COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1397

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY SANDESH R. PATIL, M.D., LICENSE 36248, 285 BEECHWOOD DRIVE, LONDON, KENTUCKY 40744

AGREED ORDER

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Hearing Panel B, and Sandesh R. Patil, M.D. ("licensee"), and, based upon their mutual desire to fully and finally resolve the Complaint without an evidentiary hearing, hereby ENTER INTO the following **AGREED ORDER**:

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Agreed Order:

1. At all relevant times, Sandesh R. Patil, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is Cardiovascular Disease.
3. On March 22, 2011, the Kentucky Board of Medical Licensure (hereafter "the Board") received an anonymous grievance alleging that the licensee and others were performing unnecessary stenting and angioplasty procedures.
4. Following a preliminary review by the Board's consultant, the Board obtained five (5) patient records from the licensee involving those procedures. Following review, the consultant reached the following conclusions, in part,

   Patient A

   There is more than enough information to form an opinion. Diagnosis is clearly below minimum standards. Never once during the extended course of events did this

patient have a physiologic exam to assess whether there actually existed any objective evidence of ischemia. This could have been any of a variety of stress test, or during a procedure, pressure wire measurement. Instead, there is a consistent inappropriate rush to invasive testing to show anatomy, sometimes scheduled by a mid-level provider. On my count, the patient presented eleven times and was taken to the cath lab ten of those times; each trip to the lab was associated with an intervention. The IVUS device is utilized more than usual or necessary, almost always to push for revascularization rather than as a tool to show that another procedure is not required. This is followed by consistent exaggeration of the severity of stenosis at angiography and with the IVUS device. Records are below minimum standards. Never once is there a work-up by Dr. Patil that would "pass muster" for a billable H&P, or an office note or in-patient consultation that justifies the diagnosis and plan with details of a history or exam. Treatment is below minimum standards as discussed extensively above. It seems that the plan to treat and the procedure to be done are often pre-determined before the anatomy has even been seen. In the end, the patient needed surgery to correct complications of her treatment, not her disease. Clearly, this case is below minimum standards. This case includes multiple instances of unnecessary stents as well as other unnecessary procedures. These departures from minimum standards are justified by Dr. Patil as attempts to help this patient who in retrospect is likely to have had a psychiatric illness. There can be no legitimate justification for the careless, casual, systematic over utilization of invasive and interventional treatments in this case. While it is true that some of the procedures became necessary to treat eventual complications, these complications arose from illegitimate procedures that were not necessary at the onset. It is doubtful that remedial education is the solution to this pattern of gross over utilization. It is my understanding that this physician has relocated to a different area in a different practice. Certainly leaving this hospital that accepts rudimentary documents as appropriate records will possibly help. Getting out of the London practice that appears to be totally oriented to maximal procedural billing will likely help. Advances in interventional cardiology that help avoid inappropriate intervention are available and are known to the patient. Total or random review of all invasive procedures performed by this physician as well as requirement of his submitting appropriate records with emphasis on history, physical exam, tests, etc may be appropriate. Remedial education may be helpful for the latter.

Patient B

Diagnosis is opinioned to be below minimum standards. There is no physiologic study before or during revascularization procedures on the native right coronary artery or the native left main. There is no testing of the pulmonary system until after the patient has already been through the difficult process of coming off Coumadin that is continuously essential for the safe function of the metallic valve in place in the aorta to do the arterial puncture. There is only review of an earlier poorly done angiogram followed by an inexplicable plan to place stents into an unobstructed native right coronary artery. Treatment is also suboptimal when this plan is carried out, but only after stenting a main left coronary artery that only supplies small

branches that remain after occlusion of the LAD and circumflex years ago. Records are very poor both by not having details important to the case, and by having nonsense assessment and plan sections in the document serving as the admission H&P. Overall my opinion is that the case is below minimum standards. Unnecessary stenting is noted. The reasons for this opinion are discussed above. It is my impression that the London, Kentucky hospital has already changed procedures in an effort to supervise physician utilization of the cath lab, both for diagnostic and therapeutic uses. Remedial instruction is possible for record keeping, etc. More appropriate hospital expectations for records would also be welcome. The rebuttal letter from Dr. Patil implies that use of more stringent criteria and tools to rectify inappropriate stenting are already his policy in his new job, but random or more than random oversight of procedures might be beneficial as well. Medical peer review of complications and mortality had been in place at London, Kentucky and would be reassuring in all hospital systems if not obligatory. There have not been problems with complications or mortality identified with Dr. Patil's treatment that I'm aware from review of the peer review documents.

Patient C

Diagnosis is suboptimal in that the original reason to proceed is based on what appears to be a false positive stress test. This led to an angiogram that really did not demonstrate a stenosis in the graft, leading to an intervention that in my opinion was not appropriate for reasons above noted. Treatment is opined to be suboptimal as above. The approach seems to be that the interventionist is meeting the patient at the time of the intervention, filling out a terse form that serves as H&P and performs the expected intervention as per the referring cardiologist. This approach might have to be altered to allow for reflection before intervening on ten year old bypass grafts with non-critical lesions that don't match the nuclear result. Pressure wire assessments were available at this hospital at this time and would likely have shown it was safe to defer this intervention, though even placing a wire in these grafts can be complicated. Overall, the case is below minimum standards and involves inappropriate stenting. Remedial education about appropriate records and the comments above concerning oversight of invasive procedures as above are applicable here as well.

Patient D

By way of opinion, the diagnosis aspect of this case is suboptimal. The work-up initially consists of simply stating the patient had angina equivalent symptoms and no additional non-invasive diagnostic modalities were used. After jumping to the invasive angiogram, the lesions are over estimated visually not once but twice in two days. No effort to provide physiologic testing at the time of either angiogram to justify intervention and drug eluting stent placement is expanded. Treatment is equally suboptimal, i.e., placing stents without justification in a patient with atypical symptoms who subsequently failed to improve at all. Records are poor, with the EMR based office notes difficult to follow, drawing conclusions that have no logical

development as though conjured up to justify an inappropriate unjustified invasive approach. Overall opinion is below minimum standards.

There appears to be a pattern of inappropriate assessment and invasive plans, followed by overestimate of the severity of stenoses and inappropriate stenting. Dr. Patil does not appear to comprehend that some patients have continued to have problems and have sought care elsewhere; his assumption is that there is a conspiracy resulting in patients moving to other practitioners that hopefully is not the case. He does seem to know how to avoid unwarranted procedures, but monitoring seems to be indicated to avoid future problems. Records are deficient, magnified by EMR shortcomings.

Patient E

The consultant found that the licensee's treatment and care of the fifth patient reviewed met the applicable standards.

5. The licensee filed a lengthy response with supporting documentation to the Board consultant's report, in which he disagreed with much of the consultant's findings. In concluding his response, the licensee asserted that: "I never placed a stent unless I found it clinically necessary and would benefit a patient." The licensee also noted that: "these few cases represent a very small portion of my previous practice. Indeed, these cases are less than 0.2% of my patient volume over those two years.

6. The licensee also stated, through legal counsel, the following:

   Based upon the very limited number of patient records reviewed - and only those identified by an anonymous complainant, the age of the patient records and the change in Dr. Patil's practice setting, it is our opinion that continuing the investigation to review an additional random selection of records in the near future is the best option to fairly assess Dr. Patil's patient care. Four (4) records hand selected by an anonymous complainant do not adequately reflect the practice of Dr. Patil nor does it create a pattern of suboptimal diagnosis or treatment. Thus, a subsequent review of current patient records by random selection will more adequately represent his practice standards.

7. After reviewing the licensee's submissions, the consultant stated as follows:

   His attorney's point that these cases may not be a fair representation of his work is also a consideration. If documentation is enhanced and random cases show favorable

review in the future, it seems as though Dr. Patil could contribute through his talents and training to the benefit of patients in his new setting.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Agreed Order:

1. The licensee's medical license is subject to regulation and discipline by the Board.
2. While the licensee denies that he engaged in any conduct which violates KRS 311.595, he agrees that, based upon the Stipulations of Fact, the Hearing Panel could conclude that he has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(3) and (4). Accordingly, there are legal grounds for the parties to enter into this Agreed Order.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending Complaint without an evidentiary hearing by entering into an informal resolution such as this Agreed Order.

AGREED ORDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally resolve this pending Complaint without an evidentiary hearing, the parties hereby ENTER INTO the following **AGREED ORDER:**

1. The license to practice medicine within the Commonwealth of Kentucky held by Sandesh R. Patil, M.D., SHALL BE SUBJECT to this Agreed Order for a period of five (5) years from the date of filing of the Agreed Order.

2. During the effective period of this Agreed Order, the licensee's medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:

   a. Within twenty (20) days of the filing of this Agreed Order, the licensee SHALL make all necessary arrangements to enroll in the Documentation Seminar at the Center for Personalized Education for Physicians (CPEP), 7351 Lowry Boulevard, Suite 100, Denver, Colorado 80230 – 303/577-3232, for the earliest seminar at which CPEP has an opening. The licensee shall complete the Documentation Seminar at the time and date(s) scheduled, at his expense;

   b. The licensee SHALL also take all necessary steps to enroll in the CPEP Personalized Implementation Program. The licensee shall complete the Personalized Implementation Program, at his expense, as directed by CPEP's staff.

   c. The licensee SHALL provide the Board's staff with written verification that he has successfully completed CPEP's Documentation Seminar, promptly after completing the Seminar, and that he has enrolled in the 6-month Personalized Implementation Program;

   d. The licensee SHALL provide the Board's staff with written verification that he has successfully completed the 6-month Personalized Implementation Program promptly after completing that program.

   e. The licensee SHALL take all steps necessary, including signing any waiver and/or consent forms required to ensure that CPEP will provide a copy of any evaluations from the Documentation Seminar and

Personalized Implementation Program to the Board's Legal Department promptly after their completion;

f. The licensee SHALL obtain an adequate history and physical evaluation for each patient that supports the diagnosis and any procedure performed;

g. The licensee SHALL include documentation in each patient's medical record that meets Medicare documentation standards for Level 4-5 before performing any invasive procedure, unless the patient requires emergency treatment. In the event the patient requires emergency treatment, the licensee may provide treatment appropriate to address the emergency, but must meet this documentation requirement promptly after completing the emergency procedure;

h. The licensee SHALL ONLY perform a diagnostic coronary angiography when the appropriate use criteria of 2012 J.Am. College of Cardiology Appropriate Use Criteria for Diagnostic Catheterization (5/9/12) are present and supported by the patient record;

i. The licensee SHALL ONLY perform a coronary revascularization when the appropriate use criteria of 2012 Appropriate Use Criteria for Coronary Revascularization Focused Update, Vol. 59, No. 9, 2012 are present and supported by the patient record;

j. The licensee SHALL ONLY perform an invasive procedure on a patient when a stress test has been performed or over-read by another nuclear cardiologist, unless the licensee can adequately justify upon the patient

record that a stress test is medically inappropriate for the particular patient;

k. The licensee SHALL calculate the Duke Treadmill score for regular treadmill stress testing for each patient;

l. The licensee SHALL ONLY perform an invasive procedure where nuclear stress testing and echo cardiogram stress test level of risk for the specific patient are specific and recent;

m. The licensee SHALL permit the Board's agents to inspect, copy and/or obtain patient records, upon request, for review by the Board's agents and/or consultants;

n. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Agreed Order. Once the Board receives the invoice from the consultant(s) for each review, it will provide the licensee with a redacted copy of that invoice, omitting the consultant's identifying information. The licensee SHALL pay the costs noted on the invoice within thirty (30) days of the date on the Board's written notice. The licensee's failure to fully reimburse the Board within that time frame SHALL constitute a violation of this Agreed Order;

o. The licensee understands and agrees that at least one favorable consultant review must be completed, on terms determined by the Panel or its staff, before the Panel will consider a request to terminate this Agreed Order;

p. The licensee SHALL pay the costs of the investigation in the amount of $6,906.25 within twenty-four (24) months from the date of entry of this Agreed Order;

q. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Agreed Order, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Agreed Order would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Agreed Order;

4. The licensee understands and agrees that any violation of the terms of this Agreed

Order would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13).

SO AGREED on this 30 day of November, 2012.

FOR THE LICENSEE:

SANDESH R. PATIL, M.D.

L. CHAD ELDER
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

RANDEL C. GIBSON, D.O.
CHAIR, HEARING PANEL B

C. LLOYD VEST II
General Counsel
Kentucky Board of Medical Licensure
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WAIVER OF RIGHTS

I, Sandesh R. Patil, M.D., am presently the Respondent in Kentucky Board of Medical Licensure Case No. 1397. I understand that, under 201 KAR 9:082, I must waive certain rights if I wish to resolve this matter by informal dispensation. Accordingly, I WAIVE my right to raise any constitutional, statutory or common law objection(s) I may have to the Hearing Panel rejecting the proposed informal dispensation or to the curtailment of such a settlement by the Board's General Counsel or Assistant General Counsel.

Furthermore, if the Hearing Panel accepts the proposed Agreed Order as submitted, I WAIVE my right to demand an evidentiary hearing or to raise additional constitutional or statutory objections in this matter. However, if the Hearing Panel should reject the proposed Agreed Order, I understand that further proceedings will be conducted in accordance with KRS 311.530 et seq, and I will have the right to raise any objections normally available in such proceedings.

Executed this 30 day of November, 2012.

SANDESH R. PATIL, M.D.
Respondent

L. CHAD ELDER
COUNSEL FOR THE RESPONDENT