deputy Counsel  
Bureau of Professional Medical Conduct