New York State Board for Professional Medical Conduct

Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

Barbara A. DeBuono, M.D., M.P.H.
Commissioner of Health

Charles J. Vacanti, M.D.
Chair

February 21, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Louis Roland Timothee, M.D.
2566 Seventh Street
East Meadow, New York 11554

Re: NY License No. 153556

Dear Dr. Timothee:

Effective Date: 02/28/96

Enclosed please find Order #BPMC 96-24 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

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

Board for Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Tower Building-Room 438
Albany, New York 12237-0756

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

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

Sincerely,

Charles Vacanti, M.D.
Chair
Board for Professional Medical Conduct

Enclosure

cc: Howard B. Greenberg, Esq.
Van Leer & Greenberg
132 Nassau Street
New York, New York 10038

Claudia Bloch, Esq.

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

IN THE MATTER

OF

LOUIS ROLAND TIMOTHEE, **M.D.**

CONSENT

ORDER

BPMC #96-24

Upon the application of LOUIS ROLAND TIMOTHEE, M.D. (Respondent) for Consent Order, which application is made a part hereof, it is

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

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

SO ORDERED.

DATED: 16 February 1996

Charles J. Vacanti

CHARLES J. VACANTI, M.D
Chairperson
State Board for Professional
Medical Conduct

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

IN THE MATTER

OF

LOUIS ROLAND TIMOTHEE, M.D.

APPLICATION
FOR
CONSENT ORDER

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

LOUIS ROLAND TIMOTHEE, M.D., being duly sworn, deposes and says:

That on or about March 11, 1983, I was licensed to practice as a physician in the State of New York, having been issued License No. 153556 by the New York State Education Department.

My current address is 2566 Seventh Street, East Meadow, N.Y. 11554 , and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I understand that the New York State Board for Professional Medical Conduct has charged me with Forty-Four specifications of professional misconduct.

A copy of the Statement of Charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

I admit guilt to the Thirty-Third Specification (Failure to Supervise) and the Forty-Fourth Specification (Having Been Found Guilty of Violation of State Regulations), in full satisfaction of the charges against me. I hereby agree to the penalty that my license to practice medicine in the State of New York be suspended for two (2) years and that said suspension is stayed and that I be placed on probation for a period of three (3) years, in accordance with the terms set forth in the attached Exhibit "B". I further hereby agree to pay a fine in the amount of $7,500.00 which may be paid out in equal monthly installments over

the course of the three year probationary period. At any point during the three year period, my failure to make prompt, full, and timely monthly payment when due shall be deemed a violation of the terms of this consent and subject me to further discipline pursuant to N.Y. Educ. Law Section 6530(29). In the event that I make full payment of the fine ($7,500.00) prior to the end of the third year of probation, but subsequent to the second year of probation, my probationary period shall end. I understand that I shall remain on probation for at least two years from the effective date of the Consent Order. I further hereby agree that my license to practice medicine shall be limited to psychiatry pursuant to Pub. Health Law Section 230-a (3). Should I at any time, either during or subsequent to the two (2) or three (3) year period of probation, wish to practice medicine in an area other than psychiatry, I shall notify the Director of the Office of Professional Medical Conduct and I shall than be placed on probation for a period of five (5) years from the date I commence practicing medicine in such other area and in accordance with the terms set forth in the attached Exhibit "C".

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

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

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner.

LOUIS ROLAND TIMOTHEE, M.D.
RESPONDENT

Sworn to before me this

day of , 19 .

NOTARY PUBLIC

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

IN THE MATTER

OF

LOUIS ROLAND TIMOTHEE, M.D.

APPLICATION

FOR

CONSENT ORDER

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: _____ _____

LOUIS ROLAND TIMOTHEE, M.D.
Respondent

DATE: _____ _____

HOWARD GREENBERG, ESQ.
Attorney for Respondent

DATE: 2/12/96 Claudia M. Bloch

CLAUDIA MORALES BLOCH
Associate Counsel
Bureau of Professional
Medical Conduct

DATE: 2/15/96

~~KATHLEEN M. TANNER~~
Director
Office of Professional Medical Conduct

DATE: 16 February 1996

CHARLES J. VACANTI, M.D.
Chairperson
State Board for Professional Medical Conduct

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

IN THE MATTER

OF

LOUIS ROLAND TIMOTHEE, M.D.

STATEMENT

OF

CHARGES

LOUIS ROLAND TIMOTHEE, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 11, 1983, by the issuance of license number 153556 by the New York State Education Department. During all times mentioned in the instant Charges, Respondent was enrolled as a physician provider with the New York State Medical Assistance Program holding Provider number 00905697. Patients A through J were recipients enrolled in the New York State Medical Assistance Program. (Patients A through J are identified in the attached Appendix along with their respective Medicaid identification numbers).

FACTUAL ALLEGATIONS

A. On or about November 6, 1989 and on or about December 18, 1989, Respondent undertook the care and treatment of Patient A at his medical offices located at 1939 Madison Avenue, New York, N.Y. 10035 (hereinafter referred to as "his Madison Avenue office").

1. On each visit by Patient A, Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. On each visit, Respondent inappropriately prescribed:

   a. Flexeril

   b. Zantac

   c. Proventil Inhaler

3. On the first visit of November 6, 1989, Respondent inappropriately performed an electrocardiogram on Patient A.

4. Respondent failed to interpret and/or note in the chart an interpretation of the electrocardiogram he performed.

5. On each visit, Respondent failed to perform an adequate work-up and evaluation of Patient A's complaints and/or Respondent's diagnoses of peptic ulcer decease and asthma.

6. Respondent billed the Medical Assistance Program (hereinafter referred to as "the Program") and received reimbursement from the Program for performing "Muscle Testing, total body including hands" on Patient A. In fact, Respondent did not perform this test. The bill submitted by Respondent was knowingly false.

7. Respondent billed the Program and received reimbursement from the Program for a Comprehensive Office Visit with Patient A on March 12, 1990. In fact, Respondent did not see nor treat Patient A on that date.

The bill submitted by Respondent was knowingly false.

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

9. Respondent, or an individual acting at the direction of the Respondent, created a record for Patient A which is false and inaccurate and does not reflect legitimate patient care and treatment.

B. On or about January 12, 1990, Respondent undertook the care and treatment of Patient B at his Madison Avenue Office.

1. Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

a. Prozac

b. Pepcid

c. Tetracycline

d. Flexeril

3. Respondent failed to perform an adequate work-up and evaluation to support a diagnosis of urinary tract infection.

4. Respondent billed the Program and was reimbursed for performing a "Muscle Testing, total body, including hands." In fact, Respondent did not perform this test. The bill submitted by Respondent was knowingly false.

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

6. Respondent, or an individual acting at the direction of the Respondent, created a record for Patient B which is false and inaccurate and does not reflect legitimate patient care and treatment.

C. On or about November 3, 1989, Respondent undertook the care and treatment of Patient C at his Madison Avenue Office.

1. Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

   a. Proventil Inhaler

   b. Flexeril

   c. Lotrisone cream

   d. Zantac

3. Respondent inappropriately performed an electrocardiogram on Patient C.

4. Respondent failed to interpret and/or note in the chart an interpretation of the electrocardiogram and pulmonary function test he performed.

5. Respondent billed the Program and was reimbursed for performing a "Muscle Testing, total body, including hands." In fact, Respondent did not perform this test. The bill submitted by Respondent was knowingly false.

6. Respondent failed to maintain a record for Patient C which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

7. Respondent, or an individual acting at the direction of the Respondent, created a record for Patient C which is false and inaccurate and does

not reflect legitimate patient care and treatment.

D. On or about September 12, 1989, February 7, 1990 and March 14, 1990, Respondent undertook the care and treatment of Patient D at his Madison Avenue office..

1. On each visit by Patient D, Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

a. Naprosyn on two occasions.

b. Prozac on one occasion.

c. Proventil Inhaler on one occasion.

d. Seldene on one occasion.

e. Pepcid on one occasion.

f. Keflex on one occasion.

g. Voltaren on one occasion.

3. Respondent inappropriately performed an electrocardiogram on Patient D.

4. Respondent failed to interpret and/or note in the chart an interpretation of the electrocardiogram he performed.

5. Respondent failed to perform an adequate work-up and evaluation of Patient D's complaints and/or diagnoses of depression, peptic ulcer disease, asthma, and back pain.

6. Respondent billed the Program and was reimbursed for performing a "Muscle Testing, total body, including hands." In fact, Respondent did not perform this test. The bill submitted by Respondent was knowingly false.

7. Respondent failed to maintain a record for Patient D which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

8. Respondent, or an individual acting at the direction of the Respondent, created a record for Patient D which is false and inaccurate and does not reflect legitimate patient care and treatment.

E. On or about October 13, 1989, January 5, 1990, and March 16, 1990, Respondent

undertook the care and treatment of Patient E at his Madison Avenue office.

1. On each visit by Patient E, Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

   a. Pepcid on two occasions.

   b. Keflex on two occasions.

   c. Proventil Inhaler on two occasions.

3. Respondent failed to provide any care and/or treatment with regard to Patient E's "feet fungus."

4. Respondent inappropriately performed an electrocardiogram on Patient E.

5. Respondent failed to interpret and/or note in the chart an interpretation of the electrocardiogram he performed.

6. On two occasions, Respondent billed the Program and was reimbursed for performing a "Muscle Testing, total body, including

hands." In fact, Respondent did not perform this test on either occasion. The bills submitted by Respondent were knowingly false.

7. Respondent failed to maintain a record for Patient E which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

8. Respondent, or an individual acting at the direction of the Respondent, created a record for Patient E which is false and inaccurate and does not reflect legitimate patient care and treatment.

F. On or about November 13, 1989, Respondent undertook the care and treatment of Patient F at his Madison Avenue office.

1. Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

a. Ceclor

b. Proventil Inhaler

c. Lotrisone Cream

3. Respondent inappropriately performed an electrocardiogram on Patient F.

4. Respondent failed to interpret and/or note in the chart an interpretation of the electrocardiogram he performed.

5. Respondent billed the Program and was reimbursed for performing a "Muscle Testing, total body, including hands." In fact, Respondent did not perform this test. The bill submitted by Respondent was knowingly false.

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

7. Respondent, or an individual acting at the direction of the Respondent, created a record for Patient F which is false and inaccurate and does not reflect legitimate patient care and treatment.

G. On or about February 8, 1990, Respondent undertook the care and treatment of Patient G at his Madison Avenue Office.

1. Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

a. Proventil Inhaler

b. Lotrisone

3. Respondent failed to perform an adequate work-up and evaluation to support a diagnosis of urinary tract infection.

4. Respondent billed the Program and was reimbursed for performing a "Muscle Testing, total body, including hands." In fact, Respondent did not perform this test. The bill submitted by Respondent was knowingly false.

5. Respondent failed to maintain a record for Patient G which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

6. Respondent, or an individual acting at the direction of the Respondent, created a record for Patient G which is false and inaccurate and does not reflect legitimate patient care and treatment.

H. Between on or about July 24, 1989 and April 30, 1990, Respondent undertook the care and treatment of Patient H on approximately 5 occasions at his medical offices located at 104-07 Glenwood Road, Brooklyn, N.Y. 11236 (hereinafter referred to as "his Brooklyn office").

1. On each visit by Patient H, Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed Sinequan to Patient H on August 30,1989.

3. Respondent failed to note in his chart the medications he prescribed to Patient H on the visits of August 15, 1989 and March 14, 1990.

4. On July 24, 1989, Respondent inappropriately performed the following tests :

   a. Electrocardiogram

   b. Pulmonary Function Test

   c. Range of Motion Test

5. Respondent failed to interpret and/or note in the chart an interpretation

of the electrocardiogram and pulmonary function test he performed.

6. Respondent billed the Program and was reimbursed for performing a "Muscle Testing, total body, including hands." In fact, Respondent did not perform this test. The bill submitted by Respondent was knowingly false.

7. Respondent billed the Program and received reimbursement from the Program for an Intermediate Office Visit with Patient H on August 21, 1989. In fact, Respondent did not see nor treat Patient H on that date. The bill submitted by Respondent was knowingly false.

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

9. Respondent, or an individual acting at the direction of the Respondent, created a record for Patient H which is false and inaccurate and does not reflect legitimate patient care and treatment.

I. On or about March 14, 1990, Respondent undertook the care and treatment of Patient I at his Brooklyn office.

1. Respondent failed to:

a. Obtain and note an adequate history.

b. Perform and note an adequate physical examination.

2. Patient I presented with a complaint of burning on urination. Respondent failed to do any urine testing to appropriately evaluate for urinary infection.

3. Respondent inappropriately performed the following tests:

a. Electrocardiogram

b. Pulmonary Function Test

c. Range of Motion Test

4. Respondent failed to interpret and/or note in the chart an interpretation of the electrocardiogram and pulmonary function test he performed.

5. Respondent billed the Program and was reimbursed for performing a "Muscle Testing, total body, including hands." In fact, Respondent did not perform this test. The bill submitted by Respondent was knowingly false.

6. Respondent billed the Program and received reimbursement from the Program for an Intermediate Office Visit with Patient I on April 17, 1990. In fact, Respondent did not see nor treat Patient I on that date.

The bill submitted by Respondent was knowingly false.

7. Respondent failed to maintain a record for Patient I which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

8. Respondent, or an individual acting at the direction of the Respondent, created a record for Patient I which is false and inaccurate and does not reflect legitimate patient care and treatment.

J. On or about August 21, 1989 and September 13, 1989, Respondent undertook the care and treatment of Patient J at his Brooklyn office.

1. On each visit by Patient J, Respondent failed to:

   a. Obtain and note an adequate history.

   b. Perform and note an adequate physical examination.

2. Respondent inappropriately prescribed:

   a. Velosef on August 21, 1989.

   b. Vitamins on September 13, 1989

3. Respondent failed to appropriately evaluate and/or manage an

abnormal CBC.

4. Respondent failed to appropriately diagnosis and/or manage an axillary lymph node which Respondent incorrectly noted as a sebaceous cyst and inappropriately prescribed an antibiotic for.

5. Respondent inappropriately performed a range of motion examination on Patient J.

6. Respondent billed the Program and received reimbursement from the Program for a Comprehensive Office Visit with Patient J on September 12, 1989. In fact, Respondent did not see nor treat Patient J on that date. The bill submitted by Respondent was knowingly false.

7. Respondent failed to maintain a record for Patient J which accurately reflects the patient's history, examination, diagnosis, tests, and treatment rendered.

8. Respondent, or an individual acting at the direction of the Respondent, created a record for Patient J which is false and inaccurate and does not reflect legitimate patient care and treatment.

K. Respondent employed a Physician's Assistant, FRANCIS NARCISSE, who rendered care and treatment to Patients A through G. Respondent failed to exercise appropriate supervision over FRANCIS NARCISSE'S care and treatment of Patients A through J, as set forth in paragraphs A through J and each subparagraph thereof.

L. On or about May 16, 1994, a Decision After Hearing was issued by the New York State Department of Social Services which found the Respondent guilty of violating New York State Regulations, in that it was found that Respondent had committed several unaccepted practices on a routine basis. The Decision After Hearing is a final decision and no appeal is pending from that decision.

1. The Respondent was found to have violated the following Department of Social Services Regulations:

a. Section 540.7 and Section 515.2(a)(1), in failing to appropriately document his charts;

b. Section 515.2(b)(6), in failing to maintain records that fully disclose the medical necessity for and the nature and extent of medical care furnished;

c. Section 515.2(b)(1)(i)(a), in submitted false claims by billing for EKG reports and muscle tests that he did not perform;

d. Section 515.2(b)(6), in failing to document the medical basis and specific need for services which he ordered.

e. Section 518.3, in ordering services which are not properly document and not medically necessary;

f. Section 515.2(b)(1)(i)(c), in submitting claims for medical

care, services, or supplies which he provided at a frequency or in an amount not medically necessary.

2. The violations Respondent was found guilty of would constitute professional misconduct pursuant to Educ. Law Sections 6530(2), practicing the profession fraudulently; 6530(16), a willful or grossly negligent failure to comply with substantial provisions of state regulations governing the practice of medicine; 6530(21), willfully filing a false report; 6530(32), failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient; and 6530(35), ordering excessive tests and treatment not warranted by the condition of the patient.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1995) by practicing the profession with negligence on more than one occasion in that Petitioner charges two or more of the following:

1. The facts in paragraphs A, A(1)(a), A(1)(b), A(2)(a) through A(2)(c), A(3), A(4), A(5), A(8), A(9), B , B(1)(a), B(1)(b), B(2)(a) through B(2)(d), B(3), B(5), B(6), C, C(1)(a), C(1)(b), C(2)(a) through C(2)(d), C(3), C(4), C(6), C(7), D, D(1)(a), D(1)(b), D(2)(a) D(2)(g), D(3), D(4), D(5), D(7), D(8), E, E(1)(a), E(1)(b), E(2))(a) through E(2)(c), E(3), E(4), E(5), E(7), E(8), F, F(1)(a), F(1)(b), F(2)(a) through F(2)(c), F(3), F(4), F(6), F(7), G, G(1)(a), G(1)(b), G(2)(a), G(2)(b), G(3), G(5), G(6), H, H(1)(a), H(1)(b), H(2), H(3), H(4)(a) through H(4)(c), H(5), H(8), H(9), I, I(1)(a), I(1)(b), I(2), I(3)(a) through I(3)(c), I(4), I(7), I(8), J, J(1)(a), J(1)(b), J(2)(a), J(2)(b), and J(3), J(4), J(5), J(7), J(8) and K.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1995) by practicing the profession with incompetence on more than one occasion in that Petitioner charges two or more of the following:

2. The facts in paragraphs A, A(1)(a), A(1)(b),

A(2)(a) through A(2)(c), A(3), A(4), A(5), A(8), A(9), B , B(1)(a), B(1)(b), B(2)(a) through B(2)(d), B(3), B(5), B(6), C, C(1)(a), C(1)(b), C(2)(a) through C(2)(d), C(3), C(4), C(6), C(7), D, D(1)(a), D(1)(b), D(2)(a) through D(2)(g), D(3), D(4), D(5), D(7), D(8), E, E(1)(a), E(1)(b), E(2))(a) through E(2)(c), E(3), E(4), E(5), E(7), E(8), F, F(1)(a), F(1)(b), F(2)(a) through F(2)(c), F(3), F(4), F(6), F(7), G, G(1)(a), G(1)(b), G(2)(a), G(2)(b), G(3), G(5), G(6), H, H(1)(a), H(1)(b), H(2), H(3), H(4)(a) through H(4)(c), H(5), H(8), H(9), I, I(1)(a), I(1)(b), I(2), I(3)(a) through I(3)(c), I(4), I(7), I(8), J, J(1)(a), J(1)(b), J(2)(a), J(2)(b), and J(3), J(4), J(5), J(7), J(8) and K.

THIRD THROUGH TWELFTH SPECIFICATIONS

UNNECESSARY TESTS AND/OR TREATMENT

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(35) (McKinney Supp. 1995) by ordering excessive tests and/or treatments not warranted by the condition of the patient, in that Petitioner charges:

3. The facts in paragraphs A(2)(a) through A(2)(c), and A(3).

4. The facts in paragraphs B(2)(a) through B(2)(d).

5. The facts in paragraphs C(2)(a) through C(2)(d), and C(3).

6. The facts in paragraphs D(2)(a) through D(2)(g), and D(3).

7. The facts in paragraphs E(2)(a) through E(2)(c), and E(4).

8. The facts in paragraphs F(2)(a) through F(2)(c), and F(3).

9. The facts in paragraphs G(2)(a) and G(2)(b).

10. The facts in paragraphs H(2), and H(4)(a) through H(4)(c).

11. The facts in paragraphs I(3)(a) through I(3)(c).

12. The facts in paragraphs J(2)(a), J(2)(b), and J(5).

THIRTEENTH THROUGH TWENTY-SECOND SPECIFICATIONS

PRACTICING FRAUDULENTLY

The Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(2) (McKinney Supp. 1995) by practicing medicine fraudulently in that, Petitioner charges:

13. The facts in paragraphs A, A(1)(a), A(1)(b), A(2)(a) through A(2)(c), and A(3) through A(9).

14. The facts in paragraphs B , B(1)(a), B(1)(b), B(2)(a) through B(2)(d), and B(3) through B(6).

15. The facts in paragraphs C, C(1)(a), C(1)(b), C(2)(a) through C(2)(d), and C(3) through C(7).

16. The facts in paragraphs D, D(1)(a), D(1)(b), D(2)(a) through D(2)(g), and D(3) through

D(8).

17. The facts in paragraphs E, E(1)(a), E(1)(b), E(2)(a) through E(2)(c), and E(3) through E(8).

18. The facts in paragraphs F, F(1)(a), F(1)(b), F(2)(a) through F(2)(c), and F(3) through F(7).

19. The facts in paragraphs G, G(1)(a), G(1)(b), G(2)(a), G(2)(b), and G(3) through G(6).

20. The facts in paragraphs H, H(1)(a), H(1)(b), H(2), H(3), H(4)(a) through H(4)(c), and H(5) through H(9).

21. The facts in paragraphs I, I(1)(a), I(1)(b), and I(2), I(3)(a) through I(3)(c), and I(4) through I(8).

22. The facts in paragraphs J, J(1)(a), J(1)(b), J(2)(a), J(2)(b), and J(3) through J(8).

TWENTY-THIRD THROUGH THIRTY-SECOND SPECIFICATIONS

FILING FALSE REPORTS

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(21) (McKinney Supp. 1995) by willfully making and/or filing a false report in that, Petitioner charges:

23. The facts in paragraphs A(6), A(7) and A(9).

24. The facts in paragraph B(4) and B(6).

25. The facts in paragraph C(5) and C(7).

26. The facts in paragraph D(6) and D(8).

27. The facts in paragraph E(6) and E(8).

28. The facts in paragraph F(5) and F(7).

29. The facts in paragraph G(4) and G(6).

30. The facts in paragraphs H(6), H(7), and H(9).

31. The facts in paragraphs I(5), I(6), and I(8).

32. The facts in paragraph J(6) and J(8).

THIRTY-THIRD SPECIFICATION

FAILURE TO SUPERVISE

The Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(33) (McKinney Supp. 1995) by failing to exercise appropriate supervision over a person or persons who were authorized to practice only under the supervision of the Respondent, in that, Petitioner charges:

33. The facts in paragraph K.

THIRTY-FORTH THROUGH FORTY-THIRD SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

The Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1995) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

34. The facts in paragraphs A(1)(a), A(1)(b), A(4), A(8), and A(9).

35. The facts in paragraphs B(1)(a), B(1)(b), B(5), and B(6).

36. The facts in paragraphs C(1)(a), C(1)(b),

C(4), C(6), and C(7).

37. The facts in paragraphs D(1)(a), D(1)(b), D(4), D(7), and D(8).

38. The facts in paragraphs E(1)(a), E(1)(b), E(5), E(7), and E(8).

39. The facts in paragraphs F(1)(a), F(1)(b), F(4), F(6), and F(7).

40. The facts in paragraphs G(1)(a), G(1)(b), G(5), and G(6).

41. The facts in paragraphs H(1)(a), H(1)(b), H(3), H(5), H(8), and H(9).

42. The facts in paragraphs I(1)(a), I(1)(b), I(4), I(7) and I(8).

43. The facts in paragraphs J(1)(a), J(1)(b), J(7) and J(8).

FORTY-FOURTH SPECIFICATION

HAVING BEEN FOUND GUILTY OF VIOLATION OF STATE REGULATIONS

Respondent is charged with committing professional misconduct within the meaning

of N.Y. Educ. Law Section 6530(9)(c) (McKinney Supp. 1995) by having been found guilty in an adjudicatory proceeding of violating a state regulation, pursuant to a final determination, and when no appeal is pending and the violation constitutes professional misconduct pursuant to N.Y. Educ. Law Section 6530, in that Petitioner charges:

44. The facts in paragraphs L, L(1)(a) through L(1)(f), and L(2).

DATED: June , 1995
New York, New York

ROY NEMERSON
Deputy Counsel,
Bureau of Professional
Medical Conduct

EXHIBIT "B"

TERMS OF PROBATION

1. LOUIS ROLAND TIMOTHEE, M.D., during the period of probation, shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession;

2. Respondent shall submit written notification to the New York State Department of Health (NYSDOH), addressed to the Director, Office of Professional Medical Conduct, New York State Department of Health, Corning Tower Building, 4th Floor, Empire State Plaza, Albany, New York 12237 of any employment and practice, of Respondent's residence and telephone number, and of any change in Respondent's employment, practice, residence, or telephone number within or without the State of New York;

3. Respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that Respondent has paid all registration fees due and owing to the NYSED and Respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by Respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, within the first three months of the period of probation;

4. Respondent shall submit written proof to the NYSDOH, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, that 1) Respondent is currently registered with the NYSED, unless Respondent submits written proof that Respondent has advised DPLS, NYSED, that Respondent is not engaging in the practice of Respondent's profession in the State of New York and does not desire to register, and that 2) Respondent has paid any fines which may have previously been imposed upon Respondent by the Board or by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

5. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the order of the Board and shall assume and bear all costs related to compliance with the Terms of Probation;

6. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non renewal of permits or licenses (Tax Law §171(27); State Finance Law §18; CPLR §5001; Executive Law §32);

7. So long as there is full compliance with every term herein set forth, Respondent may continue to practice his aforementioned profession in accordance with the terms of probation; provided, however, that upon receipt of evidence of noncompliance with, or any violation of these terms,

the Director of the Office of Professional Medical Conduct and/or the Board may initiate a violation of probation proceeding and/or such other proceeding against Respondent as may be authorized pursuant to the Public Health Law.

8. If at any time during the period of probation Respondent is not engaged in the active practice of medicine in the State of New York, the period of probation shall be tolled until and unless Respondent again engages in the active practice of medicine in the State of New York. Furthermore, until completion of the term of probation, Respondent shall notify the Director, in writing, **prior** to any change in that status.

EXHIBIT "C"

TERMS OF PROBATION

1. LOUIS ROLAND TIMOTHEE, M.D., during the period of probation, shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession;

2. Respondent shall submit written notification to the New York State Department of Health (NYSDOH), addressed to the Director, Office of Professional Medical Conduct, New York State Department of Health, Corning Tower Building, 4th Floor, Empire State Plaza, Albany, New York 12237 of any employment and practice, of Respondent's residence and telephone number, and of any change in Respondent's employment, practice, residence, or telephone number within or without the State of New York;

3. Respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that Respondent has paid all registration fees due and owing to the NYSED and Respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by Respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, within the first three months of the period of probation;

4. Respondent shall submit written proof to the NYSDOH, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, that 1) Respondent is currently registered with the NYSED, unless Respondent submits written proof that Respondent has advised DPLS, NYSED, that Respondent is not engaging in the practice of Respondent's profession in the State of New York and does not desire to register, and that 2) Respondent has paid any fines which may have previously been imposed upon Respondent by the Board or by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

5. Respondent shall meet on a quarterly basis with an OPMC Medical Coordinator or other physician designated by the Director of OPMC for a review of Respondent's patient records and discussion of Respondent's

medical practice. Respondent shall select and produce records for review in a manner and number determined by said Medical Coordinator and/or designee. Respondent shall produce for review at such meetings any and all medical and related records required by said Medical Coordinator and/or designee and shall cooperate in all respects with the review of his medical practice;

6. At the discretion of the Director of OPMC, the Respondent shall permit an employee, representative and/or designee of the OPMC access to and inspection of Respondent's medical office and patient records;

7. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the order of the Board and shall assume and bear all costs related to compliance with the Terms of Probation;

8. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non renewal of permits or licenses (Tax Law §171(27); State Finance Law §18; CPLR §5001; Executive Law §32);

9. So long as there is full compliance with every term herein set forth, Respondent may continue to practice his aforementioned profession in accordance with the terms of probation; provided, however, that upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of the Office of Professional Medical Conduct and/or the Board may initiate a violation of probation proceeding and/or such other proceeding against Respondent as may be authorized pursuant to the Public Health Law.

8. If at any time during the period of probation Respondent is not engaged in the active practice of medicine in the State of New York, the period of probation shall be tolled until and unless Respondent again engages in the active practice of medicine in the State of New York. Furthermore, until completion of the term of probation, Respondent shall notify the Director, in writing, **prior** to any change in that status.