BEFORE THE DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
	)	
AMEER DIXIT, M.D.	)	File No: 09-90-4759
Certificate #C-38145	)	OAH No: L-55752
	)	
	)	
Respondent.	)	
	)	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Medical Board of California, Department of Consumer Affairs, State of California as its Decision in the above-entitled matter.

This Decision shall become effective on August 8, 1996.

DATED July 9, 1996.

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

Ira Lubell, M.D.
Chair, Panel A

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: AMEER DIXIT, M.D. aka AMEER DIKSHIT, M.D. One Copley Place Laguna Niguel, Ca. 92677 Physician and Surgeon License No. C38145 Respondent.	Case No. D-4559 OAH No. L-55752

PROPOSED DECISION

On May 29, 1996, in San Diego, California, Stephen E. Hjelt, Administrative Law Judge, Office of Administrative Hearings, heard this matter.

Richard D. Garske, Deputy Attorney General, represented the complainant, Medical Board of California.

Respondent Ameer Dixit, M.D., was present and represented by Craig A. Horowitz and Janine R. Menhennet, of the law firm of Ott and Horowitz.

Evidence was received, the record was held open until the close of business on Monday, June 10, 1996 to allow the complainant to file a certified original of Exhibit 2. This was done and the matter was thereafter submitted for decision on June 10, 1996.

FINDINGS OF FACT

I

Complainant filed an Accusation and a First Amended Accusation against respondent. These pleadings were made and filed by the Executive Director of the Medical Board in such official capacity and not otherwise.

II

On or about July 24, 1978, the Medical Board issued Physician and Surgeon's Certificate No. C38145 to respondent Ameer Dixit, M.D. At all times relevant to the determination of issues herein this Certificate was in full force and effect.

In the past respondent has been the supervisor of a physician assistant pursuant to license No. SA13399. This license has been in a delinquent status since October 31, 1993.

III

On or about June 5, 1995, in the United States District Court, Central District of California, in the case of United States of America v. Ameer M. Dikshit, aka Ameer M. Dixit, Case Nos. CR 90-960(f) and CR 90-960(g), respondent entered guilty pleas to six counts of mail fraud in violation of 18 U.S.C. section 1341. At the pronouncement of judgment, respondent was sentenced to a term of one year on each of the six counts to run consecutively to each other. Further, execution of the sentence was suspended, and respondent was placed on probation for a period of three years under certain terms and conditions.

IV

Respondent's criminal convictions referred to in Finding III above stemmed from his involvement in a vast insurance fraud scheme. Respondent, from 1986 to 1988, worked as a physician employed by, under contract to or associated with various clinics, including but not limited to Fitness Spectrum, in Tustin California; Sports Spectrum, in Tustin, California; Oceanside Multi Specialty Medical Clinic, in Oceanside, California; North County Medical Center in Oceanside, California; Central County Medical Services in Vista, California; Escondido Medical Center in Escondido, California; Central County Medical Services in Escondido, California; Palm Medical Group in San Diego, California; Oceanside Medical Outpatient Center in San Diego, California; and W. Medical Group, Inc. in San Diego, California. Respondent was employed as a medical director or supervising physician at several of the above listed clinics. All the clinics were owned and operated by individuals unlicensed by the Medical Board.

The business of these clinics was operated as follows:

A. Telephone sales people solicited members of the general public to undergo comprehensive physical examinations, including state of the art diagnostic testing, at one of the clinics, at no cost, or at nominal cost of the examinee. In some instances, prospective patients were requested to, but were not required to,

make a donation to cover the cost of their deductibles and co-payment obligations under their medical insurance policies.

B. Each prospective patient was required to complete a form providing the details of his or her medical insurance coverage, including the name and address of the insurer, the name of the patient's employer, and the group or individual policy number. Each prospective patient was also required to execute a blank insurance claim form, assigning to the clinic the right to receive payment from the insurer for the examination and testing. Respondent and the owners and operators of the clinics used the insurance information and assignments to make claims for payment by the patient's insurance companies for the examination and diagnostic tests.

C. Each prospective patient was required to complete a medical history form, indicating from a preprinted list which of a variety of listed physical symptoms the patient then had or ever had. Respondent and the owners and operators of the clinics used the medical history forms to justify claims for insurance payments covering the examinations and diagnostic tests.

D. Each patient who entered the clinic was subjected to a battery of diagnostic tests, including but not limited to blood chemistries and live cell analysis, urinalysis, allergy tests, body composition and muscular-skeletal evaluations, electrocardiograms, echocardiograms, and cardiac stress tests, pulmonary function tests, abdominal ultrasounds, non-invasive vascular studies, including CPA doppler, spectrum, blood flow analysis, B-mode and olethysmography, and auditory and visual testing. All of the tests offered at the clinics were performed on every patient, regardless of the patient's physical condition or need for the tests, unless the patient declined the test or the technician performing the test or a doctor or physician's assistant examining the patient determined the test to be hazardous to the patient's physical health. In many instances, some or all of the tests were performed. The patient had been examined by a doctor or physician's assistant.

E. Respondent and the owners and operators of the clinics created or caused to be created, medical charts and records for each patient. The charts and records were used to record symptoms and diagnoses for the patient, which were in turn used to support claims to the patients' insurance carriers for payment for the physical examinations and diagnostic tests. To increase the likelihood insurance companies would pay claims for the physical examinations and diagnostic tests, respondent and the owners and operators of the clinics directly, and through employees working under their supervision, engaged in the following additional fraudulent practices with regard to the patients' medical charts and records:

1. They entered, and directed doctors and physicians assistants working under their supervision to enter, in the patients' medical charts and records, diagnoses they believed most likely to result in payment by the insurance companies, regardless of whether such diagnoses were warranted by the patients' medical histories and current symptoms, if any;

2. They added symptoms and diagnoses to, and otherwise altered, patients' medical histories, charts and records to make it appear that the tests performed on the patients were medically necessary and appropriate to the patient's physical condition.

F. They caused medical billings to be created and sent to insurance companies, claiming payment for the examinations and diagnostic tests. The medical billings contained false representations and omissions of fact creating the false impression that:

1. The patients had presented themselves to the clinic complaining of specific current medical problems;

2. A medical doctor or a physician's assistant working under the immediate supervision of a medical doctor had ordered the tests for which payment was claimed because the tests were medically necessary to treat illnesses or injuries which currently existed.

V

The evidence established convincingly that respondent by virtue of his involvement in the above scheme made himself subject to disciplinary action pursuant to the following Business and Professions Code sections: 1) 125 (conspiring with unlicensed persons in violation of the Medical Practice Act; 2) 725 (excessive use of diagnostic procedures); 3) 810 (presenting fraudulent claims to insurance companies); 4) 2234(b) (gross negligence), 2234(c) (repeated negligent acts), 2234(d) (incompetence), 2234(e) (commission of acts involving dishonesty or corruption which are substantially related to the qualifications, functions, or duties of a physician and surgeon); and, 5) 2262 (altering, modifying, or creating false medical records with fraudulent intent).

VI

It was established by the evidence that complainant incurred actual costs for investigation and prosecution of this matter in the amount of $24,263.76.

However, based up a variety of factors the above figure is not reasonable. Complainant supported its request for costs with a "Certification of Costs" and a declaration of the Deputy

Attorney General who was the trial attorney. These two documents fall far short of justifying this large request for reimbursement particularly in light of the posture of the case when it went to hearing.

It has for quite some time been the general rule in California that fees paid to an attorney are not recoverable from the opposing party as "costs" in the absence of express statutory or contractual authority. (D'Amico v. Board of Medical Examiners (1974) 11 Cal.3d 1, 24-27; Reid v. Valley Restaurants, Inc. (1957) 48 Cal.2d 606, 610; LaFave v. Dimond (1956) 46 Cal.2d 868, 870.) There has been no compelling reason set forth either by way of statutory or case law or by policy to indicate this rule should not apply to governmental agencies which seek to recover fees paid to an attorney representing the agency in a proceeding.

Section 125.3 provides in relevant part:

> ". . . the board may request the administrative law judge to direct a licentiate found to have committed a violation. . . of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.
>
> . . .
>
> (c). . . The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General."

Although this statute is anything but the model of clarity, principles of statutory construction establish that the phrase "charges imposed by the Attorney General" should be interpreted to include the charges imposed on the agency for the services of the Deputy Attorney General who prosecuted the case. However, the charges are for 272.75 hours in a case where the basis for the imposition of discipline is a criminal conviction which respondent stipulated to. On the face of it the request for reimbursement of costs is clearly excessive. Without any documentation of what the charges were for, it is very difficult for the administrative law judge to identify precisely what should be fairly recoverable. However, under the circumstances, respondent objected to the reasonableness of the charges, and the burden shifts to the complainant to justify their appropriateness. No such explanation has been supplied. This was a federal prosecution stemming from what appears to be a federal investigation. None of the prosecution of these federal charges appears to have directly involved the Medical Board of California or the Attorney General's office.

The sum of $5,000 represents the reasonable cost of investigation and prosecution of the case pursuant aid Business and Professions Code section 125.3.

VII

The conduct underlying the six felony convictions is egregious and contrary to all that an ethical care giver stands for. It is true that respondent was not the ringleader of this vast criminal enterprise. However, his position in it was essential to its success. Furthermore, he knew full well what he was doing and that what he was doing was not only illegal but also the antithesis of appropriate medical care.

Respondent's conduct lasted almost two years, ending in the summer of 1988. Since that time, he has alternately cooperated with the federal investigation, agreed to plead guilty to one count of mail fraud, then changed his mind and disavowed all that he had told the government, i.e. denied the truth of the truth, and then later changed his mind and agreed once again to cooperate with the federal government, after he got new legal representation.

It is not disputed that when he finally agreed to cooperate, he gave invaluable assistance to the federal government in its preparation for trial against the other more prominent defendants. It is not disputed that respondent is 61 years old and in ill health and that he and his family have gone through very rough times personally and financially since his involvement in this criminal activity. It is not disputed that respondent works in a medical practice that serves the less fortunate. It is not disputed that respondent had a long unblemished service to the public as a physician and that he served his country as a navy medical officer.

Respondent's conduct since his arrest does not demonstrate rehabilitation. His changing his story and denying the truth of the information he gave the government is an example of weakness and lack of judgment and most definitely does not demonstrate a mature appreciation of the gravity of the harm that he did. It does not show any remorse, only that he was prepared to do or say anything to save his skin. This isn't rehabilitation; this is cold, calculating self-interest.

Furthermore, respondent has continued to work as a physician throughout the entire time since he posted bail in 1990. Respondent's employment in a variety of different clinics served the less fortunate. However, this was not pro bono work; he was paid and continues to be paid.

The simple fact remains: respondent engaged in an elaborate fraudulent scheme for almost two years that he knew

very early on was illegal. His participation in this scheme amply justifies the revocation of his license. Indeed, for this type of serious misconduct, any sanction short of outright revocation fails fundamentally to protect the public from potential risk of harm. The only thing that has happened since then is that respondent has told us that he is remorseful and would not break the law again. The only problem is that respondent made that same promise when he became a physician, only to violate it in a base and dishonorable way.

The loss of his medical license is a harsh sanction for respondent and he and his family will no doubt suffer in ways as a result thereof. The loss of a professional license invariably has grave consequences for the professional. They lose income and status and often are personally devastated. However, the loss of his license is not some act of god, or bad break or lousy turn of luck. Respondent is the architect of the empty professional house he lives in. When all is said and done, he was motivated by greed and was prepared to act in ways that couldn't be called grey areas. This was pure and simple wrongdoing for financial gain, using his medical license as the key to unlocking the door to the insurance company's check book.

DETERMINATION OF ISSUES

I

Cause was established to impose discipline upon respondent under Business and Professions Code section 125 because he conspired with unlicensed persons and allowed his license to be used in violation of the Medical Practice Act, by virtue of Finding of Fact IV.

II

Cause was established to impose discipline upon respondent under Business and Professions Code section 2234 on the grounds of unprofessional conduct and section 725 in that he was guilty of excessive use of diagnostic procedures, by virtue of Finding of Fact IV.

III

Cause was established to impose discipline upon respondent under Business and Professions Code section 2234 and 810 in that he is guilty of submitting fraudulent claims to insurance companies, by virtue of Finding of Fact IV.

IV

Cause was established to impose discipline upon respondent under Business and Professions code section 2234(b) in

that he was grossly negligent in the practice of medicine by virtue of Finding of Fact IV.

V

Cause was established to impose discipline upon respondent under Business and Professions Code section 2234(d) in that he was incompetent in the practice of medicine by virtue of Finding of Fact IV.

VI

Cause was established to impose discipline upon respondent under Business and Professions Code section 2234(e) in that he was guilty of dishonesty or corruption in over-utilizing laboratory modalities and over prescribing diagnostic tests for purposes of submitting fraudulent claims to insurance companies for financial gain by virtue of Finding of Fact IV.

VII

Cause exists to impose discipline upon respondent under Business and Professions Code section 2234 on the grounds of unprofessional conduct as defined by section 2262 because he helped create, alter and modify medical records indicating that patients suffered from ailments which did not exist, indicating that certain diagnostic procedures were performed which, in fact, were not performed by virtue of Finding of Fact IV.

VIII

Cause exists to impose discipline upon respondent under Business and Professions Code section 2234 on the grounds of unprofessional conduct as defined by section 2236 in that he was convicted of offenses which are substantially related to the qualifications, functions or duties of a physician and surgeon by virtue of Finding of Fact III.

IX

It was established that the complainant incurred actual and reasonable costs of investigation and prosecution of this matter in the sum of $5,000.

X

The sole issue in dispute in this case relates to the issue of discipline. Put very simply, do the facts in this case justify anything other than outright revocation of respondent's medical license.

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Respondent was a knowing and willing part of an astounding criminal enterprise that defrauded insurance companies out of tens of millions of dollars. Respondent was in no way a ring leader or a mastermind. However, he was an active participant in a criminal course of conduct whose sole mission was to reap profit, not treat patients or heal the sick.

Respondent is not a hardened criminal. He is meek and timid. He became caught up in a sophisticated criminal scheme the scope of which he may not have completely comprehended. However, evil doing assumes many poses and being a foot soldier, "just doing my job" is one of those poses. Respondent knew within a few weeks of beginning work at the first clinic in Oceanside that there were serious ethical, moral and legal concerns about what was being done. He chose, for whatever reason, to remain a part of this evil.

It might have seemed to him that there was no patient harm done here. But the fraud on the insurance companies was only part of the picture. Because this was solely a cash delivery system for the ring leaders, the encounter between doctor and patient was a sham. People were seen and given a blizzard of sophisticated diagnostic tests, even when there was no legitimate medical indication. Much worse was the fact that some patients never received follow up for real conditions that were uncovered by these tests. Once the physical examination and the battery of tests was performed the patient charts were taken from the clinic premises thus effectively preventing rendering of follow up care. If in fact none of respondent's patients during this time suffered any physical harm as a result of his encounter with them, this result was purely fortuitous.

Harm is measured in many ways. The harm done to the public in general by this massive, calculated dishonesty is immeasurable. Each and every member of the public is harmed when fraud on this scale occurs. The medical profession is stained by the conduct of respondent and other doctors. This fraud could not have happened without their involvement. Only through the "findings" of a physician could this elaborate battery of diagnostic tests be found to be medically necessary.

ORDER

I

Physician and Surgeon's Certificate Number C38145 issued to respondent Ameer Dixit, M.D. is revoked. Any other licenses or certificates held by virtue of any grant of authority by the Medical Board are likewise revoked.

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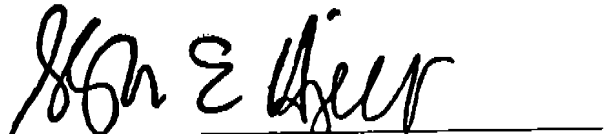
II

Respondent shall pay to the complainant the sum of $5,000 as and for the actual costs of investigation and prosecution.

Dated: June 18, 1996



STEPHEN E. HJELT
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Office of Administrative Hearings

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Attorneys for Complainant

BEFORE THE

MEDICAL BOARD OF CALIFORNIA

DIVISION OF MEDICAL QUALITY

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against: AMEER DIXIT, M.D. aka AMEER DIKSHIT, M.D. One Copley Place Laguna Niguel, CA 92677 Physician and Surgeon License No. C38145 Respondent.	CASE NO. D-4559 OAH NO. ACCUSATION

COMES NOW Complainant, Kenneth Wagstaff, who as cause for disciplinary action, alleges:

1. Complainant is the Executive Director of the Medical Board of California (hereinafter the "Board") and makes and files this accusation solely in his official capacity.

LICENSE STATUS

2. On or about July 24 1978, Physician and Surgeon Certificate No. C38145 was issued by the Board to Ameer M. Dixit,

M.D. (hereinafter "respondent"), and at all times relevant herein, said Physician and Surgeon Certificate was in full force and effect.

3. Additionally, respondent is a supervisor of a physician assistant pursuant to license No. SA13399. License No. SA13399 has been in a delinquent status since May 31, 1988.

STATUTES

4. This accusation is made in reference to the following Sections of the California Business and Professions Code (hereinafter "Code"):

a. Code section 2220 provides, in pertinent part, that the Board may take action against all persons guilty of violating the Medical Practice Act.

b. Code section 2227 provides that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act.

c. Code section 125 provides:

"Any person, licensed under the provisions of Division 1, 2, or 3 of this code is guilty of a misdemeanor and subject to the disciplinary provisions of this code applicable to him, who conspires with a person not so licensed to violate any provision of this code or who, with intent to aid or assist such person in violating such provisions:

"(a) Allows his license to be used by such person.

"(b) Acts as his agent or partner."

d. Code section 725 provides, in pertinent part:

"Repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon . . . ."

e. Code section 810 provides:

"(a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his professional activities:

"(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.

"(2) Knowingly prepare, make, or subscribe any writing with the intent to present or use the same, or to allow it to be presented or used in support of any such claim.

"(b) As used in this section, health care professional means any person licensed or certified pursuant to this Division, or licensed pursuant to the

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Osteopathic Initiative Act, or the Chiropractic Initiative Act."

f. Code section 2234 provides that unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting a violation of, or conspiring to violate any provision of this Chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

g. Code section 2262 provides, in pertinent part:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct."

FACTS

THE OVERALL SCHEME

5. On or about and between 1986 and 1988, respondent worked as a medical doctor employed by, under contract to, or associated with various clinics, including but not limited to

Fitness Spectrum, in Tustin, California; Sports Spectrum, in Tustin, California; Oceanside Multi Specialty Medical Clinic, in Oceanside, California; North County Medical Center in Oceanside, California; Central County Medical Services in Vista, California; Escondido Medical Center in Escondido, California; Central County Medical Services, Inc. in Escondido, California; Physician's Care Medical Services in Escondido, California; Palm Medical Group in San Diego, California; Oceanside Medical Outpatient Center in San Diego, California; and W. Medical Group, Inc. in San Diego, California. Respondent was employed as a medical director or supervising physician at several of the above-listed clinics. All the clinics were operated under the direction and control respondent's unlicensed co-schemers.

6. The modus operandi of respondent and his unlicensed co-schemers in conducting their fraudulent medical practices was as follows:

a. Telephone sales people solicited members of the general public to undergo comprehensive physical examinations, including state of the art diagnostic testing, at one of the clinics at no cost, or at nominal cost to the examinee. In some instances, prospective patients were requested to, but were not required to, make a donation to cover the cost of their deductibles and co-payment obligations under their medical insurance policies.

b. Each prospective patient was required to complete a form providing the details of his or her medical insurance coverage, including the name and address of the insurer, the name

of the patient's employer, and the group or individual policy number. Each prospective patient was also required to execute a blank insurance claim form, assigning to the clinic the right to receive payment from the insurer for the examination and testing. Respondent and his unlicensed co-schemers used the insurance information and assignments to make claims for payment by the patients' insurance companies for the examinations and diagnostic tests.

c. Each prospective patient was required to complete a medical history form, indicating from a preprinted list which of a variety of listed physical symptoms the patient then had or ever had. Respondent and his unlicensed co-schemers used the medical history forms to justify claims for insurance payments covering the examinations and diagnostic tests.

d. Each patient who entered the clinic was subjected to a battery of diagnostic tests, including but not limited to blood chemistries and live cell analysis, urinalysis, allergy tests, body composition and muscular-skeletal evaluations, electrocardiograms, echocardiograms, and cardiac stress tests, pulmonary function tests, abdominal ultrasounds, non-invasive vascular studies, including CPA doppler, spectrum, blood-flow analysis, B-mode and olethysmography, and auditory and visual testing. All of the tests offered at the clinics were performed on every patient, regardless of the patient's physical condition or need for the tests, unless the patient declined the test or the technician performing the test or a doctor or physician's assistant examining the patient determined the test to be

hazardous to the patient's physical health. In many instances, some or all of the tests were performed before the patient had been examined by a doctor or physician's assistant.

e. Respondent and his unlicensed co-schemers created or caused to be created, medical charts and records for each patient. Respondent and his unlicensed co-schemers used the charts and records to record symptoms and diagnoses for the patient, which were in turn used to support claims to the patients' insurance carriers for payment for the physical examinations and diagnostic tests. To increase the likelihood insurance companies would pay claims for the physical examinations and diagnostic tests, respondent and his unlicensed co-schemers, directly, and through employees working under their supervision, engaged in the following fraudulent practices with regard to the patients' medical charts and records:

(1) Respondent and his unlicensed co-schemers entered, and directed doctors and physicians assistants working under their supervision to enter, in the patients' medical charts and records, diagnoses respondent and his unlicensed co-schemers believed most likely to result in payment by the insurance companies, regardless of whether such diagnoses were warranted by the patients' medical histories and current symptoms, if any;

(2) Respondent and his unlicensed co-schemers added symptoms and diagnoses to, and otherwise altered, patients' medical histories, charts and records to make it appear that the tests performed on the patients were medically necessary and appropriate to the patient's physical condition.

f. Respondent and his unlicensed co-schemers caused medical billings to be created and sent to insurance companies, claiming payment for the examinations and diagnostic tests. The medical billings contained false representations and omissions of fact creating the false impression that:

(1) The patients had presented themselves to the clinic complaining of specific current medical problems;

(2) A medical doctor or a physician's assistant working under the immediate supervision of a medical doctor had ordered the tests for which payment was claimed because the tests were medically necessary to treat illnesses or injuries which currently existed.

7. As a result of respondent's custom and habit or modus operandi evidenced by his pattern and conduct in treating patients and conspiring with unlicensed person(s) in perpetrating frauds against insurance companies, respondent is subject to disciplinary action pursuant to Code section 125 [conspiring with unlicensed persons in violating the Medical Practice Act]; Code section 725 [excessive use of diagnostic procedures]; Code section 810 [presenting fraudulent claims to insurance companies]; Code section 2234, subdivision (b) [gross negligence]; Code section 2234, subdivision (c) [repeated negligent acts]; Code section 2234, subdivision (d) [incompetence]; Code section 2234, subdivision (e) [commission of acts involving dishonesty or corruption which are substantially related to the qualifications, functions, or duties of a physician and surgeon]; and Code section 2262 [altering,

modifying, or creating false medical records with fraudulent intent].

SPECIFIC EXAMPLES

BENJA P.

8. On or about January 2, 1987, Benja P. went to the Oceanside Multy Specialty Medical Clinic in Oceanside, California for a general physical examination as a result of a telephone solicitation. The caller represented to Benja P. that the physical examination would be conducted at no cost to Benja P. because Oceanside Multy Specialty Medical Clinic would settle for whatever the insurance company would pay, as payment in full.

9. On or about January 2, 1987, when Benja P. went to the Oceanside Multy Specialty Medical Clinic, her only physical complaint was neck pain.

10. After waiting with 40 to 60 other patients in the waiting room of Oceanside Multy Specialty Medical Clinic, Benja P. was administered the following tests:

(1) Eye sight and hearing tests;

(2) Lung/breath test (she was required to blow into a tube.);

(3) Sonagram of her liver, lungs, and heart;

(4) Blood and urine samples were taken; and

(5) An EKG.

11. It was not until Benja P. had already undergone some of the tests that respondent entered the testing area and introduced himself. Respondent examined Benja P.'s breasts, and listened to her breathe. Respondent also reviewed Benja P.'s

health questionnaire. Benja P. got dressed and as she was preparing to leave, respondent told her to stop smoking, go on a diet, and see a physical therapist concerning Benja P.'s neck pain.

12. Respondent diagnosed Benja P. as suffering from peripheral vascular disease. However, nothing in Benja P.'s medical records provides a basis for that diagnosis.

13. Benja P. was at the Oceanside Multi Specialty Medical Clinic for approximately five and one-half hours. During that time she spent no more than several minutes with respondent, and she recalls signing one insurance form for billing purposes. As a result of this one visit to the Oceanside Multi Specialty Medical Clinic, Benja P.'s insurance company was billed a total amount of $12,751.

14. Although a medical doctor by the name of Lockwood is listed as the referring physician on many of Benja P.'s health insurance claim forms, Benja P. has never seen nor heard of a doctor by the name of R. A. Lockwood. Additionally, Benja P.'s insurance company was billed for a "comprehensive follow-up" with respondent which allegedly occurred on February 10, 1987. However, no such "follow-up" occurred. To date, Benja P. has only seen respondent one time, for a few minutes, on January 2, 1987.

15. Most of the tests indicated on the insurance claim forms as having been given Benja P. either were not given, or to the extent some of the tests were given, the tests were not indicated by Benja P.'s physical examination or diagnoses listed

in her medical charts.

16. As a result of the conduct described in paragraphs 5, 8-14 above, respondent is subject to disciplinary action pursuant to Code section 125 because he conspired with unlicensed person(s) and allowed his license to be used in violation of the Medical Practice Act.

17. As a result of the conduct described in paragraphs 8-14 above, respondent is subject to disciplinary action pursuant to Code section 725 because of his excessive use of diagnostic procedures.

18. As a result of the conduct described in paragraphs 8-14 above, respondent is subject to disciplinary action pursuant to Code section 810 because of his submission of fraudulent claims to insurance companies.

19. As a result of the conduct described in paragraphs 8-14 above, respondent is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in having tests performed on Benja P. which were not indicated by any diagnoses.

20. As a result of the conduct described in paragraphs 8-14 above, respondent is subject to disciplinary action pursuant to Code section 2234, subdivision (d) because of his incompetence in diagnosing Benja P. as having peripheral vascular disease, when in fact, there was no basis for that diagnosis.

21. As a result of the conduct described in paragraphs 8-14 above, respondent is subject to disciplinary action pursuant to Code section 2234, subdivision (e) because of his dishonesty

or corruption in over-utilizing laboratory modalities and over-prescribing diagnostic tests for purposes of submitting fraudulent claims to insurance companies for financial remuneration.

22. As a result of the conduct described in paragraphs 8-14 above, respondent is subject to disciplinary action pursuant to Code section 2262 because of his alteration, modification, and creation of false medical records indicating Benja P. suffered from ailments which did not exist, indicating that certain diagnostic procedures were performed, which in fact were not performed, indicating that Benja P.'s referring physician was "R. A. Lockwood," and billing for a "comprehensive follow-up" which never occurred.

HAROLD L.

23. On or about January 11, 1988, as a result of a telephone solicitation, Harold L. went to either K. Medical facility, Sports Spectrum or Fitness Spectrum, in Tustin, California for a "routine physical." Harold L. was told that he would receive a physical examination for the total sum of $20.00 and whatever his insurance company would pay.

24. On or about January 11, 1988, when Harold L. arrived for his "routine physical" he received a brief, approximately 5 minute, physical. Harold L. was feeling fine and had no physical complaints at the time.

25. On or about January 11, 1988, in addition to the physical examination, Harold L. recalls having a urine test, a blood test, a "lung test," an ultrasound, vascular tests, and a

"live cell analysis." After completion of these tests, Harold L. was asked to return on January 28, 1988, for further testing.

26. On or about January 28, 1988, Harold L. returned to the medical facility and underwent a "treadmill test."

27. As a result of Harold L.'s January 11, 1988, and January 28, 1988, visits to respondent's facility, his insurance company, State Mutual, was billed the total sum of $13,178. Many of the tests performed on Harold L. were billed to the insurance company twice. Furthermore, although Harold L. gave no history of serious problems concerning his vascular system, respondent ordered multiple tests for the diagnosis of weight increase, fatigue, respiratory disease, and peripheral vascular insufficiency. None of the tests ordered by respondent were required. In fact, respondent essentially ruled out the fact Harold L. suffered from any type vascular disease. Accordingly, the basis for the insurance bill to State Mutual was a false diagnosis or diagnoses.

28. As a result of the conduct described in paragraphs 5, 23-27 above, respondent is subject to disciplinary action pursuant to Code section 125 because he conspired with unlicensed person(s) and allowed his licensed to be used in violating the Medical Practice Act.

29. As a result of the conduct described in paragraphs 23-27 above, respondent is subject to disciplinary action pursuant to Code section 725 because of his excessive use of diagnostic procedures.

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30. As a result of the conduct described in paragraphs 23-27 above, respondent is subject to disciplinary action pursuant to Code section 810 because of his fraudulent claims to Harold L.'s insurance company.

31. As a result of the conduct described in paragraphs 23-27 above, respondent is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in prescribing unnecessary diagnostic tests, and providing false diagnoses in support of insurance claims submitted to State Mutual.

32. As a result of the conduct described in paragraphs 23-27 above, respondent is subject to disciplinary action pursuant to Code section 2234, subdivision (d) because of his incompetence in prescribing unnecessary diagnostic tests, and creating false medical records in support of claims made to Harold L.'s insurance company.

33. As a result of the conduct described in paragraphs 23-27 above, respondent is subject to disciplinary action pursuant to Code section 2234, subdivision (e) because of his dishonesty or corruption in prescribing unnecessary diagnostic tests, creating false medical records, and submitting false claims to an insurance company.

34. As a result of the conduct described in paragraphs 23-27 above, respondent is subject to disciplinary action pursuant to Code section 2262 because respondent entered false diagnoses on the medical records for Harold L. in support of respondent's fraudulent insurance claims.

DONNA H.

35. On or about January 18, 1988, Donna H. went to Fitness Spectrum in Tustin, California for a physical examination as a result of a telephone solicitation. Donna H. was told that there would be a minor charge for the physical ($10.00), and her insurance company would pay the remainder.

36. On or about January 18, 1988, when Donna H. appeared at the clinic for her physical examination, she had no physical complaints.

37. Donna H. began the testing process before being seen by respondent. When respondent saw Donna H., he did not review the medical questionnaire which Donna H. had filled out, and he did not ask her any questions concerning her health. The physical examination performed by respondent was very brief and Donna H. was not even required to disrobe.

38. Respondent ordered a multitude of tests be performed on Donna H., including, but not limited to peripheral vascular disease testing, and abdominal scanning. Virtually all the tests performed, including the peripheral vascular disease testing and multiple abdominal scans were not indicated on the basis of Donna H.'s medical history or physical examination. Nonetheless, respondent falsely noted findings on Donna H's medical records to justify the tests.

39. With the exception of certain pulmonary function tests, respondent failed to note any test results in Donna H.'s chart.

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40. As a result of Donna H.'s single visit to Fitness Spectrum, her insurance company was billed $8,933.00.

41. As a result of the conduct described in paragraphs 35-40 above, respondent is subject to disciplinary action pursuant to Code section 125 because he conspired with unlicensed person(s) and allowed his license to be used in violation of the Medical Practice Act.

42. As a result of the conduct described in paragraphs 35-40 above, respondent is subject to disciplinary action pursuant to Code section 725 because of his excessive use of diagnostic procedures.

43. As a result of the conduct described in paragraphs 35-40 above, respondent is subject to disciplinary action pursuant to Code section 810 because of his submission of a fraudulent claim to an insurance company.

44. As a result of the conduct described in paragraphs 35-40 above, respondent is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in prescribing unnecessary diagnostic tests/procedures, and his modification and creation of false medical records to defraud an insurance company.

45. As a result of the conduct described in paragraphs 35-40 above, respondent is subject to disciplinary action pursuant to Code section 2234, subdivision (d) because of his incompetence in prescribing unnecessary diagnostic tests/procedures, and his altering, modifying, and creating false medical records for purposes of defrauding an insurance company.

46. As a result of the conduct described in paragraphs 35-40 above, respondent is subject to disciplinary action pursuant to Code section 2234, subdivision (e) because of his dishonesty and corruption in altering, modifying, and creating false medical records for purposes of defrauding an insurance company.

47. As a result of the conduct described in paragraphs 35-40 above, respondent is subject to disciplinary action pursuant to Code section 2262, because of his alterating, modifying, and creating false medical records for purposes of defrauding an insurance company.

WHEREFORE, complainant requests the Board hold a hearing on the matters alleged herein; and following said hearing, the Board issue a decision:

1. Revoking or suspending respondent's physician and surgeon license;

2. Revoking or suspending respondent's license to supervise physician's assistants; and

3. Taking such other and further action the Board deems appropriate to protect the public health, safety and welfare.

DATED: June 24, 1991

KENNETH WAGSTAFF
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

RWH:sol
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