STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

CONNECTICUT MEDICAL EXAMINING BOARD

October 22, 1997

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Inter-Departmental Mail

RE: Henri Schapira, M.D. - Petition No. 960514-01-083

Dear Attorneys Oliver and Lederer:

Enclosed please find the Memorandum of Decision issued by the Connecticut Medical Examining Board in the above referenced matter.

Sincerely,

Kathie J. Pirolo
Board Liaison

c: Marianne Horn, Assistant Attorney General
Stephen A. Harriman, Commissioner, DPH
Debra J. Tomassone, Section Chief, L&R
Debra L. Johnson, Health Program Supervisor
Linda J. Mead, Hearing Officer
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STATE OF CONNECTICUT
CONNECTICUT MEDICAL EXAMINING BOARD

Henri Schapira, M.D.
85 Barnes Road, Suite 211
Wallingford, Connecticut 06492

Petition No. 960514-01-083

MEMORANDUM OF DECISION

PROCEDURAL BACKGROUND

The Department of Public Health ("Department") presented the Connecticut Medical Examining Board ("Board") with a Motion for Summary Suspension, dated May 17, 1996, brought against Henri Schapira, M.D. ("Respondent"). The Motion for Summary Suspension was based on a Statement of Charges, also dated May 17, 1996, issued by the Department against the Respondent, alleging grounds for disciplinary action pursuant to Connecticut General Statutes §20-13c(4) and §20-13c(5). (Department Exhibit A).

The Board considered the Motion for Summary Suspension and the evidence to support it and, pursuant to its authority under Connecticut General Statutes §4-182(c) and §19a-17(c), issued a Summary Suspension Order on May 19, 1996. The Board ordered that the Respondent's license to practice medicine and surgery in the State of Connecticut, license number 014032, be suspended pending a final determination by the Board of the allegations contained in the Statement of Charges. (Department Exhibit A).

The Department sent the Statement of Charges and a Notice of Hearing for June 10, 1996 to the Respondent and his attorney via certified mail, return receipt requested. (Department Exhibit 1). The hearing set for June 10, 1996 was continued at the request of the Respondent.

The Respondent submitted a Motion to Preclude, dated July 10, 1996, to preclude the introduction of confidential communications and records of any and all of the Respondent's patients who had not provided the Board with written consent to release such records. The Department did not object to the Motion. The Board granted the Motion to Preclude.

The Respondent also submitted a Motion to Compel Medical Records, dated July 10, 1996, requesting the Board obtain certain medical records and other related information for him from the Office of the Chief State's Attorney of the State of Connecticut, which had seized these records from the Respondent without providing him copies. The Department requested this Motion be denied due to the fact that the relief was outside the Board's jurisdiction and that the Department would provide the Respondent with copies of all documentary evidence it would use in the case against the Respondent. The Board denied the Motion to Compel Medical Evidence.

After numerous continuances were granted, the administrative hearing to adjudicate this case was held on March 25, 1997 and June 24, 1997 before a duly authorized panel of the Board. The panel included Richard Ratzan, M.D.; Edward J. Fredericks, M.D.; and Pamela Nole. The Respondent appeared with his attorney, Robert G. Oliver, Esq., of New Haven, Hartford, Connecticut. Judith Lederer, Esq., represented the Department. Both the Department and the Respondent presented evidence and conducted cross-examination of witnesses.

The panel conducted the hearing in accordance with Connecticut General Statutes Chapter 54 and the Regulations of Connecticut State Agencies §19-2a-1, et seq. All panel members involved in this decision attest that they have either heard the case or read the record in its entirety. The Board reviewed the panel's proposed final decision in accordance with the provisions of Connecticut General Statutes §4-179. This decision is based entirely on the record and the specialized professional knowledge of the Board in evaluating the evidence.

STATEMENT OF CHARGES[1]

In paragraphs 1, 2 and 5 of the Statement of Charges, the Department alleged that the Respondent is, and has been at all times referenced in the Statement of Charges, the holder of Connecticut medical license number 014032 and has been a Medicaid provider with a specialty in psychiatry.

With Regard to the First Count

In paragraph 3 of the Statement of Charges, the Department alleged that since at least October of 1992, until at least February of 1996, the Respondent has submitted claims for services provided to Medicaid patients, which claims were false.

In paragraph 4 of the Statement of Charges, the Department alleged that the above described facts constitute grounds for disciplinary action pursuant to Connecticut General Statutes §20-13c(4).

With Regard to the Second Count

In paragraph 6 of the Statement of Charges, the Department alleged that during the above-referenced times, the Respondent continued to prescribe and/or dispense controlled substances to persons who presented as Medicaid patients without adequate monitoring and without determining the ongoing need for such treatment.

In paragraph 7 of the Statement of Charges, the Department alleged that the above described facts constitute grounds for disciplinary action pursuant to Connecticut General Statutes §20-13c, including but not limited to:

a. 20-13c(4); and/or
b. 20-13c(5).

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[1] Department Exhibit A.

ANSWER[2]

The Respondent admitted paragraphs 1, 2 and 5 and denied paragraphs 3, 4, 6 and 7 of the Statement of Charges.

FINDINGS OF FACT

1. The Respondent has been at all times referenced in the Statement of Charges the holder of Connecticut medical license number 014032. (Respondent Exhibit 1).

2. The Respondent's license to practice medicine in the State of Connecticut was summarily suspended on May 21, 1996 by order of the Board. His license has been under suspension since that time. (Department Exhibit A; Transcript 3/25/97 p. 4).

3. The Respondent has, at all times referenced in the Statement of Charges, been a Medicaid provider, with a specialty in psychiatry. (Respondent Exhibit 1).

4. Alexandra Mathiasen is a pharmacist registered with the State of Connecticut. She is employed as a drug control agent with the Drug Control Division of the Connecticut Department of Consumer Protection and has been so employed since April of 1985. (Transcript 3/25/97 pp. 86-87, 120-121).

5. In October of 1995, Ms. Mathiasen was assigned go into Respondent's office, undercover, as a patient. She was to represent herself as "Sandra Britton," a welfare, single mother with no significant medical problems. (Department Exhibits E & F; Transcript 3/25/97 pp. 88-89, 125-128).

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[2] Respondent Exhibit 1; Transcript 6/24/97 p. 4.

6. Ms. Mathiasen's first appointment with the Respondent on January 29, 1996:

a. Ms. Mathiasen filled out an insurance form indicating she was entitled to Title XIX (Medicaid) health benefits;

b. During her appointment the Respondent took information, such as her name, address, children's names and ages, and a short description of background;

c. Ms. Mathiasen told the Respondent that she was new to the area and had been on Xanax previously and life was much better when she was on Xanax. She was given a prescription for 42 capsules of 1.0 milligram of Xanax and told to take it three times a day. There were no instructions or precautions given to her about taking the drug;

d. The Respondent told Ms. Mathiasen to come back in two weeks; and

e. The appointment lasted thirteen minutes.

(Department Exhibits F & G; Transcript 3/25/97 pp. 89-92, 133, 137-145, 148-149).

7. Ms. Mathiasen's second appointment with the Respondent on February 8, 1996:

a. The Respondent asked Ms. Mathiasen for her full name and how she was. Ms. Mathiasen replied that she was feeling much better now that she was back on Xanax. The Respondent asked if she was "wired or angry" when she was off Xanax and Ms. Mathiasen replied "no;"

b. Ms. Mathiasen told the Respondent that he had given her a prescription for Xanax, 1 milligram, to take four times a day, on the previous visit. The Respondent made out a new prescription for Xanax based on what she told him, rather than on what was actually given at the previous appointment. Ms Mathiasen was given a prescription for 56 capsules of Xanax, 1.0 milligram, to be taken four times a day;

c. In response to the Respondent's question of what else she took besides the Xanax, Ms. Mathiasen told the Respondent that she had been taking Restoril, 15 milligrams. The Respondent wrote her a prescription for 19 capsules of Restoril, 15 milligrams;

d. The Respondent told Ms. Mathiasen to return in two weeks; and

e. The appointment lasted approximately four minutes.

(Department Exhibits F & G; Transcript 3/25/97 pp. 92-95, 155, 158-162).

8. Ms. Mathiasen's third appointment with the Respondent on February 22, 1996:

a. Ms Mathiasen told the Respondent that she was doing fine and everything was all right. He asked her if she liked Xanax or Ativan. Ms. Mathiasen replied "both." The Respondent asked, "I gave you Xanax, right?" Ms. Mathiasen responded affirmatively and the Respondent prescribed 56 capsules of Xanax, 1.0 milligram;

b. Ms. Mathiasen also told the Respondent that she liked the Restoril. The Respondent gave her a prescription for 20 capsules of Restoril, 15 milligrams;

c. Ms. Mathiasen asked the Respondent if there was something else he could give her. The Respondent suggested Ms. Mathiasen try Trazadone without ever discussing why he was suggesting it. The Respondent gave Ms. Mathiasen a prescription for 14 capsules of Trazadone, 50 milligrams, to be taken at bedtime;

d. The Respondent told Ms. Mathiasen to return in two weeks; and

e. The appointment lasted approximately seven minutes.

(Department Exhibits F & G; Transcript 3/25/97 pp. 95-98, 164, 168, 170-172).

9. Ms. Mathiasen's fourth appointment with the Respondent on March 4, 1996:

a. The Respondent asked Ms. Mathiasen what medication she took and the strength of each. He also asked her what her last name was;

b. Ms. Mathiasen told the Respondent she was taking 1.0 milligram of Xanax four times a day. He gave her another prescription for 56 capsules of Xanax, 1.0 milligram;

c. Ms. Mathiasen told the Respondent that she liked the Restoril and the Respondent prescribed 12 capsules of Restoril, 30 milligrams, to be taken at bedtime;

d. Ms. Mathiasen told the Respondent that she did not like the Trazadone. That prescription was not renewed;

e. The Respondent told Ms. Mathiasen to return in two weeks; and

f. The appointment lasted approximately one minute.

(Department Exhibits F & G; Transcript 3/25/97 pp. 98-99, 176-178).

10. Ms. Mathiasen's fifth appointment with the Respondent on March 18, 1996:

a. The Respondent asked Ms. Mathiasen how she was feeling and she responded that she was all right. He asked her what her last name was;

b. The Respondent asked Ms. Mathiasen what she took for medicines, to which she responded that she took Xanax, 1 milligram four times a day. The Respondent wrote a prescription for 56 capsules of Xanax, 1.0 milligram;

c. Ms. Mathiasen told the Respondent that she also took Restoril, 30 milligrams. The Respondent prescribed 10 capsules of Restoril, 30 milligrams;

d. At this visit, Ms. Mathiasen also told the Respondent that she needed Trazadone. The Respondent prescribed 14 capsules of Trazadone, 50 milligrams, without inquiring why she had previously told him she did not like it; and

e. The appointment lasted approximately two minutes.

(Department Exhibits F & G; Transcript 3/25/97 pp. 99-101, 179-180, 183-184).

11. Ms. Mathiasen did not return to the Respondent's office after March 18, 1996. (Transcript 3/25/97 pp. 101, 119, 188).

12. Xanax, Restoril and Trazadone are controlled substances.

13. There was no adequate monitoring of Ms. Mathiasen, as patient, by the Respondent. Neither was there any determination by the Respondent that the prescriptions for controlled substances he provided to Ms. Mathiasen were based on her medical and/or psychiatric needs.

14. The Respondent's office records show that the charge for Ms. Mathiasen's initial appointment was $55.00 and the charge for the remaining four appointments were $46.75 each. (Department Exhibit H).

15. Title XIX Medical Assistance Program (Medicaid) paid physicians $55.00 for general clinical psychiatric diagnostic/evaluative interview procedure 90801 and $46.50 for psychiatric therapeutic procedure 90844. There were no other procedures on the Medical Assistance Policy Fee Schedule that paid these amounts. (Department Exhibit B; Transcript 3/25/97 pp. 19-22, 41-42, 54, 74).

16. Procedure 90801: "Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. . . .) Consultation for psychiatric evaluation of a patient includes examination of a patient and exchange of information with primary physician and other informants such as nurses or family members, and preparation of report. . . ." (Department Exhibit B; Transcript 3/25/97 pp. 20, 24-25, 42-45, 47).

17. Procedure 90844: Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy; time approximately 45 to 50 minutes. (Department Exhibit B; Transcript 3/25/97 pp. 20, 25, 47-48).

18. There were 158 days from November 16, 1993 to February 13, 1996 when the Respondent submitted fifteen claims or more for Medicaid reimbursement. The following shows the number of days that these claims were made:[3]

18 days	15 claims
22 days	16 claims
19 days	17 claims
23 days	18 claims
19 days	19 claims
5 days	20 claims
8 days	21 claims
5 days	22 claims
6 days	23 claims
7 days	24 claims
3 days	25 claims
4 days	26 claims
4 days	27 claims
6 days	28 claims
4 days	29 claims
2 days	30 claims
2 days	31 claims
1 day	35 claims

(Department Exhibit B; Transcript 3/25/97 pp. 22-23).

19. Thirty-one claims were submitted for June 13, 1995 and August 8, 1995. On June 13, 1995, five claims were made for medical procedure 90801 and 26 claims were made for medical procedure 90844 (each of which requires a session of 45-50 minutes). On August 8, 1995, two claims were made for medical procedure 90801,

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[3] The vast majority of the claims were for psychiatric therapeutic procedure 90844 (which requires a session of approximately 45 to 50 minutes); a fair number were made for diagnostic/evaluative procedure 90801; and a few were made for cross-over claims, which are co-pays due on claims first submitted to Medicare. Other than these three categories of claims, there were only five other claims: Two submissions on August 8, 1995 for psychiatric therapeutic procedure 90843, which is like 90844, but is for a session approximately 20-30 minutes long; one submission on March 8, 1994 for psychiatric therapeutic procedure 90841, which is also like 90844, but with a session which is "time unspecified;" one submission on November 15, 1994 for procedure 9084, which appears to be an incomplete number, but which would fall under the category of "psychiatric therapeutic procedures;" and one submission on December 15, 1995 for diagnostic/evaluative procedure 90825, which covers "Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes." (Department Exhibit B; Transcript 3/25/97 pp. 24-27, 47-48, 51-52).

27 claims were made for medical procedure 90844, and two claims were made for cross-over claims from Medicare. (Department Exhibits B & C; Transcript 3/25/97 pp. 27-34, 39-40).

20. Thirty-five claims were submitted for June 27, 1995, two of which were made for medical procedure 90801, 32 of which were made for medical procedure 90844, and one of which was made for a cross-over claim from Medicare. (Department Exhibits B & D; Transcript 3/25/97 pp. 34-42).

21. The Respondent submitted claims for services provided to Medicaid patients, which claims were false.

DISCUSSION AND CONCLUSIONS OF LAW

Connecticut General Statutes §20-13c provides in pertinent part:

> The [Connecticut Medical Examining Board] is authorized to restrict, suspend or revoke the license or limit the right to practice of a physician or take any other action in accordance with section 19a-17, for any of the following reasons: (4) illegal, incompetent or negligent conduct in the practice of medicine; (5) possession, use, prescription for use, or distribution of controlled substances or legend drugs, except for therapeutic or other medically proper purposes; . . . In each case, the board shall consider whether the physician poses a threat, in his practice of medicine, to the health and safety of any person. If the board finds that the physician poses such a threat, the board shall include such finding in its final decision and act to suspend or revoke the license of said physician.

With Regard to the First Count

The Department did not prove that between October of 1992 and November 15, 1993, the Respondent submitted false claims for services provided to Medicaid patients.

The Department proved that between November 16, 1993 and until at least February of 1996, the Respondent submitted claims for services provided to Medicaid patients, which claims were false.

Evidence for the proof of the allegations in the First Count are the documentary evidence of Department Exhibits B, C, and D along with the credible testimony of Mark Comerford to explain the billing statistics, as well as the credible testimony of Ms. Mathiasen regarding her personal experiences as an undercover patient of the Respondent.

The evidence established that there were 158 days when the Respondent billed Medicaid for fifteen or more claims. Fifteen or more claims in one day, most of which were based on a procedure which required at least 45 minutes, is not reasonable billing for a psychiatric practice. When a psychiatrist bills this number of claims it raises significant suspicions regarding his medical practice and/or his honesty in billing.

The Board has found that the Respondent's appointments with Ms. Mathiasen lasted from one to thirteen minutes, for an average over five appointments of 5.5 minutes per appointment. Billing Medicaid for patients after seeing them for a fraction of the amount of time required, can account for the large numbers of Medicaid claims the Respondent submitted per day.

The Respondent billed for 24 or more total Medicaid claims on 33 individual days. On eleven of these days he billed over 24 claims solely for procedure 90844, which at a minimum required a 45 minute appointment.[4] And, most egregious, for June 27, 1995, the Respondent billed Medicaid for 35 claims, 32 of which were for procedure 90844, with its 45 to 50 minute time-frame. There are clearly not enough hours in the day to do what the Respondent claimed he did through his billing. Neither is this a one-time occurrence which might be attributable to a mathematical error. The statistical evidence the Board has been presented with is indicative of a dishonest money-making operation which had nothing to do with the practice of medicine.

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[4] Additionally, other types of claims were filed for these days.

Submitting false claims for payment for services to Medicaid patients is illegal conduct and as such constitutes grounds for disciplinary action pursuant to Connecticut General Statutes §20-13c(4).

With Regard to the Second Count

The Department did not prove that the Respondent personally dispensed controlled substances. However, the Department did prove that the Respondent prescribed controlled substances to Ms. Mathiasen in her undercover role as a Medicaid patient, without adequate monitoring and without determining the ongoing need for such treatment.

Ms. Mathiasen was a credible witness and the Board has relied upon her testimony and the accompanying documentary evidence with regard to the Second Count. Ms. Mathiasen's initial diagnostic and evaluative interview, which lasted thirteen minutes, was the longest of the five appointments she had with the Respondent. The remaining appointments lasted from one to seven minutes, with an average of 3.5 minutes for these four appointments. Ms. Mathiasen's descriptions of what went on during these appointments is consistent with the length of time taken. The Respondent began the appointments by asking what her last name was. He then asked her what medications she took, at what strength and what number of dosages per day. Then he simply wrote the prescriptions, told her to return in two weeks, and sent her on her way. There is no evidence of any adequate information from Ms. Mathiasen to the Respondent about her symptoms nor any diagnostic determinations of Ms. Mathiasen's condition by the Respondent, that would support or justify the prescriptions of the controlled substances of Xanax, Restoril or Trazadone.

The Respondent made no good faith attempt to get a medical or psychiatric history of Ms. Mathiasen nor to provide adequate monitoring or follow-up of her condition. Ms.

Mathiasen's appointments with the Respondent were merely a superficial basis for prescribing controlled substances.

Writing prescriptions for controlled substances, without determining a therapeutic or other medically proper purpose, is conduct which is grounds for disciplinary action pursuant to Connecticut General Statutes §20-13c(5).

Connecticut General Statutes §19a-17(a) provides in pertinent part:

> Disciplinary action by ... boards .... (a) [The Connecticut Medical Examining Board, established by chapter 370] may take any of the following actions, singly or in combination, based on conduct which occurred prior or subsequent to the issuance of a permit or a license upon the finding the existence of good cause:
>
> (1) Revoke a practitioner's license . . . .

The Respondent has exhibited blatantly dishonest behavior. His license to practice medicine was used as a cover for wholesale deceit in his billing practice of Medicaid and his violation of trust with respect to his many patients. Such conduct is so egregious that the Board finds the only appropriate remedy is the revocation of the Respondent's license.

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ORDER

Based upon the record in these cases, the above findings of fact and the conclusions of law, and pursuant to the authority vested in it by Connecticut General Statutes §20-13c and §19a-17, the Board orders the following in the case of Henri Schapira, M.D., Petition number 960514-01-083, medical license number 014032:

The Respondent's license to practice medicine within the state of Connecticut, license number 014032, shall be revoked.

The Respondent shall send all copies of his license to:

Bonnie Pinkerton
Department of Public Health
410 Capitol Avenue MS# 12 HSR
P.O. Box 340308
Hartford, CT 06134-0308

Richard M. Ratzan, MD — 10/21/97

by: Richard M. Ratzan, M.D., Chairperson — Date
Connecticut Medical Examining Board

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