BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against Angela Lorenzo, PA-C, Respondent.	**Case No. 17-28540-1**

FILED
AUG 22 2017
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board) hereby issues this formal Complaint (Complaint) against Angela Lorenzo, PA-C., (Respondent), a licensed physician assistant in Nevada. After investigating this matter, the IC has a reasonable basis to believe that Respondent has violated provisions of Nevada Revised Statutes (NRS) chapter 630 and Nevada Administrative Code (NAC) chapter 630 (collectively, Medical Practice Act). The IC alleges the following facts:

A. Respondent's Licensure Status

1. Respondent is currently licensed in Nevada in active status (License No. PA816), and has been so licensed by the Board since January 9, 2003.

B. Respondent's Disreputable Conduct

2. On or about February 5, 2013, Respondent knowingly sent, or directed that her patient, Patient X, send via FEDEX (or other express consignment company) a parcel from within the State of Indiana to a "Shawn Smith" at "5033 Longhorn Way, Antioch, CA 94531," containing $185,070 in cash, in vacuum heat-sealed bundles ("Respondent's Parcel"). Patient X's true identity is not disclosed herein to protect his privacy as a purported patient of Respondent, but is disclosed in the Patient Designation served upon Respondent along with a copy of this

[1] The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) was composed of Board members Wayne Hardwick, M.D., Chairman, Theodore B. Berndt, M.D., member and M. Neil Duxbury, public member.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

Complaint.

3. Respondent's Parcel was intercepted by the Indiana State Police, and a canine trained in narcotics detection alerted the officers to the scent of narcotics on the parcel.

4. Respondent's Parcel was seized by the Indiana State Police and turned over to Federal authorities, pursuant to 21 U.S.C. § 881(a)(6), which reads in pertinent part: "The following shall be subject to forfeiture to the United States and no property right shall exist in them: (6) All moneys, negotiable instruments, securities, or other things of value furnished or intended to be furnished by any person in exchange for a controlled substance or listed chemical in violation of this subchapter, all proceeds traceable to such an exchange, and all moneys, negotiable instruments, and securities used or intended to be used to facilitate any violation of this subchapter."

5. On or about March 30, 2013, and subsequently, Respondent attested under penalty of perjury in a series of written declarations that the $185,070 in cash was "100%" hers, and was being sent to herself at the aforementioned address in Antioch, CA, which is 541 miles away from Respondent's then residence at 1404 Peyton Stewart Court, North Las Vegas, Nevada 89086.

6. Respondent demanded its return under 18 U.S.C. § 983(a)(2)(A), noting her address as P.O. Box 36190, Las Vegas, NV 89133.

7. On April 8, 2014, $92,535 of that seized cash, the entirety of which Respondent claimed was "100%" hers, was ordered "forfeited" to the U.S. government pursuant to 21 U.S.C. § 881(a)(6) as money furnished in exchange for a controlled substance.

8. Accordingly, Respondent, a licensed physician assistant in active practice, with a license to prescribe controlled substances, had $92,535 seized and forfeited to the federal government pursuant to 21 U.S.C. § 881(a)(6).

Count I

NRS 630.301(9) (Disreputable Conduct)

9. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

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Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

10. Conduct that brings the medical profession into disrepute is grounds for discipline pursuant to NRS 630.301(9), including, without limitation, conduct that violates any provision of a code of ethics adopted by the Board by regulation based on a national code of ethics.

11. The seizure and forfeiture of $92,535 of Respondent's money that was found by a U.S. District Court to be derived from dealings in controlled substances, under the circumstances set forth herein, constitutes engaging in conduct that brings the medical profession into disrepute.

12. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

C. Respondent's Deceptive Conduct

13. In claiming that $185,070 in cash, in vacuum heat-sealed bundles, was "100% hers," Respondent declared under penalty of perjury in a written statement dated March 30, 2013: "I withdrew the funds from my bank account at Bank of America and entrusted the Funds to [Patient X], **my fiancée** and business partner, to purchase an airplane as part of a business venture." [emphasis added].

14. Respondent repeated this statement in her verified Answer to the Complaint of forfeiture under 21 U.S.C. § 881(a)(6), on November 27, 2013.

15. Engaging in any sexual activity with a patient who is currently being treated by a practitioner is grounds for discipline pursuant to NRS 630.301(5).

16. In a letter from Board Investigator, Don Andreas, dated December 23, 2014, Mr. Andreas inquired, "It is alleged that you are engaging in a sexual relationship with patient and finance [sic][should read "fiancée"] [Patient X]. Therefore, your treatment may have fallen below the standard of care."

17. In a letter dated March 16, 2015, Respondent stated (in bold print): "In regards to the allegations that we [Patient X and I] are engaged, that simply is not true. He [Patient X] is **not my fiancée**. He is a friend, a business associate as stated previously, and an active patient."

18. Accordingly, when trying to retrieve her $185,070 in cash seized as suspected drug-money, Respondent claimed to Federal authorities that Patient X was "my fiancée and business partner," but when the Board's investigator presented the allegation that Respondent may

be improperly engaging in a sexual relationship with her patient, Respondent insisted that this claim ". . . simply is not true. He is not my fiancée."

Count II

NRS 630.306(1)(b)(1) (Deceptive Conduct)

19. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

20. Engaging in any conduct which is intended to deceive is grounds for discipline pursuant to 630.306(1)(b)(1).

21. Respondent's statements to either the Board or Federal authorities, or both, were patently deceptive and intended to deceive.

22. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

D. Respondent's Misrepresentations In Renewing Her License

23. In 2012, Respondent was investigated for, charged with and pled no contest to three counts of violating Nevada law pertaining to the dispensing of controlled substances by the Nevada State Board of Pharmacy (Pharmacy Board), as follows:

(1) "dispensing controlled substances to patients without reporting the same to the Task Force" in violation of NRS 453.1545(1) and/or NRS 639.210(4), and/or NAC 639.745(1)(f) and/or NAC 639.945(1)(i);

(2) "allowing medical personnel access to controlled substances and dangerous drugs while [Respondent] was absent from her practice so they could administer and dispense the same to patients," in violation of NRS 639.210(4) and/or (12), and/or NAC 639.742(3)(c) and/or NAC 639.945(1) and/or (i),

(3) "failing to dispense drugs personally to patients or by mailing drugs to a patient in California," in violation of NRS 639.210(4) and/or (12) and/or NAC 639.742(3)(f) and/or NAC 639.945(1)(i).

24. For these offenses, Respondent had her "dispensing practitioner" license revoked by the Pharmacy Board on July 18, 2012, which revocation became official on August 17, 2012,

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

and such revocation was reported to the National Practitioners Data Bank.

25. On June 12, 2013, on her 2013-2015 Nevada Physician Assistant License Renewal Application, Respondent answered "no" to the question "Have you been . . . investigated for, charged with, convicted of, or pled guilty or nolo contendere to [any offense of federal, state or local law] . . . or for any offense which is related to the . . . dispensing of controlled substances?"

Count III

NRS 630.304(1) (Misrepresentation in Renewing a License)

26. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

27. Renewing a license to practice medicine by misrepresentation or by any false, misleading, inaccurate or incomplete statement is grounds for discipline pursuant to NRS 630.304(1).

28. Respondent renewed her license to practice medicine by misrepresentation and by a false, misleading, and inaccurate statement when she did not report on her license renewal application that she was investigated for, charged with, and pled nolo contendere to three counts related to the dispensing of controlled substances by the Pharmacy Board in 2013.

29. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

E. Respondent's Improper Patient Care

Patient A

30. Patient A was a 60-year-old female, 5'2" tall, weighing 128.5 lbs., when she established care with Respondent on September 5, 2013. Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint. Respondent treated Patient A for depression, anxiety, agoraphobia, "obesity" (though Patient A was not obese), and other patient complaints, and saw Patient A weekly for injections of vitamin B12 and other unspecified substances.

31. On January 30, 2014, Respondent saw Patient A, who complained of anxiety and depression. Respondent wrote a prescription to Patient A for Percocet (Oxycodone-

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Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

Acetaminophen) 7.5 mg-325 mg tablets, 50 tablets for a 25-day supply, for a Morphine Milligram Equivalent (MME) dosage of 900 mg/day. Respondent also wrote prescriptions for Patient A for: Prozac, 10 mg tablet, 1 Every Morning for 90 days; Lexapro, 20 mg tablet, 1 Every Morning for 90 days; Xanax, 1 mg tablet, Three times per day for 15 days;

32. Respondent failed to perform a physical examination before prescribing these opioid analgesics, and/or failed to document such examination, failed to support her diagnoses with physical examination findings before prescribing opioid analgesics, and/or failed to document such findings, failed to query the Nevada Prescription Monitoring Program (PMP) before prescribing opioid analgesics, and/or failed to document that query.

33. Over the next twenty-seven months, Respondent regularly wrote numerous prescriptions to Patient A for Oxycodone-Acetaminophen with MME dosages of up to 1800 mg/day; Respondent also regularly wrote prescriptions to Patient A for Alprazolam and Phentermine.

34. Respondent's records for Patient A from September 2013 through April 2016 indicated that at various times during her treatment, Patient A was prescribed the following medications concurrently, with Respondent's knowledge and/or at her direction:

a. Escitalopram, 5 mg tablet, Every Morning;

b. Valium, 10 mg tablet, Twice a day PRN[2];

c. Qsymia, 3.75/23 Extended Release tablet, 1 Every Morning;

d. Bontril Slow-Release, 105 mg capsule, Twice a day;

e. Clonazepam, 1 mg tablet, At bedtime PRN;

f. Xanax, 1 mg tablet, Three times per day;

g. Lexapro, 20 mg tablet, 1 Every Morning;

h. Prozac, 10 mg tablet, 1 Every Morning;

i. Phentermine, 37.5 mg, Twice a day;

j. Percocet, 7.5-325 mg tablet, Twice a day.

35. According to Respondent's records for Patient A from March 9, 2016, Patient A

[2] PRN means "when necessary." It is an abbreviation from the Latin "pro re nata," for an occasion that has arisen, as circumstances require, as needed.

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Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

was taking the following medications concurrently, with Respondent's knowledge and/or at her direction:

a. Flexeril, 10 mg tablet, Twice a day PRN;

b. Lexapro, 20 mg tablet, 1 Every Morning;

c. Prozac, 20 mg capsule, 1 Every Morning;

d. Xanax, ½-1 mg tablet, Twice a day PRN;

e. Percocet, 10-325 mg tablet, Three times a day PRN;

f. Phentermine, 37.5 mg tablet, ½-1 per day PRN.

36. According to Respondent's records for Patient A from April 21, 2016, Patient A was taking the following medications concurrently, with Respondent's knowledge and/or at her direction:

a. Flexeril, 10 mg tablet, Twice a day PRN;

b. Lexapro, 20 mg tablet, 1 Every Morning;

c. Prozac, 20 mg capsule, 1 Every Morning;

d. Xanax, ½-1 mg tablet, Twice a day PRN;

e. Percocet, 10-325 mg tablet, Three times a day PRN.

37. On or about April 27, 2016, Patient A died; the cause of her death was oxycodone and alprazolam intoxication.

38. During the course of her treatment of Patient A, Respondent: failed to perform physical examinations before prescribing opioid analgesics, and/or failed to document such examinations; failed to support her diagnoses with physical examination findings before prescribing opioid analgesics, and/or failed to document such findings; failed to query the Nevada Prescription Monitoring Program (PMP) before prescribing opioid analgesics, and/or failed to document those queries; performed only cursory, duplicative ongoing assessments of Patient A's response to treatment with opioids, benzodiazepines, phentermine appetite suppressants, anticonvulsants, and SSRI antidepressants; failed to identify treatment objectives to evaluate treatment progress, and/or failed to document such; failed to monitor, discuss and adapt her treatment plan, and/or failed to document such efforts; failed to take any substantial action in

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Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

response to repeated negative drug test results for the medications she prescribed to Patient A; failed to refer or consult with a pain management specialist for Patient A's case, and/or failed to document such consultation and referral; failed to track progress toward discontinuation of opioid therapy, and/or failed to document such; repeatedly injected Patient A with "Fat Burner Diet Injections," "B-Complex Injections," and various other substances of unspecified content and origin, the chemical contents of which are not described anywhere in Patient A's medical records; failed to appropriately keep medical records as described herein, and by duplicating notes as well as medications prescribed without any explanation or supporting documentation; and failed to inquire, monitor or manage how Patient A was taking the medications prescribed to ensure the medications were not being hoarded or diverted.

Count IV – Patient A

NRS 630.301(4) (Malpractice)

39. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

40. Malpractice is grounds for disciplinary action against a licensee pursuant to NRS 630.301(4).

41. NAC 630.040 defines malpractice as the failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when treating a patient.

42. Respondent committed malpractice with respect to Patient A by:

a. failing to perform physical examinations before prescribing opioid analgesics, and/or failing to document such examinations;

b. failing to support her diagnoses with physical examination findings before prescribing opioid analgesics, and/or failing to document such findings;

c. failing to query the PMP before prescribing opioid analgesics and other controlled substances, and/or failing to document those queries;

d. performing only cursory, duplicative ongoing assessments of Patient A's response to treatment with opioids, benzodiazepines, phentermine appetite suppressants, anticonvulsants, and SSRI antidepressants;

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

e. failing to identify treatment objectives to evaluate treatment progress, and/or failing to document those objectives;

f. failing to monitor, discuss or adapt her treatment plan;

g. failing to take any substantial action in response to repeated negative drug test results for the medications she prescribed to Patient A, and/or failing to document such actions;

h. failing to refer Patient A to, or consult with, a pain management specialist, and/or failing to document that consultation and referral;

i. failing to track Patient A's progress toward discontinuation of opioid therapy;

j. repeatedly injecting Patient A with "Fat Burner Diet Injections," "B-Complex Injections," and various other substances of unspecified content and origin, the chemical contents of which are not described anywhere in Patient A's medical records;

k. failing to appropriately keep medical records, duplicating notes as well as medications prescribed without any explanation or supporting documentation;

l. and/or failing to inquire, monitor or manage how Patient A was taking the medications prescribed to ensure the medications were not being hoarded or diverted.

43. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Count V – Patient A

NRS 630.306(1)(b)(2) (Violation of Standards of Practice)

44. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

45. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).

46. The Board adopted by reference the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain*, July 2013, published by the Federation of State Medical Boards

of the United States, Inc. (the Model Policy).

47. Pursuant to NAC 630.230(1)(k), a licensee shall not engage in the practice of writing prescriptions for controlled substances to treat acute pain or chronic pain in a manner that deviates from the policies set forth in the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain* adopted by reference in NAC 630.187;

48. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by:

a. failing to perform physical examinations before prescribing opioid analgesics, and/or failing to document such examinations;

b. failing to support her diagnoses with physical examination findings before prescribing opioid analgesics, and/or failing to document such findings;

c. failing to query the PMP before prescribing opioid analgesics, and/or failing to document that queries;

d. performing only cursory, duplicative ongoing assessments of Patient A's response to treatment with opioids, in combination with benzodiazepines, phentermine appetite suppressants, anticonvulsants, and SSRI antidepressants;

e. failing to identify treatment objectives to evaluate treatment progress, and/or failing to document such objectives;

f. failing to monitor, discuss and adapt her treatment plan, and/or failing to document such;

g. failing to take any substantial action in response to repeated negative drug test results for the medications she prescribed to Patient A, and/or failing to document such actions;

h. failing to refer or consult with a pain management specialist, and/or failing to document such referral and consultation;

i. failing to track progress toward discontinuation of opioid therapy, and/or failing to document such;

j. failing to appropriately keep medical records as described herein, as well as

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

duplicating notes and medications prescribed without any explanation or supporting documentation;

k. and/or failing to inquire, monitor or manage how Patient A was taking the medications prescribed to ensure the medications were not being hoarded or diverted.

49. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Count VI – Patient A

NRS 630.306(1)(p) (Engaging in Unsafe or Unprofessional Conduct)

50. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

51. Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board is grounds for disciplinary action against a licensee pursuant to NRS 630.306(1)(p).

52. Respondent engaged in unsafe acts regarding Patient A by the conduct described in paragraph 48 above, and/or by failing to abide by the Model Policy adopted by the Board.

53. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Count VII – Patient A

NRS 630.3062(1)

(Failure to Keep Timely, Legible, Accurate, and Complete Medical Records)

54. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

55. NRS 630.3062(1) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating discipline against a licensee.

56. Respondent failed to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of Patients A, as outlined above, by:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

a. failing to document physical examinations before prescribing opioid analgesics;

b. failing to query the PMP before prescribing opioid analgesics, and to include the PMP report in Patient A's medical record;

c. failing to document support for her diagnoses with physical examination findings;

d. failing to document treatment objectives to evaluate treatment progress;

e. failing to document her efforts to monitor and adapt her treatment plan;

f. failing to document any substantial action in response to repeated negative drug test results for the medications she prescribed;

g. failing to document her referral to or consultation with a pain management specialist;

h. failing to document Patient A's progress toward discontinuation of opioid therapy;

i. repeatedly injecting Patient A with "Fat Burner Diet Injections," "B-Complex Injections," and various other unknown substances without specifying their chemical content in Patient A's medical records;

j. failing to appropriately keep medical records by duplicating notes as well as medications prescribed without any explanation or supporting documentation;

k. and/or failing to document how she inquired about, monitored or managed Patient A's use of the medications prescribed to ensure the medications were not being hoarded or diverted.

57. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Count VIII – Patient A

NRS 630.306(1)(e) (Practicing Beyond the Scope of a Licensee's Training or Competence)

58. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

59. Practicing beyond the scope of a licensee's training or competence is grounds for disciplinary action by the Board pursuant to NRS 630.306(1)(e).

60. Respondent is a physician assistant; she is neither a medical doctor nor a pain

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

medicine specialist.

61. Medical guidelines for prescribing of opioids for chronic pain establish that any dose above 90 MME is high dose opioid therapy, and recommend referral and/or consultation with a pain medicine specialist for daily opioid doses above 90 MME.

62. Respondent prescribed Patient A daily morphine equivalent doses from 900 MME, and up to 1800 MME, for more than 25 months.

63. Respondent failed to refer Patient A to a pain medicine specialist, failed to consult with a pain management specialist regarding Patient A's condition, and/or failed to document such referral and consultation.

64. Respondent practiced beyond the scope of her training or competence by prescribing in this manner inappropriately large amounts of short-acting opioids to Patient A.

65. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Patient B

66. Patient B was a 40-year-old male when he established care with Respondent on July 30, 2013. Patient B's true identity is not disclosed herein to protect his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

67. Respondent was ordered to produce medical records for Patient B on June 23, 2016.

68. Respondent failed to produce any records of her encounters with Patient B.

69. On July 30, 2013, Respondent wrote a prescription to Patient B for Oxycodone-Acetaminophen 10 mg-325 mg tablets, 120 tablets for a 15-day supply, for an MME dosage of 2400 mg/day, and a prescription for Hydrocodone-Clorpheniramine suspension, 177 doses over 18 days, for an additional MME dosage of 212.4 mg/day.

70. Over the next three years, Respondent went on to prescribe the following medications for Patient B, repeatedly:

a. Fentanyl, 75mcg/hr patch, 15 patches over 30 days, for an MME dosage of 8,100 per day;

b. Oxycodone-Acetaminophen, 10-325 mg tablets, 120 tablets over 24 days, for an MME dosage of 1,800 per day;

c. Alprazolam, 0.5 mg tablet, 60 tablets over 30 days.

71. During this three year period, assuming Patient B was taking the medications as directed by Respondent, Patient B regularly had an active MME in excess of 9,000 mg/day, and beginning in April 2015, he had an active MME in excess of 15,000 mg/day.

72. During the course of her treatment of Patient B, Respondent: failed to perform physical examinations before prescribing opioid analgesics, and/or failed to document such examinations; failed to support her diagnoses with physical examination findings before prescribing opioid analgesics, and/or failed to document such findings; failed to query the PMP before or after prescribing opioid analgesics, and/or failed to document those queries; failed to identify treatment objectives to evaluate treatment progress, and/or failed to document those objectives; failed to obtain an informed consent or treatment plan agreement, and/or failed to document such; failed to query the PMP, and/or failed to document such; failed to discuss, monitor and adapt her treatment plan, and/or failed to document such; failed to obtain urinalysis to confirm her patient was taking the prescribed medications as directed, and/or failing to document such; failed to refer Patient B to, or consult with, a pain management specialist, and/or failed to document such referral and consultation; failed to track Patient B's progress toward discontinuation of opioid therapy; failed to appropriately keep medical records; and failed to inquire, monitor or manage how Patient B was taking the medications prescribed to ensure the medications were not being hoarded or diverted.

Count IX – Patient B

NRS 630.301(4) (Malpractice)

73. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

74. Malpractice is grounds for disciplinary action against a licensee pursuant to NRS 630.301(4).

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

75. NAC 630.040 defines malpractice as the failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when treating a patient.

76. Respondent committed malpractice with respect to Patient B by:

a. failing to perform physical examinations before prescribing opioid analgesics, and/or failing to document such examinations;

b. failing to support her diagnoses with physical examination findings before prescribing opioid analgesics, and/or failing to document such findings;

c. failing to query the PMP before or after prescribing opioid analgesics, and/or failing to document those queries;

d. failing to identify treatment objectives to evaluate treatment progress, and/or failing to document such objectives;

e. failing to obtain an informed consent or treatment plan agreement, and/or failing to document such;

f. failing to obtain urinalysis to confirm her patient was taking the prescribed medications as directed, and/or failing to document such;

g. failing to discuss, monitory or adapt her treatment plan, and/or failing to document such;

h. failing to refer Patient B to, or consult with, a pain management specialist, and/or failing to document such referral and consultation;

i. failing to track Patient B's progress toward discontinuation of opioid therapy;

j. failing to appropriately keep medical records or her encounters;

k. and/or failing to inquire, monitor or manage how Patient B was taking the medications prescribed to ensure the medications were not being hoarded or diverted.

77. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Count X – Patient B

NRS 630.306(1)(b)(2) (Violation of Standards of Practice)

78. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

79. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).

80. The Board adopted by reference the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain*, July 2013, published by the Federation of State Medical Boards of the United States, Inc.

81. Pursuant to NAC 630.230(1)(k), a licensee shall not engage in the practice of writing prescriptions for controlled substances to treat acute pain or chronic pain in a manner that deviates from the policies set forth in the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain* adopted by reference in NAC 630.187;

82. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by:

a. failing to perform physical examinations before prescribing opioid analgesics, and/or failing to document such examinations;

b. failing to support her diagnoses with physical examination findings before prescribing opioid analgesics, and/or failing to document such findings;

c. failing to query the PMP before or after prescribing opioid analgesics, and/or failing to document those queries;

d. failing to identify treatment objectives to evaluate treatment progress, and/or failing to document those objectives;

e. failing to obtain an informed consent or treatment plan agreement, and/or failing to document these;

f. failing to discuss, monitor and adapt her treatment plan, and/or failing to document such;

g. failing to obtain urinalysis to confirm her patient was taking the prescribed medications as directed, and/or failing to document such;

h. failing to refer Patient B to, or consult with, a pain management specialist, and/or

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1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

failing to document such referral and consultation;

i. failing to track Patient B's progress toward discontinuation of opioid therapy;

j. failing to appropriately keep medical records;

k. and/or failing to inquire, monitor or manage how Patient B was taking the medications prescribed to ensure the medications were not being hoarded or diverted.

83. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Count XI – Patient B

NRS 630.306(1)(p) (Engaging in Unsafe or Unprofessional Conduct)

84. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

85. Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board is grounds for disciplinary action against a licensee pursuant to NRS 630.306(1)(p).

86. Respondent engaged in unsafe acts regarding Patient B by the conduct described in paragraph 82 above, and/or by failing to abide by the Model Policy adopted by the Board.

87. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Count XII – Patient B

NRS 630.3062(1)

(Failure to Keep Timely, Legible, Accurate, and Complete Medical Records)

88. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

89. NRS 630.3062(1) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating discipline against a licensee.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

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(775) 688-2559

90. Respondent failed to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of Patient B by failing to keep and produce any medical records of her encounters with Patient B as outlined above, and by:

a. failing to document a physical examination before prescribing opioid analgesics;
b. failing to document support for her diagnoses with physical examination findings before prescribing opioid analgesics;
c. failing to query the PMP and include the PMP report in Patient B's medical record;
d. failing to document her efforts to monitor and adapt her treatment plan;
e. failing to document her referral to or consultation with a pain management specialist;
f. failing to document Patient B's progress toward discontinuation of opioid therapy;
g. failing to appropriately keep medical records, duplicating notes as well as medications prescribed without any explanation or supporting documentation;
h. and/or failing to document how she inquired about, monitored or managed Patient B's use of the medications prescribed to ensure the medications were not being hoarded or diverted.

91. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Count XIII – Patient B

NRS 630.306(1)(e) (Practicing Beyond the Scope of a Licensee's Training or Competence)

92. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

93. Practicing beyond the scope of a licensee's training or competence is grounds for disciplinary action by the Board pursuant to NRS 630.306(1)(e).

94. Respondent is a physician assistant; she is neither a medical doctor nor a pain medicine specialist.

95. Medical guidelines for prescribing of opioids for chronic pain establish that any dose above 90 MME is high dose opioid therapy, and recommend referral and/or consultation with

a pain medicine specialist for daily opioid doses above 90 MME.

96. Respondent prescribed Patient B daily morphine equivalent doses in excess of 90 mg/day, and as high as 15,000 MME, for more than two years.

97. Respondent failed to refer Patient B to a pain medicine specialist, failed to consult with a pain management specialist regarding Patient B's condition, and/or failed to document such referral and consultation.

98. Respondent practiced beyond the scope of her training or competence by prescribing in this manner inappropriately large amounts of short-acting opioids to Patient B.

99. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Patient C

100. Patient C was a 53-year-old female, 5'8" tall, weighing 217 lbs., when she established care with Respondent on October 24, 2013. Patient C's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

101. On September 19, 2014, Respondent wrote a prescription to Patient C for Hydrocodone-Acetaminophen 5 mg-325 mg tablets, 60 tablets for an eight-day supply, for an MME dosage of 180 mg/day.

102. Respondent failed to perform a physical examination before prescribing these opioid analgesics, and/or failed to document such examination, failed to support her diagnoses with physical examination findings, and/or failed to document such findings, and failed to query the Nevada Prescription Monitoring Program (PMP) before prescribing opioid analgesics, and failed to document that query.

103. On October 7, 2017, 2014, Respondent wrote another prescription to Patient C for Hydrocodone-Acetaminophen 5 mg-325 mg tablets, 120 tablets for a 15-day supply, or eight tablets per day, for an MME dosage of 360 mg/day.

104. Over the next eight months, Respondent wrote numerous prescriptions to Patient C for Hydrocodone-Acetaminophen with MME dosages of up to 900 mg/day.

OFFICE OF THE GENERAL COUNSEL
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105. During the course of her treatment of Patient C, Respondent also: performed only cursory, duplicative ongoing assessments of Patient C's response to treatment with opioids; failed to identify treatment objectives to evaluate treatment progress, and/or failed to document such; failed to regularly query the PMP or monitor and adapt her treatment plan, and/or failed to document such; failed to refer to or consult with a pain management specialist for Patient C's case, and/or failed to document such consultation and referral; failed to track progress toward discontinuation of opioid therapy, and/or failed to document such; failed to appropriately keep medical records as described herein, and also by duplicating notes as well as medications prescribed without any explanation or supporting documentation; and failed to inquire, monitor or manage how Patient C was taking the medications prescribed to ensure the medications were not being hoarded or diverted.

Count XIV – Patient C

NRS 630.301(4) (Malpractice)

106. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

107. Malpractice is grounds for disciplinary action against a licensee pursuant to NRS 630.301(4).

108. NAC 630.040 defines malpractice as the failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when treating a patient.

109. Respondent committed malpractice with respect to Patient C by:

a. failing to perform a physical examination before prescribing opioid analgesics, and/or failing to document such examination;

b. failing to support her diagnoses with physical examination findings before prescribing opioid analgesics, and/or failing to document such findings;

c. failing to regularly query the PMP before prescribing opioid analgesics, and/or failing to document that query;

d. performing only cursory, duplicative ongoing assessments of Patient C's response to treatment with opioids;

e. failing to identify treatment objectives to evaluate treatment progress, and/or failing to document those objectives;

f. failing to monitor and adapt her treatment plan;

g. failing to refer Patient C to, or consult with, a pain management specialist, and/or failing to document such referral and consultation;

h. failing to track Patient C's progress toward discontinuation of opioid therapy;

i. failing to appropriately keep medical records, duplicating notes as well as medications prescribed without any explanation or supporting documentation;

j. and/or failing to inquire, monitor or manage how Patient C was taking the medications prescribed to ensure the medications were not being hoarded or diverted.

110. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Count XV – Patient C

NRS 630.306(1)(b)(2) (Violation of Standards of Practice)

111. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

112. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).

113. The Board adopted by reference the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain*, July 2013, published by the Federation of State Medical Boards of the United States, Inc.

114. Pursuant to NAC 630.230(1)(k), a licensee shall not engage in the practice of writing prescriptions for controlled substances to treat acute pain or chronic pain in a manner that deviates from the policies set forth in the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain* adopted by reference in NAC 630.187;

115. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
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(775) 688-2559

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a. failing to perform physical examinations before prescribing opioid analgesics, and/or failing to document such examination;

b. failing to support her diagnoses with physical examination findings before prescribing opioid analgesics, and/or failing to document such findings;

c. failing to regularly query the PMP before prescribing opioid analgesics, and failing to document that query;

d. performing only cursory, duplicative ongoing assessments of Patient C's response to treatment with opioids;

e. failing to identify treatment objectives to evaluate treatment progress, and/or failing to document such objectives;

f. failing to monitor and adapt her treatment plan, and/or failing to document such;

g. failing to refer Patient C to, or consult with, a pain management specialist, and/or failing to document such referral and consultation;

h. failing to track Patient C's progress toward discontinuation of opioid therapy;

i. failing to appropriately keep medical records as described herein, and by duplicating notes as well as medications prescribed without any explanation or supporting documentation;

j. and/or failing to inquire, monitor or manage how Patient C was taking the medications prescribed to ensure the medications were not being hoarded or diverted.

116. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Count XVI – Patient C

NRS 630.306(1)(p) (Engaging in Unsafe or Unprofessional Conduct)

117. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

118. Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board is grounds for disciplinary action against a licensee pursuant to

NRS 630.306(1)(p).

119. Respondent engaged in unsafe acts regarding Patient C by the conduct described in paragraph 115 above, and by failing to abide by the Model Policy adopted by the Board.

120. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Count XVII – Patient C

NRS 630.3062(1)

(Failure to Keep Timely, Legible, Accurate, and Complete Medical Records)

121. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

122. NRS 630.3062(1) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating discipline against a licensee.

123. Respondent failed to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of Patient C, as outlined above, by:

a. failing to document a physical examination before prescribing opioid analgesics;
b. failing to document support for her diagnoses with physical examination findings before prescribing opioid analgesics;
c. failing to regularly query the PMP and include the PMP reports in Patient C's medical record;
d. failing to document her efforts to monitor and adapt her treatment plan;
e. failing to document her referral to or consultation with a pain management specialist;
f. failing to document Patient C's progress toward discontinuation of opioid therapy;
g. failing to appropriately keep medical records, duplicating notes as well as medications prescribed without any explanation or supporting documentation;

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h. and/or failing to document how she inquired about, monitored or managed Patient C's use of the medications prescribed to ensure the medications were not being hoarded or diverted.

124. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Count XVIII – Patient C

NRS 630.306(1)(e) (Practicing Beyond the Scope of a Licensee's Training or Competence)

125. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

126. Practicing beyond the scope of a licensee's training or competence is grounds for disciplinary action by the Board pursuant to NRS 630.306(1)(e).

127. Respondent is a physician assistant; she is neither a medical doctor nor a pain medicine specialist.

128. Medical guidelines for prescribing of opioids for chronic pain establish that any dose above 90 MME is high dose opioid therapy, and recommend referral and/or consultation with a pain medicine specialist for daily opioid doses above 90 mg morphine equivalents.

129. Respondent prescribed Patient C daily morphine equivalent doses in excess of 90 MME, for more than eight months.

130. Respondent failed to refer Patient C to a pain medicine specialist and failed to consult with a pain management specialist regarding Patient C's condition, and failed to document such referral and consultation.

131. Respondent practiced beyond the scope of her training or competence by prescribing in this manner inappropriately large amounts of short-acting opioids to Patient C.

132. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the IC prays that the Board:

1. Give Respondent notice of the charges set forth in this Complaint;

2. Give Respondent notice that Respondent may file an answer to the Complaint as

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
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set forth in NRS 630.339(2) within 20 days of service of the Complaint;

3. Set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

4. Determine the sanctions it will impose if it finds Respondent violated the Medical Practice Act;

5. Make, issue, and serve on Respondent, in writing, its findings of fact, conclusions of law and order, which shall include the sanctions, if imposed; and

6. Take such other and further action as may be just and proper in this matter.

Dated this 22 day of AUGUST, 2017.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

Robert Kilroy, Esq., General Counsel
Jasmine Mehta, Deputy General Counsel
Aaron Bart Fricke, Deputy General Counsel
Attorneys for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

VERIFICATION

STATE OF NEVADA)

) ss.

COUNTY OF WASHOE)

Wayne Hardwick, M.D., hereby deposes and states under penalty of perjury under the laws of the state of Nevada that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the foregoing Complaint against the Respondent herein; that he has read the foregoing Complaint; and based upon information discovered during the course of the investigation into a complaint against Respondent, he believes the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

Dated this 22nd day of August, 2017.

Wayne Hardwick

Wayne Hardwick, M.D.
Chairman, Investigative Committee
Nevada State Board of Medical Examiners

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
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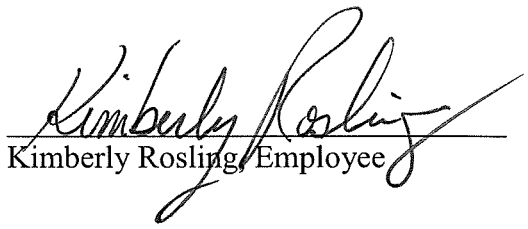
CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 22nd day of August, 2017, I served a file-stamped copy of the COMPLAINT and FINGERPRINT INFORMATION, via USPS e-certified return receipt mail **(9171 9690 0935 0096 2326 72)** to the following:

Angela Lorenzo, PA-C
911 North Buffalo Road, Suite 113
Las Vegas, NV 89128

DATED this 22nd day of August, 2017.



Kimberly Rosling, Employee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559