[redacted] [redacted]

PAULA T. DOW
ATTORNEY GENERAL OF NEW JERSEY
Division of Law
Hughes Justice Complex
25 Market Street
P.O. Box 093
Trenton, New Jersey 08625

By: Kay R. Ehrenkrantz
Deputy Attorney General
Tel. (609)984-5065

STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF THE SUSPENSION OR REVOCATION OF THE LICENSE OF AMGAD A. HESSEIN, M.D. LICENSE NO. 25 MA 676500 TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF NEW JERSEY	Administrative Action VERIFIED COMPLAINT

PAULA T. DOW, Attorney General of the State of New Jersey, by Kay R. Ehrenkrantz, Deputy Attorney General, with offices located at Hughes Justice Complex, 25 Market Street, P.O. Box 093, Trenton, New Jersey, on the basis of information and belief, by way of Verified Complaint says:

GENERAL ALLEGATIONS

1. Complainant, Attorney General of New Jersey, is charged with the responsibility of enforcing the laws of the State of New Jersey pursuant to N.J.S.A. 52:17A-4(h), and is empowered to initiate administrative disciplinary proceedings against persons

licensed by the New Jersey State Board of Medical Examiners pursuant to N.J.S.A. 45:1-14 et seq.

2. The New Jersey State Board of Medical Examiners ("Board") is charged with the duty and responsibility of regulating the practice of medicine and surgery in the State of New Jersey pursuant to N.J.S.A. 45:9-1 et seq.

3. Respondent Amgad Hessein, M.D. ("Respondent"), is an individual who, at all times relevant hereto, has been a physician licensed to practice medicine and surgery in the State of New Jersey with License Number MA 67650. (Biennial Renewal Applications for 7/1/07-6/30/09 and 7/1/09-6/30/11, annexed hereto as Exhibit D).

4. Respondent Hessein is a Board certified anesthesiologist, specializing in interventional pain management. (Exhibit D).

5. Respondent is the owner of Advanced Pain Management Specialists, P.C., with offices located over the last ten years at: 268 Martin Luther King Blvd. in Newark; 2081 Morris Avenue in Union; Roseland; 303 Belmont Avenue in Belleville; and in South Orange, New Jersey. (Certificate of Incorporation, annexed hereto as Exhibit C).

6. At all times pertinent to the Complaint, Respondent has maintained privileges at St. Michaels Medical Center in Newark, where he performs procedures, in addition to his private practice. (Statements of Employees, attached hereto as Exhibit K).

7. On or about November 16, 2010, the Union County Prosecutor, by Detective David S. Nechamkin, filed a Search Warrant Affidavit with the Honorable Joseph P. Donohue, J.S.C, and acquired arrest and search warrants for Respondent's Belleville office and home. (Certification of Detective David Nechamkin, including November 16, 2010 Certified Search Warrant Affidavit and Order, annexed as Exhibit A).

8. On or about November 17, 2010, the Union County Prosecutor's office ("UCPO") along with other law enforcement personnel executed a search warrant at Respondent's Belleville office, seized patient records, billing records, computers and other documents, including Respondent's medical records for B.Z., J.C., T.A., A.G., D.C., J.S., J.R. and K.S-A.. (Patient records of B.Z., J.C., T.A., A.G., D.C., J.S., and J.R., annexed hereto as Exhibit s N-T respectively; November 17, 2010 Complaint-Warrant 2010-001746, Exhibit A).

9. On November 17, 2010, Respondent and his brother Sami Ashraf, his office manager, were arrested and criminally charged with conspiracy to commit health care claims fraud, a violation of N.J.S.A. 2C:5-2a(1) and multiple charges of submitting false claims for reimbursement from health insurance companies, contrary to N.J.S.A. 2C:21-4.3(a), all crimes of the second degree. (Exhibit A).

10. On November 17, 2010, following the execution of the search warrant at the Belleville office, Enforcement Bureau Investigators Gina Galloni and Marianne Nucci performed an office investigation, seeking to verify Respondent's compliance with Board regulations pertaining to maintenance of medications, office hygiene and professional standards. (See Certifications of Galloni and Nucci, annexed hereto as Exhibits G and L).

11. Initials, patient numbers, and specimen numbers are being used in this Verified Complaint to protect the confidentiality of the patients referenced herein. The patients' true identities have been made known to Respondent and to the Board.

12. At all times pertinent to this Complaint, Respondent has performed invasive procedures and injections on his patients as a means of pain relief, including foraminal epidural steroid injections. (See Exhibits N-T).

13. A transforaminal epidural injection is performed by inserting a needle tip until it enters the neural foramen of the nerve root suspected to be the patient's primary pain generator. The objective of a transforaminal epidural steroid injection is the precise delivery of both local anesthetics and anti-inflammatory steroids directly to the suspected nerve root sleeve. (Expert Report of Jennifer Yanow, M.D. dated September 21, 2011, annexed hereto as Exhibit E).

14. The medical standard of care when performing transforaminal epidural steroid injections requires use of fluoroscopy and contrast agents to obtain a safe and effective needle tip placement for the injection of local anesthetics and steroids into the patient's epidural space. (Exhibit E, page 6).

15. When a physician is performing a transforaminal epidural injection, especially in the cervical region, the needle tip is placed in close proximity to the carotid artery, vertebral artery, spinal nerve root, and spinal cord. (Exhibit E, page 6).

16. Inadvertent needle placement can cause catastrophic consequences. A risk of cervical transforaminal epidural steroid injections in particular is the injection of particulate steroid into a radicular artery, which can cause brainstem infarction and death, or quadriparesis. Thoracic or lumbar transforaminal injections can cause paraplegia. (Exhibit E, page 6).

17. Fluoroscopy is a form of imaging guidance which permits the physician in real-time to visualize the placement of the needle tip in relation to the spine and its adjacent structures as it is advanced into the epidural space during the performance of an epidural steroid injection. (Exhibit E, page 7).

18. When performing a transforaminal epidural injection, the standard of care requires that satisfactory needle position be achieved with fluoroscopic exposure, by use of contrast dye

injection, with the retention of at least one hard copy of the fluoroscopic image. (Exhibit E, page 6-7).

19. The standard of care when performing transforaminal epidural steroid injections is to inject approximately 1 to 2 cc's of contrast agent into the epidural space prior to any injection of local anesthetic or steroid so that proper needle tip placement can be confirmed through use of fluoroscopy. (Exhibit E, page 7).

20. The standard of care with respect to the frequency of performing transforaminal epidural steroid injections is based on the patient's clinical response to the initial or previous injection coupled with the type of long-acting steroid administered. If the patient has a positive response to the first epidural steroid injection, as manifested by an overall decrease in pain, a second injection usually follows within one to two weeks. Most practicing physicians will not perform more than three to four injections in a six month time span. (Exhibit E, page 3).

21. The International Spine Intervention Society (ISIS), the preeminent specialty society in the field of interventional pain management, practice guidelines state that lumbar transforaminal epidural steroid injections "should be limited to a total of no more than four injections in a six-month period". These same guidelines, in reference to repeat injections, suggest that if a patient does well after a transforaminal injection but their pain

starts to return, a repeat injection should not be repeated in less than two weeks. (Exhibit E, page 4).

22. Current Medicare guidelines allow for: four (4) transforaminal epidural injections per side per region (cervical/thoracic or lumbar/sacral) per year; four (4) facet injections per side per region per year; four (4) interlaminar epidural injections per region per year; and four (4) sacroiliac joint injections per side per year. (Exhibit E, page 4).

23. Kenalog, a type of corticosteroid is a 'particulate' steroid, which means that is composed of particles that form aggregates that are larger than red blood cells. Therefore, if Kenalog is injected into an artery that feeds the spinal cord (which is possible even when live fluoroscopy is used), it could stop blood flow to the spinal cord, resulting in paralysis, stroke or death (depending on location). (Exhibit E, page 6).

24. This complication can arise from both transforaminal, and interlaminar epidural injections, although it is more of a risk with the transforaminal route (neural foraminal injection). Practitioners should minimize the dose of corticosteroids per year by limiting unnecessary procedures. (Exhibit E, Pages 3-4).

25. The general practice guideline for the total annual steroid dosage to be administered is 3mg/kg of body weight of steroid or 210 mg per year in a person of average weight, and a lifetime dose of 420 mg of steroid. (Exhibit E, page 3).

26. Due to the potential side effects of exogenous steroid administration, especially since many of the side effects may be clinically subtle or delayed in onset (i.e. changes in appetite, water retention, suppression of hormones), informed consent counseling of these invasive injection patients is necessary. (Exhibit E, page 3).

27. Some of these side effects could be quite serious, for instance, if a patient required surgery and the doctors were unaware of the doses of steroid to which the patient had been exposed. (Exhibit E, page 3-4).

28. Performing a cervical epidural procedure on a patient taking Plavix, or other anti-coagulant is extremely dangerous, potentially resulting in a cervical epidural hematoma, paralysis, or death. The American Society of Regional Anesthesia recommends stopping Plavix 7 days prior to any neuraxial (epidural) procedure. (Exhibit E, pages 10-11).

29. Radiofrequency ablation (RFA) procedures, during which an electrode is used to apply electric current to a nerve to coagulate it (rendering it temporarily non-functional), on average provides more than a year of pain relief, and therefore should not need to be repeated at shorter intervals. (Exhibit E, page 4).

30. The PDD (Percutaneous Disc Decompression) procedure is used to treat patients with radicular pain from a contained disc herniation. It involves inserting a radiofrequency probe into the

affected disc and ablating a small amount of disc material, in an effort to decompress the disc and relieve the pressure on the nerve root. (Exhibit E, page 5).

31. The IDET procedure (IntraDiscal ElectroThermal coagulation) is used for people with believed discogenic pain. It involves inserting a catheter into the boundary between the nucleus and the annulus of a disc, and delivering thermal energy in an effort to turn off some of the pain fibers in this area. (Exhibit E, page 5).

32. In order to best prevent side effects of exogenous steroid administration, when using Kenalog, injections should be spaced at least 6 weeks apart, [which he disregards, as documented in his medical records, by his injections over consecutive days for multiple patients.] (Compilations of Respondent's Office Records, Scheduler and Healthquist Data, attached hereto as Exhibit H, Exhibits N-T, Exhibit E, pages 2-3).

33. Informed consent is mandatory prior to procedures, and should include all potential risks and complications, not only those relatable to the injections themselves. (Exhibit E, page 5).

34. Accurate history and physical examination, including labs or imaging when indicated, are mandatory for correct diagnosis and subsequent treatment, as well as for uncovering potentially dangerous pathology. Follow-up on prior symptoms and complaints is also important. (Exhibit E, page 9).

35. All patients having intravenous sedation should have their vital signs monitored, as clearly detailed in the Standards for Basic Anesthetic Monitoring, as published by the American Society of Anesthesiologists. (Exhibit E, page 11)

36. Even if IV sedation is not being given, in the event that local anesthetic gets into the subdural or intrathecal space, or into an artery, IV access is necessary for resuscitation. (Exhibit E, page 11).

Count I

1. Complainant repeats the General Allegations set forth above as if fully set forth herein and incorporated by reference.

2. Respondent regularly grossly and repeatedly deviated from accepted standards of good medical practice as demonstrated by, but not limited to, his treatment of patients B.Z., J.C., T.A., G.A., and J.S. (Exhibit E, Exhibits N-T).

3. Respondent performs an excessive number of steroid-containing injections on his patients. The sheer number of steroid-containing injections that he documents performing puts his patients at significantly increased risk for side effects from exogenous steroid administration. (Exhibit E, pages 3-5).

4. The number of interventional procedures that Respondent performs on his patients is extremely excessive. Respondent does not inform patients about the risks of the large amounts of steroids they receive. (Exhibit E, page 5).

5. There is no documentation that Respondent discussed these potential side effects with the patients either at their initial evaluation or prior to their procedures, thereby denying them the opportunity to provide informed consent. (Exhibit E, page 4).

6. Respondent did not document questioning the patients about side effects of the steroids, and therefore would not likely know if any of his patients required additional care or referrals for steroid-related issues. (Exhibit E, page 5, Exhibits N through T).

7. Respondent's failure to offer alternative therapies or treatment modalities denied patients the opportunity for potentially efficacious treatment. (Exhibit E, pages 5, 7, 14).

8. The vast number of injections becomes even more unacceptable when taking into consideration that Respondent does not document referring the patients to a surgeon or other specialist despite therapeutic goals not being met. Even if this was offered and declined, it should be documented. (Exhibit E, page 5).

9. Contrary to the standard of care, the procedures performed by Respondent are often done without a procedure note or operative report. When there is a procedure note, it is often vague or incomplete. (Exhibit E, page 6, Exhibits N-T).

10. Respondent's procedure notes for his 'neural foraminal injections' are nonsensical, and the procedure described is not a

steroid-containing transforaminal epidural injection, for which he bills his patients. This same improper and illogical procedure note is used for cervical, thoracic, and lumbar procedures. (Exhibit E, page 6).

11. Respondent's procedure note states that the spinal needle is passed 'into the neural foramen [then] into the corresponding disks'. When performing this injection, the needle should actually *not* be put into the discs, and should instead remain in the foramen. There is no documentation that any medication is injected other than the local anesthetic to numb the skin prior to spinal needle insertion. The procedure described in these notes is not a transforaminal epidural injection, and should therefore not be billed as one. (Exhibit E, page 6).

12. Respondent does not document using fluoroscopy during contrast dye injection and sometimes does not document using contrast dye during his steroidal epidural procedures. (Exhibit E, page).

13. Respondent's 'neural foraminal injection' procedure notes generally contain no documentation of injection of contrast dye. (Exhibit E, page 6).

14. Respondent does not attempt to make his procedures safer by utilizing a test dose for any of his transforaminal epidural procedures, or by checking more than one fluoroscopy view (for example, AP and lateral). (Exhibit E, Exhibit N-T).

15. Performing neural foraminal injection procedures the way it is described in the records maintained by Respondent without real-time viewing of contrast dye injection prior to steroid injection (if steroid medication is actually injected) as he bills for it is contrary to the standard of care. (Exhibit E, pages 6-7).

16. Respondent's neural foraminal injection procedure note does not substantiate billing CPT codes 64479/64480/64483/64484. (Exhibit E, page 7).

17. Respondent demonstrates inadequate clinical skills, including poor or non-existent history-taking and physical examinations, potentially dangerous procedures, and completely insufficient follow up. (Exhibit E, page 7).

18. Respondent repeats his radiofrequency ablation (RFA) procedures at too frequent intervals. (Exhibit E, page 4).

19. Respondent does not routinely follow up with patients regarding their response to prior procedures, continues to repeat the same procedures over and over without significant relief. (Exhibit E, page 4).

20. Respondent should have explored or offered patients alternative treatment strategies when they required procedures to be repeated so often because they were not effective. (Exhibit E, page 5).

21. Contrary to the standard of care, Respondent performs cervical interlaminar epidural injections without using contrast

dye, although the procedure note states it is done "under fluoro." (Exhibit E, page 7).

22. Respondent's patient records include vague and incomprehensible procedures notes. Additionally, many procedures billed by Respondent lack any procedure note. (Exhibit E, pages 6-7, 14).

23. There are numerous examples of grossly negligent care as documented by Respondent's records, which lack: an adequate description of patients' pain, including but not limited to specifics regarding location (for example simply 'right leg pain'); questioning about antecedent trauma or causality; documentation of alleviating or aggravating factors; and description of patients' response to prior treatment or attempted alternative treatments (such as physical therapy). (Exhibit E, page 7).

24. Respondent documents that patients have pain, performs a nerve block or other type of injection, and then does not follow up with them regarding potentially dangerous issues. (Exhibit E, page 7).

25. Respondent's patients are potentially receiving incorrect, unnecessary treatments and procedures as a function of his inadequate care. (Exhibit E, page 9)

26. His practice of performing injections with inadequate history and physical examination information creates a significant potential for harm to patients. (Exhibit E, page 9)

27. Respondent repeatedly performs unnecessary medical tests, including EMG/NCVs and urine tests and unnecessary procedures on patients, presumably for the purpose of being reimbursed. (Exhibit E, page 10)

28. Respondent performs EMG/NCS without an explanation regarding why the tests are being performed and/or repeated. There is no indication given for performing the test, and Respondent's treatment of the patient does not change after the results. (Exhibit E, pages 9-10)

29. As part of his EMG/NCS tests and interpretation, Respondent incorrectly performs the H-reflex part of the NCV exam and consequently inappropriately bills using CPT code 95934 for this part of the test. (Exhibit E, page 13)

30. Respondent does not take adequate measures to avoid risk, serious side effects and potential harm. (Exhibit E, pages 3-4).

31. Most of Respondent's consent to treatment forms are either blank or incomplete. The consent forms that were available are generalized. (Exhibit E, page 10).

32. Respondent did not document discussions about specific potential risks or complications with the patients, such as the risks of infection, bleeding, nerve damage, or paralysis from the injections, or the possible side effects from receiving steroid medication. (Exhibit E, page 10).

33. Respondent did not document that he instructed patients to cease taking their anticoagulant medications prior to injections. (Exhibit E).

34. Respondent's performance of an elective cervical epidural procedure on a patient on Plavix with no documentation of discussed risks could have resulted in serious or fatal complications for this patient. (Exhibit E, page 11).

35. Respondent fails to monitor and document vital signs when administering IV sedation, contrary to N.J.A.C. 13:35-4A. (Exhibit E, page 11).

36. As an anesthesiologist, Respondent should be well aware that patients receiving IV sedation must be monitored and vital signs must be documented. (Exhibit E, page 11).

37. Respondent's patients received IV sedation for a procedure, without vital signs recorded. There are no anesthesia records in any of the five patient files reviewed by the expert for any date of service, and there is no documentation that there was even a second medical professional in the room during the procedure to monitor the vital signs. (Exhibit E, page 11).

38. Respondent failed to have IV access in place when performing a cervical transforaminal injection constitutes a gross deviation (Exhibit E, page 11).

39. Respondent documents using volumes of injectate that are excessive or impossible. Either Respondent is not actually

performing the injections he is billing for, or he is injecting this high volume and rupturing joint capsules. (Exhibit E, page 11).

40. Respondent fails to follow up lab or diagnostic test abnormalities, routinely not documenting following up with his patients regarding abnormalities seen on their imaging studies or blood work (Exhibit E, pages 11-12).

41. Respondent ordered excessive and unnecessary urine tests, as he did not document suspected abuse, misuse, or suspicious behavior. (Exhibit E, page 12)

42. Respondent's above-stated conduct constitutes gross negligence, malpractice or incompetence in violation of N.J.S.A. 45:1-21(c), and/or constitutes repeated acts of negligence, malpractice or incompetence, in violation of N.J.S.A. 45:1-21(d). Alternatively and additionally, Respondent fails to maintain a proper patient record and fraudulently bills for services not rendered which constitutes misrepresentation, deception, gross and/or repeated negligence, malpractice and incompetence, professional misconduct, and failure to comply with the rules of the Board requiring preparation and maintenance of a proper medical record, contrary to N.J.A.C. 13:35-6.5, all in violation of N.J.S.A. 45:1-21(c), (d) and/or (b), (e), and (h).

43. The aforesaid conduct by Respondent demonstrates that his continued practice presents a clear and imminent danger to the public health, safety, and welfare pursuant to N.J.S.A. 45:1-22.

COUNT II

1. Complainant repeats the General Allegations and the allegations of Count I as if fully set forth herein and incorporated by reference.

2. Patient B.Z., a 69 year-old female was Respondent's patient from (Exhibit N, pages).

3. Respondent treated B.Z. with injections for lumbar radiculopathy, lumbar facet joint pain, knee pain (with intra-articular steroid and Orthovisc injections), cervical radiculopathy, shoulder pain (with both intra-articular injections and suprascapular nerve block), leg pain (with tibial nerve blocks), cervical facet joint pain, lateral epicondylitis, sacroiliac joint pain, hip pain, and intercostal neuritis. (Exhibit E, page 1, Exhibit N)

4. Respondent uses Kenalog (triamcinolone acetonide) as the steroid for virtually all of his procedures, performing multiple injections with Kenalog over a very brief time, including on consecutive days. (Exhibit E, page 3, Exhibit N).

5. Patient B.Z. had injection procedures with steroids on 8/24/2010, 8/25/2010, 8/27/2010, and 8/28/2010. (Exhibit E, page 3, Exhibit N)

6. Patient B.Z. (91kg) received steroid injections of approximately 340 mg in 2010, 450 mg in 2009, and 530 mg in 2008. (Exhibit E, page 3, Exhibit N).

7. Patient B.Z. underwent 14 Orthovisc injections, 14 lumbar neural foraminal injections, and 14 lumbar facet procedures in 2010. (Exhibit E, page 4, Exhibit N).

8. In 2009, B.Z. had 16 Orthovisc injections, 6 lumbar epidural and 9 lumbar facet injections, and 7 cervical epidural procedures. (Exhibit E, page 4, Exhibit N).

9. In 2008, B.Z. had approximately 20 lumbar facet procedures and 20 cervical facet procedures. More generally, in 2008, for this patient, there were 26 dates of service where injections were performed, with approximately 60 injections given. (Exhibit E, page 4, Exhibit N).

10. In 2009 B.Z. had 34 dates of service with approximately 50 injections. (Exhibit E, page 4, Exhibit N).

11. In 2010, there were 30 dates of service with nearly 50 injections. (Exhibit E, page 4, Exhibit N).

12. Contrary to the standard of care, B.Z. underwent a left L4-5, L5-S1 RFA procedure on 9/14/2010, then again on 10/28/10. She underwent a left L3-4, L4-5, and L5-S1 RFA on 10/18/2007, bilateral L4-5 and L5-S1 RFA on 3/25/2008, then a repeat bilateral procedure on 7/1/2008. (Exhibit E, page 5, Exhibit N).

13. On July 13, 2010, patient B.Z. underwent a cervical

interlaminar epidural. Respondent did not document using contrast dye, although the record reflects the procedure was done 'under fluoro'. (Exhibit E, page 7, Exhibit N).

14. Respondent also prescribed multiple medications for B.Z. for her pain with significant side effects, described in a letter from the patient to Respondent, and dated 11/16/2010. These medications included Vicoden, Xanax, Cymbalta, Topamax, Celebrex, Flector patch, and a 'stomach medicine'. (Exhibit E page 2, Exhibit N).

15. Respondent documents that B.Z. has pain, proceeds to do a nerve block or other type of injection, and then does not follow up with her regarding potentially dangerous issues, such as:

- On 5/31/2007, Respondent documented that B.Z. had 'severe neck' and 'right upper extremity pain' but failed to document any other information. (Exhibit E, page 7)
- B.Z.'s physical examination that same day 5/31/2007 documents weakness and a sensory deficit of the entire right upper extremity which was not present on the prior or subsequent date of service. Respondent's impression was 'R/O plexopathy' and 'R/O cervical radiculopathy'. (Exhibit E, page 7)
- Respondent did not make any attempt to determine where these new neurologic deficits were coming from, and instead proceeded to do a right axillary brachial plexus injection.

Based on Respondent's observation goal of ruling out 'plexopathy', he should have, but failed to, document questions regarding trauma or traction injury, recent infections, or any recent symptoms suggestive of cancer, and a physical examination evaluating each peripheral nerve separately. A brachial plexus injection was medically contra-indicated and should absolutely not have been performed based on the information documented. (Exhibit E, page 7)

- Despite documenting that B.Z. may have 'plexopathy', there was absolutely no appropriate medical follow up regarding her response to the injection or current right arm symptoms on the subsequent date of service. (Exhibit E, page 7)
- On 8/7/2008, patient B.Z. had upper back 'redness and swelling', although Respondent did not describe exactly the location of this redness and swelling. Respondent wanted to rule out cellulitis. He did nothing to actually rule out cellulitis, but performed a bilateral cervical facet radiofrequency procedure despite the possible localized infection. This elective procedure should not have been done in the presence of an infection. The next day of service, 9/13/2008, Respondent made no mention of the continued presence or resolution of this possible infection. (Exhibit E, page 9)
- Respondent performed an incision and drainage of a

forearm abscess for patient B.Z. on 11/11/2008, without documenting how she developed the abscess, what was actually drained from the abscess, prescribing her antibiotics or referring her to an infectious disease specialist or internist. No follow up was done at all on this condition. (Exhibit E, page 9)

16. Patient B.Z. underwent upper extremity EMG/NCSs on 8/6/2009, and again on 6/16/2010 without a documented reason. There was no change in symptoms or exam, and no discussion of the test by Respondent either before it was done or after. (Exhibit E, page 10, Exhibit N).

17. This patient had lower extremity EMG/NCS performed on 4/23/2009. This test was repeated on 11/14/2009, which was not medically necessary as on this date, the patient was only reporting cervical symptoms, and in fact underwent a cervical epidural steroid injection that same day. (Exhibit E, page 10, Exhibit N).

18. Respondent prescribed Daypro, a NSAID, for patient B.Z. on 6/7/2010, and then performed a cervical epidural steroid injection on her on 7/13/2010, without documenting that she had stopped the medication as required. (Exhibit E, page 10, Exhibit N).

19. Respondent failed to monitor B.Z.'s vital signs during procedures when he administered IV sedation on 11/16/2010, 8/24/2010, 8/3/2010, and 9/14/2010. Respondent did not comment on

BZ's MRI from 6/11/2008, which was questionable for a sacral fracture. (Exhibit E, page 11, Exhibit N).

20. In a 2-year period, B.Z. underwent eleven (11) urine toxicology tests. Respondent billed for 11 dates of urine test interpretation, with eight of these bills billed using a weekly charge x 6, meaning Respondent tested B.Z.'s urine 6 days of the week. The number of tests is excessive, as there is no documentation of a medical rationale for the frequent testing. (Exhibit E, page 12, Exhibit N).

21. Respondent's above-stated conduct constitutes gross negligence, malpractice or incompetence in violation of N.J.S.A. 45:1-21(c), and constitutes repeated acts of negligence, malpractice or incompetence, in violation of N.J.S.A. 45:1-21(d). Alternatively and additionally, Respondent fails to maintain a proper patient record and fraudulently bills for services not rendered which constitutes misrepresentation, deception, gross and/or repeated negligence, malpractice and incompetence, professional misconduct, and failure to comply with the rules of the Board requiring preparation and maintenance of a proper medical record, contrary to N.J.A.C. 13:35-6.5 and -4A, all in violation of N.J.S.A. 45:1-21(c), (d) and/or (b), (e), and (h).

22. The aforesaid conduct by Respondent demonstrates that his continued practice presents a clear and imminent danger to the public health, safety, and welfare pursuant to N.J.S.A. 45:1-22.

COUNT III

1. Complainant repeats the General Allegations and the allegations of all prior Counts as if fully set forth herein and incorporated by reference.

2. Patient J.C., was born in 1953, and first saw Respondent on 8/5/2004. (Exhibit E, page 2, Exhibit Q)

3. J.C. was also an employee of Respondent. (Exhibit E, page 2, Statements of J.C., hereto attached as Exhibit J P0375-0424, Exhibit Q).

4. Over the six years that J.C. was a patient of Respondent, she was treated with injections for sacroiliac joint pain, greater trochanteric bursitis, gluteus medius tendinitis, piriformis pain, right ankle 'flexor tendinitis', hip pain, occipital neuralgia, cervical radiculopathy, cervical facet joint pain, myofascial pain, lumbar radiculopathy, intercostal neuritis, lumbar facet joint pain, median neuritis, knee pain, thoracic radiculitis, and thoracic facet joint pain. (Exhibit E, page 2, Exhibit Q).

5. Contrary to the standard of care, J.C. received six (6) injections of Kenalog in less than 3 weeks (from 4/9/2009-4/29/2009). This frequent use of a particulate steroid creates a significant risk of harm and was not medically indicated for J.C. (Exhibit E, page 3, Exhibit Q)

6. J.C. (weight unknown but documented "cachexia", wasting syndrome on 5/18/2006) received approximately 480 mg of Kenalog in

2008, 450 mg in 2009, and 260 mg in 2010, superseding the annual maximum steroid dose according to the standard of care. (Exhibit E, page 3, Exhibit Q).

7. J.C. had documented osteoporosis on 7/1/2008, yet Respondent gave her more than 90 steroid-containing injections after this date, with absolutely no documented discussion of the likelihood that the steroids could be worsening her osteoporosis. (Exhibit E, page 3, Exhibit Q)

8. Respondent did not routinely follow up with J.C. regarding her response to prior procedures, and continued to repeat the same procedures over and over when they clearly failed to afford her significant relief and when the repetition posed a significant risk of harm to then patient. (Exhibit E, page 4, Exhibit Q).

9. J.C. had eight (8) L5 and eight (8) S1 neural foraminal injections in a 4-month period, and ten (10) sacroiliac joint injections in a 4-month period. (Exhibit E, page 4, Exhibit Q, Exhibit H).

10. During 2004 (in only 4 months), J.C. had ten (10) dates of service where injections were performed, for a total of seventeen (17) injections. (Exhibit E, page 4, Exhibit Q, Exhibit H).

11. In 2005, J.C. had sixteen (16) dates of service with over fifty (50) injections performed. (Exhibit E, page 4)

12. In 2006, she had nineteen (19) dates of service where injections were performed, for a total of nearly seventy (70) injections. (Exhibit E, page 6, Exhibit Q).

13. In 2007, J.C. had sixteen (16) dates of service where injections were performed and nearly sixty (60) injections, in addition to the IDET procedure. (Exhibit E, page 6, Exhibit Q).

14. In 2008, there were thirteen (13) dates of service where injections were performed and approximately seventy (70) injections; in 2009, twenty-one (21) dates of service and nearly fifty (50) injections; in 2010, eleven (11) dates of service and approximately twenty-five (25) injections. (Exhibit E, page 6, Exhibit Q, Exhibit H)

15. Patient J.C. underwent a bilateral L3-4, L4-5, and L5-S1 RFA on 4/15/2006, which was repeated on 7/27/2006, and again on 9/9/2006 with the addition of the L2-3 level. (Exhibit E, page 5, Exhibit Q).

16. Patient J.C. underwent a 2-level lumbar IDET on 3/14/2007. Subsequently, Respondent performed approximately forty (40) lumbar injections on J.C. (Exhibit E, page 6, Exhibit Q).

17. Following the IDET procedure, J.C. continued to have persistent pain, which Respondent treated with numerous additional procedures. However, Respondent should have referred J.C. to a surgeon for further evaluation, due to the ineffective epidural treatments. (Exhibit E, Exhibit Q).

18. Respondent documented that J.C. suffered from pain, proceeded to do nerve blocks or other types of injection, and then did not follow up with her regarding potentially dangerous issues, including but not limited to on 3/14/2007, Respondent documented that patient J.C. had new onset complete foot drop (paralysis of the muscles that bring the ankle up), less than two weeks after he had performed epidural injections on her. He ordered an MRI, ordered blood work that showed an elevated white blood cell count, and then proceeded to perform a two level IDET procedure on her. This patient should have been immediately referred to a surgeon when the significant new weakness was documented. The elevated white blood cell count, may or may not have been secondary to chronic steroid use, should have at least been documented and addressed medically by Respondent, with additional steps taken to evaluate for an infectious etiology. (Exhibit E, page 8, Exhibit Q).

19. Patient J.C. underwent EMG/NCSs of the lower extremities on 9/3/2009, which were not necessary, since her symptoms and exam had not changed. Respondent did not document concerns for an alternate diagnosis (i.e. peripheral neuropathy, which would have supported the testing), and his treatment did not change based on the results. (Exhibit E, pages 9-10, Exhibit Q).

20. For the same reasons, the EMG/NCSs that he performed on J.C.'s upper extremities on 11/16/2010 were also not medically

necessary. (Exhibit E, page 1, Exhibit Q).

21. For reasons unknown, Respondent repeated EMG/NCSs testing of the lower extremities on 4/1/2010. (Exhibit E, page 10, Exhibit Q).

22. J.C. was prescribed multiple medications for pain (Percocet, Duragesic, Vicodin, Skelaxin, MS Contin, roxicodone, Lyrica, naproxen), and for depression and anxiety (Prozac, Xanax, Provigil, Cymbalta, Effexor, Lexapro, Abilify, Zoloft). (Exhibit E, page 2, Exhibit Q).

23. Respondent prescribed multiple psychiatric medications, for depression and anxiety (Prozac, Xanax, Provigil, Cymbalta, Effexor, Lexapro, Abilify, Zoloft), which could have had very serious side effects (including increased suicidality, seizures, hallucinations, death), none of which were apparently discussed with J.C. (Exhibit E, page 10, Exhibit Q).

24. Respondent failed to monitor JC's vital signs during procedures when he administered IV sedation on 6/2/2009, 6/25/2010, 8/1/2010, and 2/10/2010. (Exhibit E, page 11, Exhibit Q).

25. According to Respondent's patient record for J.C., he injected 6 cc of Kenalog into a sacroiliac joint for patient J.C. on 10/14/2004, and a total of 21 cc into two sacroiliac joints for her on 3/18/2006, which is impossible as the sacroiliac joint only holds approximately 2.5 cc of fluid. (Exhibit E, page 11, Exhibit Q).

26. Respondent sent J.C. for x-rays to evaluate her for a vertebral compression fracture but never documented or discussed the results with her. (Exhibit E, Exhibit Q).

27. Patient J.C. had eight (8) urine tests from 1/3/2008-8/3/2010. Several of these tests were very close together, 6/1/2010, 7/7/2010, 8/3/2010, and 10/12/2010 and Respondent did not document why these tests were necessary. During this period of 2.5 years, Respondent billed for urine test interpretation on six (6) different dates of service, but three (3) of them were billed (as if she were tested six times per week) weekly x 6, and one was billed weekly x 4. (Exhibit E, page 12).

28. Respondent's above-stated conduct constitutes gross negligence, malpractice or incompetence in violation of N.J.S.A. 45:1-21(c), and/or constitutes repeated acts of negligence, malpractice or incompetence, in violation of N.J.S.A. 45:1-21(d). Alternatively and additionally, Respondent fails to maintain a proper patient record and fraudulently bills for services not rendered which constitutes misrepresentation, deception, gross and/or repeated negligence, malpractice and incompetence, professional misconduct, and failure to comply with the rules of the Board requiring preparation and maintenance of a proper medical record, all in violation of N.J.S.A. 45:1-21(c), (d) and/or (b), (e), and (h).

29. The aforesaid conduct by Respondent demonstrates that his

continued practice presents a clear and imminent danger to the public health, safety, and welfare pursuant to N.J.S.A. 45:1-22.

COUNT IV

1. Complainant repeats the General Allegations and the allegations of Count I as if fully set forth herein and incorporated by reference.

2. T.A., born in 1958 began treating with Respondent on 7/6/2002. (Exhibit E, page 2, Exhibit P, J P0201-227).

3. Respondent's care and treatment of T.A. constitutes gross negligence and/or repeated acts of negligence. (Exhibit E, page 5, Ex P).

4. Since 2008, Respondent has treated T.A. with injections for left arm pain (with a brachial plexus block and stellate ganglion blocks), shoulder pain, cervical radiculopathy, intercostal neuritis, thoracic radiculopathy, and cervical facet pain. (Exhibit E, page 2, Exhibit P).

5. Contrary to the standard of care, Respondent gave T.A. steroid injections on 11/19/2009, 11/20/2009, and 11/21/2009. (Exhibit E, page , Exhibit P).

6. Contrary to the standard of care regarding a safe annual steroid dose, T.A. (weight unknown) received Kenalog steroid injections of approximately 890mg in 2008, 550mg in 2009, and 320 mg in 2010. (Exhibit E, page 3, Exhibit P).

7. Respondent performed on T.A. over fifteen (15) cervical

neural foraminal injections in a 4-month period in 2008, an additional sixteen (16) in 2009, and fourteen (14) in 2010. (Exhibit E, page 4, Exhibit H, Exhibit P).

8. T.A. had twenty-one dates of service during 2008 where injections were performed, with more than fifty (50) injections total; twenty (20) dates of service in 2009, with more than thirty-five (35) injections; and thirteen (13) dates of service in 2010, with approximately twenty (20) injections. (Exhibit E, page 4, Exhibit H, Exhibit P).

9. Contrary to the standard of care, Respondent performed a bilateral, two-level cervical RFA on T.A. on 9/20/2008, followed by two levels repeated on the left side on 10/16/2008. The exact levels Respondent injected are unknown, as his records do not contain notes for these dates of service, only bills. (Exhibit E, page 5, Exhibit P).

10. During a 3-year period, T.A. received approximately fifty (50) neural foraminal injections and was never referred to a surgeon. (Exhibit E, page 5, Exhibit P, Exhibit H).

11. Respondent wrote vague or non-existent procedure notes for T.A. including, but not limited to, suprascapular nerve blocks on 5/2/2008 and an intercostal nerve block on 5/31/2008. (Exhibit E, page 7, Exhibit P).

12. The EMG/NCSs of the upper extremities that Respondent performed for patient T.A. on 6/11/2009 were not medically

necessary, nor were the repeat upper extremity tests performed for him on 3/17/2010. (Exhibit E, page 10, Exhibit P)

13. The lower extremity EMG/NCSs performed for this patient on 10/22/2009 and 6/16/2010 were absolutely not necessary as the patient was not reporting any lower extremity symptoms, and there were no neurologic abnormalities of the lower extremities documented. (Exhibit E, page 10, Exhibit P).

14. Respondent failed to monitor TA's vital signs during a procedure when he administered IV sedation on 1/21/2010, contrary to N.J.A.C. 13:35-4A. (Exhibit E, page 11, Exhibit P).

15. Respondent did not comment in T.A.'s medical record on TA's MRI from 6/27/2009, which revealed a thyroid nodule, or his blood work, which showed elevated triglycerides. (Exhibit E, page 11, Exhibit P).

16. TA had twelve (12) urine toxicology tests performed in less than a year and a half (5/15/2009-10/21/2010), seemingly without reason, as his record did not include documentation of suspected abuse, misuse, diversion, or suspicious behavior. (Exhibit E, page 12, Exhibit P).

17. During this period of time, Respondent billed for urine test interpretation (80101 or G0431) on eleven (11) different dates of service. However, he billed the code as a weekly code x 6 four (4) times (10/22/2009, 1/21/2010, 7/15/2010, and 8/17/2010) and as a weekly code x 4 once (10/12/2010). There is also a bill x 4 weeks

for date of service 11/11/2010. (Exhibit E, page 12).

18. Respondent's above-stated conduct constitutes gross negligence, malpractice or incompetence in violation of N.J.S.A. 45:1-21(c), and/or constitutes repeated acts of negligence, malpractice or incompetence, in violation of N.J.S.A. 45:1-21(d). Alternatively and additionally, Respondent fails to maintain a proper patient record and fraudulently bills for services not rendered which constitutes misrepresentation, deception, gross and/or repeated negligence, malpractice and incompetence, professional misconduct, and failure to comply with the regulation of the Board requiring preparation and maintenance of a proper medical record, all in violation of N.J.S.A. 45:1-21(c), (d) and/or (b), (e), and (h).

19. The aforesaid conduct by Respondent demonstrates that his continued practice presents a clear and imminent danger to the public health, safety, and welfare pursuant to N.J.S.A. 45:1-22.

COUNT V

1. Complainant repeats the General Allegations and the allegations of all prior counts as if fully set forth herein and incorporated by reference.

2. A.G., born in 1943, has been a patient of Respondent's since 2003. (Exhibit E, page 2, Exhibit R).

3. Respondent treated A.G. with repeated injections for hip pain, shoulder pain (with intra-articular injections and

suprascapular nerve blocks), lumbar radiculopathy, right groin pain (with iliohypogastric, ilioinguinial, and 'iliofemoral' nerve blocks), right ankle pain (with posterior tibial, sural, deep peroneal, superficial peroneal and saphenous nerve blocks), cervical radiculopathy, lumbar facet joint pain, lumbar radiculopathy, metatarsal pain, cervical facet joint pain, calcaneal pain, and knee pain. (Exhibit E, page 2, Exhibit R).

4. Respondent wrote vague or non-existent procedure notes for injections performed on A.G. including, but not limited to, shoulder injections on 11/30/06, hip injections on 3/31/2007, nerve root injections on 6/7/2007 and 11/29/2008, and peripheral nerve blocks on 6/9/2007, 6/10/2007, and 11/29/2007. (Exhibit E, page 7, Exhibit R).

5. Respondent documented that A.G. had pain, proceeded to perform nerve block or other type of injection, and then did not follow up with her regarding potentially dangerous issues, (Exhibit E, page 7), including but not limited to:

- Respondent evaluated A.G. on 6/9/2007. At this time, she was reporting "severe right groin pain" and "severe right hip pain". Physical examination showed tenderness over the right lower quadrant. No other physical examination was performed of the abdomen, and no questions were asked regarding this pain. There was no documentation of whether or not the patient was febrile. This could have been indicative

of severe intra-abdominal pathology, especially in a patient with a prior cervical spinal cord injury and questionable sensory deficits. (Exhibit E, page 8, Exhibit R)

- Instead of performing a thorough history and exam, and possibly referring the patient for further evaluation (blood work, abdominal ultrasound), Respondent performed three (3) abdominal and groin nerve blocks. Of note, one of these blocks was of the 'iliofemoral nerve', which does not exist. (Exhibit E, page 8, Exhibit R).

- Respondent's treatment could have resulted in serious harm to this patient. He saw her again *the following day*, when she was reporting "severe right ankle and leg pain". He did not ask about her abdominal pain or check for persistent tenderness or any other sign of infection, nor did he ask anything about her leg pain (for example, any trauma?). (Exhibit E, page 8, Exhibit R).

- That same day, on June 9, 2007, without documenting an adequate physical examination, he then proceeded to perform 3 right lower extremity nerve blocks. This patient was again seen on 12/1/2008 with 'severe right ankle pain', with no questioning performed about trauma, and no physical exam of the ankle except 'very tender'. No evaluation for infection, no note of swelling, erythema, skin breakdown, cellulitis, etc. (Exhibit E, page 8).

- On 1/29/2010, Respondent performed a metatarsal injection for patient A.G., documented 'swelling' of the joint, but did not document if she were febrile, if the skin was warm, or if there was any skin breakdown. Respondent should have documented a much more thorough history and physical prior to the injection. (Exhibit E, pages 8-9, Exhibit R).

6. Respondent did not document advising A.G. to stop her NSAID medication prior to her cervical neural foraminal injection on 11/17/2007. (Exhibit E, page 10-11).

7. On 1/29/2010, Respondent injected 11 cc of fluid into her metatarsal joint, which is anatomically impossible. (Exhibit E, page 11).

8. Respondent's above-stated conduct constitutes gross negligence, malpractice or incompetence in violation of N.J.S.A. 45:1-21(c), and/or constitutes repeated acts of negligence, malpractice or incompetence, in violation of N.J.S.A. 45:1-21(d). Alternatively and additionally, Respondent fails to maintain a proper patient record and fraudulently bills for services not rendered which constitutes misrepresentation, deception, gross and/or repeated negligence, malpractice and incompetence, professional misconduct, and failure to comply with the regulation of the Board requiring preparation and maintenance of a proper medical record, contrary to N.J.A.C. 13:35-6.5, all in violation of N.J.S.A. 45:1-21(c), (d) and/or (b), (e), and (h).

9. The aforesaid conduct by Respondent demonstrates that his continued practice presents a clear and imminent danger to the public health, safety, and welfare pursuant to N.J.S.A. 45:1-22.

COUNT VI

1. Complainant repeats the General Allegations and the allegations of all prior counts as if fully set forth herein and incorporated by reference.

2. Patient J.S., born in 1938, was Respondent's patient from _____. (Exhibit E, page 4, Exhibit S).

3. Respondent treated her for cervical facet joint pain, cervical radiculopathy, knee pain (treated with intra-articular steroids and Orthovisc), shoulder pain, and hand pain (treated with wrist injections and median nerve blocks, as well as a lysis of adhesions of the median nerve). (Exhibit E, page 3, Exhibit S).

4. Contrary to the standard of care, Respondent performed steroid injections on Patient J.S. during five (5) procedures in less than a month (5/26/2009-6/23/2009). (Exhibit E, page 3, Exhibit S).

5. J.S. (weight unknown) received Kenalog steroid injections of approximately 580 mg in 2008, 380 mg in 2009, and 440 mg in 2010. (Exhibit E, page 3, Exhibit S).

6. J.S. received fourteen (14) cervical facet joint injections in less than four months, and twelve (12) cervical epidural injections in six months in 2008. (Exhibit E, page 3,

Exhibit S, Exhibit H).

7. During 2008, over seventeen dates of service, she received injections, for a total of more than thirty-five (35) injections, not including a cervical discogram, and a two-level cervical disc decompression and IDET. (Exhibit E, page 4) (Exhibit E, page 4, Exhibit S, Exhibit H).

8. During 2009, J.S. had eighteen (18) dates of service when she received injections, for a total of nearly thirty (30) injections. (Exhibit E, pages 4-5, Exhibit S).

9. During 2010, she had thirteen (13) dates of service when she received injections, for a total of fifteen (15) injections. (Exhibit E, page 5, Exhibit S).

10. Contrary to the standard of care, even after more advanced procedures, such as an IDET or PDD, when Respondent's procedures fail to provide symptom relief, he did not refer J.S. for a surgical consult. (Exhibit E, page 5, Exhibit S).

11. J.S. underwent a 2 level cervical IDET and PDD procedure on 7/21/2010, and subsequently underwent over twenty (20) additional cervical injections. (Exhibit E, Exhibit S).

12. Following the IDET/PDD procedure, Respondent documented that J.S. continued to have such persistent neck pain that she required many additional procedures, and he should have referred her to a surgeon for further evaluation. (Exhibit E, page 6, Exhibit S).

13. Respondent's procedure note for J.S.'s discogram, a test to determine the anatomical source of lower back pain and subsequent IDET and PDD from 7/21/2010 is also problematic. The discogram note does not document concordant pain, where dye recreates patient's usual pain thereby indicating a specific disc is the cause of a patient's pain, or discordant pain, where pain generated is dissimilar to a patient's pain and indicating that it is not the disc causing pain, which is the entire reason for performing a discogram in the first place. Without this information, the discogram is useless. (Exhibit E, page 7, Exhibit S).

14. Respondent's procedure note for the IDET/PDD documents that he placed a needle into the disc at C6-7, which is completely unnecessary and contrary to the standard of care. (Exhibit E, page 7, Exhibit S).

15. Respondent wrote vague or non-existent procedure notes for J.S., including, but not limited to, those for suprascapular nerve blocks given on 6/24/2008 and 4/7/2009, shoulder injection on 7/31/2008, and knee injections on 10/14/2008 and 2/10/2009. (Exhibit E, page 7, Exhibit S).

16. Respondent performed a cervical interlaminar epidural injection on J.S. on 6/26/2008, but contrary to the standard of care there is no documentation of his using contrast dye, although he documented that it was performed 'under fluoro.' (Exhibit E, page

7, Exhibit S).

17. Respondent billed for performing an EMG/NCS on J.S. on 12/13/2008, but there was no copy of the EMG report provided. Respondent performed the same test again on 7/2/2009, with no documentation in the office notes of symptoms or exam findings necessitating the test. (Exhibit E, page 10, page S).

18. Respondent documented that this patient was taking Plavix, an anticoagulant, on 6/3/2008, the same day that she underwent bilateral cervical neural foraminal injection. There was no documentation in her medical record that she subsequently discontinued taking Plavix prior to another cervical epidural steroid injection on 6/26/2008. He exposed her to serious harm. (Exhibit E, page 11, Exhibit S).

19. Respondent documented injecting 11 cc of fluid into J.S.'s 'wrist joint' on 3/26/2010, which is anatomically impossible, as an injection to this joint is typically 2-3 cc. (Exhibit E, page 11, Exhibit S).

20. Contrary to the standard of care, Respondent billed for interpreting three urine tests taken by J.S. (6/27/2008, 8/1/2008, 12/5/2008), when she was only being prescribed NSAIDs, and there was no documentation of erratic or suspicious behavior. (Exhibit E, page 12, Exhibit S).

21. Respondent's above-stated conduct constitutes gross negligence, malpractice or incompetence in violation of N.J.S.A.

45:1-21(c), and/or constitutes repeated acts of negligence, malpractice or incompetence, in violation of N.J.S.A. 45:1-21(d). Alternatively and additionally, Respondent fails to maintain a proper patient record, contrary to N.J.A.C. 13:35-6.5, and fraudulently bills for services not rendered, which constitutes misrepresentation, deception, gross and/or repeated negligence, malpractice and incompetence, professional misconduct, and failure to comply with the regulation of the Board requiring preparation and maintenance of a proper medical record, all in violation of N.J.S.A. 45:1-21(c), (d) and/or (b), (e), and (h).

22. The aforesaid conduct by Respondent demonstrates that his continued practice presents a clear and imminent danger to the public health, safety, and welfare pursuant to N.J.S.A. 45:1-22.

COUNT VII

1. Complainant repeats the General Allegations and the allegations of all prior counts as if fully set forth herein and incorporated by reference.

2. Respondent repeatedly improperly and excessively billed patients and their health insurance companies for numerous procedures. (Exhibit E, page 13, Exhibit H, and Exhibit I).

3. The fluoroscopy CPT code 77003 (or 77002), is typically billed once per day of service, although it can be billed once per region per procedure. For example, if a cervical region and a lumbar injection are performed, according to Medicare guidelines,

this code could be billed twice. If 4 lumbar region procedures are performed, this code should only be billed once. Respondent bills this code multiple times per date of service, for example he bills it three (3) times if he performs three (3) lumbar neural foraminal injections. Since his charge for this code is $1,000.00, this practice adds up to several thousands of dollars of excessive billing per date of service. (Exhibit E, page 13, Exhibit H, and Exhibit I).

4. For patient T.A., on 5/2/2008, Respondent billed for four (4) separate suprascapular nerve blocks, however there are only two (2) suprascapular nerves. The procedure notes do not medically reflect more than one injection for each nerve. (Exhibit E, page 13, Exhibit P, Exhibit H P0163-0175).

5. Respondent repeatedly bills for services for which there are no office or procedure notes or other document in the record for the billed date of service, including but not limited to: for patient T.A. on 7/24/08, 7/25/08, 7/26/08, 8/23/08, 9/20/08, 10/14/08, 10/15/08, 10/16/08, 11/12/08, 11/13/08, 12/11/08, 12/19/08, 12/9/10; and for patient J.S. on 12/2/2008, 12/13/2008, 9/16/2009, 11/17/2009, 11/18/2009, 12/15/2009, 1/19/2010, 1/20/2010, 1/21/2010, 3/23/2010. (Exhibit E, page 13, Exhibit P, Exhibit H).

6. Respondent also documents one procedure, yet bills for a different procedure. For example: for B.Z. on 3/8/2008, he billed

for Orthovisc but did not perform. On 3/5/2009, his office note says radiofrequency was performed, but he billed for facet injections, and on 7/1/2008, his procedure note is for a facet injection, but he billed for radiofrequency. (Exhibit E, page 13, Exhibit N).

7. Respondent also submitted multiple bills for physical therapy with no documentation of physical therapy actually being performed. For example, he billed for physical therapy without documentation for:

a. Patient B.Z., for dates of service 5/7/2010, 8/6/2010, 3/24/2009, 11/13/2009, 3/15/2008, and 1/24/2008. (Exhibit E, page 13, Exhibit N).

b. Patient T.A. for dates of service 5/2/2008, 5/3/2008, and 6/28/2008 without documentation in the patient record for any physical therapy provided. (Exhibit E, page 13, Exhibit P).

8. Respondent incorrectly performs the lower extremity EMG/NCS H-reflex test and consequently inappropriately billed for providing the service, using code 95934. (Exhibit E, page 13, page, Exhibits N-T).

9. Respondent's 'neural foraminal injection' procedure note does not support billing for a transforaminal epidural steroid injection. The described needle placement is intradiscal, which is not compatible with a foraminal injection. There is no documentation of injecting steroid or contrast dye, although he

billed for both. (Exhibit E, page 13, Exhibits N-T).

10. Respondent fails to maintain a proper patient record and fraudulently bills for services not rendered, which constitutes misrepresentation, deception, professional misconduct, and failure to comply with the rules of the Board requiring preparation and maintenance of a proper medical record, contrary to N.J.A.C. 13:35-6.5, all in violation of N.J.S.A. 45:1-21(b), (e), and (h).

11. The aforesaid conduct by Respondent demonstrates that his continued practice presents a clear and imminent danger to the public health, safety, and welfare pursuant to N.J.S.A. 45:1-22.

COUNT VIII

1. Complainant repeats the General Allegations and the allegations of all prior counts as if fully set forth herein and incorporated by reference.

2. During the period January 1, 2008 until at least December 30, 2010, Respondent systematically submitted false and fictitious health care claims for thousands of medical services and procedures that he did not provide. (See Exhibits, Patient Records and Billing Summary Chart, Certification of Investigator Gina Galloni and attached Compilations of Respondent's Records for B.Z., D.C., T.A., J.C., J.R., and A.G, attached hereto as Exhibits G, H, and I, Patient Statements of A.G., K.S.A, M.S., H.E., F.C., T.A., J.A., J.C., B.Z. and B.B attached hereto as Exhibit J; and Employee Statements of S.M., K.G., D.G., attached hereto as Exhibit K).

3. Respondent was reimbursed for thousands of medical services and procedures that he did not provide, including but not limited to: neural foraminal injections; physical therapy, counseling for drug addiction/abuse and improving social activity; NCVs; and urine test interpretations. (Exhibits J, K, H and I).

4. Respondent engaged in a pattern of health care claims fraud by repeatedly billing for fictitious medical services and procedures performed on days when he was not in the office, i.e. Sundays, Mondays and holidays. (See Exhibits H, I, J, and K).

5. Exhibits H and I delineate with specificity Respondent's repetitive pattern of fraudulent billing for six patients, including those whose grossly negligent care was described in detail in Count II (B.Z.), Count III (J.C. ,), Count IV (T.A.), Count V (A.G.), and Count X (J.R.), plus patient D.C. (Exhibit O). As Exhibit H demonstrates, Respondent billed for fictitious medical care allegedly provided on consecutive days, Sundays and Mondays, and without his requisite signed Consent for Treatment Forms. The above named patients, as well as numerous others, denied receiving those services. Exhibit H details Respondent's billing for B.Z. on P122-140, J.C. D.C. on P141-162, T.A. on P0163-175, J.R. on 178-180, A. G. on P0181-192, and includes abbreviations, CPT codes and a calendar for the years 2008-2010 on P193-197. Finally, Exhibit I summarizes all the fraudulent billing analyzed in Exhibit H, but represents only the specific codes reviewed a subset of

Respondent's fraudulent billing.

6. As an example, Respondent billed T.A. for the following days when his office was closed: Monday 1/12/09; Sunday 8/20/09; and Sunday 12/20/09. (See Exhibit H)

7. Respondent repeatedly billed for fictitious medical services and procedures performed on consecutive days. (Exhibits H, I, J, K, N-T).

8. As an example, one patient record shows, Respondent billed T.A. for consecutive day treatments on: 5/2 and 5/3/08; 7/24, 7/25 and 7/26/08; 10/14, 10/15, and 10/16/08; 1/12,1/14, and 1/15/09; 6/10 and 6/11/09; 8/28/, 8/29, and 8/30, 09; 11/19, 11/20, and 11/21/09; 12/19 and 12/20/09; 6/16/6/17, and 6/18/10.

9. Respondent repeatedly billed for the use of fluoroscopy and steroids, but without contrast dye, thereby performing dangerous injections without real-time visualization, and fraudulently billing for a neural forceminal injections. (Exhibit N-T).

10. Respondent repeatedly billed insurance companies for counseling patients regarding potential drug abuse or addiction issues when he did not provide those services. (Exhibits J and K).

11. Respondent repeatedly billed insurance companies for counseling patients regarding improving activity levels when those services were not provided. (Exhibits H, I, J and K).

12. Respondent or his agent forged or had his employee forge

patient signatures on consent to procedure forms. (Exhibit K).

13. As one example of fictitious billing, Respondent's medical record for T.A. does not include signed Consent for Treatment Forms and his office appointment Scheduler does not reflect an appointment for the following dates: 1/13/08; 3/1/08; 5/2/08;6/2/08; 7/24/08; 10/14/08; 10/15/08; 11/12/08; 1/12/09; 1/14/09; 6/10/09; 8/28/09; 11/20/09; 11/21/09; 3/17/10; 6/16/10; 6/18/10; and 12/9/10. (Exhibit H, T.A., P).

14. Another example of fictitious billing is demonstrated by Respondent's billing and patient records for Patient A.G. Respondent's medical file does not include signed Consent for Treatment Forms for dates of services: 11/29 and 12/01/08; 8/13, 8/14, or 8/16/09; and 1/29 and 1/30/10. (Exhibit H). The only days A.G.'s name appears on Respondent's Scheduler were: December 2, 2008; August 15, 2009; and January 28, 2010. Respondent billed A.G. for services provided on December 1, 2008, a Monday and August 16, 2009, a Sunday. Respondent also billed A.G. for services rendered on the following consecutive days: November 29, December 1, and December 2, 2008; August 13, August 14, August 15, and August 16, 2009; and January 28, January 29 and January 30, 2010. (Exhibit H, Exhibit R).

15. Respondent repeatedly billed for physical therapy services that were either not performed or not for the amount of time billed. (Exhibits J and K).

16. The following patients, among others, provided sworn statements to the Union County Prosecutor's Office revealing a common pattern of fraudulent billing of patients' health insurance companies, which included billing for dates of services during which they did not see Respondent, including consecutive days, Sunday and Mondays, and contained common patterns of omitted documentation for those billed medical services, including a lack of Consent to Treatment Forms and no appointment on Respondent's Appointment Scheduler. They are representative of patients for whom Respondent submitted false health claims for the purpose of unjust financial remuneration.

Patient A.G (Exhibit J P0281-0294)

a. As discussed in Court I above, A.G., a 68 year-old female, was a pain management patient of Respondent from at least January 1, 2007 until November 17, 2010.

b. A.G. had pain in her lower back, neck, knee, leg and "all over".

c. Respondent treated A.G. with trigger point injections.

d. A.G. treated with Respondent at his Roseland and his Union office.

e. A.G. did not receive treatment from Respondent on consecutive days.

f. On January 28, 2010, A.G. had an office visit with Respondent and received trigger point injections in her neck, back and shoulder.

g. A.G. did not see Respondent or receive treatment from him on January 29, 2010 or January 30, 2010.

h. A.G. never had an office visit with Respondent on a

Sunday, as the office was closed.

i. A.G.'s office visits lasted approximately forty-five minutes, with perhaps fifteen to twenty minutes discussing medication and pain.

j. Respondent prescribed Neurontin, Ultram and Lexeral to A.G.

k. Respondent never discussed drug addiction or abuse, or her social activities.

l. As part of office procedure, office staff required that A.G. sign a consent form before seeing Respondent at each office visit.

m. A.G. signed a Consent to Treatment Form.

n. Respondent used the fluoroscopy machine during her back injection, not her shoulder or legs.

o. The Union office was closed on Sundays and Mondays.

Patient K.S-A (Exhibit J, P0295-0318)

a. K.S-A., a forty-two year old woman was a patient of Respondent's, beginning in 2006.

b. Initially, K.S-A first saw Respondent at his Newark office, then in Union, and eventually at his South Orange office.

c. K.S-A sought treatment for joint pain, which she experienced all over body.

d. As part of office procedure, office staff required that K.S-A sign a consent form before seeing Respondent at each office visit.

e. K.S-A saw Respondent in Union on Saturdays.

f. K.S-A never saw Respondent on a Sunday, as she always attends church on Sundays.

g. K.S-A did not receive medical treatment from Respondent on consecutive days, until after he was arrested, when he directed her to return on the following day.

h. K.S-A never saw Respondent on a holiday.

i. K.S-A identified her signature on a April 26, 2009 consent form to the Union County prosecutor's office.

j. K.S-A denied signing a April 27, 2009 Consent Form shown to her.

k. Once, Respondent's office manager Sami Ashraf told her to sign a stack of consent forms, stating that she had failed to sign them as required.

l. K.S-A's office visits with Respondent lasted approximately fifteen minutes, including injections and discussion.

m. Respondent spoke to K.S-A three times about potential addiction issues.

n. K.S-A did not have any medical issues with addiction or abuse of medication.

o. K.S-A did not see Respondent on the day he was arrested.

p. K.S-A treatment included five minutes in an exam room and then fifteen minutes in the procedure room, which included preparation of the machine, and injections.

Patient M.S. (Exhibit J, P0319-331)

a. Patient M.S. saw Respondent on 12/15/09 in his Union office.

b. She sought medical treatment from Respondent twice.

c. Her first visit, she was a walk-in patient.

d. She had to sign a Sign-in Sheet at front desk, and then fill out and sign a Consent to Treatment Form.

e. She identified her signature on consent form.

f. She received injections in her shoulder and back, and Respondent wore a lead apron.

g. Her appointment lasted perhaps thirty minutes.

h. On 11/10/10, M.S. saw Respondent at his Belleville office after she scheduled an appointment, signed-in on arrival at the window on a handwritten sheet, signed a consent form, which she identified, and received an injection in her knee-left. Her appointment lasted perhaps 20 minutes, did not include a discussion about addiction or abuse.

i. M.S. was asked to provide urine samples, although she never received prescriptions from Respondent.

j. M.S. does not recall seeing respondent after her November 10, 2010 appointment, i.e. on November 11, 2010 or November 12, 2010.

k. But Respondent billed insurance companies for medical services provided on consecutive days.

Patient H.E.

a. H.E., an 88 year old male, was a patient of Respondent for four years.

b. Respondent treated H.E. for shoulder bursitis, hand numbness and arthritis.

c. H.E.'s children schedule his medical appointments and arrange transportation among themselves for those medical appointments.

d. Respondent saw H.E. at his Union office and his Newark office, in St. Michael's Hospital.

e. H.E. never received medical treatment or saw Respondent on consecutive days, but Respondent billed insurance companies for medical services provided on consecutive days.

f. Respondent did not provide shoulder injections with fluoroscopy to H.E.

Patient F.C. (Exhibit J, P0261-280)

a. F.C. never saw Respondent on a Sunday or Monday, or on consecutive days.

b. F.C. always signed in on a Sign-in sheet.

c. F.C. signed a consent form, perhaps 70% time.

d. Respondent never provided substance abuse discussion or counseling.

e. Respondent directed F.C. to provide a urine specimen at every visit.

f. Respondent prescribed Soma and Percocet to F.C. for post-surgery pain.

g. F.C.'s wife was present with him every time he saw respondent, and she provided a consistent sworn statement.

h. F.C. sought to refuse medications at times, but Respondent wrote prescriptions anyway.

i. F.C. only received injections in his lower back.

j. After surgery, Respondent gave him a prescription to go to Kessler Rehabilitation.

k. F.C. never received physical therapy from Respondent or his staff, specifically, no hot/cold packs, electrical stimulation or massage therapy, however, Respondent submitted bills for services on 1/5/10, including massage, and hot/cold packs.

l. Respondent never counseled or discussed drug abuse/addition issues with F.C.

Patient T.A. (Exhibit J, P201-227)

a. As described in Count IV above, T.A., a 53 year old male, is a patient of Respondent's.

b. In late 1999, he was referred to Respondent when he was a patient at St. Michael's.

c. Between 2006 and November 2010, T.A. treated with Respondent.

d. T.A. saw Respondent for medical care at his Newark office, then his Roseland and Union offices, and eventually at his Belleville office.

e. From 2006 until 2011, T.A. saw Respondent approximately every four weeks with a standing appointment, scheduled as he left the office.

f. T.A. signed-in on a sheet at a receptionist window when he arrived for his appointments.

g. T.A. was brought to an exam room and required to sign a consent form before seeing Respondent.

h. T.A. received numerous forms of injections from Respondent.

i. T.A. never received injections in his knees, lower extremities or below his elbows.

j. Respondent performed trigger point injections on T.A. in the exam room.

k. As part of his office visit, Respondent talked with T.A. about his condition while his head was in the face hole awaiting procedures.

l. Respondent never discussed addiction or abuse issues with T.A.

m. Respondent never counseled T.A. about improving his social life.

n. Beginning in 2006 or 2007, Respondent required T.A. to provide a urine specimen at approximately 80% of his office visits.

o. Respondent prescribed medication for T.A., including Percocet and Xanax.

p. Respondent also renewed T.A.'s prescriptions ordered by other physicians, including cardiac medication.

q. Respondent never opened his office on a Sunday or Monday for T.A.

r. Respondent did not treat T.A. on consecutive days, specifically, not 12/19 and 12/20/2009; 11/19, 20 and 21/2009, or 8/28, 29 and 30/2009, 6/10 and 11/2009; 1/14 and 15/2009, 11/12 and 13/2008; 10/14, 15 and 16/2008; 7/24, 25 and 26/2008; 5/2 and 3/2008; 7/20, 21/2007; 5/24 and 25/2007, 11/9 and 11/10/2006.

s. T.A.'s appointments with Respondent were typically on Saturdays.

Patient J.A. (Exhibit J, P0237-248)

a. J.A., a 69 year-old man, has been a patient of Respondent's for at least 10 years.

b. J.A. saw Respondent in his Newark, Union and Belleville offices.

c. J.A. saw Respondent for medical treatment approximately once a month at scheduled office visits.

d. J.A. never received medical care from Respondent on consecutive days.

e. J.A. did not see Respondent for treatment on a holiday.

f. J.A. never saw Respondent on a Sunday or Monday, those days Respondent's office was closed.

g. On arrival at Respondent's office, J.A. always signed a sign-in sheet at the receptionist desk.

h. An employee escorted J.A. to a room in the back, where he was required to sign a Consent Form before seeing Respondent.

i. Between 2006 and 2010, J.A.'s face to face time with Respondent was usually twenty (20) minutes.

j. Respondent never counseled T. A. about drug abuse or addiction for thirty minutes.

k. Respondent provided J.A. with injections in his neck and along the areas of a herniated disk.

l. Once Respondent injected J.A.'s left knee, but never his right knee.

Patient B.B. (Exhibit J P0249-260)

a. B.B., a 71 year old woman, has been a patient of Respondent's for about four years.

b. B.B. saw Respondent for treatment for arthritis pain in her hands, back, both legs and her knee.

c. B.B. saw Respondent at scheduled appointments every three to four weeks.

d. B.B. saw Respondent for medical treatment at his Union, Belleville, and South Orange offices.

e. On arrival at his office, B.B. always signed in at the reception window on a sign-in sheet.

f. An employee would escort B.B. to an exam room, where she was always required to sign a consent form for treatment.

g. B.B. received injections in her back in the procedure room with the fluoroscopy machine.

h. B.B did not see Respondent on consecutive days for treatment, except once when he hurt a nerve.

i. B.B.'s face to face time with Respondent was fifteen to twenty minutes in an exam room, and about twenty to thirty minutes if she received a procedure in the back room, which included an exam, injections, his preparation and post-injection recovery.

j. Respondent never discussed addiction to pain medication with B.B.

k. A few times, Respondent advised B.B. about taking her medicine only according to schedule, for perhaps 5 or 10 minutes.

l. Respondent never opened his office specifically for B.B.

17. Respondent's demand and acceptance of a fee for the fictitious provision of diagnostic and medical services allegedly as part of multiple patients' treatment represents misrepresentation and fraudulent billing, a violation of N.J.S.A. 45:1-21(b), professional misconduct, a violation of N.J.S.A. 45:1-21(e), acts constituting moral turpitude, a violation of N.J.S.A. 45:1-21(f) and conduct that constitutes insurance fraud, a violation of N.J.S.A. 45:1-21(k).

18. Additionally, Respondent's billing practices, including

but not limited to, unbundling of charges, billing for procedures that are not within the standard of care, billing for procedures that were not properly performed, and billing for services not provided, constitutes professional misconduct under N.J.S.A. 45:1-21(e) and misrepresentation, a violation of N.J.S.A. 45:1-21(b).

19. The aforesaid conduct by Respondent Hessein demonstrates that his continued practice presents a clear and imminent danger to the public health, safety, and welfare pursuant to N.J.S.A. 45:1-22.

COUNT IX

1. Complainant repeats the General Allegations and the allegations of all prior counts as if fully set forth herein and incorporated by reference.

2. During the November 17, 2010 inspection of his Belleville office, Enforcement Bureau Investigators observed and documentated that Respondent maintained hundreds of expired medications, in each exam and procedure room among medications he provided to and injected in his patients. (See EB Investigator Nucci and Galloni certifications, Exhibits G and L, certified photographs of Respondent's Belleville office and Certification by Investigator Galloni, hereto attached as Exhibit M).

3. Respondent failed to maintain running water and hot water in two bathrooms. (Exhibits G and L).

4. Respondent kept medication in a dirty refrigerator with

food and beverages. (Exhibit G, L and M).

5. Respondent's failure to dispose of expired medication, contrary to Board regulation N.J.A.C. 13:35-7.5, constitutes a violation of N.J.S.A. 45:1-21(h).

6. The aforesaid conduct by Respondent Hessein demonstrates that his continued practice presents a clear and imminent danger to the public health, safety, and welfare pursuant to N.J.S.A. 45:1-22.

COUNT X

1. Complainant repeats the General Allegations and the allegations of all prior counts as if fully set forth herein and incorporated by reference.

2. Respondent indiscriminately prescribed CDS to patients. Between 2001 and 2009, R.J., a fifty-five year-old male, was a patient of Respondent's. (Exhibit T, J P0332-358, Exhibit J).

3. J.R. received numerous trigger point injections and one injection with fluoroscopic guidance. (Exhibit T, H P0178-179, Exhibit J at 8).

4. J.R. scheduled appointments with Respondent for every three or four weeks, seeing him in both the Newark and Union offices. (Exhibit J at 7).

5. Respondent required J.R. to provide urine samples, beginning in or around 2008, at approximately 90% of his office visits. (Exhibits T, H, J at 8).

6. Periodically, J.R. tested positive for cocaine or other illegal medications, which Respondent knew because he interpreted the urine test results. (Exhibits T, H, J at 10).

7. Despite his positive urine tests, Respondent prescribed C.D.S. to J.R., including Oxycontin and Roxicodone, anyway, never denying him a prescription. (Exhibit J, at 9-10).

8. Respondent never counseled J.R. about drug abuse or addiction. (Exhibit J, at 10).

9. Appointments lasted about ten to fifteen minutes, and approximately 75% of the time consisted of Respondent writing J.R. a prescription, for which Respondent billed J.R.'s insurance company between $1800 and $3000. (Exhibit J at 15-17, H and T).

10. Respondent provided medications that J.R. specifically sought, including benzodiazepines. (Exhibit J at 15).

11. When J.R. abused his medication and ran out early, Respondent saw J.R. earlier than his scheduled appointment as a walk-in patient, and required that he pay cash, between $100 and $175, for the office visit. (Exhibit J at 11-12).

12. J.R. received a notice from an insurance company that Respondent had charged $5690 for services for a November 9, 2009 date of service, which he denied receiving. (Exhibit J at 16-17).

13. J.R. spoke with the office manager and Respondent about the bill for services, which he did not receive. (Exhibit J, at 16-18).

14. Employees informed Respondent that patients were illegally selling medications that he prescribed to them. (Exhibit K).

15. Respondent continued to prescribe medications for patients despite knowing that they were selling the CDS prescriptions or medications. (Exhibit J, Exhibit K).

16. Respondent's above-stated conduct constitutes gross negligence, malpractice or incompetence in violation of N.J.S.A. 45:1-21(c), and/or constitutes repeated acts of negligence, malpractice or incompetence, in violation of N.J.S.A. 45:1-21(d). Alternatively and additionally, Respondent fails to maintain a proper patient record, contrary to N.J.A.C. 13:35-6.5, and fraudulently bills for services not rendered which constitutes misrepresentation, deception, gross and/or repeated negligence, malpractice and incompetence, professional misconduct, and failure to comply with the rules of the Board requiring preparation and maintenance of a proper medical record, all in violation of N.J.S.A. 45:1-21(c), (d) and/or (b), (e), and (h). Respondent indiscriminately prescribes C.D.S. to his patients, in violation of N.J.S.A. 45:1-21(m).

17. The aforesaid conduct by Respondent Hessein demonstrates that his continued practice presents a clear and imminent danger to the public health, safety, and welfare pursuant to N.J.S.A. 45:1-22.

WHEREFORE, Complainant demands the entry of an Order:

1. Finding that each of the acts, practices and/or omissions of Respondent Hessein constitutes multiple and separate instances of unlawful dangerous conduct, representing a clear and imminent danger to the public;

2. Imposing the temporary suspension or other limitation on the license of Respondent Hessein on an emergent basis premised upon the Verified Allegations of Count I-X and pending conclusion of a plenary hearing in this matter, pursuant to N.J.S.A. 45:1-22;

3. Suspending or revoking the license heretofore issued to Respondent Hessein to practice medicine and surgery in the State of New Jersey;

4. Imposing the maximum statutory civil penalties for each separate unlawful act as set forth above;

5. Imposing costs, including investigative costs, attorney's fees, fees for expert and fact witness expenses, and costs of hearing including transcripts;

6. Reimbursing patients/examinees and/or third party payors of all monies received for acts found to be unlawful in the circumstances alleged herein;

7. Prohibiting Respondent Hessein from profiting from any medical practice alleged herein; and,

8. Directing such other and further action or relief as may be deemed necessary and appropriate by the Board to protect the

public's health, safety, and welfare.

PAULA T. DOW
ATTORNEY GENERAL OF NEW JERSEY

By: Kay R Ehrenkrantz
Kay R Ehrenkrantz
Deputy Attorney General

Dated: October 12, 2011