IN THE MATTER OF	*	**BEFORE THE**
ABULHASAN U. ANSARI, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D24208	*	**Case Number: 2009-0473**

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CONSENT ORDER

On February 21, 2012, the Maryland State Board of Physicians (the "Board") charged Abulhasan U. Ansari, M.D., (the "Respondent") (D.O.B. 10/01/1944), License Number D24208, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2009 Repl. Vol. and 2011 Supp.).

The pertinent provisions of the Act under H.O. § 14-404 provide the following:

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
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> (3) Is guilty of:
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> (ii) Unprofessional conduct in the practice of medicine;
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> (11) Willfully makes or files a false report or record in the practice of medicine;
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> (18) Practices medicine with an unauthorized person or aids an unauthorized person in the practice of medicine;
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> (19) Grossly overutilizes health care services;
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> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;
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> (40) Fails to keep adequate medical records as determined by appropriate peer review[;].

The pertinent provisions of the Board's regulations under Code of Md. Regs., tit. 10, § 32.12 provide the following:

.04 Scope of Delegation.

A. A physician may not delegate to an assistant technical acts which are exclusively limited to any individual required to be licensed, certified, registered or otherwise recognized pursuant to any provision of the Health Occupations Article and the Education Article, Annotated Code of Maryland.

E. A physician may not delegate to an assistant acts which include but are not limited to:

(6) Providing physical therapy.[1]

.05 Prohibited Conduct.

B. A delegating physician, through either act or omission, facilitation, or otherwise enabling or forcing an assistant to practice beyond the scope of this chapter, may be subject to discipline for grounds within Health Occupations Article, § 14-404(a), Annotated Code of Maryland, including, but not limited to, practicing medicine with an unauthorized person or aiding an unauthorized person in the practice of medicine.

In addition, Respondent is charged under the Maryland Radiation Therapy, Radiography, Nuclear Medicine Technology, and Radiology Assistance Act with violating HO § 14-5B-18.1 as follows:

(a) Physicians. - Except as otherwise provided in this subtitle, a licensed physician may not employ or supervise an individual practicing ... radiography ... without a license or temporary license.

On April 4, 2012, the parties appeared before a Case Resolution Committee of the Board. As a result of negotiations, the parties agreed to enter into this Consent Order.

[1] The practice of physical therapy includes...administering treatment with...mechanical devices...that use the physical, chemical, or other properties of ..., electricity...." HO § 13-101 (i)(iv).

FINDINGS OF FACT

The Board makes the following findings of fact:

I. Background

1. At all times relevant hereto, Respondent was and is licensed to practice medicine in the State of Maryland. Respondent was originally licensed to practice medicine in Maryland on September 20, 1979. Respondent last renewed his license in or about August 2010. His license will expire on September 30, 2012.

2. Respondent maintains an office for the practice of internal medicine at 9135 Piscataway Road, Suite 100, Clinton, Maryland 20735. Respondent is the sole licensed medical practitioner in the office.

3. Respondent is also licensed to practice medicine in the District of Columbia and Virginia.

4. In 1995, Respondent became board-certified in internal medicine .His board-certification expired in 2005. To date, Respondent has not become re-certified.

5. In correspondence dated June 15, 2006 and September 6, 2006, Respondent utilized office letterhead bearing the reference, "Diplomate of A.B.I.M." (American Board of Internal Medicine.)

6. Similarly, in correspondence dated May 5, 2009, Respondent utilized office letterhead bearing the reference, "Diplomate of American Board of Internal Medicine."

7. Respondent reported that he holds hospital privileges at a hospital in southern Maryland.[2]

II. Complaint and Investigation

8. On or about December 23, 2008, the Board received a complaint from an investigator in a special investigations unit of an automobile insurance company. The investigator stated that Respondent had submitted bills in reference to two of their insureds, Patient 1 and Patient 2. These submissions prompted an investigation by the insurance company's special investigation unit. The investigation revealed that Respondent overbilled, over-utilized procedures, and practiced with unlicensed individuals. The Complainant attached a document highlighting Respondent's billing record for Patient 1, as well as notes documenting the investigators' January 31, 2008 inspection of Respondent's office, and pictures taken while in the office.

9. On July 14, 2009, the Board staff interviewed the investigator and a co-investigator. The insurance company investigator informed Board staff about a third insured that the insurance company was investigating, Patient 3, because her bills were also very high.

10. On September 21, 2009, the Board staff made an unannounced visit to Respondent's office. Board staff hand-delivered subpoenas *duces tecum* to Respondent requesting 1) the ledger of all patients being treated using the neural-scan[3] machine; 2)

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[2] To ensure confidentiality, the names of individuals, patients, and institutions involved in this case are not disclosed in this document. Respondent may obtain the identity of all individuals, patients, and institutions referenced in this document by contacting the administrative prosecutor.

[3] According to Respondent, a neural scan machine is used to find sensory deficiencies or nerve damage due to diabetes, an accident, or arthritis. The test involves the use of an electrical current, which is slowly increased until the patient reports that he/she can feel it. If the voltage is increased very high, the patient will experience a "shock."

all medical and billing records of Patient 1, Patient 2[4], and Patient 3, the three patients whose names had been provided by the Complainant; and 3) a list of all current employees. Board staff also took photographs of Respondent's office.

11. Respondent's "Employees List" lists eleven (11) individuals, several who were identified as "Medical Assistants," two were identified as "Dexa Scan Technicians," two as "Echocardiographers," one as a "Sonographer," and one as an "X-ray Technician."

12. On September 29, 2009, Respondent provided the "entire billing" of his office for Patients 1, 2, and 3.

13. On October 5, 2009, the Board staff interviewed Respondent. Respondent reported that he maintains in his office an x-ray machine, ultrasound (sonogram) machine,[5] an echocardiogram ("ECHO"),[6] a vascular Doppler machine,[7] a videonystagmogram ("VNG") machine,[8] a neural-scan machine,[9] a machine to perform

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[4] According to Respondent, Patient 2 has multiple files. Respondent gave Board staff only the chart that was available on-site at the time of the visit.

[5] Ultrasound, or sonogram, is a diagnostic imaging technique used to create an image of part of the inside of the body, *i.e.* tendons, muscles, joints, and internal organs, to diagnose pathology or lesions.

[6] An echocardiogram is a diagnostic imaging technique using reflected sounds waves to create a moving image of the heart.

[7] A Doppler ultrasound is a diagnostic imaging technique using reflected sound waves to measure direction and velocity of blood flow through a blood vessel.

[8] A videonystagmogram is a diagnostic imaging technique using infrared cameras to directly measure movements of the eyes to test inner ear and central motor functions.

[9]Neural-Scan is the trademarked name for a machine that "precisely identifies the exact level and side of the nerve root cause of pain that is usually not detected during motor nerve studies performed with EMG/NCV". See http://neuralscan.net

pulmonary function tests, a "horizontal therapy" machine,[10] and a laboratory.[11] Respondent had recently acquired a digital x-ray machine.

14. Respondent's medical records contain computer-generated reports that show that he also has a machine in his office which performs "ANSAR testing as part of a cardiac work-up."[12]

15. Respondent does not employ any licensed health professionals. Respondent stated that he has "staff members who are physicians in other countries, who are not licensed in this country." Respondent stated that he provides and bills for physical therapy in his office. Respondent does not employ a physical therapist.

16. On October 16, 2009, Respondent sent the Board:

a. log sheets of the PT machine (Horizontal Therapy or PT) and log sheets of the Neural-Scan machine;

b. letter from the President of Hako-Med (manufacturer of the Horizontal Therapy machine[13]) dated October 9, 2009;

c. copy of the manual of the Horizontal Therapy machine;

d. letter from the manufacturer of the Neural-Scan machine dated September 29, 2009;

e. copy of the manual of the Neural-Scan machine, and

f. copy of the "wallet certificate" of the x-ray technician who he employed.

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[10] "Horizontal Therapy" is Respondent's term for a machine that he uses that sends electrical currents to muscles and ligaments. Hako-Med, the manufacturer, refers to the medical device as the PRO ElectDT 2000. There is a link from the web site for the neural scan machine to the Hako-Med website.

[11] Respondent's in-office laboratory is certified by the Department of Health and Mental Hygiene, Office of Health Care Quality.

[12] ANSAR is a "noninvasive, real-time, digital autonomic nervous system testing and monitoring machine." See Http://www.ans-hrv.com

[13] Horizontal Therapy is manufactured by Hako-Med. According to Hako-Med's website, Horizontal Therapy is an "electromedicine" device which treats osteo-arthritis in a non-invasive way with no negative side-effects, and is covered by most insurance carriers. See http://www.hakomed.com.

17. On April 15, 2010, the Board sent Respondent a subpoena for the complete medical and billing records of five (5) additional patients whose names were randomly selected by Board staff from the log sheets submitted by Respondent.

III. Neural-Scan Machine

18. Since 2005, Respondent has maintained in his office a "Neural-Scan" machine. According to the manufacture's manual, the Neural-Scan is a "diagnostic device that allows the quantitative detection of various sensory neurological impairments caused by various pathological conditions or toxic substance exposures." The manufacturer further describes it as a diagnostic device which provides electrical stimulation of sensory nerves. It tests pain fibers in order to locate injured nerves. The manual states that "the Neural-Scan received FDA marketing clearance December 1, 1997."

19. In correspondence of September 29, 2009, to Respondent, a representative of the manufacturer of the device stated that Respondent and his staff received training from a representative of the company in October 2005 on using the "Neural Scan Medical Device for a Pain Fiber – NCS Examination."

20. In the October 5, 2009 interview with Board staff, Respondent stated that he and a few members of his staff were trained in the use of the Neural-Scan machine by representatives of the manufacturer and by other physicians who were using the system. Respondent then trained other staff in his office in the use of the machine. Respondent interprets all of the results. Respondent uses the Neural-Scan test with patients who report tingling and numbness or weakness in the legs. Respondent usually tests these patients once a year, unless the patient has been in an accident and

is "getting worse." The areas which Respondent tests are the cervical plexus (16 "nolls[14]" on each side), lumbar plexus (7 "nolls" on each side), and thoracic pelvis (12 "nolls") on each side). Respondent has used the Neural-Scan machine in his practice since approximately 2005. The machine has not been serviced in this time period.

21. In the October 5, 2009 interview with Board staff, Respondent stated that Employee B is the individual who operates the Neural-Scan machine.[15] Employee B is not a licensed health care provider.

22. On October 16, 2009, Respondent submitted to the Board, log sheets of names of patients who his office has diagnosed with the Neural-Scan machine from October 27, 2005 through September 19, 2009. A review of these log sheets shows that Respondent's office staff used the Neural-Scan machine almost daily on the average of five to eight patients a day during the first year. Thereafter, Respondent continued to use the machine almost daily although with a smaller number of patients. All of the entries are hand-written with the patient's name, initials of the area that was tested, such as "LS" (lumbar sacral), "CX" (cervical), "TH" (thoracic), and the initials of the operator of the machine. Respondent did not provide the Board a list with the initials and corresponding names of employees. A high majority of the tests were in the lumbar sacral area.

23. The Neural-Scan provided a computer generated report titled "Electrodiagnostic Exam," on which Respondent added a few handwritten notes and the

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[14] A noll is described by Respondent as the initial portion of a nerve root. It is not a term currently used in the medical literature or in current anatomy, pathology or physiology textbooks.

[15] Although Employee B's initials appear for many of the entries on the log of neural screen, there are initials of other employees as well. None of Respondent's employees are currently licensed as health care providers.

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date.

IV. "Horizontal Therapy"/Physical Therapy

24. Since 2005, Respondent has maintained in his office a medical device called Hako-Med Electromedical, Pro ElectDT 2000 and VasoPulse 2000 ("Hako-Med"). Respondent refers to this machine as "Horizontal Therapy or PT."

25. In an interview with Board staff, Respondent described the "Horizontal Therapy" machine as having a suction cup which is placed where the patient has pain. The machine sends electrical currents to the muscle or ligaments and is "programmed for 15, 30 or 45 minutes, with most patients needing a half hour of therapy." Respondent's office provides the therapy to the patient two to three times a week.

26. The User Guide for the Hako-Med describes the machine as indicated for pain management, and muscle stimulation providing "electromedical treatments." The accessories that are supplied with the machine include a hospital grade power cord, adhesive electrodes, and a lead wire set.

27. Correspondence on October 9, 2009 from the president of the manufacturer of the device to Respondent states that the machine is FDA "510(k)" approved.

28. In an interview with Board staff, Respondent stated that the manufacturer of the "Horizontal Therapy" machine trained his office staff to provide therapy on the machine. Respondent's employees have subsequently trained other staff. Respondent stated that he does not have certificates of this training because he "was told [by the manufacturer] that this is such a simple machine, because it's improved technology, you don't need training. Anybody can do it."

29. Respondent stated that this is not physical therapy "in a strict sense," and he tells his patients that they are receiving "electrical nonstimulation therapy."

V. Practice of medicine with an unauthorized person and aiding an unauthorized person in the practice of medicine

Radiography

30. One of the employees on Respondent's "Employees List" is identified as an "X-ray Technician," hereinafter identified as Employee A.[16]

31. On October 5, 2009, in an interview with Board staff, Respondent stated that Employee A, "the new x-ray tech ... she does all the x-rays right now." Respondent has employed Employee A as an x-ray technician since approximately 1998. Respondent interprets all of the x-rays.

32. Employee A has never been licensed or certified by the Board as a radiographer.[17]

33. None of Respondent's other employees listed were, or ever have been, licensed to practice radiography.

34. On October 19, 2009, the Board received a letter from Respondent which stated that Employee A's "registration" had expired. Respondent included a copy of Employee A's "wallet X-Ray Tech certificate." The certificate is from the American Registry of Radiologic Technologists, a national certifying board, and was valid through August 1995.

35. On November 23, 2010, Respondent submitted correspondence to the

[16] The employee's name is not used in the charging document. Respondent is aware of the identity of Employee A.

[17] Radiographers are commonly referred to as x-ray technicians. The Board began certifying medical radiation technologists in 1988. In 2002, the Board began licensing of medical radiation technologists. In 2008, the term was changed to radiographers.

Board in response to his review of the peer review reports in this case. Respondent stated that "at the time of her (Employee A) hiring her license was current" and that Respondent "had assumed that she was keeping her license current till (sic) it was questioned by [the Board]." Respondent stated that he terminated Employee A's employment once he found out that her license was expired, however, Respondent acknowledged that "not checking her credentials was a failure on my part."

Physical Therapy

36. In the October 5, 2009 interview, Respondent informed Board staff that he does not employ a physical therapist.

37. In the "Employees List" from Respondent's office dated September 21, 2009, none of the employees listed are licensed physical therapists.

38. On October 16, 2009, Respondent submitted to the Board, log sheets of names of patients who his office employees have treated with "Horizontal Therapy or PT" from December 30, 2005 through October 9, 2009. A review of these log sheets shows that Respondent used "Horizontal Therapy" machine almost daily on the average of 10 to 20 patients a day during the first year. Thereafter, Respondent continued to use the machine almost daily although with a smaller number of patients (average of 2 to 8 patients a day). All of the entries were hand-written with the patient's name, initials of the region that was treated, such as "LS" (lumbar sacral), "CX" (cervical), "TH" (thoracic), the number of minutes the machine was used (almost always 30 minutes), and the initials of the operator of the machine. Respondent did not provide a list with the initials and corresponding names of the employees. A high majority of the treatments were in the lumbar sacral area.

39. Respondent uses a pre-printed "Horizontal Therapy Procedure Report" form which has patient identifying information, chief complaint, diagnosis, and assessment of pain, muscle strength, and other findings. The form also has a chart on which the employees record the region, program, initial intensity, and final intensity of the electrical stimulation.

40. Under the Code of Maryland Regulations, Title 10, section 32.12.04, Respondent may not delegate the provision of physical therapy to an assistant.

VI. Fails to meet Standards of Quality Patient Care and Inadequate Documentation

41. On April 27, 2010, pursuant to a subpoena, Respondent submitted to the Board the medical records of five (5) additional patients and a typed summary of all eight (8) patients that were the subject of the Board's investigation.

42. On or about July 20, 2010, the Board referred the case to Permidion, Inc., an independent peer review organization, for peer review by two reviewers who are both board certified in internal medicine. The peer reviewers were provided with copies of 1) the complaint; 2) Respondent's response to the complaint; 3) transcripts of Board staff's separate interviews with Respondent and Complainant; and 4) the medical records of eight (8) patients as provided by Respondent including Respondent's dictated summaries of care of these patients.

43. In or about October 2010, the Board received the reports from the peer reviewers which were subsequently provided to Respondent.

44. On November 23, 2010, Respondent submitted to the Board a written response to the Peer Review reports.

45. The results of the peer review and the Board's investigation are set forth below. The peer reviewers reviewed a total of eight (8) cases. While the peer reviewers identified different areas of concern, ultimately the two peer reviewers concurred that Respondent failed to meet both standard of care and documentation requirements in a majority of the cases.

VII. Summary of Quality of Care Deficiencies and Documentation Deficiencies

46. One of the reviewers reported:

> The standard of care in Dr. Ansari's office appears to be poor and driven by diagnostic and therapeutic procedures offered within the office. Patients undergo a multilevel lab panel often annually, sometimes more often than that. ... These panels seem to be conducted *carte blanche* with no discrimination as to what type of test is indicated or necessary. ...There are no legible notes in the patients' charts indicating why the tests are being conducted.
>
> An examination of Dr. Ansari's coding sheet used for the purposes of billing indicates that his office performs (multiple tests.) Apparently Dr. Ansari reads and interprets many (sic – all) of these tests himself in spite of the fact that he does not appear to have received advanced training in radiology, bone density, cardiology and neurophysiology. On the basis of computer readouts and his own interpretation Dr. Ansari embarks upon a course of care that is not legibly documented in the patient's record and which appears to include multiple repeat tests and multiple procedures of questionable value, all of which are conducted on his equipment and in his office. ... His medical practice appears to be driven by the procedures he performs rather than evidence based medical necessity. His billing for his services is confusing, complicated, is often late, and consists of thousands of dollars of charges for a certain type of "physical therapy" conducted by untrained and unlicensed medical professionals in his office.
>
> There is very little, if no, external consultation, and test results are not corroborated by external sources.
>
> The documentation is very poor; records are haphazard, and often not chronological.

47. The other reviewer noted excessive charging for "horizontal therapy," excessive and repetitive tests without clinical indication, exorbitant charges for services,

and illegible handwritten records.

VIII. Patient Specific Findings

Patient 1

48. According to Respondent's typed summary, Respondent had treated Patient 1 (d.o.b. September 1971), a female, since 1994-95 for various conditions, such as hypertension, obesity, congestive heart failure, arthritis, and possible sleep apnea. The majority of Respondent's notes are not legible so it is not possible to ascertain what medications Respondent prescribed for Patient 1 or what her chief complaint was for each visit.

49. In 2002, Respondent ordered multiple laboratory testing and a DEXA scan, as well as other tests, which were performed in his office.

50. In 2003, Respondent ordered multiple comprehensive laboratory panels, chest x-rays, x-ray's of hips, pelvis, knees, and spine and a DEXA scan, as well as other tests, including a treadmill test, which were performed in his office. The DEXA scan showed T scores that are consistent with normal bone density. On April 23, 2003, Patient 1 had a sleep study.

51. In 2004, Respondent obtained multiple comprehensive laboratory workups, chest x-ray, and x-rays of the cervical spine and skull, as well as a thyroid sonogram, abdominal sonogram, pelvic sonogram, which were performed in his office.

52. On March 18, 2004, Respondent prescribed Fosamax[18] for Patient 1.

53. In 2005, Respondent ordered multiple comprehensive laboratory testing, chest x-ray and DEXA scan, as well as other tests

[18] Fosamax is a bisphosphonate that slows bone resorption. It is used to maintain bone mass and to reduce the risk of future fractures in patients with osteoporosis.

54. On August 12, 2006, Patient A, then a 34-year old female, presented to Respondent, following a motor vehicle accident (MVA) on August 11, 2006. Respondent ordered x-rays of Patient 1's spine, ribs, and chest and conducted the in-office interpretation. Respondent also ordered "neuro testing", or an "electro diagnostic exam." According to the typed summary, Respondent assessed "sprain" of the cervical, thoracic, and lumbar spine, both shoulders and hips.

55. On August 12, 2006, Respondent prescribed Tylenol #4 (with codeine), Flexeril, and Naprosyn.

56. Beginning August 12, 2006, Respondent ordered multiple sessions of "physical therapy" for Patient 1, consisting of electrostimulation with the "Horizontal Therapy" machine.

57. In 2006, Respondent obtained a comprehensive laboratory work-up, as well as testing in relation to the MVA. Each session consisted of placement of electrodes in the cervical, thoracic and lumbar areas.

58. On March 14, 2007, Respondent documented that Patient 1 was "fully recovered" from the MVA and no further treatment was indicated.

59. In 2009, Respondent obtained a repeat DEXA scan. The DEXA scan showed T scores that are consistent with normal bone density. Respondent also obtained TSH, ocular testing known as infrared ENG[19], ANSAR testing, "cardio-respiratory coupling," echocardiogram, VNG, and testing of the autonomic nervous system.

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[19] Electronystagmography (ENG) is a diagnostic test to record involuntary movements of the eye caused by a condition known as nystagmus. It diagnoses the cause of vertigo, dizziness or balance dysfunction.

60. Respondent failed to meet standards for quality medical care with regard to his care and treatment of Patient 1 in that Respondent:

a. Repeatedly screened Patient 1 with DEXA scans without an underlying indication;

b. Prescribed Fosamax for Patient 1 which was not indicated by the results of her DEXA scans, which had no abnormal T scores;

c. Failed to work-up Patient 1 for possible premenopausal osteoporosis and/or refer Patient 1 to an endocrinologist for evaluation of possible osteopenia or osteoporosis in a premenopausal patient, prior to beginning Fosamax;

d. Failed to start Patient 1 on continuous positive airway pressure (CPAP), despite having a sleep study done in April 2003 which showed severe sleep apnea;

e. Failed to refer Patient 1 to a cardiologist or pulmonologist/sleep specialist;

f. Provided little to no interpretation of test results that were primarily computer printouts suggestive of a diagnosis;

g. Ordered multiple laboratory tests and multiple repeat x-rays without medical justification;

h. Failed to order an MRI of the spine, and/or obtain consultation from an orthopedist, physiatrist or neurologist prior to initiating electromedical or physical therapy;

i. Failed to recommend a home exercise program to include a routine of gentle stretching and strengthening movements, and if necessary, followed by referral of Patient 1 to a licensed physical therapist for physical therapy and the use of ultrasound, massage, heat or ice packs, and electrical stimulation;

j. Authorized unlicensed staff to conduct physical therapy on Patient 1 in Respondent's office;

k. Authorized unlicensed staff to conduct x-rays on Patient 1; and

l. Billed Patient 1 for 20 units of physical therapy between August 12 and October 14, 2006 at $300.00 per unit for a total of $6,000.000.

61. Respondent failed to keep adequate medical records with regard to his care of Patient 1 in that Respondent:

a. Failed to maintain legible documentation, making it difficult to determine her chief complaints for each visit, and the extent of work up done for her spinal strain;

b. Failed to document on Patient 1's DEXA scan on March 14, 2009 that she was taking Fosamax for osteoporosis;

c. Failed to provide a discernible problem list, a list of medications taken by Patient 1, and documentation supporting Patient 1's diagnosis of spinal sprain; and

d. Failed to document a care plan discussing steps taken to diagnose and treat Patient 1.

Patient 2

62. On February 6, 2008, Patient 2 (d.o.b. August 1971), then a 39 year old female, presented to Respondent for care following a MVA on February 3, 2008.

63. Respondent treated Patient 2 until March 17, 2008.

64. Respondent treated Patient 2 with NSAIDS, narcotics, and a muscle relaxant, and ruled out any fractures by x-ray.

65. On February 12, 15, 19, 22, 26 and March 4, 2008, Respondent authorized Patient 2 to be treated with physical therapy by an unlicensed person in his office.

66. On May 2, 2008, the automobile insurance company that was processing Patient 2's claim sent correspondence to Respondent as a follow-up on medical records received from Respondent with regard to Patient 2. The insurance company stated, "Unfortunately we were unable to read the notes as we received them," and requested a

typed copy of Patient 2's treatment notes. Respondent's records of Patient 2 that were provided to the Board were typed.

67. Respondent failed to meet standards for quality medical care with regard to his care and treatment of Patient 2 in that Respondent:

a. Authorized unlicensed staff to conduct physical therapy on Patient 2 in Respondent's office; and

b. Authorized unlicensed staff to obtain x-rays of Patient 2 in Respondent's office.

Patient 3

68. Respondent has treated Patient 3 (d.o.b. January 1957) for approximately 15 years, beginning in approximately 1991, for multiple medical problems including sleep apnea, depression, questionable congestive heart failure (CHF), hypercholesterolemia, and neuropathy.

69. On May 27, 2000, Respondent obtained a DEXA scan in his office on Patient 3 who was then a 43 year old female.

70. On November 18, 2000, Respondent repeated the DEXA scan although the DEXA scan in May 2000 was "normal" in that the T-scores were below -1.0.

71. On June 8, 2002, Respondent repeated the DEXA scan although the DEXA scan in November 2000 was normal.

72. In March 2006, Patient 3, then 50 years old, was assaulted by a child on a school bus. On March 13, 2006, Respondent obtained a "Neural-Scan" of the LS, CX and TH areas on Patient 3 in his office.

73. On June 1, 2006, Respondent documented that Patient 3 "has shakes in the right hand and occasionally on both feet...she states her head feels full[,] [her]

memory is getting bad, forgets even when talking on the phone" and "has pain in the neck, back, hips and knees."

74. Respondent subsequently assessed traumatic brain injury due to the assault.

75. In 2007, a test documented in Respondent's records shows severe sleep apnea.

76. On October 20, 2007, Respondent repeated the DEXA scan although the DEXA scan in June 2002 was normal.

77. As of May 5, 2008, Respondent documented that Patient 3 was suffering from "memory problems, difficulties with reasoning and judgment, significant pain and muscular problems, generalized weakness, lack of balance, aphasia, numbness, amnesic episodes...lack of concentration...depression with its associated symptoms, and suicidal ruminations" as a result of injuries sustained during the assault.

78. Respondent prescribed multiple pain medications, statin therapy, and obtained x-rays.

79. Respondent referred Patient 3 to an LCSW-C social worker, a psychiatrist, and a psychologist.

80. Respondent prescribed anti-depressant, anti-psychotics, and medications for seizure disorder.

81. Patient 3 was in two or three MVAs in 2007 or 2008.

82. On December 18, 2008, Patient 3 was examined by an orthopedic surgeon. An MRI showed significant abnormalities.

83. From September 4, 2008 through September 16, 2008, Respondent authorized Patient 3 to be treated with physical therapy by unlicensed staff in his office.

84. On May 16, 2009, Respondent obtained a "Neural-Scan" of the LS area of Patient 3 in his office.

85. On May 16, 2009, Respondent repeated the DEXA scan although the DEXA scan in October 2007 was normal. Respondent also performed ANSAR testing.

86. On May 15, 2008, Respondent noted on a laboratory slip Patient 3's elevated glucose level at 222. Respondent advised the American Diabetes Association diet.

87. Patient 3 continued to have elevated glucose levels for over a year. On the last note, on July 9, 2009, Patient 3's glucose was still elevated at 127.

88. Respondent failed to meet standards for quality medical care with regard to his care and treatment of Patient 3 in that Respondent:

a. Failed to recommend a home exercise program to include a routine of gentle stretching and strengthening movements, and if necessary, referral of Patient 3 to a licensed physical therapist, if necessary, for physical therapy and the use of ultrasound, massage, heat or icepacks, and electrical stimulation;

b. Authorized unlicensed staff to conduct physical therapy;

c. Failed to start Patient 3 on CPAP[20] for sleep apnea, after a test showed severe sleep apnea in 2007;

d. Failed to recommend exercise, in addition to the American Diabetes Association diet, for up to six months as a means of controlling Patient 3's glucose levels, and if unsuccessful, to start Patient 3 on oral medications;

e. Ordered, completed, and charged for tests for internists, not physical therapists and physiotherapists;

[20] CPAP is a continuous positive airway pressure machine used at home for the treatment of sleep apnea.

f. Authorized x-rays which were performed by an unlicensed radiographer who was employed by Respondent;

g. Failed to provide modalities in recognized standards of care for chronic pain from arthritis other than electro stimulation;

h. Obtained inconsistent results on the neural-scans; and

i. Ordered excessive and repetitive tests, such as five DEXA scans, three pelvic abdominal/thyroid sonograms, two ECHOs, two carotid duplex Dopplers and two lower extremity duplex Dopplers, Neural Scan testing on two occasions, which were not clinically indicated. For example, Patient 3 did not meet the guidelines for repeat DEXA scans since she did not have any of the risk factors for osteoporosis.

89. Respondent failed to maintain adequate medical records with regard to his care of Patient 3 in that Respondent:

a. Failed to document an interpretation of test results other than computer printouts suggestive of a diagnosis;

b. Failed to document a discernible problem list, a list of medications taken by Patient 3, and documentation supporting Patient 3's diagnosis of spinal sprain;

c. Failed to maintain legible progress notes;

d. Failed to document a legible, discernible plan of treatment; and

e. Failed to provide a documented care plan discussing steps taken by Respondent to diagnose and treat Patient 3.

Patient 4

90. Patient 4 (d.o.b. June 1929), a female, has been a patient of Respondent since 2002 when she was a 73 year old female, with problems of neck, back, hip and knee pain. Respondent, as stated in his typed patient summary, diagnosed arthritis.

91. In 2009, when Patient 4 was 80 years old, Respondent documented a history of hypercholesterolemia, peripheral vascular disease (PVD), peptic ulcer

disease, transient ischemic attacks, coronary artery disease, anxiety, osteoporosis, and peripheral neuropathy.

92. Respondent obtained blood tests, x-rays, ocular studies, and neural-scans. Respondent authorized physical therapy consisting of electrostimulation from March 22, 2010 to April 21, 2010 and provided pain medications.

93. Respondent failed to meet standards for quality medical care with regard to his care and treatment of Patient 4 in that Respondent:

a. Failed to provide modalities such as physical therapy, other than electrostimulation, pain management, and failed to refer to a pain specialist for chronic "unresponsive" pain from arthritis;

b. Failed to recommend a home exercise program to include a routine of gentle stretching and strengthening movements, and if necessary, referral of Patient 4 to a licensed physical therapist for physical therapy;

c. Authorized unlicensed staff to conduct physical therapy;

d. Authorized an unlicensed radiographer to perform x-rays;

e. Failed to provide an interpretation of test results other than computer printouts suggestive of a diagnosis;

f. Ordered excessive number of blood tests, specifically immumoglobins, frequent electrostimulation physical therapy sessions, and unnecessary ocular studies; and

g. Charged excessive fees for the tests which were performed in his office.

94. Respondent failed to maintain adequate medical records with regard to his care of Patient 4 in that Respondent:

a. Failed to maintain legible progress notes;

b. Failed to document a medical indication for the tests which he ordered;

c. Failed to document a medical justification for the excessive number of tests;

d. Failed to provide a discernible problem list, a list of medications taken by Patient 4, and documentation supporting Patient 4's diagnosis of spinal sprain; and

e. Failed to provide a documented care plan discussing steps taken by Respondent to diagnose and treat Patient 4.

Patient 5

95. Patient 5 (d.o.b. January 1950), a male, has been a patient of Respondent since approximately 2000. Respondent saw Patient 5 a couple of times a year in 2003 and 2004. According to Respondent's typed patient summary, Patient 5 has hypertension and sleep apnea.

96. In 2005, when Patient 5 was 55 years old, Respondent saw Patient 5 on ten visits during which Respondent obtained testing with the ANSAR machine in his office.

97. In 2006, Respondent saw Patient 5 on 11 visits and obtained ECHO testing, exercise stress test (STT), thyroid scan, abdominal sonogram including gall bladder scan, DEXA scan with recommended follow-up in 1 year, and Holter monitor, all of which were performed in his office.

98. In 2007, Respondent saw Patient 5 on nine visits and obtained ECHO, Carotid Doppler scan, Doppler of lower Extremities, ANSAR testing, and ENG infrared video report (occular studies).

99. In 2008, Respondent saw Patient 5 on seven visits.

100. In June 2009, Patient 5 presented to Respondent after having been assaulted at his work as a correctional officer. Respondent documented a history of gout, hypertension, sleep apnea, bronchospasm, and hypercholesterolemia.

101. In 2009, Responded saw Patient 5 on 20 visits, with 9 visits between June 1, 2009 and October 21, 2009. Respondent obtained a DEXA scan, sonogram (scan) of abdomen, gall bladder scan, thyroid scan, ECHO, Duplex doppler of the lower extremities, Exercise stress test (ETT), ocular studies, and electrodiagnostic examination of the lumbar plexis, which were performed in his office.

102. Respondent assessed "spinal sprain."

103. Respondent saw Patient 5 for two visits for treatment following the assault, in addition to his primary care appointments.

104. Respondent failed to maintain adequate medical records with regard to his care of Patient 5 in that Respondent:

a. Failed to maintain a legible medical record;

b. Failed to document a medical indication for the tests which he ordered;

c. Ordered excessive number of tests without medical justification;

d. Failed to provide an interpretation of test results other than computer printouts suggestive of a diagnosis;

e. Failed to provide a discernible problem list, a list of medications taken by Patient 5, and documentation supporting Patient 5's diagnosis of spinal sprain; and

f. Failed to provide a documented care plan discussing steps taken by the physician to diagnose and treat Patient 5.

Patient 6

105. Patient 6 (d.o.b. December 1935), a male, has been a patient of Respondent since at least 2006, with recurrent back pain. In 2006, when Patient 6 was 75 years old, Respondent obtained a Holter monitor test, DEXA scan, nine x-rays of the skeletal system, ANSAR testing, ECHO, Carotid duplex Doppler, Duplex Doppler of the

lower extremities.

106. In 2007, Respondent obtained ANSAR testing.

107. In 2008, Respondent obtained an electrodiagnostic exam- lumbar plexus study with standard machine analysis, ECHO, Carotid duplex Doppler, duplex Doppler of the lower extremities, ANSAR testing 3 or 4 times, thyroid scan, gall balder and abdominal scan, and nine x-rays of the skeletal system.

108. In 2009, Respondent obtained two electro diagnostic examinations - lumbar plexus study, infrared video ENG, Balance check screen, ANSAR testing, Exercise stress test, three comprehensive laboratory workups (including chem. 7, LFTs, cholesterol panel, iron deficiency work up, APO lipoprotein, direct LDL, uric acid, amylase, rheumatoid factor[21], C3 and C4, phosphorous, Ig panel, CBC), multiple "horizontal therapy", ECHO, Carotid Duplex Doppler, Duplex Doppler of the lower extremities, DEXA scan, nine x-rays of skeletal system, thyroid sonogram, sonogram of gall bladder and abdomen, all of which were performed in Respondent's office.

109. In 2010, Respondent obtained ANSAR testing, two comprehensive laboratory work ups (including chem 7, LFTs, cholesterol panel, iron deficiency work up, APO lipoprotein, direct LDL, uric acid, amylase, rheumatoid factor, C3 and C4, phosphorous, Ig panel, CBC), in his office.

110. Respondent treated Patient 6 with NSAIDS, narcotics, "horizontal therapy" and bed rest.

111. Respondent authorized at least 13 physical therapy sessions by an unlicensed person from April 21, 2009 to July 17, 2009.

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[21] The rheumatoid factor (RF) is a serum autoantibody used as part of a diagnostic criteria for rheumatoid arthritis (RA) to help distinguish it from other forms of arthritis or other conditions that cause similar symptoms.

112. Respondent failed to meet standards for quality medical care with regard to his care and treatment of Patient 6 in that Respondent:

a. Authorized unlicensed staff to conduct physical therapy in Respondent's office; and

b. Authorized unlicensed staff to obtain x-rays in Respondent's office.

113. Respondent failed to maintain adequate medical records with regard to his care of Patient 6 in that Respondent:

a. Failed to maintain a legible medical record;

b. Failed to document the medical indication for the tests which he ordered;

c. Ordered excessive number of tests without medical justification;

d. Failed to provide an interpretation of test results other than computer printouts suggestive of a diagnosis;

e. Failed to provide a discernible problem list, a list of medications taken by Patient 6, and documentation supporting Patient 6's diagnosis of spinal sprain; and

f. Failed to provide a documented care plan discussing steps taken by the physician to diagnose and treat Patient 6.

Patient 7

114. In December 2007, Patient 7 (d.o.b. June 1925), then an 82 year old female, presented to Respondent. According to Respondent's typed summary, Patient 7 has a history of arthritis, severe back pain, and peripheral sensory neuropathy.

115. In 2007, Respondent obtained a DEXA scan, Mimi Mental Status Examination ("MMSE"), pelvic sonogram (Patient 7 has a history of total abdominal hysterectomy (TAH)), abdominal sonogram, thyroid sonogram, Carotid Duplex Doppler, Duplex Doppler of the lower extremities, ANSAR testing, Video VNG, and

Electrodiagnostic examination, which were all performed in his office.

116. In 2008, Respondent obtained an Exercise stress test, in an elderly patient with severe back pain, MMS.E, and ANSAR testing on two occasions, which were performed in his office.

117. In 2009, Respondent obtained a DEXA scan, ten x-rays of spine and joints, full laboratory panel as described under Patient 6, ECHO on two occasions, Duplex Doppler of lower extremities on two occasions, Carotid Duplex Doppler on two occasions, pelvic sonogram in a patient with a history of TAH, thyroid sonogram, ANSAR neuro testing on three occasions, and balance check screening. Patient 7 received "physical therapy" in Respondent's office from February 17, 2009 to April 9, 2009.

118. In 2010, Respondent obtained a full laboratory panel as described under Patient 6, PFTs, and ANSAR testing, which were performed in his office. Respondent authorized Patient 7 to receive multiple sessions of physical therapy by unlicensed staff.

119. Respondent assessed "spinal sprain."

120. Respondent ordered NSAIDS, muscle relaxants, narcotics, and Lyrica.

121. Respondent failed to meet standards for quality medical care with regard to his care and treatment of Patient 7 in that Respondent authorized unlicensed staff to conduct physical therapy in Respondent's office.

122. Respondent failed to maintain adequate medical records with regard to his care of Patient 7 in that Respondent:

a. Failed to maintain a legible medical record;

b. Failed to document the medical indication for the tests which he ordered;

c. Ordered excessive number of tests without medical justification;

d. Provided little to no interpretation of test results that were primarily computer printouts suggestive of a diagnosis;

e. Failed to provide a discernible problem list, a list of medications taken by Patient 7, and documentation supporting Patient 7's diagnosis of spinal sprain; and

f. Failed to provide a documented care plan discussing steps taken by the physician to diagnose and treat Patient 7.

Patient 8

123. Respondent treated Patient 8 (d.o.b. June 1939), a 70 year old female, who, according to Respondent's dictated statement, has a history of diabetes. hypertension, hypercholesterolemia, arthritis and degenerative joint disease (DJD), peripheral sensory neuropathy of lower extremities, and radiculopathy.

124. In 2008, Respondent obtained x-rays, ANSAR testing on three occasions, DEXA scan, ECHO, Carotid duplex Doppler, Lower extremity Duplex Doppler, pelvic sonogram, abdominal sonogram, thyroid sonogram, balance, check, infrared/video ENG. Electrodiagnostic lumbar plexus sensory conduction testing.

125. Patient 8 received physical therapy with the "Horizontal Therapy" machine in Respondent's office from March 4, 2008 to April 18, 2008.

126. Respondent authorized Patient 8 to receive multiple sessions of physical therapy by unlicensed staff.

127. In 2009, Respondent obtained complete laboratory testing, ANSAR testing, ECHO, Carotid Duplex, Doppler scan, Lower extremity duplex Doppler scan, pelvic sonogram, abdominal sonogram (gall bladder), thyroid sonogram, DEXA scan,

balance check, infrared video ENG (ocular studies), and electrodiagnostic lumbar plexus sensory conduction testing in his office.

128. Respondent's laboratory reports showed that Patient 8 had low HGB, HCT and RBC on September 9, October 7, December 1, 2008, and January 12, 2009.

129. Respondent failed to meet standards for quality medical care with regard to in his care and treatment of Patient 8 in that Respondent:

a. Failed to obtain iron studies, B12, folate, and a peripheral smear in a work up for anemia;

b. Ordered an excessive number of tests without a documented medical indication;

c. Failed to recommend a home exercise program to include a routine of gentle stretching and strengthening movements, and if necessary, referral of Patient 8 to a licensed physical therapist for physical therapy;

d. Authorized unlicensed staff to conduct physical therapy in Respondent's office; and

e. Authorized unlicensed staff to obtain x-rays in Respondent's office.

130. Respondent failed to maintain adequate medical records with regard to his care of Patient 8 in that Respondent:

a. Failed to provide legible progress notes;

b. Failed to document the medical indication for the tests which he ordered;

c. Ordered excessive number of tests without medical justification;

d. Provided little to no interpretation of test results that were primarily computer printouts suggestive of a diagnosis;

e. Failed to provide a discernible problem list, a list of medications taken by Patient 8, and documentation supporting Patient 8's diagnosis of spinal sprain; and

f. Failed to provide a documented care plan discussing steps he had taken to diagnose and treat Patient 8 and the extent of the workup done for

Patient 8's recurrent severe back pain other than medications and rest along with electrostimulation.

VIII. Gross Overutilization of Health Care Services

131. In all eight (8) patients, regardless of age or underlying conditions, Respondent obtained a large number of diagnostic tests and procedures on multiple occasions with no documented rationalization for such testing.

132. Respondent obtained repeat carotid duplex dopplers, venous dopplers of the lower extremities, abdominal ultrasounds, balance testing, and neurophysiology testing for autonomic insufficiency in patients with superficial nerve damage, in his office.

133. Respondent obtained repeat panels of blood tests, including thyroid function tests, sometimes several times a year, when their usefulness and relevance to the particular patient or monitoring interval is not supported by evidence in the record.

134. Respondent obtained multiple DEXA scans on his patients using an in-office machine, which is considered not to be reliable and often over-read the results on osteopenia or osteoporosis. Respondent fails to follow the guidelines of the American College of Physicians, the American College of Radiology, the American College of Obstetricians and Gynecologists, and the American College of Rheumatology with regard to the use and frequency of use of DEXA scans, exposing patients to unnecessary radiation.

135. Respondent repeatedly conducted neurophysiology testing in his office which he then used to justify physical therapy sessions with his "Horizontal Therapy" machine (electrical stimulation), performed by unlicensed personnel in his office.

136. Respondent failed to follow evidence-based clinical practice guidelines as the basis for ordering diagnostic tests and treatment procedures.

137. Respondent authorized unlicensed office staff to use diagnostic (x-rays) and therapeutic ("Horizontal Therapy") machines in his office.

138. Respondent read and interpreted all of the diagnostic tests and studies which he obtained. Respondent relied on the computer readouts from the various procedures and tests and entered very little interpretation of his own. Respondent used the results of the tests and studies to justify further testing and treatment and to bill for the excessive use of the tests and treatments.

139. Respondent's gross overutilization of health care services is evidenced by his excessive billing for all eight (8) patients.

Patient 1

140. On August 12, 2006, Respondent billed Patient 1 for 56 neural-scans costing $100.00 each for a total of $5,600.00. From August 12, 2006 through October 14, 2006, Respondent billed for 20 "units" of "horizontal therapy," which he billed as "physical therapy," on six dates. Respondent billed Patient 1 $300.00 per unit totaling $6,000.00.

Patient 2

141. Between February 6, 2008 and February 20, 2009, Respondent billed Patient 2 $6,170.00 for tests and physical therapy with regard to care following a MVA. From February 12, 2008 through March 4, 2008, Respondent billed for 12 units of "horizontal therapy" at $300.00 a unit, on six dates for a total of $6,000.00. On May 30, 2008, Respondent billed Patient 2 $1,485.00 for EKG and laboratory tests.

Patient 3

142. Between March 18, 2006 and April 13, 2006, Respondent billed Patient 3 for 64 units of physical therapy at $300.00 per unit, on 11 dates for a total of $19,200.00. Between October 9, 2007 and March 17, 2008, Respondent billed Patient 3 $4,485.00 for x-rays and neuromuscular tests with regard to care following a MVA. Between May 10, 2004 and June 29, 2009, Respondent billed Patient 3 $26,235.00 for treatment and tests.

Patient 4

143. From August 5, 2002 to April 11, 2009, Respondent billed Patient 4 $82,255.00 for treatments and tests.

Patient 5

144. Respondent's records for Patient 5 contain 65 pages of laboratory testing between August 2003 and November 2009 which include repeated CBC, CMP, thyroid function tests, full hormonal panel, homocystine, immunoglobulin fractionations and multiple DEXA scans. In 2006, Respondent billed Patient 5 $23,154.00 for treatments and test; in 2007, Respondent billed $8,455.00; in 2008, Respondent billed $3, 655.00; and in 2009, Respondent billed $8,930.00.

Patient 6

145. From September 16, 2006 through July 14, 2009, Respondent billed Patient 6 $35,630.00 for treatments and tests.

Patient 7

146. From December 4, 2007 through July 3, 2009, Respondent billed Patient 7 for $28,970.00 for treatments and tests.

Patient 8

147. From December 18, 2007 through July 18, 2009, Respondent billed Patient 8 $23,085.00 for treatments and tests.

IX. Unprofessional Conduct in the Practice of Medicine

148. Respondent billed "Horizontal Therapy" as physical therapy and used CPT (Current Procedural Terminology) code 97799, for "unlisted physical medicine/ rehabilitation service or procedure." The physical therapy consists entirely of electrical stimulation that is performed by an unlicensed individual; although Respondent is listed as the provider.

149. Respondent billed for each area that is treated with "horizontal therapy" on a single visit. Respondent billed fees of $300.00 multiple times for a single session of electrical stimulation, resulting in bills of $600.00 to $1,800.00 per visit for this procedure.

150. Respondent billed neural-scans as "neuro scan" and used CPT (Current Procedural Terminology) code # 95904, for "neurology and neuromuscular procedures." Respondent billed for multiple scans on a single visit, resulting in thousands of dollars in fees for this one test.

151. Respondent billed ANSAR testing as sympathetic nervous system testing, CPT code 95922, for $150.00, and parasympathetic nervous system testing, CPT code 95921, for $150.00, for a total of $300.00 each time he used the test.

152. Respondent billed for x-rays which are performed by an individual who is not licensed.

153. Respondent identified himself on his letterhead as board-certified in

internal medicine when in fact he is not.

X. Summary of Allegations

A. Unprofessional conduct in the practice of medicine, Practice of medicine with an unauthorized person and aiding an unauthorized person in the practice of medicine

154. Respondent's use of an unlicensed radiographer to obtain x-rays, use of unlicensed staff to conduct physical therapy, Respondent's subsequent billing for x-rays conducted by an unlicensed radiographer, billing for physical therapy conducted by unlicensed staff, and "double" or "quadruple" billing for physical therapy is evidence of unprofessional conduct in the practice of medicine in violation of **H.O. § 14-404(3)(ii),** willfully making or filing false reports or records in the practice of medicine in violation of **H.O. § 14-404(11),** and practicing medicine with an unauthorized person or aiding an unauthorized person in the practice of medicine in violation of **H.O. § 14-404(18).**

B. Gross Over-utilization of health care services

155. Respondent's excessive and repeated use of tests and procedures without documented medical indication, especially with regard to Patients 1, 2, 3, 5, 7, and 8 is evidence of gross over-utilization of health care services in violation of **H.O. § 14-404(19).**

C. Fails to meet appropriate standards for delivery of quality medical care

156. Respondent's actions with regard to Patients 1, 2, 3, 4, 6, and 8, constitute, in whole or in part, failure to meet appropriate standards for the delivery of quality medical care, in violation of **H.O. § 14-404(a)(22)**.

D. Fails to maintain adequate medical records

157. Respondent's actions with regard to Patients 1, 3, 4, 5, 6, 7, and 8[22], constitute, in whole or in part, failure to keep adequate medical records, in violation of **H.O. § 14-404(a)(40)**.

CONCLUSIONS OF LAW

The Board dismisses the charge under H.O. § 14-404(a)(11) (files false report). Based on the foregoing Findings of Fact, the Board concludes as a matter of law that Respondent violated H.O. § 14-404(a)(3)(ii) (unprofessional conduct), § 14-404(a)(18) (aids unauthorized practice), § 14-404(a)(19) (gross overutilization), § 14-404(a)(22) (fails to meet standards) and § 14-404(a)(40) (inadequate documentation).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 24th day of May, 2012, by a majority of a quorum of the Board considering this case hereby:

ORDERED, that Respondent is **REPRIMANDED**; and be it further

ORDERED, effective the date of this Consent Order, Respondent is placed on **PROBATION** for a minimum of **three (3) years** and until he fully and satisfactorily complies with the following conditions of probation:

1. Respondent shall immediately cease delegating to any assistant technical acts of providing physical therapy, which includes use and operation of electrical stimulation machines;

2. Within one (1) week from the date of this Consent Order, Respondent shall begin utilizing an electronic medical records system for all medical record documentation or Respondent shall dictate and have transcribed all of his medical record documentation;

[22] Respondent's records of Patient 3 were legible to the peer reviewers only because previously, the insurance company required that Respondent transcribe the records since they were illegible.

3. Within two (2) weeks from the date of this Consent Order, Respondent shall submit to the Board the name of the individual who he employs as an x-ray technician with a copy of the individual's Maryland license to practice radiology assistance. Respondent shall have an ongoing requirement for the duration of the probationary period to update this information regarding every new x-ray technician which he employs;

4. Within two (2) months of the date of this Consent Order, Respondent shall enroll in, and within six (6) months of the date of enrollment, Respondent shall successfully complete, a Board-approved course in medical record keeping;

5. Within two (2) months of the date of this Consent Order, Respondent shall enroll in, and within six (6) months of the date of enrollment, Respondent shall successfully complete, a Board-approved individual tutorial in professional ethics, which focuses on the issues in this case;

6. These courses shall be in addition to any continuing education requirements mandated for continuing licensure. Any continuing education credits earned shall not count toward fulfilling other continuing education requirements that Respondent must fulfill in order to renew his license to practice medicine;

7. Within two (2) months of the date of this Consent Order, Respondent shall undergo an audit, assessment, and evaluation of his operations, coding, billing, and documentation to support the billing by a Board-approved expert in coding and medical billing.

    i. Respondent shall agree that the Board will provide the expert with a copy of this Consent Order, and any other documents from the investigation file that the Board deems relevant, including the Peer Review Reports of October 8, 2010 and October 14, 2010;

    ii. Respondent shall ensure that the expert submit a report to the Board regarding the audit, assessment, and evaluation;

    iii. Respondent shall comply with all recommendations of the expert for proper procedures for medical coding and billing;

8. Within two (2) months of the date of this Consent Order, Respondent shall begin supervision with a Board-approved supervisor who is Board-certified in Internal Medicine. Respondent shall obtain prior approval from the Board of the supervisor before entering into the supervisory arrangement. As part of the approval process, Respondent shall provide the Board with the curriculum vitae and any other information requested by the Board

regarding the qualifications of the physician who is submitted for approval. The supervisory arrangement shall continue as described for a minimum of one (1) year, subject to the following:

i. The supervisor shall have no personal, professional relationship with Respondent;

ii. The supervisor shall notify Board in writing of acceptance of the supervisory role with Respondent;

iii. Respondent shall agree that the Board will provide the supervisor with a copy of the charging document, this Consent Order, and any other documents from the investigation file that the Board deems relevant, including the Peer Review Reports of October 8, 2010 and October 14, 2010;

iv. Respondent shall meet in person with the supervisor on a monthly basis who will review a random selection of Respondent's medical charts. The supervisor will assess and provide feedback to Respondent with regard to whether his practices, including Respondent's use of diagnostic and therapeutic procedures in his office and use of external consultations, are within the appropriate standard of quality care and whether the documentation is adequate;

v. Respondent shall ensure that the supervisor submits written reports to the Board on a quarterly basis regarding his/her assessment of Respondent's compliance with appropriate standards of care and appropriate documentation;

vi. Respondent shall have sole responsibility for ensuring that the supervisor submits the required quarterly reports to the Board in a timely manner; and

vii. Respondent may petition the Board for a decrease in the frequency of supervisory meetings after one (1) year of supervision;

9. Within six (6) months from the date of the Consent Order, Respondent shall pay a monetary penalty of twenty-five thousand dollars ($25,000.00), by certified check or money order, payable to the "Maryland Board of Physicians," P.O. Box 37217, Baltimore, Maryland 21297, to be deposited into the General Fund;

10. Within six (6) months after Respondent completes the required courses, Respondent's practice shall be subject to peer review by an appropriate peer review entity, pursuant to H. O. § 14-401 (c) & (e) and/or a chart

review[23] by a Board designee, to be determined at the discretion of the Board;

11. An unsatisfactory peer review by an appropriate peer review entity shall be deemed a violation of probation, as described in paragraph in the first "Ordered" paragraph below;

12. Within six (6) months after Respondent completes the required audit, assessment, and evaluation of his coding and medical billing practices, Respondent's practice shall be subject to re-review by the Board-approved expert. Respondent shall ensure that the expert submit a report to the Board;

13. An unsatisfactory review by the medical billing expert shall be deemed a violation of probation, as described in the first "Ordered" paragraph below;

14. Respondent shall be responsible for all costs associated with fulfilling the terms and conditions of this Consent Order;

15. There shall be no early termination of probation; and be it further

ORDERED if Respondent violates any term or condition of probation or this Consent Order, the Board, in its discretion, after notice and an opportunity for a show cause hearing before the Board, or opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, may impose any sanction which the Board may have imposed in this case under §§ 14-404(a) and 14-405.1 of the Medical Practice Act, including a probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty, said violation of the terms and conditions being proved by a preponderance of the evidence; and be it further

ORDERED that after a minimum of **three (3) years** from the effective date of this Consent Order, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be

[23] Respondent requests that a chart review must precede the peer review process.

terminated, through an order of the Board or designated Board committee. The Board, or designated Board committee, will grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and be it further

ORDERED that the Consent Order is a public document pursuant to Md. State Gov't Code Ann. §§ 10-611 *et seq.* (2009 Repl. Vol. and 2011 Supp).

5-24-12
Date

Carole J. Catalfo, Esquire, Executive Director
Maryland Board of Physicians

CONSENT

I, Abulhasan U. Ansari, M.D., License No. D24208, by affixing my signature hereto, acknowledge that:

1. I have consulted with counsel, Bruce L. Marcus, Esquire, and Janine M. Evans, Esquire, and knowingly and voluntarily elect to enter into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

2. I am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Health Occ. Code Ann. § 14-405 (2009 Repl. Vol. & 2011 Cum. Supp.) and Md. State Gov't Code Ann §§ 10-201 *et seq.* (2009 Repl. Vol. & 2011 Cum. Supp.).

3. I acknowledge the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I am waiving those procedural and substantive protections.

4. I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. I waive any right to contest the Findings of Fact and Conclusions of Law and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order or any adverse ruling of the Board that might have followed any such hearing.

5. I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

5-17-12
Date

ABDULHASAN UZ
~~Abdulhasan~~ U. Ansari, M.D.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF

I HEREBY CERTIFY that on this 5th day of May, 2012 before me, a Notary Public of the State and County aforesaid, personally appeared Abdulhasan U. Ansari, M.D, License number D24208, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public
My commission expires: 03/20/2013