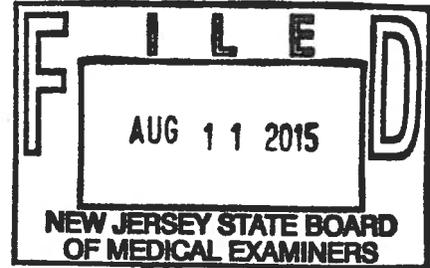


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STATE OF NEW JERSEY
DEP'T OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF AN INQUIRY :
INTO THE PROFESSIONAL PRACTICE OF

ADMINISTRATIVE ACTION

CHI I. LEE, M.D.
LICENSE NO. 25MA03146400

ORDER OF REPRIMAND
BY CONSENT

PRACTICING MEDICINE AND SURGERY
IN THE STATE OF NEW JERSEY :

This matter was presented to the State Board of Medical Examiners by Joan D. Gelber, Senior Deputy Attorney General, on inquiry into the professional practice of Chi I. Lee, M.D.

Respondent Chi I. Lee, M.D. has been licensed to practice medicine during all times pertinent herein. He practices internal medicine at 717 N. Beers Street, Suite 1A, Holmdel, NJ 07733.

Dr. Lee was directed to appear before a Board Committee because he had failed to timely provide the treatment records of his former patients G.B. and wife T.B., which they had requested to be sent to their new treating physician in New York.

The B. couple reported that they had told Dr. Lee in advance of their intended move to New York, and on February 24, 2014, they had faxed separate written requests to Dr. Lee from the office of their new physician, seeking their records. Mr. G.B., age 88, is a diabetic, and Dr. Lee's chart shows that Mrs. T.B. age 80, had been diagnosed with a cognitive disorder. Although the requests needed a

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prompt response, the patients reported that no records were received. Multiple calls from the patients' family, as well as a call from the office of the new physician, were made to find out when the files would be forwarded, without success. The frustrated patients submitted a consumer complaint to the Board on April 24, 2014.

Medical Board staff then attempted to resolve this matter. Dr. Lee's office staff initially responded that the records would not be released, allegedly because of "HIPAA" (the Health Insurance Portability and Accountability Act). The Board office informed Dr. Lee's staff that the statute did not preclude release in these circumstances. The Board was then informed by the new doctor's office that Dr. Lee had subsequently sent only a few pages of each patient's record. Only after a second Board staff intervention did Dr. Lee fax the complete records to the New York doctor.

Dr. Lee submitted documents requested by the Board: his curriculum vitae, proofs of certain continuing medical education credits for the most recent biennial registration cycle (July 1, 2011 - June 30, 2013), and his patient records for Mr. G.B. and Mrs. T.B. He chose to represent himself on June 25, 2014 at the Committee inquiry.

Dr. Lee stated that he is in solo practice in Holmdel. He admitted that his CV, which lists Board-certifications in Internal Medicine, Geriatric Medicine and Emergency Medicine, contained inaccuracies: the certifications in Geriatric Medicine and Emergency Medicine had lapsed and are not current. At Board direction, Dr. Lee submitted a corrected CV.

Dr. Lee has admitted that he received the separate February 24, 2014 requests faxed by each of the patients from the office of their new physician. He claims that he sent the records timely, but he has no confirming documentation to dispute the patients' complaint. Dr. Lee has denied being informed that the records had not been received by the new doctor's office until he was contacted

by the Medical Board office on May 14, 2014. However, a certification from the office of the new doctor states that a call was made to Dr. Lee's office well before the month of May 2014, reminding that the records had not been received.

The request for records from each patient specifies that the entire record was to be released. Board Committee review of Dr. Lee's charts discloses one fax transmission date of May 15, 2014 containing only a recent lab result (incomplete) and an EKG printout for the diabetic Mr. G.B., and a fax form of the same date with some lab results for the ailing Mrs. T.B. At the Board's request, on May 19, 2014, Dr. Lee sent a subsequent fax transmission with the rest of the chart for each patient.

The Board Committee's review of Dr. Lee's charts raised several concerns. Mr. G.B. was 88 years old and a diabetic. Mrs. T.B. was 80 years old, with a cognitive disorder and other ailments. Both charts contained numerous lab test reports with flagged abnormalities. The Committee inquired about the content of progress notes in each chart. Dr. Lee's record for the 88 year-old Mr. G.B. includes handwritten "SOAP" progress notes from 2010 - 2011 with a number and virtually no content, e.g., "3" or "4" or "5" on various dates. Dr. Lee said that the numbers are his shorthand that he will bill CPT 99213 or 99214 or 99215 as his Evaluation and Management code for that visit. Dr. Lee stated that in 2011, he commenced use of a computerized program of electronic medical records, supplementing his handwritten notes. However, his charts for at least five office visit dates in 2012 and 2013 included no handwritten or computer-generated documentation other than the Evaluation and Management codes.

For other dates found in his computer-generated reports - printed in tiny type - there are extensive detailed denials of numerous specific symptoms, and claims of largely negative findings, with *verbatim* language in many sections, as if each of the follow-up visits had been a comprehensive examination visit rather than a subsequent visit for an established patient. In

addition, several of the computer reports were incomplete and some were scanned out of page order and even out of date order, or with no dates or patient name to confirm to which visit they belonged. Yet all visits were coded as CPT 99213, 99214 and 99215.

Dr. Lee's charts failed to include the two February 24, 2014 record releases faxed from the new physician's office, nor was there any note of the admitted repeated calls from the patients' family nor the calls from the Medical Board office. Dr. Lee denied awareness of a call from the office of the new doctor. His chart contained no cover letter confirming that the entire records were sent promptly upon written request. The Board notes also that when the records were sent in part and then in full, each of the four fax cover pages listed only a fax number for the recipient and the name of the patient, and failed to contain the name of the doctor to whose office the (unencrypted) records were being sent, nor did the fax cover pages list a contact number for Dr. Lee as sender.

The Board has considered this matter and has found numerous concerns warranting correction and remedial measures. Board rule N.J.A.C. 13:35-6.5(c) requires transmittal of a patient's full record, on patient request, no later than 30 days from receipt of a request from a patient or authorized representative. Subsection (b)3(vii) of the rule requires that when a record has been prepared on a computer, a printout of each day's entry, whether preliminary or final, shall be made available "promptly" to a physician responsible for the patient's care, and to a patient "in the event of emergency." Here, two elderly patients, one a diabetic, the other with a diagnosed cognitive disorder, and both with numerous abnormal lab tests, sought their records for continuation of care by a new physician after the couple moved to New York. They had alerted Dr. Lee to the move prior to their departure from New Jersey, and provided duly executed record releases on February 24, 2014. Yet it took repeated intervention by the Board office staff before Dr. Lee finally sent the records, some 3 months after

receiving the proper written requests from the patients and the new physician.

Dr. Lee has denied that he maintained his list of the monthly evaluation and management codes for each patient, adding a medical service from time to time, in order to vary CPT codes on successive visits. The Board notes that a physician who has an established patient with generally established diagnoses can properly utilize the same CPT code supported by progress notes adequately and truthfully summarizing the patient's chief complaint (if any) or other reason for that visit, subjective symptoms, objective findings, assessment and plan of treatment. The codes billed must represent medical judgment specific to the care of the patients on each visit.

The Board also notes that Dr. Lee's computer software program contained repeated *verbatim* content of many paragraphs, not consistent with expected documentation for interim visits. Further, some of the computer-generated notes appear to be unsupported by the handwritten notes, such as a diagnosis for a G.B. office visit which did not appear in prior or subsequent progress notes and which failed to list any chief complaint relating to the purported problem. This raises concern that the claimed detail in the entries for subsequent visits was not medically supported, and suggests undue reliance upon a medical record software program without assurance of accurate individualized records as required by N.J.A.C. 13:35-6.5.

The Board finds that Respondent Dr. Lee has engaged in conduct in violation of Board law and rules:

1. Dr. Lee's pre-prepared computer-generated progress notes do not exhibit the independent exercise of medical judgment in documenting reliable notes of evaluation and management; N.J.A.C. 13:35-6.5; and

2. Dr. Lee repeatedly failed to make a timely and proper release of the full treatment records of patients G.B. and T.B., delaying full production for three months; N.J.A.C. 13:35-6.5.

Each of the above is a violation of N.J.S.A. 45:1-21(h).

Dr. Lee neither admits nor denies any misconduct, and asserts that he did not intentionally violate Board law or rules. However, in lieu of further proceedings, he has agreed to accept this resolution of the matter. Dr. Lee has been specifically advised that he has a right to retain an attorney in this matter, as the entry of this Order affects his legal rights. Respondent has voluntarily chosen to enter into this Order without the advice of counsel.

The Board has determined that the following disposition is warranted by the above violations, and is expected to be adequately protective of the public health, safety and welfare.

For sufficient cause shown,

IT IS, ON THIS **11** DAY OF **AUGUST** 2015

ORDERED that

1. Respondent Dr. Lee is hereby reprimanded for the above-summarized misconduct;

2. Respondent shall cease and desist from further violations and shall implement measures to assure compliance with Board rules;

3. Respondent shall ensure that henceforth, he completes the required number of CME credits for each cycle, and retains proof thereof;

4. Respondent shall ensure that henceforth he timely complies with all Board investigations and inquiries pursuant to N.J.A.C. 13:45C-1, et seq.;

5. Respondent is assessed a penalty of \$7,150.00 for the cited deficiencies in conduct;

6. The total financial assessment of \$7,150.00 shall be paid within 10 days of the entry of this Order, by certified bank check, Postal Service Money Order, wire transfer or credit card, payable to the State Board of Medical Examiners, 140 E. Front St., 2nd floor, P.O. Box 183, Trenton, NJ 08625-0183. Any other form of payment will be rejected and returned to the party making payment. If installment payments are requested, and granted for good cause

shown, a Certificate of Debt shall be filed by the Board for the unpaid balance, pursuant to N.J.S.A. 45:1-24, with interest.

7. Within six months of the entry of this Order, Respondent shall submit proof of having satisfactorily completed, and having received an unconditional passing grade in a Board-approved course of professional ethics.

8. The Disciplinary Directives attached hereto are incorporated in this document.

THIS ORDER IS EFFECTIVE UPON ENTRY

STATE BOARD OF MEDICAL EXAMINERS

BY: *Stewart A. Berkowitz*
Stewart A. Berkowitz, M.D.
President

I have read and understood the within Order and I agree to comply with its terms.

Chi I. Lee

Chi I. Lee, M.D.

Witness:

Rosemarie Sembler

**Rosemarie Sembler
Notary Public of New Jersey
My Commission Expires 1-06-16**

August 4, 2015

**NOTICE OF REPORTING PRACTICES OF BOARD
REGARDING DISCIPLINARY ACTIONS**

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Medical Examiners are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy will be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record, including the transcript and documents marked in evidence, are available for public inspection, upon request.

Pursuant to 45 CFR Subtitle A 60.8, the Board is obligated to report to the National Practitioners Data Bank any action relating to a physician which is based on reasons relating to professional competence or professional conduct:

- (1) Which revokes or suspends (or otherwise restricts) a license,
- (2) Which censures, reprimands or places on probation,
- (3) Under which a license is surrendered.

Pursuant to 45 CFR Section 61.7, the Board is obligated to report to the Healthcare Integrity and Protection (HIP) Data Bank, any formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation or any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such Federal or State agency that is publicly available information.

Pursuant to N.J.S.A. 45:9-19.13, if the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, it is obligated to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders are provided to that organization on a monthly basis.

Within the month following entry of an order, a summary of the order will appear on the public agenda for the next monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy.

Within the month following entry of an order, a summary of the order will appear in a Monthly Disciplinary Action Listing which is made available to those members of the public requesting a copy.

On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board.

From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.