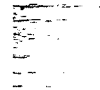
BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against Robert Rand, M.D., Respondent.	**Case No. 17-25704-1**



FILED

FEB - 2 2017

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

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

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board) hereby issues this formal Complaint (Complaint) against Robert Rand, M.D. (Respondent), a licensed physician 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 was licensed by the Board, pursuant to the provisions of the Medical Practice Act, on July 1, 2005, and is currently licensed in active status (License No. 11470).

B. Respondent's Patients[2]

Patient A:

2. Patient A is a 46- year-old female. Patient A's records from October 2013 through April 2016 showed that her history was significant for low back pain, facial numbness and

[1] The Investigative Committee of the Nevada State Board of Medical Examiners is composed of Board members Rachakonda D. Prabhu, M.D., Victor M. Muro, M.D., and Ms. Sandy Peltyn.

[2] The true identities of the patients listed herein are not disclosed in this Complaint to protect their identities, but their identities have been disclosed to Respondent in the Patient Designation contemporaneously served on Respondent with a copy of this Complaint.

fingertip numbness. She had magnetic resonance imaging (MRI) examinations of her lumbar and cervical spine in 2010, reported as demonstrating lumbar disc bulges, mild lumbar stenosis and cervical degenerative changes. Her musculoskeletal and neurological examinations were normal. She was taking oxycodone 240 mg per day at the time of initial evaluation, or 360 morphine milligram equivalents (MME). Diagnoses were listed as brachial neuritis/radiculitis, lumbago, lumbar spinal stenosis, and disorders of menstruation.

3. Over approximately the next 30 months, Respondent increased her oxycodone dose to 30 mg (12 pills per day) and added hydrocodone/acetaminophen 10 mg hydrocodone/325 mg acetaminophen (10/325) tablets, titrating to 6 pills per day, for an approximate MME of 600. On Patient A's initial treatment with Respondent, on or about October 7, 2013, Respondent started Patient A on a narcotic dose of approximately 360 MME; no musculoskeletal or neurological examinations were documented. No Nevada State Board of Pharmacy Prescription Monitoring (NSBPPM) report was requested. On or about December 27, 2013, Respondent increased Patient A's MME to approximately 480 without sufficient explanation or history of poor pain control. On or about February 17, 2014, Respondent increased Patient A's MME to approximately 660 without sufficient medical justification. In addition he prescribed gabapentin and recommended ibuprofen. Respondent did not order advanced spinal imaging or refer Patient A to pain medicine or spinal surgery specialists. Urine drug tests were performed and appeared to be appropriate for the drugs prescribed to Patient A, except for the results from a test on or about July 16, 2015, when non-prescribed amphetamine was detected. Patient A reported stolen prescriptions on or about March 3, 2016. In 2016, references were made to buprenorphine as a listed medication. On or about December 8, 2015, it was documented that the patient "overtook her medication," and was prescribed buprenorphine/naloxone as treatment to prevent withdrawal while waiting for her next prescription.

4. Respondent failed to support diagnoses with physical examination findings. Respondent's ongoing assessments were cursory. Respondent failed to recommend diagnostic procedures. Respondent performed no opioid risk analysis. Respondent titrated opioids to high levels without evidence of efficacy. Respondent inappropriately utilized two short-acting opioids,

oxycodone and hydrocodone/acetaminophen simultaneously. Despite Patient A having an aberrant urine test, which tested positive for non-prescribed amphetamine, and reporting a stolen prescription, Respondent did not modify treatment of Patient A. Despite daily morphine equivalent doses of over 600 mg and evidence of misuse, Respondent failed to refer the patient to a specialist. Additionally, Patient A was tachycardic for over 75% of her visits, which Respondent never addressed. In summary, Respondent provided no significant medical care other than providing inappropriately large amounts of short-acting opioids.

Patient B:

5. Patient B was a 33-year-old female treated by Respondent for lumbago, asthma and migraines from approximately April 26, 2010 to December 31, 2010, and again from approximately May 15, 2014 to March 24, 2016. Patient B's medical records showed that a pain specialist provided trigger point injections and recommended lumbar interventions in 2013. A 2013 lumbar MRI demonstrated lumbar discopathy. On or about December 31, 2010, Respondent documented that Patient B was taking thirty sleeping pills a day (zalepon 10 mg). On or about May 15, 2014, when Patient B reestablished care by Respondent, Respondent started Patient B on Percocet (a combination of oxycodone and acetaminophen) 7.5/324 mg 1-2 tablets every 4 hours as needed, which was a morphine milligram equivalent dose of approximately 135, without documentation regarding why Respondent was prescribing pain medication. Respondent failed to document physical examination findings other than tight lumbar muscles on or about May 15, 2014. On or about May 23, 2014, Respondent documented that he discussed "doctor shopping"[3] with Patient B, based on an aberrant NSBPPM report. By March 2016 Respondent increased Patient B's opioid prescription to approximately 540 MME. On or about November 21, 2014, Patient B expressed a desire to taper off her pain medications; instead, Respondent continued her existing prescription of oxycodone. Respondent tried Patient B on suboxone therapy to wean her from narcotics beginning on or about December 5, 2014, but discontinued suboxone on or about December 18, 2014 and resumed Patient B's prior dose of oxycodone. In 2015, Respondent

[3] "The term 'doctor shopping' has traditionally referred to a patient obtaining controlled substances from multiple healthcare practitioners without the prescribers' knowledge of the other prescriptions." Centers for Disease Control & Prevention, Office for State, Tribal, Local and Territorial Support, www.cdc.gov/phlp/docs/menu-shoppinglaw.pdf

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

obtained cervical, thoracic and lumbar MRI examinations that documented degenerative changes and an L45 annular tear. Respondent prescribed various opioids in various forms, including hydromorphone suppositories, oxycodone pills and oxycodone suspension. In late 2015, he prescribed buprenorphine/naloxone, presumably as part of an opioid weaning protocol. After one week, the buprenorphine/naloxone was stopped and Respondent upwardly titrated oxycodone 30 mg 180 pills/month in December 2014 to 360 pills/month in January 2015. He trialed her on oxycodone ER along with the short-acting oxycodone for one month, then returned to prescribing only the short-acting oxycodone (30 mg, 300 to 360 pills/month). NSBPPM reports noted codeine cough syrup prescribed by another physician, as well as a prescription for oxycodone from another physician on or about August 28, 2015. Multiple urine drug tests were non-aberrant.

6. Despite evidence of aberrant substance use behaviors[4] (previous zalepon abuse, aberrant NSBPPM reports), Respondent prescribed extremely high doses of short-acting oxycodone (540 MME). Rather than refer Patient B to an addiction specialist after failing to wean her from opioids, Respondent increased her opioid dose. Respondent failed to refer her to another pain or spine specialist. Respondent failed to document abnormal physical examination findings that supported her diagnoses and justified increasing her opioid dosages.

7. Patient B had numerous visits with significant tachycardia that was never addressed, which failure to address fell below the standard of care.

8. Respondent failed to adequately address and treat Patient B's asthma by failing to adequately monitor or evaluate Patient B's asthma, failing to order pulmonary function tests, and failing to take a history to evaluate asthma control, which fell below the standard of care.

Patient C:

9. Patient C is a 37-year-old male. Respondent treated Patient C for lumbago and anxiety from about August 9, 2012 until about July 3, 2015. During these three years of treatment, no musculoskeletal examination or neurological examination was documented. No advanced

[4] Aberrant Substance Use Behaviors is defined in the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain,* adopted as policy by the House of Delegates of the Federation of State Medical Boards in July 2013, as "Behaviors that are outside the boundaries of the agreed-upon treatment plan may constitute aberrant substance use behaviors. For example, obtaining prescriptions for the same or similar drugs from more than one physician or other health care provider without the treating physician's knowledge is aberrant behavior, as is use of illicit drugs."

imaging was performed. No specialty referral was documented. Respondent commenced opioid therapy with oxycodone 30 mg, titrating from 100 pills/month, an MME starting dose of 180, to 300-360 pills/month. During the course of treatment, Respondent added oxycodone 15 mg (140/month) and diazepam 2 mg (60/month). Respondent escalated Patient C's opioid load, without adequate medical justification, from an initial MME of approximately 180 on or about August 9, 2012 to an MME of approximately 720 on or about October 23, 2013. Respondent escalated Patient C's opioid dosage, even though Patient C reported low levels of pain.

10. Patient C reportedly lost his medications once, reported his medications stolen once and stated that the police confiscated his medications once after he was arrested. Respondent wrote prescriptions without evaluating the patient twelve times. Urine drug tests demonstrated aberrant drug use behavior on multiple occasions, including the presence of cocaine on or about August 29, 2013, non-prescribed alprazolam on or about September 16, 2014, and amphetamine, methamphetamine, tetrahydrocannabinol ("THC"), codeine and hydrocodone on or about July 3, 2015, at which point Respondent discharged Patient C and recommended a methadone clinic.

11. Respondent failed to document a physical examination consistent with pain pathophysiology. Respondent failed to refer the patient to a pain medicine specialist, a spine specialist or an addiction specialist. Respondent rapidly escalated short-acting oxycodone prescriptions to 720 mg morphine equivalents/day. Respondent simultaneously prescribed two short-acting versions of the same opioid (oxycodone 30 mg and oxycodone 15 mg). Respondent failed to evaluate Patient C over one-third of the time, allowing prescriptions to be issued by his staff. While Respondent did perform some available opioid risk mitigation measures, such as requesting NSBPPM reports and urine drug tests, he failed to act on two aberrant urine tests. Respondent failed to recognize obvious signs of high risk behavior, failed to adequately evaluate the patient and failed to refer the patient to appropriate specialists.

12. Respondent prescribed valium to Patient C for insomnia and anxiety, which is relatively contraindicated when the patient is concomitantly using opioids. There is limited documentation in regards to medical indication for such prescription, especially given Patient C's opioid prescriptions, response to the medication, and medication dose increases.

Patient D:

13. Patient D is a 32-year-old male treated by Respondent for left upper extremity pain from approximately September 5, 2013 through March 8, 2016. The stated diagnoses were pain in limb, chronic pain due to trauma and upper limb mononeuritis multiplex. No neurological or musculoskeletal examination was documented. No neurophysiological testing results were noted. Respondent prescribed 100 pills of oxycodone of 15 mg on his first visit, and titrated upwards to oxycodone 30 mg (300 pills). On several occasions, Respondent prescribed two separate prescriptions for oxycodone.

14. Patient D admitted during his first visit using non-prescribed oxycodone. On or about March 29, 2014, Patient D stated his medications were stolen. Despite findings indicating a high risk of opioid abuse, Respondent failed to order urine drug tests for two years. Respondent provided prescriptions on five occasions without evaluating the patient. Multiple times, Patient D received his medications 5-7 days early.

15. Urine drug tests revealed drug abuse (marijuana on or about April 15, 2016; methamphetamine on or about February 16, 2016 and March 2, 2016) and possible diversion (no evidence of prescribed oxycodone on or about February 16, 2016). Despite these aberrant substance use behaviors, Respondent prescribed 300 pills of oxycodone 30 mg on or about March 8, 2016 and April 5, 2016.

16. Respondent provided massive doses of short-acting oxycodone (450 MME/day) to a patient with no documented physical examination findings, no neurophysiological testing, no documented advanced imaging and early evidence of aberrant behavior. Respondent failed to refer Patient D to subspecialists, such as neurologists, orthopedic surgeons or pain medicine specialists. Respondent failed to employ reasonable risk mitigation and monitoring techniques. Respondent failed to order an urine drug test or NSBPPM report for over two years. No medical justification existed for Respondent to prescribe two separate prescriptions for oxycodone on the same day. Urine drug tests revealing illegal drugs and the absence of prescribe medication did not result in decisive, responsible action.

//

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

Patient E:

17. Patient E is a 48-year-old female treated by Respondent from July 11, 2008 through March 11, 2016 for various diagnoses, including polyarthropathy, bilateral knee pain, anxiety and chronic pain. She was taking oxycodone ER prior to becoming Respondent's patient. Respondent escalated Patient E's opioid load, from 60 oxycodone extended release (ER) 40 mg pills per month (approximately 120 MME/day) to 120 oxymorphone 40 mg pills per month and 560 oxycodone 30 mg pills per month (over 1900 MME/day). In addition, Respondent prescribed alprazolam 1mg (60/month), a benzodiazepine, which is relatively contraindicated when a patient is taking opioid medications.

18. Respondent rapidly escalated Patient E's opioid load, from an MME of approximately 120 on July 11, 2008; to approximately 240 MME on July 31, 2008; to approximately 360 MME on September 15, 2008; to approximately 480 MME on October 8, 2008; to approximately 960 MME on November 26, 2008. Although her medication was cut back in May 2009, Respondent again began to escalate her prescriptions shortly thereafter. By January 13, 2011, Respondent prescribed an MME of approximately 1020, and an MME of approximately 1902 on May 7, 2012. It wasn't until January 2016 that Respondent expressed concern regarding Patient E's extremely high opioid load.

19. Respondent's documentation failed to demonstrate significant physical examination findings. Respondent's only non-opioid treatment was a right knee steroid injection in 2009. He ordered a left knee MRI examination in 2008, which diagnosed a torn ACL. Despite several aberrant urine drug tests, aberrant "pill counts," and one aberrant NSBPPM report, Respondent continued to prescribe massive amounts of opioids. Patient E was evaluated by Respondent in slightly less than monthly intervals, resulting in approximately 13 "monthly" prescriptions per year.

20. Respondent recommended a referral to an addiction specialist in 2009, but Patient E did not comply. After documenting aberrant behavior in 2012, Respondent noted that he would "keep an eye on her" and that he did not "suspect foul play" or "diversion."

21. Respondent provided massive doses of opioids (almost 2,000 MME/day), along

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

with alprazolam, a benzodiazepine, which is relatively contraindicated for a person on opioid medication. Respondent failed to document evidence of pathology. While monitoring Patient E for compliance, Respondent failed to act on documented aberrant behavior and failed to refer Patient E to an appropriate specialist.

22. Patient E had abnormal vitals that were not addressed or were addressed after a significant delay.

Patient F:

23. Patient F is a 41-year-old male treated by Respondent. Patient F's listed diagnoses were lumbago, pain in pelvic region and thighs, cervicalgia, brachial neuritis or radiculitis, fracture of greater tuberosity of humerus. Medical records from October 19, 2011 through May 26, 2015 show that Patient F presented with a history of opioid use, specifically morphine ER 60 mg twice daily and both tramadol 50 mg and hydrocodone/acetaminophen 7.5/650 mg as needed, or "prn". Patient F's MME at his first visit to Respondent on or about October 19, 2011 was approximately 175. Respondent increased Patient F's opioid load in response to a motor vehicle accident on or about December 7, 2012 by adding hydromorphone 4 mg 4 times a day (60 pills/month) to his regimen. Over the next two years, Respondent escalated Patient F's opioid load to approximately 520 MME without sufficient medical justification. On or about May 26, 2015, Respondent changed the morphine ER 60 mg tid to morphine IR 30 mg "two pills three times a day" without documenting any medical decision making as to this change. As documented on or about May 26, 2015, Patient F was prescribed three short-acting opioids simultaneously: morphine IR 30 (180/month), oxycodone 20 mg (200/month) and tramadol 50 mg (90/month), which total over 500 MME/day. The reviewed medical record failed to demonstrate any evidence of abnormal examination findings. No specialty referral was initiated. The only documented advance imaging was from hospital emergency room visits. Respondent did not order any. NSBPPM queries and urine drug tests were ordered and were non-aberrant. Respondent evaluated the patient every other month.

24. Respondent failed to document examination findings or imaging findings to

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

support the massive opioid load prescribed to this Patient. Respondent failed to refer Patient F to an appropriate specialist. Contrary to the standard of care, Respondent prescribed two and three short-acting opioids simultaneously. For undocumented reasons, Respondent changed Patient F's long-acting morphine prescription to short-acting morphine. There is no medical rationale for adding tramadol, which has one-tenth the potency of morphine, to the massive amounts of prescribed morphine. Respondent failed to evaluate Patient F on a monthly basis. This opioid regimen is outside the standard of care and without clinical justification.

Patient G:

25. Patient G is a 29-year-old male treated by Respondent from April 12, 2013 through March 28, 2016. His listed diagnoses include cervicalgia, chronic pain, joint pain, lower leg joint pain, shoulder joint pain and decreased libido. No physical examination findings were ever documented to support the diagnoses of severe pain or significant joint dysfunction. Patient G's opioid level escalated from an MME of approximately 120 on or about April 15, 2013 to approximately 720 on or about September 18, 2014.

26. Patient G signed a document stating that "if you go through your medication faster than it is prescribed you may not be issued a refill until the prescription is actually due." Respondent performed multiple risk mitigation measures, including several urine drug tests, multiple NSBPPM queries and two pill counts. Patient G reported stolen medications on or about July 5, 2013 and November 18, 2015, requested an early refill on or about October 6, 2014, had a refill picked up by a friend on or about March 19, 2015 and had multiple aberrant urine drug tests on or about May 18, 2015 (non-prescribed morphine and hydrocodone), May 6, 2013 (cocaine), and March 23, 2015 (non-prescribed benzodiazepine). Respondent directed Patient G to another physician to renew his medical marijuana card but made no other specialty referrals. On or about July 5, 2013, Respondent signed a note indicating that further requests for early medications, further inconsistent toxicology screens or any other incidents regarding narcotic medication would result in a referral to pain management and that Respondent would no longer prescribe narcotic medication to Patient G. Despite multiple aberrancies subsequent to that date, no such pain medicine referral was made and Respondent continued to prescribe opioid medications to

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

Patient G.

27. Patient G's opioid prescriptions were quickly increased over time without medical justification for doing so. On Patient G's initial visit, Respondent prescribed 55 tablets of oxycodone 10 mg. Approximately three days later, he prescribed 120 pills of oxycodone 15mg and 120 pills of tramadol 50 mg. Approximately three weeks after that, Respondent prescribed 210 pills of oxycodone 15 mg. Respondent continued to escalate the doses of short-acting opioids to oxycodone 30 mg (300 pills/month) and oxycodone 15 mg (150 pills/month), or approximately 720 MME/day. On or about August 15, 2015, Respondent added alprazolam 0.5 mg (30 pills/month) to the regimen, which is relatively contraindicated.

28. Despite the use of medical marijuana and multiple aberrant urine drug tests (and documentation that Respondent recognized the problem), Respondent took no definitive action to ensure compliance with prescription usage. In fact, Respondent continued to increase the short-acting oxycodone prescriptions to a massive opioid load. Respondent added a benzodiazepine to the opioid regimen. No pertinent examination findings were documented to support prescribing such large quantities and doses of opioid medication or anxiety medication. Respondent failed to refer the patient to a pain medicine specialist or an addition specialist. Respondent provided two separate prescriptions of the same opioid per month (30 mg pills and 15 mg pills of oxycodone) without documenting the reasoning for doing so.

Patient H:

29. Patient H is a 41-year-old male treated by Respondent from approximately September 19, 2012 through April 8, 2016 for pain diagnoses of brachial neuritis, cervicalgia, muscle spasm, shoulder pain, ankle/foot pain, left knee pain and left knee anterior cruciate ligament (ACL) tear. In addition, Patient H was diagnosed with hypogonadism. During Patient H's initial evaluation, Patient H admitted obtaining oxycodone from a family member. Other than well documented lower extremity findings consistent with a deep venous thrombosis in 2015, no physical examination evidence was documented to support Patient H's pain complaints. On multiple occasions, Respondent failed to report a physical examination. On ten occasions, Respondent provided opioid prescriptions without even evaluating Patient H. While Patient H

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

was referred to an orthopedic surgeon in 2013, Respondent did not refer him to pain medicine or addiction specialists. Respondent performed only one NSBPPM query, on the initial evaluation date, and this documented multiple opioid providers. Urine drug tests were performed multiple times with no evidence of illegal drugs or non-prescribed medications. Respondent's treatment of Patient H's pain consisted of the rapid escalation of opioids, from an extremely high starting MME of 480 on or about September 19, 2012, culminating in approximately 540 MME in 2016.

30. Despite evidence of aberrant opioid use, including obtaining prescription drugs from a family member, and an aberrant NSBPPM report, Respondent aggressively escalated Patient H's short-acting oxycodone dose to approximately 540 MME per day. Respondent failed to examine Patient H on multiple office exams, failed to document any physical examination findings when he did examine Patient H and failed to even evaluate Patient H on ten occasions. No referral to a pain medicine or addiction specialist was made. Two prescriptions for short-acting oxycodone were prescribed each month without any documentation supporting the reason for those prescriptions.

31. Respondent also managed Patient H's low testosterone. Respondent's documentation and labs are inadequate to make a diagnosis of low testosterone, or hypogonadism. Respondent used a breast cancer drug in an off label use to suppress estradiol.

32. Patient H's vitals demonstrated a persistent tachycardia, which Respondent failed to recognize over several office visits. Respondent failed to document a plan for cardiac evaluation and additional work up.

Patient I:

33. Patient I is a 40-year-old male with the diagnoses of obesity, pain in multiple joints and chronic pain. He was treated for hypogonadism. Respondent's medical records for Patient I from approximately January 16, 2013 through January 7, 2016 show that Respondent's initial evaluation noted multiple pelvic scars and a "foot drop." No detailed musculoskeletal or neurological examination was documented. Respondent initially provided a two-week prescription of hydromorphone 4 mg (112 pills), which is approximately 128 MME/day. Approximately two weeks later, Respondent prescribed oxycodone 10 mg (150 pills/month) and, thereafter, escalated

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

the opioid load to 240 oxycodone 30 mg pills per month (approximately 540 MME/day). Patient I demonstrated aberrant urine drug tests on four occasions. Three were positive for THC and one was positive for the metabolite of ethanol. Respondent provided opioid prescriptions on five occasions without evaluating Patient I. No referral to orthopedic, neurosurgical or pain medicine specialists was documented.

34. Respondent rapidly escalated Patient I's opioid load without seeking diagnostic information; documenting any indication for doing so, such as worsening pain or decreased function; addressing alternate treatments; or referring to other specialists. Other than the inconsistently documented observation of an "antalgic gait'" and "foot drop," no examination findings were documented to support the opioid prescriptions. Respondent failed to address the aberrant urine drug test results. Respondent prescribed the short-acting oxycodone without an evaluation on multiple occasions.

35. Respondent also prescribed benzodiazepines to Patient I to treat sleep or anxiety, in spite of the black box warning cautioning against use of combination therapy because of increased risk of respiratory suppression. Respondent should have used alternate medicines as first line therapy.

36. Respondent treated Patient I with testosterone, even though Patient I's hematocrit of 50% contraindicated testosterone treatment. Furthermore, Respondent did not confirm the diagnosis with a second test or evaluate Patient I for secondary causes. Patient I was seen by an endocrinologist, and it would have been appropriate for Respondent to defer to this provider.

Patient J:

37. Patient J is a 60-year-old male with the diagnoses of chronic pain and lower leg joint pain. Records from approximately January 16, 2015 through May 21, 2015 show that no abnormal physical examination findings were documented. On the initial visit, Respondent prescribed oxycodone 10 mg for two weeks (60 pills), a starting MME of approximately 150, and requested medical records. After two weeks and without evidence of past medical record review, Respondent prescribed 300 pills of oxycodone 10 mg. This opioid dose was doubled to 20 mg, 150 pills/month (180 MME/day) without explanation. By March 4, 2016, Patient J was prescribed

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

270 MME/day. One urine drug test was aberrant, testing positive for non-prescribed oxazepam. Respondent failed to take any action as a result. On seven separate occasions, Respondent prescribed the short-acting oxycodone without evaluating Patient J.

38. Without documented physical examination findings or corroborating medical records to justify the opioid prescriptions, Respondent prescribed large amounts of short-acting opioids. Respondent failed to address an aberrant urine drug test. On multiple occasions, Respondent prescribed opioid prescriptions without evaluating the patient. No referral to an orthopedic surgeon or pain medicine specialist was documented.

39. Patient J has high cholesterol with a 10-year heart attack risk rate of 17.9%. Respondent did not timely start a high intensity statin for Patient J, which would have decreased his risk to 4.8%. Such failure fell below the standard of care.

Patient K:

40. Patient K was a 33-year-old male treated by Respondent from approximately June 4, 2014 until his death on or about October 7, 2015. His pain diagnoses were lumbago, joint pain and generalized pain. He was also treated with testosterone for decreased libido. During his 16 months of treatment, multiple aberrant behaviors were documented, including stolen medications, lost medications, multiple requests for early prescriptions, an aberrant urine drug test that showed he was taking non-prescribed medication and two aberrant NSBPPM reports that noted opioid prescriptions from other physicians. The medical records document no abnormal physical examination findings. Respondent specifically documented that Patient K did not drink alcohol or use illegal drugs. Respondent initially prescribed oxycodone/acetaminophen 5/325 mg (150/month) (a starting dose of approximately 90 MME), followed by a rapid escalation in the opioid load to 180 oxycodone 30 mg pills/month (approximately 270 MME/day).

41. The Washoe County Coroner's Report determined Patient K's cause of death as alcohol and oxycodone intoxication with a contribution by the condition of cardiomegaly. Patient K's prior physician reported that he had previously treated Patient K for polysubstance addiction (alcohol, cocaine) and communicated this information to Respondent. Respondent's medical records fail to document communication with Patient K's former treating physician.

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

42. Respondent treated non-specific pain diagnoses with massive amounts of short acting oxycodone. Despite multiple aberrancies, Respondent failed to reduce or eliminate the opioids or to refer Patient K to a pain medicine or addiction specialist. Respondent failed to document communication from another physician regarding Patient K's previous aberrant drug use. There is no evidence that Respondent altered his treatment despite obvious aberrant behaviors and expressed concerns by a fellow physician, which treatment regimen ultimately contributed to Patient K's death. Despite multiple sources of information regarding high opioid risk (aberrant urine drug tests, aberrant NSBPPM reports, previous history of substance abuse), Respondent failed to take appropriate action and continued to prescribe large doses of the short-acting oxycodone.

43. Respondent failed to address Patient K's frequent elevated pulse rate.

44. Respondent treated Patient K for hypogonadism without confirming the diagnosis with a second laboratory test. Respondent monitored Patient K for estradiol, which is not part of the standard of care, and treated Patient K with arimidex for elevated estradiol. Respondent also started Patient K on Viagra for erectile dysfunction without any medical work up or documented medical decision making regarding etiologies for a 30-year-old male to require Viagra.

Patient L:

45. Patient L is a 39-year-old male treated by Respondent for pain, endocrine issues, obesity and attention deficit disorder. Records from approximately January 4, 2011 through April 19, 2016 show that pain diagnoses included cervicalgia, shoulder joint pain, post-laminectomy syndrome, cervical post-laminectomy syndrome, lumbar post-laminectomy syndrome, thoracic and cervical spinal stenosis, kyphosis, thoracic spine pain, thoracic vertebrae fracture, pathological fracture, chronic pain, obesity, lumbago, chronic neck pain, and back muscle spasm. Documentation of previous cervical and thoracolumbar surgeries was noted. Respondent documented no meaningful examination findings during his four years of treatment of Patient L, occasionally noting limited spinal motion, various scars and joint hypomobility. Respondent provided Patient L with massive doses of opioids, using various combinations of oxycodone, morphine, methadone, oxycodone/acetaminophen, tapentadol and fentanyl. On or about March 10,

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

2016, Respondent prescribed approximately 1460 MME/day.

46. Patient L reported that he lost his medications on or about May 22, 2012 and reported his medications stolen on or about August 8, 2012. On or about April 11, 2011, Respondent documented that Patient L had received oxycodone from another physician. On or about July 26, 2011, Respondent received a copy of a "discharge letter" from the other physician, stating that Patient L was receiving oxycodone from both Respondent and the other physician. On or about June 24, 2014, Aetna Insurance sent Respondent a letter regarding Patient L's medications, prompting Respondent to document that he would closely monitor the patient and purposefully prescribe the listed drug and dosage frequency. The medical record demonstrates no evidence that Patient L was counseled by Respondent regarding his aberrant behavior (lost medications, stolen medications, multiple physicians, Aetna letter). In fact, despite these aberrancies, there is no evidence that Respondent made any NSBPPM queries or obtained random urine drug tests from Patient L. Furthermore, Respondent prescribed the large doses of short-acting oxycodone without evaluating Patient L on 58 occasions.

47. While Patient L's medical history was consistent with chronic pain, Respondent failed to document examination findings to justify the large opioid load. Despite evidence of high opioid risk, Respondent failed to provide even cursory pharmacovigilance. Even after receiving direct communication from an insurance company and another physician, no action was taken. No specialty referral was made. Furthermore, Respondent provided opioid medications without any evaluation on 58 occasions. Inexplicably, Respondent provided two separate prescriptions for short-acting oxycodone on multiple occasions.

48. Respondent also managed Patient L's hypothyroidism by utilizing desiccated thyroid for treatment of hypothyroid, which is rarely used, even by a specialist. Respondent did so without establishing a need either through appropriate evaluation or referral to an endocrinologist for the use of the armour thyroid. Respondent treated Patient L for hypogonadism. Respondent failed to adjust medication for elevated testosterone levels. Respondent used anastrazole to treat elevated estradiol, which is not an indication for the use of this medication. Lab results did not show an elevated estradiol level.

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

49. Respondent coordinated a weight loss regimen for Patient L that had inadequate monitoring, use of medications at risk for abuse, multiple medications concurrently prescribed, and prolonged therapy, which put Patient L at risk for negative outcomes. Respondent prescribed Belviq and Phenteramine, which are concerning for major risk for cardiac adverse events and should not be prescribed for prolonged periods of time. Respondent prescribed Phenteramine to Patient L for over a year without improvement in weight. Respondent also utilized rHGHRH (tesamorelin) to treat Patient L's weight loss, which was an off label use as it is only approved for HIV patients with centralized obesity.

Patient M:

50. Patient M is a 32-year-old male with the pain diagnosis of trigeminal neuralgia. Respondent's medical records for Patient M from approximately February 15, 2011 through April 20, 2016 demonstrate no evidence of any physical examination findings confirming the diagnosis of trigeminal neuralgia or any other neurological abnormality. The record contained no evidence of a neurology or neurosurgical opinion confirming the diagnosis. Only once, on or about April 20, 2016, after over four years of treatment by Respondent, does the record reflect any previous treatments, stating that Patient M was previously trialed on gabapentin, methadone and oxymorphone. At the initiation of care by Respondent in 2011, Patient M had been without a provider and medication for approximately 9 months. Patient M had previously been on oxycodone, and Respondent restarted Patient M at his previous dose, which had a MME of 540/day. Patient M was essentially opioid naïve after this lapse in care, and such a dosage was potentially life-threatening. Starting on his initial encounter and continuing for over four years, Respondent prescribed massive doses of short-acting oxycodone 30 mg (540 pills/month). In addition, Respondent began prescribing alprazolam, a benzodiazepine, in June 2011 for Patient M's anxiety, which is not recommended in combination with narcotic medication due to the risk of respiratory suppression. The record contains no evidence of any referral to pain medicine, neurology, neurosurgery or psychiatry specialists. Patient M showed several aberrancies with compliance with his prescriptions. Patient M did not comply with a pill count request on or about October 31, 2011, and he had aberrant urine drug tests on or about February 9, 2014 and

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

December 16, 2014. Respondent failed to address these aberrant behaviors.

51. Respondent failed to adequately document the alleged diagnosis of trigeminal neuralgia, failed to refer the patient to an appropriate specialist, failed to consider standard therapies and provided inappropriately large doses of the short-acting opioid oxycodone. Additionally, Respondent failed to modify his prescriptions to Patient M despite aberrant behavior by Patient M.

52. Patient M had persistent tachycardia, and this was never addressed by Respondent.

53. Respondent treated Patient M for hypotestosterone, even though the diagnosis was made after a single lab value while guidelines for the treatment of hypogonadism recommend at least two labs to confirm the diagnosis. After initiating therapy, Patient M's hematocrit became severely elevated leading to a therapeutic phlebotomy, and there was a delay in decreasing Patient M's testosterone dose. Furthermore, Respondent utilized arimidex off label to treat elevated estradiol.

Patient N:

54. Patient N is a 33-year-old male with listed diagnoses of thoracic/lumbar radiculitis, lumbago, chronic pain and muscle spasm. Records from approximately March 20, 2013 to April 7, 2016 showed Respondent's initial history noted a "herniated disc" at L45 from a motor vehicle accident as well as a past history of lumbar epidural injections and a recommendation for surgery. The 2012 lumbar MRI report documented no neurocompression and mild disc degenerative changes. The record contained no evaluation from pain medicine or spine surgical specialists. Respondent initially continued Patient N's previous fentanyl dose (75 mcg/h, 15/month) and increased his oxycodone dose (30 mg, 135/month), which was approximately 180 MME. Over the next 2.5 years, he further increased Patient N's opioid load to fentanyl 150 mcg/h (30 of the 75 mcg/h patches/month) and oxycodone to 30 mg, 420 pills/month, which was equivalent to approximately 1080 mg morphine per day. No further pain medicine or spine surgery referrals were recommended. Respondent failed to document any abnormal musculoskeletal or neurological examination findings to justify the opioid prescriptions. On or about February 19, 2014, Patient N's medical records indicate that he was using his medications prudently in spite of multiple early

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

refills and lost or stolen medications over the last 12 months.

55. Opioids were refilled on 12 occasions without an evaluation. Patient N reported his medications stolen on or about November 13, 2015. Marijuana was documented in his urine on or about July 30, 2015. Methamphetamine was documented in his urine on or about June 9, 2015 and THC on or about July 1, 2015. Despite this evidence of aberrant behavior, Respondent failed to refer Patient N to an addiction specialist for these issues. On or about September 14, 2014, Respondent recommended adding long-acting morphine to the opioid regimen.

56. Respondent failed to document physical examination evidence of patient complaints justifying the extremely high opioid dose (1080 mg morphine equivalents per day). Respondent failed to refer Patient N to a pain medicine specialist. Despite the evidence of opioid aberrancies (early refills, illegal drugs in urine, stolen medications), Respondent provided opioid refills without any evaluation on numerous occasions and failed to refer Patient N to an appropriate specialist. Respondent's suggestion to add long acting morphine to Patient N's extremely high opioid regimen demonstrated a fundamental lack of knowledge of basic opioid analgesic management. Respondent's solution to Patient N's alleged pain was to increase the opioid load.

57. Respondent also prescribed xanax to Patient N for his anxiety, despite the FDA black box warning against use of benzodiazepines and narcotics, as well as valium for insomnia. The significant level of benzodiazepines with narcotics had a high potential for adverse reactions.

Patient O:

58. Patient O is a 38-year-old female treated by Respondent for diagnoses of knee enthesopathy, lower leg joint pain, chronic postoperative pain and migraine. Records from approximately November 13, 2013 to October 2, 2015 showed that while Patient O's initial NSBPPM report revealed multiple opioid prescriptions from multiple physicians, Respondent opined that there does not appear to be "doctor shopping." Despite no documented evidence of any abnormal examination findings and no abnormal imaging findings, Respondent initially provided Patient O with two short-acting opioids, hydrocodone/acetaminophen and oxycodone with a morphine milligram equivalent dose of 320, and rapidly titrated these medications to extremely

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

high doses. By April, 2014, Respondent was prescribing hydrocodone/acetaminophen 10/325 (100/month) and oxycodone 30 mg (300/month), which was over 600 MME/day. Respondent prescribed opioids twice on or about March 11, 2014 and June 8, 2015 without an evaluation. When Patient O reported her medications stolen on or about December 17, 2013, she was provided replacement medications without an evaluation. Despite an urine drug test on or about July 31, 2015 detecting the illegal drug methamphetamine, she was provided the usual massive opioid prescriptions. Despite an October 2, 2015 urine drug test negative for opioids, indicating possible diversion, Respondent took no definitive action; instead he prescribed more opioids. Patient O called to inform Respondent she was going through withdrawals on or about November 5, 2015, at which point, Respondent refused to refill her normal opioids and offered her buprenorphine/naloxone therapy.

59. Patient O had no specific pain generating diagnosis, no examination evidence to support her use of opioids and abundant evidence of aberrant substance use behavior (previous medications from multiple physicians, aberrant urine drug tests, stolen medications). Respondent aggressively titrated her opioid load upwards without medical indication, and, contrary to the standard of care, provided two short-acting opioids simultaneously. Respondent only stopped providing opioids when her urine drug test demonstrated no opioids, a finding consistent with diversion. Respondent, again, used high doses of opioids to treat poorly documented pain and failed to perform appropriate risk mitigation actions when inappropriate behavior was documented until November 5, 2015.

Patient P:

60. Patient P is a 43-year-old male treated by Respondent for diagnoses of coccydynia, lumbago, muscle spasm, thoracic/lumbosacral neuritis/radiculitis and joint pain, as well as anxiety disorder and hypogonadism. Records from approximately September 12, 2008 through April 15, 2016 showed that Respondent noted that Patient P consumed between zero to twenty oxycodone 15 mg tablets per day. Respondent prescribed an initial MME of approximately 540. Urine drug tests were performed occasionally, with one aberrancy (non-prescribed methadone) on or about June 17, 2009. Medications were prescribed without evaluations on or about April 11, 2014,

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

May 5, 2014 and March 14, 2016. Over the next eight years, Respondent prescribed 600 pills/month of 15 mg oxycodone pills (approximately 450 MME/day). During this time, no physical examination findings or significant imaging findings were documented. A neurosurgical evaluation on or about September 11, 2011 concluded that Patient P's high opioid load precluded surgical options. A pain medicine evaluation on or about August 17, 2011 documented the recommendations for lumbar facet joint injections, psychiatric referral, reduction of short-acting opioid, introduction of long-acting opioid morphine ER and addition of anticonvulsant medications. While each specialist noted Respondent as the referral source, Respondent failed to document the findings of either the neurosurgical or pain medicine recommendations.

61. Respondent provided Patient P with prescriptions for massive doses of short-acting oxycodone. The medical record contains no evidence of physical examination findings to justify these amounts of opioids. Respondent failed to document or act on the neurosurgical and pain medicine evaluations that documented concern regarding Patient P's opioid regimen. Respondent did not address why Patient P did not follow through with recommendations regarding interventions. Respondent failed to act on an aberrant urine drug test that demonstrated non-prescribed methadone. Respondent provided short-acting oxycodone prescriptions three times without evaluating Patient P.

62. Respondent failed to timely treat Patient P's elevated blood pressure while on testosterone. Patient P developed polycythemia likely directly related to testosterone prescriptions. Rather than decreasing the dose, per guidelines, a therapeutic phlebotomy was performed with minimal follow-up on hematocrit to confirm improvement.

63. Respondent prescribed arimidex for elevated estradiol, which is an off label use.

Patient Q:

64. Patient Q is a 49-year-old male with post-traumatic paraplegia (from gunshot wound to thoracic spine), spasticity and the diagnoses of shoulder joint pain, subscapularis pain and chronic pain. Respondent's records for Patient Q from December 19, 2012 through June 1, 2015 show that documented examination findings were nonspecific, noting lower extremity muscle spasm and sensory loss. Most office notes documented that either no formal examination

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

was done or contained a cursory exam with no neurological or musculoskeletal details. No referrals were made to pain specialists, neurologists or physical medicine and rehabilitation specialists. Respondent increased Patient Q's previously prescribed 15 mg oxycodone pills from 180 pills/month (approximately 270 MME) to 360 pills/month and then rapidly increased Patient Q's fentanyl dose from 25 mcg/h to 200 mcg/h without adequate document of medical decision making. From mid-2013 through mid-2015, Patient Q received 200 mcg/h fentanyl (20 of the 100 mcg/h patches per month) and oxycodone 15 mg (360/month), which is the equivalent of approximately 750 MME. Respondent refilled Patient Q's prescriptions 11 times without evaluating Patient Q. Patient Q reportedly lost his medications on or about December 28, 2012 and his urine tested positive for ethanol and marijuana on or about October 15, 2013. No evidence in the medical record noted that Respondent addressed these aberrancies or bothered to conduct future urine tests.

65. Patient Q received massive doses of opioids for poorly documented pain that was not supported by examination findings or diagnostic test findings. There was no evidence of referral to a physical medicine and rehabilitation specialist with experience in post spinal cord injury patients. Respondent demonstrated substandard pharmacovigilance by providing opioid medications without proper evaluation on multiple occasions and failing to address aberrant behaviors consistent with addiction.

66. Patient Q was persistently tachycardic throughout his care by Respondent, which was never addressed.

67. Patient Q's diabetes was treated by Respondent, but there is no medical documentation regarding treatment plan or objectives or appropriate monitoring of eye exams, feet exams or lab monitoring.

Patient R:

68. Patient R is a 36-year-old male with remote history of lumbar surgery and right shoulder surgery, treated by Respondent for shoulder joint pain, rotator cuff syndrome, postlaminectomy syndrome, lumbago and hypogonadism. Respondent's records from approximately April 8, 2014 through March 16, 2016 show that no examination findings were ever

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

documented. A postoperative note and preoperative MRI from 2008 documented previous shoulder pathoanatomy (labral tear, tendinopathy) and surgery (Bankhardt repair, SLAP repair). Respondent increased Patient R's opioids from oxycodone 5 mg (180 pills/month) to oxycodone 30 mg (360 pills/month, equivalent to approximately 720 MME/day), without medical justification indicated in Patient R's medical records. At one point, oxycodone ER was prescribed (60 mg three times a day) along with the oxycodone, but Patient R did not fill the medication. In spite of aberrant urine drug tests (no prescribed medications or metabolites on or about June 11, 2015 and July 9, 2015) and lost medications on or about June 11, 2015, Respondent continued to provide short-acting oxycodone prescriptions, several times without evaluating Patient R.

69. With no contemporary documentation of pathoanatomy and no documented physical examination findings, Respondent prescribed large doses of short-acting oxycodone. Minimal pharmacovigilance was noted, as Respondent continued to prescribe massive short-acting opioid doses despite aberrant behavior.

70. On or about November 17, 2015, Patient R was diagnosed by Respondent with low testosterone. It was not confirmed with a second test and additional evaluation for secondary hypogonadism was not performed. Patient R was started on therapy and labs were ordered for monitoring. The management of hypotestosterone did not meet the standard of care.

Count 1 – Patient A

NRS 630.301(4) – Malpractice

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

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

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

74. Respondent committed malpractice with respect to Patient A when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by failing to support his diagnoses with physical examination findings; making only

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

cursory ongoing assessments of Patient A's response to treatment by opioids; failing to recommend appropriate diagnostic procedures; failing to perform any opioid risk analysis; titrating opioid dosages to high levels without any evidence of efficacy; inappropriately prescribing two short-acting opioids, oxycodone and hydrocodone/acetaminophen, simultaneously; failing to modify treatment of Patient A or refer Patient A to a pain management specialist when Patient A exhibited aberrant behavior, which could indicate drug diversion; failing to address Patient A's tachycardia; and/or failing to provide any significant medical care to Patient A other than prescribing inappropriately large amounts of short-acting opioids.

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

Count 2 – Patient A

NRS 630.306(1)(b)(2)-Violation of Standard of Practice

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

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

78. 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").

79. 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.

80. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by failing to support diagnoses with physical evaluations; failing to refer Patient A to specialists; failing to evaluate efficacy of the prescriptions; failing to modify the treatment plan when Patient A exhibited aberrant behavior that suggested misuse of the prescribed opioid medications; failing to refer Patient A to a pain

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

management specialist; and/or simultaneously prescribing two short-acting opioids to Patient A.

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

Count 3 – Patient A

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

83. 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).

84. Respondent is a family medicine practitioner and not a pain medicine specialist.

85. Medical guidelines establish that any dose above 90 mg/day morphine milligram equivalent is high dose opioid therapy, and recommend referral and/or consultation with a pain medicine specialist for daily opioid doses above 90 mg morphine milligram equivalents.

86. Respondent prescribed Patient A daily morphine milligram equivalent doses of over 600 mg.

87. Respondent failed to refer Patient A to a pain medicine specialist.

88. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient A.

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

Count 4 – Patient A

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

91. 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

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

NRS 630.306(1)(p).

92. Respondent engaged in unsafe acts regarding Patient A by failing to abide by the Model Policy adopted by the Board.

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

Count 5 – Patient B

NRS 630.301(4) – Malpractice

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

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

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

97. Respondent committed malpractice with respect to Patient B when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by failing to support his diagnoses with physical examination findings; failing to perform any opioid risk analysis; failing to modify treatment of Patient B or refer Patient B to a pain management specialist when Patient B exhibited aberrant behavior; failing to address Patient B's tachycardia; failing to adequately treat Patient B's asthma; and/or failing to refer Patient B to an addiction specialist after failing to wean her from opioids.

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

Count 6 – Patient B

NRS 630.306(1)(b)(2)-Violation of Standard of Practice

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

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

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

101. 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").

102. 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.

103. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by failing to support diagnoses with physical evaluations; failing to refer Patient B to specialists; failing to modify the treatment plan when Patient B exhibited aberrant behavior that suggested misuse of the prescribed opioid medications; and/or failing to refer Patient B to an addiction specialist after unsuccessfully trying to wean her from opioids.

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

Count 7 – Patient B

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

106. 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).

107. Respondent is a family medicine practitioner and not a pain medicine specialist.

108. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

109. Respondent prescribed Patient B daily morphine milligram equivalent doses of approximately 540.

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

110. Respondent failed to refer Patient B to a pain medicine specialist.

111. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient B.

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

Count 8 – Patient B

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

114. 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).

115. Respondent engaged in unsafe acts regarding Patient B by failing to abide by the Model Policy adopted by the Board and/or failing to refer Patient B to an addiction specialist after unsuccessfully attempting to wean her from opioids.

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

Count 9 – Patient C

NRS 630.301(4) – Malpractice

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

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

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

120. Respondent committed malpractice with respect to Patient C when he failed to

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

provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by failing to support his diagnoses with physical examination findings; failing to perform any opioid risk analysis; escalating the dosage of Patient C's prescriptions when Patient C reported low levels of pain; failing to modify treatment of Patient C or refer Patient C to a pain medicine specialist or addiction specialist when Patient C exhibited aberrant behavior, including allegedly losing his medications and reporting them stolen and testing positive for cocaine on an urinalysis; and/or prescribing valium, a benzodiazepine, to Patient C while Patient C was taking opioid medication, the combination of which is relatively contraindicated.

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

Count 10 – Patient C

NRS 630.306(1)(b)(2)-Violation of Standard of Practice

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

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

124. 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").

125. 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.

126. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by failing to support diagnoses with physical evaluations; failing to refer Patient C to specialists; failing to modify the treatment plan when Patient C exhibited aberrant behavior that suggested misuse of the prescribed opioid medications; failing to refer Patient C to an addiction specialist; refilling Patient C's opioid prescriptions on

numerous occasions without evaluating the patient; and/or escalating Patient C's prescribed dosage of opioid medication when Patient C reported low levels of pain.

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

Count 11 – Patient C

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

128. 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).

129. Respondent is a family medicine practitioner and not a pain medicine specialist.

130. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

131. Respondent prescribed Patient C daily morphine equivalent doses of over 700 mg.

132. Respondent failed to refer Patient C to a pain medicine specialist or addiction specialist.

133. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient C.

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

Count 12 – Patient C

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

136. Engaging in any act that is unsafe or unprofessional conduct in accordance with

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

regulations adopted by the Board is grounds for disciplinary action against a licensee pursuant to NRS 630.306(1)(p).

137. Respondent engaged in unsafe acts regarding Patient C by failing to abide by the Model Policy adopted by the Board; failing to refer Patient C to a pain medicine specialist or addiction specialist after Patient C exhibited aberrant behavior; escalating Patient C's opioid dosage in light of low levels of pain reported by Patient C; refilling Patient C's opioid prescriptions on numerous occasions without evaluating the patient; and/or simultaneously prescribing opioid medication and benzodiazepines to Patient C.

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

Count 13 – Patient D

NRS 630.301(4) – Malpractice

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

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

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

142. Respondent committed malpractice with respect to Patient D when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by failing to support his diagnoses with physical examination findings; failing to perform any opioid risk analysis; escalating the dosage of Patient D's prescriptions without documented physical examination findings, neurophysiological testing, or advanced imaging; failing to modify treatment of Patient D or refer Patient D to a pain medicine specialist or addiction specialist when Patient D exhibited aberrant behavior, including allegedly stolen medications, evidence of diversion, and evidence of drug abuse; failing to employ reasonable risk mitigation and monitoring techniques to reduce diversion; failing to order an urine drug test or NSBPPM report for over two years; and/or prescribing two separate prescriptions for oxycodone

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

on the same day, despite no medical justification for doing so.

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

Count 14 – Patient D

NRS 630.306(1)(b)(2)-Violation of Standard of Practice

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

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

146. 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").

147. 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.

148. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by failing to support diagnoses with physical evaluations; failing to order an urinalysis or NSBPPM report for over two years; failing to refer Patient D to specialists; failing to modify the treatment plan when Patient D exhibited aberrant behavior that suggested misuse of the prescribed opioid medications; failing to refer Patient D to an addiction specialist when Patient D exhibited aberrant behavior that suggested drug abuse; and/or issuing two separate prescriptions for oxycodone to Patient D on the same day without medical justification for doing so.

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

//

//

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

Count 15 – Patient D

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

151. 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).

152. Respondent is a family medicine practitioner and not a pain medicine specialist.

153. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

154. Respondent prescribed Patient D daily morphine equivalent doses of approximately 450 mg.

155. Respondent failed to refer Patient D to a pain medicine specialist or addiction specialist.

156. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient D.

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

Count 16 – Patient D

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

159. 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).

//

160. Respondent engaged in unsafe acts regarding Patient D by failing to abide by the Model Policy adopted by the Board; failing to order an urinalysis or NSBPPM report for over two years; failing to refer Patient D to a pain medicine specialist or addiction specialist after Patient D exhibited aberrant behavior; and/or prescribing two separate prescriptions for oxycodone on the same day.

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

Count 17 – Patient E

NRS 630.301(4) – Malpractice

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

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

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

165. Respondent committed malpractice with respect to Patient E when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by prescribing extremely high daily doses of opioids (approximately 1900 mg morphine equivalents per day) without sufficient medical justification; failing to support his diagnoses with physical examination findings; failing to perform any opioid risk analysis; escalating the dosage of Patient E's prescriptions without documented physical examination findings, neurophysiological testing, or advanced imaging; failing to modify treatment of Patient E or refer Patient E to a pain medicine specialist or addiction specialist when Patient E exhibited aberrant behavior, including aberrant urinalyses, pill counts, and one NSBPPM report; failing to employ reasonable risk mitigation and monitoring techniques to reduce diversion; and/or prescribing alprazolam, a benzodiazepine, which is relatively contraindicated when the patient is taking opioid medications.

//

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

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

Count 18 – Patient E

NRS 630.306(1)(b)(2)-Violation of Standard of Practice

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

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

169. 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").

170. 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.

171. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by prescribing extremely high doses of opioids without sufficient medical justification; failing to support diagnoses with physical evaluations; failing to refer Patient E to specialists; failing to modify the treatment plan when Patient E exhibited aberrant behavior that suggested misuse of the prescribed opioid medications; failing to refer Patient E to an addiction specialist after Patient E exhibited aberrant behavior; and/or prescribing alprazolam, a benzodiazepine, which is relatively contraindicated when the patient is taking opioid medications.

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

//

//

//

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

Count 19 – Patient E

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

174. 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).

175. Respondent is a family medicine practitioner and not a pain medicine specialist.

176. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

177. Respondent prescribed Patient E daily morphine equivalent doses of approximately 1900 mg.

178. Respondent failed to refer Patient E to a pain medicine specialist or addiction specialist.

179. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient E.

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

Count 20 – Patient E

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

182. 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).

183. Respondent engaged in unsafe acts regarding Patient E by failing to abide by the

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

Model Policy adopted by the Board; prescribing extremely high doses of opioid medications without sufficient medical justification; failing to refer Patient E to a pain medicine specialist or addiction specialist after Patient E exhibited aberrant behavior; and/or prescribing alprazolam, a benzodiazepine, which is relatively contraindicated when the patient is taking opioid medications.

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

Count 21 – Patient F

NRS 630.301(4) – Malpractice

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

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

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

188. Respondent committed malpractice with respect to Patient F when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by prescribing high daily doses of opioids without sufficient medical justification; failing to support his diagnoses with physical examination findings or imaging findings; failing to perform any opioid risk analysis; escalating the dosage of Patient F's prescriptions without documented physical examination findings to indicate the necessity of such increase; prescribing two and three short-acting opioids simultaneously; and/or changing Patient F's prescription from long-acting opioids to short-acting opioids without medical indication for doing so.

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

Count 22 – Patient F

NRS 630.306(1)(b)(2) - Violation of Standard of Practice

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

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

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

192. 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").

193. 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.

194. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by prescribing extremely high doses of opioids without sufficient medical justification; failing to support diagnoses with physical evaluations; failing to refer Patient F to specialists; prescribing two and three short-acting opioids simultaneously; and switching Patient F's prescriptions from long-acting opioids to short-acting opioids without medical indication for doing so.

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

Count 23 – Patient F

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

197. 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).

198. Respondent is a family medicine practitioner and not a pain medicine specialist.

199. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

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

200. Respondent prescribed Patient F daily morphine equivalent doses of approximately 520 mg.

201. Respondent failed to refer Patient F to a pain medicine specialist or addiction specialist.

202. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient F.

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

Count 24 – Patient F

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

205. 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).

206. Respondent engaged in unsafe acts regarding Patient F by failing to abide by the Model Policy adopted by the Board; prescribing extremely high doses of opioid medications without sufficient medical justification; failing to refer Patient F to a pain medicine specialist; prescribing two and three short-acting opioids simultaneously; and/or changing the prescriptions from long-acting opioids to short-acting opioids without sufficient medical documentation.

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

Count 25 – Patient G

NRS 630.301(4) – Malpractice

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

209. Malpractice is grounds for disciplinary action against a licensee pursuant to

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

NRS 630.301(4).

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

211. Respondent committed malpractice with respect to Patient G when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by prescribing extremely high daily doses of opioids (approximately 720 MME) without sufficient medical justification; failing to support his diagnoses with physical examination findings; failing to perform any opioid risk analysis; escalating the dosage of Patient G's prescriptions without documented physical examination findings or advanced imaging; failing to modify treatment of Patient G or refer Patient G to a pain medicine specialist or addiction specialist when Patient G exhibited aberrant behavior, including aberrant urinalyses and requests for early refills; failing to employ reasonable risk mitigation and monitoring techniques to reduce diversion; prescribing two separate prescriptions of the same opioid per month without documenting the reason for doing so; and/or prescribing alprazolam, a benzodiazepine, which is relatively contraindicated when the patient is taking opioid medications, without medical justification.

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

Count 26 – Patient G

NRS 630.306(1)(b)(2)-Violation of Standard of Practice

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

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

215. 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").

216. Pursuant to NAC 630.230(1)(k), a licensee shall not engage in the practice of

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

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.

217. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by prescribing extremely high doses of opioids without sufficient medical justification; failing to support diagnoses with physical evaluations; failing to refer Patient G to specialists; failing to modify the treatment plan when Patient G exhibited aberrant behavior that suggested misuse of the prescribed opioid medications; failing to refer Patient G to an addiction specialist after Patient G exhibited aberrant behavior; prescribing two separate prescriptions for the same short-acting opioid per month without documenting any reason for doing so; and/or prescribing alprazolam, a benzodiazepine, which is relatively contraindicated when the patient is taking opioid medications, without medical justification for doing so.

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

Count 27 – Patient G

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

220. 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).

221. Respondent is a family medicine practitioner and not a pain medicine specialist.

222. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

223. Respondent prescribed Patient G daily morphine equivalent doses of approximately 720 mg.

224. Respondent failed to refer Patient G to a pain medicine specialist or addiction specialist.

225. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient G without rigorous diagnosis of the source of pain and consideration of other treatment modalities.

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

Count 28 – Patient G

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

228. 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).

229. Respondent engaged in unsafe acts regarding Patient G by failing to abide by the Model Policy adopted by the Board; prescribing extremely high doses of opioid medications without sufficient medical justification; failing to refer Patient G to a pain medicine specialist or addiction specialist after Patient G exhibited aberrant behavior; prescribing two separate prescriptions for the same short-acting opioid per month without documenting any reason for doing so; and/or prescribing alprazolam, a benzodiazepine, which is relatively contraindicated when the patient is taking opioid medications, without medical justification for doing so.

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

Count 29 – Patient H

NRS 630.301(4) – Malpractice

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

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

1 232. Malpractice is grounds for disciplinary action against a licensee pursuant to
2 NRS 630.301(4).
3 233. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient,
4 to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.
5 234. Respondent committed malpractice with respect to Patient H when he failed to
6 provide reasonable care, skills, and knowledge ordinarily used by physicians under similar
7 circumstances by prescribing extremely high daily doses of opioids (approximately 540 MME)
8 without sufficient medical justification; failing to support his diagnoses with physical examination
9 findings; failing to perform any opioid risk analysis; escalating the dosage of Patient H's
10 prescriptions without documented physical examination findings or advanced imaging; failing to
11 modify treatment of Patient H or refer Patient H to a pain medicine specialist or addiction
12 specialist when Patient H exhibited aberrant behavior, including obtaining oxycodone from a
13 family member and an NSBPPM query that showed he had multiple opioid providers; failing to
14 employ reasonable risk mitigation and monitoring techniques to reduce diversion, such as failing
15 to run NSBPPM queries after the initial consultation; prescribing two separate prescriptions of the
16 same opioid per month without documenting the reason for doing so; failing to address Patient H's
17 tachycardia for several office visits; failing to document a plan for cardiac evaluation; diagnosing
18 low testosterone in Patient H without sufficient documentation and laboratory work; and/or
19 prescribing a breast cancer drug in an off label use to suppress estradiol in Patient H.
20 235. By reason of the foregoing, Respondent is subject to discipline by the Board as
21 provided in NRS 630.352.
22 **Count 30 – Patient H**
23 **NRS 630.306(1)(b)(2)-Violation of Standard of Practice**
24 236. All of the allegations in the above paragraphs are hereby incorporated by reference
25 as though fully set forth herein.
26 237. Violation of a standard of practice adopted by the Board is grounds for disciplinary
27 action pursuant to NRS 630.306(1)(b)(2).
28 238. The Board adopted by reference The *Model Policy on the Use of Opioid Analgesics*

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

in the Treatment of Chronic Pain, July 2013, published by the Federation of State Medical Boards of the United States, Inc. (the "Model Policy").

239. 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.

240. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by prescribing extremely high doses of opioids without sufficient medical justification; failing to support diagnoses with physical evaluations; failing to refer Patient H to specialists; failing to modify the treatment plan when Patient H exhibited aberrant behavior that suggested misuse of the prescribed opioid medications; failing to refer Patient H to an addiction specialist after Patient H exhibited aberrant behavior; and/or prescribing two separate prescriptions for the same short-acting opioid per month without documenting any reason for doing so.

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

Count 31 – Patient H

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

243. 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).

244. Respondent is a family medicine practitioner and not a pain medicine specialist.

245. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

246. Respondent prescribed Patient H daily morphine equivalent doses of

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

approximately 540 mg.

247. Respondent failed to refer Patient H to a pain medicine specialist or addiction specialist.

248. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient G without rigorous diagnosis of the source of pain and consideration of other treatment modalities.

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

Count 32 – Patient H

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

251. 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).

252. Respondent engaged in unsafe acts regarding Patient H by failing to abide by the Model Policy adopted by the Board; prescribing extremely high doses of opioid medications without sufficient medical justification; failing to refer Patient H to a pain medicine specialist or addiction specialist after Patient H exhibited aberrant behavior; and/or prescribing two separate prescriptions for the same short-acting opioid per month without documenting any reason for doing so.

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

Count 33 – Patient I

NRS 630.301(4) – Malpractice

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

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

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

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

257. Respondent committed malpractice with respect to Patient I when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by prescribing extremely high daily doses of opioids (approximately 540 MME) without sufficient medical justification; failing to support his diagnoses with physical examination findings; failing to perform any opioid risk analysis; escalating the dosage of Patient I's prescriptions without documented physical examination findings or advanced imaging; failing to modify treatment of Patient I or refer Patient I to a pain medicine specialist or addiction specialist when Patient I exhibited aberrant behavior, including aberrant urinalyses; failing to refer Patient I to orthopedic or neurosurgical specialists; failing to employ reasonable risk mitigation and monitoring techniques to reduce diversion; prescribing benzodiazepines to Patient I in spite of the black box warning against combining benzodiazepines with opioids because of the risk of respiratory suppression; diagnosing low testosterone in Patient I without sufficient documentation and laboratory work; and/or treating Patient I with testosterone even though Patient I's hematocrit of 50% contraindicated testosterone treatment.

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

Count 34 – Patient I

NRS 630.306(1)(b)(2)-Violation of Standard of Practice

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

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

261. 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

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

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

262. 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.

263. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by prescribing extremely high doses of opioids without sufficient medical justification; failing to support diagnoses with physical evaluations; failing to refer Patient I to specialists; failing to modify the treatment plan when Patient I exhibited aberrant behavior that suggested misuse of the prescribed opioid medications; failing to refer Patient I to an addiction specialist after Patient I exhibited aberrant behavior; and/or rapidly escalating Patient I's opioid dosage without sufficient medical justification.

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

Count 35 – Patient I

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

266. 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).

267. Respondent is a family medicine practitioner and not a pain medicine specialist.

268. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

269. Respondent prescribed Patient I daily morphine equivalent doses of approximately 540 mg.

270. Respondent failed to refer Patient I to a pain medicine specialist or addiction

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

specialist, orthopedic specialist or neurosurgical specialist.

271. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient I without rigorous diagnosis of the source of pain and consideration of other treatment modalities.

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

Count 36 – Patient I

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

274. 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).

275. Respondent engaged in unsafe acts regarding Patient I by failing to abide by the Model Policy adopted by the Board; prescribing extremely high doses of opioid medications without sufficient medical justification; escalating Patient I's opioid dosage without sufficient medical justification; and/or failing to refer Patient I to a pain medicine specialist or addiction specialist after Patient I exhibited aberrant behavior.

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

Count 37 – Patient J

NRS 630.301(4) – Malpractice

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

278. 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

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

280. Respondent committed malpractice with respect to Patient J when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by prescribing high daily doses of opioids (approximately 270 MME) without sufficient medical justification; failing to support his diagnoses with physical examination findings; failing to perform sufficient opioid risk analysis; escalating the dosage of Patient J's prescriptions without documented physical examination findings or advanced imaging; failing to modify treatment of Patient J or refer Patient J to a pain medicine specialist or addiction specialist when Patient J exhibited aberrant behavior, including an aberrant urinalysis; providing opioid prescriptions on multiple occasions without evaluating Patient J; and/or failing to timely address Patient J's high cholesterol.

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

Count 38 – Patient J

NRS 630.306(1)(b)(2)-Violation of Standard of Practice

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

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

284. 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").

285. 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.

286. Respondent wrote prescriptions for controlled substances to treat acute or chronic

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

pain in a manner that deviates from the Model Policy by prescribing high doses of opioids without sufficient medical justification; failing to support diagnoses with physical evaluations; failing to refer Patient J to specialists; failing to modify the treatment plan when Patient J exhibited aberrant behavior that suggested misuse of the prescribed opioid medications; failing to refer Patient J to an addiction specialist after Patient J exhibited aberrant behavior; and/or rapidly escalating Patient J's opioid dosage without sufficient medical justification.

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

Count 39 – Patient J

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

289. 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).

290. Respondent is a family medicine practitioner and not a pain medicine specialist.

291. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

292. Respondent prescribed Patient J daily morphine equivalent doses of approximately 270 mg.

293. Respondent failed to refer Patient J to a pain medicine specialist or addiction specialist, or other specialists to rigorously diagnose the source of Patient J's pain.

294. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient J without rigorous diagnosis of the source of pain and consideration of other treatment modalities.

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

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

Count 40 – Patient J

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

297. 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).

298. Respondent engaged in unsafe acts regarding Patient J by failing to abide by the Model Policy adopted by the Board; prescribing extremely high doses of opioid medications without sufficient medical justification; escalating Patient J's opioid dosage without sufficient medical justification; and/or failing to refer Patient J to a pain medicine specialist or addiction specialist after Patient J exhibited aberrant behavior.

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

Count 41 – Patient K

NRS 630.301(4) – Malpractice

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

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

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

303. Respondent committed malpractice with respect to Patient K when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by prescribing extremely high daily doses of opioids (approximately 270 mg morphine equivalents per day) without sufficient medical justification; failing to support his diagnoses with physical examination findings; failing to perform sufficient opioid risk analysis;

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

escalating the dosage of Patient K's prescriptions without documented physical examination findings or advanced imaging; failing to modify treatment of Patient K or refer Patient K to a pain medicine specialist or addiction specialist when Patient K exhibited aberrant behavior, including reported stolen or lost medications, requests for early refills, an aberrant urinalysis, two aberrant NSBPPM reports that noted opioid prescriptions from other physicians, prior history of substance abuse; failing to employ reasonable risk mitigation measures in light of Patient K's aberrant behaviors, which ultimately led to Patient K's death due to simultaneous use of opioids and alcohol; failing to address Patient K's frequent elevated pulse rate; treating Patient K for hypogonadism without confirming the diagnosis with a second laboratory test; monitoring Patient K for estradiol, which is not part of the standard of care; treating Patient K with a breast cancer drug, an off label use; and/or treating Patient K with Viagra for erectile dysfunction without any medical work-up or documented medical decision-making for such treatment.

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

Count 42 – Patient K

NRS 630.306(1)(b)(2)-Violation of Standard of Practice

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

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

307. 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").

308. 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.

309. Respondent wrote prescriptions for controlled substances to treat acute or chronic

pain in a manner that deviates from the Model Policy by prescribing extremely high doses of opioids without sufficient medical justification; failing to support diagnoses with physical evaluations; failing to refer Patient K to specialists; failing to modify the treatment plan when Patient K exhibited aberrant behavior that suggested misuse of the prescribed opioid medications; failing to refer Patient K to an addiction specialist after Patient K exhibited aberrant behavior; and/or rapidly escalating Patient K's opioid dosage without sufficient medical justification.

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

Count 43 – Patient K

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

312. 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).

313. Respondent is a family medicine practitioner and not a pain medicine specialist.

314. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

315. Respondent prescribed Patient K daily morphine equivalent doses of approximately 270 mg.

316. Respondent failed to refer Patient K to a pain medicine specialist or addiction specialist, or other specialists to rigorously diagnose the source of Patient K's pain.

317. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient K without rigorous diagnosis of the source of pain and consideration of other treatment modalities.

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

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

Count 44 – Patient K

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

320. 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).

321. Respondent engaged in unsafe acts regarding Patient K by failing to abide by the Model Policy adopted by the Board; prescribing extremely high doses of opioid medications without sufficient medical justification; escalating Patient K's opioid dosage without sufficient medical justification; failing to refer Patient K to a pain medicine specialist or addiction specialist after Patient K exhibited aberrant behavior; and/or failing to take appropriate risk mitigation measures after Patient K exhibited aberrant behavior.

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

Count 45 – Patient L

NRS 630.301(4) – Malpractice

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

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

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

326. Respondent committed malpractice with respect to Patient L when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by prescribing extremely high daily doses of opioids (approximately 1460 MME) without sufficient medical justification; failing to support his diagnoses with physical examination

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

findings; failing to perform sufficient opioid risk analysis; escalating the dosage of Patient L's prescriptions without documented physical examination findings or advanced imaging; failing to modify treatment of Patient L or refer Patient L to a pain medicine specialist or addiction specialist when Patient L exhibited aberrant behavior, including reported stolen or lost medications, receipt of opioid prescriptions from other physicians, an insurance letter expressing concern about the opioid prescriptions; failing to employ reasonable risk mitigation measures in light of Patient L's aberrant behaviors; providing two separate prescriptions for short-acting oxycodone on multiple occasions; providing opioid prescriptions to Patient L without evaluating Patient L on approximately 58 occasions; prescribing desiccated thyroid for treatment of hypothyroid without establishing medical necessity for such prescription; failing to adjust medication for elevated testosterone levels; using anastrazole to treat elevated estradiol, which is not an indication for such medication and in spite of lab results that did not indicate elevated estradiol levels; prescribing Belviq and Phenteramine for weight loss over prolonged periods of time, which is contraindicated due to major risk for adverse cardiac events; and/or prescribing rHGHRH for weight loss, which is an off label use.

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

Count 46 – Patient L

NRS 630.306(1)(b)(2)-Violation of Standard of Practice

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

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

330. 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").

331. 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

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

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.

332. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by prescribing extremely high doses of opioids without sufficient medical justification; failing to support diagnoses with physical evaluations; failing to refer Patient L to specialists; failing to implement any pharmacovigilance measures; failing to modify the treatment plan when Patient L exhibited aberrant behavior that suggested misuse of the prescribed opioid medications; failing to refer Patient L to an addiction specialist after Patient L exhibited aberrant behavior; and/or rapidly escalating Patient L's opioid dosage without sufficient medical justification.

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

Count 47 – Patient L

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

335. 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).

336. Respondent is a family medicine practitioner and not a pain medicine specialist.

337. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

338. Respondent prescribed Patient L daily morphine equivalent doses of approximately 1460 mg.

339. Respondent failed to refer Patient L to a pain medicine specialist or addiction specialist, or other specialists to rigorously diagnose the source of Patient L's pain.

340. Respondent practiced beyond the scope of his training or competence by

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

prescribing inappropriately large amounts of short-acting opioids to Patient L without rigorous diagnosis of the source of pain and consideration of other treatment modalities.

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

Count 48 – Patient L

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

343. 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).

344. Respondent engaged in unsafe acts regarding Patient L by failing to abide by the Model Policy adopted by the Board; prescribing extremely high doses of opioid medications without sufficient medical justification; escalating Patient L's opioid dosage without sufficient medical justification; failing to refer Patient L to a pain medicine specialist or addiction specialist after Patient L exhibited aberrant behavior; failing to implement any pharmacovigilance measures whatsoever with respect to Patient L's use of opioids; prescribing desiccated thyroid without sufficient medical justification; prescribing anastrazole for elevated estradiol, which was not an indicated use of the medication and not necessary in light of lab results; prescribing rHGHRH for off label use; and/or prescribing diet prescriptions for prolonged periods of time without regard for significant risk of adverse cardiac events.

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

Count 49 – Patient M

NRS 630.301(4) – Malpractice

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

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

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

349. Respondent committed malpractice with respect to Patient M when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by prescribing a potentially life-threatening morphine equivalent dose of approximately 540 mg to Patient M, who was opioid naïve at that point in time; prescribing extremely high daily doses of opioids without sufficient medical justification; failing to support his diagnoses with physical examination findings; failing to perform sufficient opioid risk analysis; escalating the dosage of Patient M's prescriptions without documented physical examination findings or advanced imaging; failing to modify treatment of Patient M or refer Patient M to a pain medicine specialist or addiction specialist when Patient M exhibited aberrant behavior, including failure to comply with a pill count request and aberrant urinalyses; failing to employ reasonable risk mitigation measures in light of Patient M's aberrant behaviors; prescribing a benzodiapine to Patient M, which is relatively contraindicated when taking opioids due the risk of respiratory suppression; failing to address Patient M's persistent tachycardia; treating Patient M for hypotestosterone, even though the diagnosis was made after only a single laboratory value contrary to medical guidelines; failure to timely address Patient M's elevated hematocrit by reducing the testosterone dose; and/or using arimidex off label to treat elevated estradiol.

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

Count 50 – Patient M

NRS 630.306(1)(b)(2)-Violation of Standard of Practice

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

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

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

353. 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").

354. 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.

355. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by prescribing extremely high doses of opioids without sufficient medical justification; failing to support diagnoses with physical evaluations; failing to refer Patient M to appropriate specialists; failing to modify the treatment plan when Patient M exhibited aberrant behavior that suggested misuse of the prescribed opioid medications; failing to refer Patient M to an addiction specialist after Patient M exhibited aberrant behavior; and/or rapidly escalating Patient M's opioid dosage without sufficient medical justification.

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

Count 51 – Patient M

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

358. 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).

359. Respondent is a family medicine practitioner and not a pain medicine specialist.

360. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

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

361. Respondent prescribed Patient M daily morphine equivalent doses of approximately 540 mg.

362. Respondent failed to refer Patient M to a pain medicine specialist or addiction specialist, or other specialists to rigorously diagnose the source of Patient M's pain.

363. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient M without rigorous diagnosis of the source of pain and consideration of other treatment modalities.

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

Count 52 – Patient M

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

366. 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).

367. Respondent engaged in unsafe acts regarding Patient M by failing to abide by the Model Policy adopted by the Board; prescribing extremely high doses of opioid medications without sufficient medical justification; escalating Patient M's opioid dosage without sufficient medical justification; failing to refer Patient M to a pain medicine specialist or addiction specialist after Patient M exhibited aberrant behavior; prescribing arimidex off label to treat elevated estradiol; and/or failing to timely address Patient M's severely elevated hematocrit by lowering testosterone dosages.

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

//

Count 53 – Patient N

NRS 630.301(4) – Malpractice

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

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

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

372. Respondent committed malpractice with respect to Patient N when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by prescribing extremely high daily doses of opioids (approximately 1080 MME) without sufficient medical justification; failing to support his diagnoses with physical examination findings; failing to perform sufficient opioid risk analysis; escalating the dosage of Patient N's prescriptions without documented physical examination findings or advanced imaging after 2012; failing to refer Patient N to a spine surgical specialist for his herniated disc from a motor vehicle accident; prescribing opioid refills without evaluating Patient N on multiple occasions; failing to modify treatment of Patient N or refer Patient N to a pain medicine specialist or addiction specialist when Patient N exhibited aberrant behavior, including early refills, lost or stolen medication, and aberrant urinalyses; failing to employ reasonable risk mitigation measures in light of Patient N's aberrant behaviors; and/or prescribing a benzodiapine to Patient N, which is relatively contraindicated when taking opioids due the risk of respiratory suppression.

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

Count 54 – Patient N

NRS 630.306(1)(b)(2) - Violation of Standard of Practice

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

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

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

376. 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").

377. 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.

378. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by prescribing extremely high doses of opioids without sufficient medical justification; failing to support diagnoses with physical evaluations; prescribing refills of opioid medication to Patient N without evaluating Patient N on multiple occasions; failing to refer Patient N to appropriate specialists; failing to modify the treatment plan when Patient N exhibited aberrant behavior that suggested misuse of the prescribed opioid medications; failing to refer Patient N to an addiction specialist after Patient N exhibited aberrant behavior; and/or rapidly escalating Patient N's opioid dosage without sufficient medical justification.

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

Count 55 – Patient N

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

381. 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).

382. Respondent is a family medicine practitioner and not a pain medicine specialist.

383. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

384. Respondent prescribed Patient N daily morphine equivalent doses of approximately 1080 mg.

385. Respondent failed to refer Patient N to a pain medicine specialist or addiction specialist, or other specialists to rigorously diagnose the source of Patient N's pain.

386. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient N without rigorous diagnosis of the source of pain and consideration of other treatment modalities.

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

Count 56 – Patient N

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

389. 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).

390. Respondent engaged in unsafe acts regarding Patient N by failing to abide by the Model Policy adopted by the Board; prescribing extremely high doses of opioid medications without sufficient medical justification; escalating Patient N's opioid dosage without sufficient medical justification; prescribing opioid refills without evaluating the patient on multiple occasions; failing to refer Patient N to a pain medicine specialist or addiction specialist after Patient N exhibited aberrant behavior; and/or prescribing benzodiazepines concurrently with opioids to Patient N.

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

Count 57 – Patient O

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

NRS 630.301(4) – Malpractice

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

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

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

395. Respondent committed malpractice with respect to Patient O when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by prescribing extremely high daily doses of opioids (approximately 600 mg morphine equivalents per day) without sufficient medical justification; failing to support his diagnoses with physical examination findings; failing to perform sufficient opioid risk analysis; escalating the dosage of Patient O's prescriptions without documented physical examination findings or advanced imaging that would support the increase in dosage; failing to refer Patient O to appropriate specialists; prescribing opioid refills without evaluating Patient O on multiple occasions; failing to modify treatment of Patient O or refer Patient O to a pain medicine specialist or addiction specialist when Patient O exhibited aberrant behavior, including lost or stolen medication and aberrant urinalyses; failing to employ reasonable risk mitigation measures in light of Patient O's aberrant behaviors; and/or prescribing opioid refills without evaluating Patient O on several occasions.

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

Count 58 – Patient O

NRS 630.306(1)(b)(2) - Violation of Standard of Practice

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

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

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

1 399. The Board adopted by reference The *Model Policy on the Use of Opioid Analgesics*
2 *in the Treatment of Chronic Pain*, July 2013, published by the Federation of State Medical Boards
3 of the United States, Inc. (the "Model Policy").
4 400. Pursuant to NAC 630.230(1)(k), a licensee shall not engage in the practice of
5 writing prescriptions for controlled substances to treat acute pain or chronic pain in a manner that
6 deviates from the policies set forth in the *Model Policy on the Use of Opioid Analgesics in the*
7 *Treatment of Chronic Pain* adopted by reference in NAC 630.187.
8 401. Respondent wrote prescriptions for controlled substances to treat acute or chronic
9 pain in a manner that deviates from the Model Policy by prescribing extremely high doses of
10 opioids without sufficient medical justification; failing to support diagnoses with physical
11 evaluations; prescribing refills of opioid medication to Patient O without evaluating Patient O on
12 several occasions; failing to refer Patient O to appropriate specialists; failing to modify the
13 treatment plan when Patient O exhibited aberrant behavior that suggested misuse of the prescribed
14 opioid medications; failing to refer Patient O to an addiction specialist after Patient O exhibited
15 aberrant behavior; and/or rapidly escalating Patient O's opioid dosage without sufficient medical
16 justification.
17 402. By reason of the foregoing, Respondent is subject to discipline by the Board as
18 provided in NRS 630.352.
19 **Count 59 – Patient O**
20 **NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or**
21 **competence**
22 403. All of the allegations in the above paragraphs are hereby incorporated by reference
23 as though fully set forth herein.
24 404. Practicing beyond the scope of a licensee's training or competence is grounds for
25 disciplinary action by the Board pursuant to NRS 630.306(1)(e).
26 405. Respondent is a family medicine practitioner and not a pain medicine specialist.
27 406. Medical guidelines establish that any dose above 90 mg/day morphine equivalent
28 is high dose opioid therapy, and recommend referral and/or consultation with a pain medicine

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

specialist for daily opioid doses above 90 mg morphine equivalents.

407. Respondent prescribed Patient O daily morphine equivalent doses of approximately 600 mg.

408. Respondent failed to refer Patient O to a pain medicine specialist or addiction specialist, or other specialists to rigorously diagnose the source of Patient O's pain.

409. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient O without rigorous diagnosis of the source of pain and consideration of other treatment modalities.

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

Count 60 – Patient O

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

412. 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).

413. Respondent engaged in unsafe acts regarding Patient O by failing to abide by the Model Policy adopted by the Board; prescribing extremely high doses of opioid medications without sufficient medical justification; escalating Patient O's opioid dosage without sufficient medical justification; prescribing opioid refills without evaluating the patient on multiple occasions; and/or failing to refer Patient O to a pain medicine specialist or addiction specialist after Patient O exhibited aberrant behavior.

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

//

Count 61 – Patient P

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

NRS 630.301(4) – Malpractice

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

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

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

418. Respondent committed malpractice with respect to Patient P when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by prescribing extremely high daily doses of opioids (approximately 450 MME) without sufficient medical justification; failing to support his diagnoses with physical examination findings; failing to perform sufficient opioid risk analysis; escalating the dosage of Patient P's prescriptions without documented physical examination findings or advanced imaging that would support the increase in dosage; failing to document findings from specialists to which Patient P was referred by Respondent; failing to address Patient P's aberrant urinalysis for non-prescribed methadone; prescribing opioid refills without evaluating Patient P on multiple occasions; failing to timely treat Patient P's elevated blood pressure while Patient P was on testosterone; failing to decrease the dose of testosterone and instead giving Patient P a therapeutic phlebotomy; and/or prescribing arimidex for elevated estradiol, which is an off label use.

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

Count 62– Patient P

NRS 630.306(1)(b)(2) - Violation of Standard of Practice

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

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

422. The Board adopted by reference The *Model Policy on the Use of Opioid Analgesics*

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

in the Treatment of Chronic Pain, July 2013, published by the Federation of State Medical Boards of the United States, Inc. (the "Model Policy").

423. 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.

424. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by prescribing extremely high doses of opioids without sufficient medical justification; failing to support diagnoses with physical evaluations; failing to refer Patient P to appropriate specialists; failing to document the findings of specialists to whom Respondent referred Patient P; failing to address Patient P's aberrant urinalysis; prescribing opioid refills without evaluating Patient P on multiple occasions; and/or rapidly escalating Patient P's opioid dosage without sufficient medical justification.

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

Count 63 – Patient P

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

427. 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).

428. Respondent is a family medicine practitioner and not a pain medicine specialist.

429. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

430. Respondent prescribed Patient P daily morphine equivalent doses of approximately 450 mg.

431. Respondent failed to refer Patient P to a pain medicine specialist or addiction specialist, or other specialists to rigorously diagnose the source of Patient P's pain.

432. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient P without rigorous diagnosis of the source of pain and consideration of other treatment modalities.

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

Count 64 – Patient P

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

435. 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).

436. Respondent engaged in unsafe acts regarding Patient P by failing to abide by the Model Policy adopted by the Board; prescribing extremely high doses of opioid medications without sufficient medical justification; escalating Patient P's opioid dosage without sufficient medical justification; prescribing opioid refills without evaluating the patient on multiple occasions; failing to document or act on the neurosurgical and pain medicine evaluations that documented concern regarding Patient P's opioid regimen; and/or failing to address Patient P's aberrant urinalysis.

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

//

//

//

//

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

Count 65 – Patient Q

NRS 630.301(4) – Malpractice

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

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

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

441. Respondent committed malpractice with respect to Patient Q when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by prescribing extremely high daily doses of opioids (approximately 750 MME) without sufficient medical justification; failing to support his diagnoses with physical examination findings; failing to perform sufficient opioid risk analysis; escalating the dosage of Patient Q's prescriptions without documented physical examination findings or advanced imaging that would support the increase in dosage;; failing to address Patient Q's aberrant urinalyses for marijuana and ethanol and lost medications; prescribing opioid refills without evaluating Patient Q on multiple occasions; failing to address Patient Q's persistent tachycardia; and/or failing to document a treatment plan or objectives and monitoring of Patient Q's diabetes.

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

Count 66– Patient Q

NRS 630.306(1)(b)(2) - Violation of Standard of Practice

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

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

445. 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

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

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

446. 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.

447. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by prescribing extremely high doses of opioids without sufficient medical justification; failing to support diagnoses with physical evaluations; failing to refer Patient Q to appropriate specialists; failing to address Patient Q's aberrant urinalyses; prescribing opioid refills without evaluating Patient Q on multiple occasions; and/or rapidly escalating Patient Q's opioid dosage without sufficient medical justification.

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

Count 67 – Patient Q

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

450. 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).

451. Respondent is a family medicine practitioner and not a pain medicine specialist.

452. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

453. Respondent prescribed Patient Q daily morphine equivalent doses of approximately 750 mg.

454. Respondent failed to refer Patient Q to a pain medicine specialist or addiction specialist, or other specialists to rigorously diagnose the source of Patient Q's pain.

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

455. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient Q without rigorous diagnosis of the source of pain and consideration of other treatment modalities.

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

Count 68 – Patient Q

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

458. 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).

459. Respondent engaged in unsafe acts regarding Patient Q by failing to abide by the Model Policy adopted by the Board; prescribing extremely high doses of opioid medications without sufficient medical justification; escalating Patient Q's opioid dosage without sufficient medical justification; prescribing opioid refills without evaluating the patient on multiple occasions; failing to refer Patient Q to appropriate specialists; and/or failing to address Patient Q's aberrant urinalyses.

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

Count 69 – Patient R

NRS 630.301(4) – Malpractice

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

462. 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

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

464. Respondent committed malpractice with respect to Patient R when he failed to provide reasonable care, skills, and knowledge ordinarily used by physicians under similar circumstances by prescribing extremely high daily doses of opioids (approximately 720 MME) without sufficient medical justification; failing to support his diagnoses with physical examination findings; failing to perform sufficient opioid risk analysis; escalating the dosage of Patient R's prescriptions without documented physical examination findings or advanced imaging that would support the increase in dosage; failing to address Patient R's aberrant urinalyses and lost medications; and/or failing properly diagnose Patient R's low testosterone.

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

Count 70– Patient R

NRS 630.306(1)(b)(2)-Violation of Standard of Practice

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

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

468. 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").

469. 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.

470. Respondent wrote prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the Model Policy by prescribing extremely high doses of opioids without sufficient medical justification; failing to support diagnoses with physical

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

evaluations; failing to refer Patient R to appropriate specialists; failing to address Patient R's aberrant urinalyses; and/or rapidly escalating Patient R's opioid dosage without sufficient medical justification.

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

Count 71 – Patient R

NRS 630.306(1)(e) – Practicing beyond the scope of physician's training or competence

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

473. 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).

474. Respondent is a family medicine practitioner and not a pain medicine specialist.

475. Medical guidelines establish that any dose above 90 mg/day morphine equivalent 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.

476. Respondent prescribed Patient R daily morphine equivalent doses of approximately 720 mg.

477. Respondent failed to refer Patient R to a pain medicine specialist or addiction specialist, or other specialists to rigorously diagnose the source of Patient R's pain.

478. Respondent practiced beyond the scope of his training or competence by prescribing inappropriately large amounts of short-acting opioids to Patient R without rigorous diagnosis of the source of pain and consideration of other treatment modalities.

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

//

//

//

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

Count 72 – Patient R

NRS 630.306(1)(p) - Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board

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

481. 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).

482. Respondent engaged in unsafe acts regarding Patient R by failing to abide by the Model Policy adopted by the Board; prescribing extremely high doses of opioid medications without sufficient medical justification; escalating Patient R's opioid dosage without sufficient medical justification; failing to refer Patient R to appropriate specialists; and/or failing to address Patient R's aberrant urinalyses, which indicated possible diversion.

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

Count 73

NRS 630.306(1)(g) – Continual failure to use the same diligence as physicians in same field or specialty

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

485. NRS 630.306(1)(g) provides that a basis for disciplinary action is a physician's continual failure to use the same diligence as physicians in the same field or specialty.

486. Respondent continually failed to use the same diligence as physicians in the same field or specialty by: prescribing inordinately high doses of opioids without sufficient medical justification; rapidly escalating opioid dosages without medical justification; routinely failing to act on patients' aberrant behavior that indicated misuse of opioids or diversion; rarely referring patients to pain medicine specialists or other specialists for rigorous pain diagnoses; failing to adequately evaluate patients by not obtaining previous medical documents, by performing

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

incomplete physical examinations, by frequently skipping examinations and by frequently prescribing opioids without even seeing the patient; failing to inform patients regarding opioid risks, most notably male patients on high dose opioid therapy regarding the risk of opioid-induced hypogonadism; failing to assess and identify patients at risk for opioid misuse/abuse by failing to employ standard risk mitigation techniques; using opioid monitoring techniques such as urine drug tests and prescription drug monitoring program data, but failing to act on patient aberrancies; relying excessively on opioids for pain management and prescribing massive doses of opioids (several times the established "high dose" threshold), almost always including opioids with high abuse potential (oxycodone, fentanyl); rarely referring patients to pain medicine specialists and, when he did refer, failing to heed the recommendations; and/or failing to refer patients demonstrating opioid abuse/misuse to addiction specialists.

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

Count 74

NRS 630.3062(1) – Failure to keep timely, legible, accurate, and complete medical records

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

489. 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.

490. Respondent failed to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of Patients A through R, or any one of them, as outlined above when he failed to include: medical indications for prescribing opioids to Patients A through R, or any one of them; medical indications for escalating the opioid dosages for Patients A through R, or any one of them; verification of past medical histories for Patients A through R, or any one of them; diagnostic data for Patients A through R, or any one of them; examination findings consistent with the patient's pain complaint for Patients A through R, or any

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

one of them; and the use of benzodiazepines concurrently with opioids for Patients A through R, or any one of them.

491. 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 against him, as set forth in this Complaint, and give Respondent notice that he may file an answer to the Complaint within twenty (20) days of service of the Complaint. NRS 630.339(2);

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

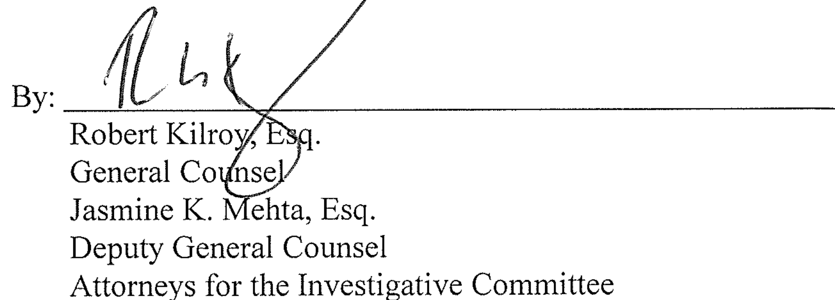
3. Determine what sanctions to impose if it finds and concludes that Respondent violated the Medical Practice Act;

4. Make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, to include sanctions to be imposed; and

5. Take such other and further action as may be just and proper in these premises.

DATED this 2nd day of February, 2017.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS



By: ______________________
Robert Kilroy, Esq.
General Counsel
Jasmine K. Mehta, Esq.
Deputy General Counsel
Attorneys for the Investigative Committee

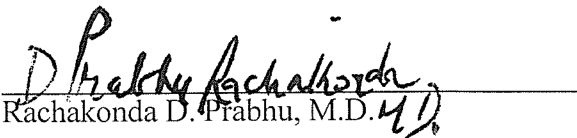
OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Rachakonda D. Prabhu, 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 that 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 2nd day of February, 2017.



Rachakonda D. Prabhu, M.D.

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