IN AND BEFORE THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION STATE OF OKLAHOMA

STATE OF OKLAHOMA, *ex rel.* OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff,	)	
vs.	)	**Case No. 16-12-5415**
DOMINIC LOSACCO, M.D., LICENSE NO. MD 10161,	)	
Defendant.	)	

VERIFIED COMPLAINT

The State of Oklahoma, *ex rel.* Oklahoma State Board of Medical Licensure and Supervision ("Board"), alleges and states as follows for its Complaint against Dominic Losacco, M.D. ("Defendant"):

1. The Board has jurisdiction over the subject matter and is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma. 59 O.S. 2011, § 480, *et seq.* and Okla. Admin. Code 435:5-1-1 *et seq.*

2. Defendant holds Oklahoma medical license number 10161.

I. ALLEGATIONS OF PROFESSIONAL MISCONDUCT

3. B.W.C. filed the initial complaint with the Board on behalf of patient A.S.C., and alleged Defendant was prescribing large doses of Xanax to patients who were simultaneously receiving Methadone through an Opioid Treatment Program (OTP). The complainant stated that Defendant does not provide reasonable psychiatric assessments or conduct follow-up drug testing on patients and has become known in the "Methadone Maintenance" community as someone who will hand out pills with little justification.

4. The medical records for patient A.S.C. were subpoenaed on May 25, 2017 by Board Investigator Larry Carter.

5. When obtaining the patient record, Investigator Carter spoke with Defendant regarding the concerns expressed in the initial complaint. Defendant was aware that his patients, including A.S.C., are in an OTP while he is treating them for anxiety. Defendant stated he finds that many of these patients suffer from ADD, which may fuel their anxiety, so it

is not uncommon for Defendant to begin a drug therapy that includes Xanax and an amphetamine. Defendant stated that Methadone and opioids pose the greatest risk for overdose, and benzodiazepines, such as Xanax, are completely safe, and only pose a risk to the patient if they are stopped abruptly.

6. Defendant claimed that several OTP medical directors referred their patients to him for treatment of anxiety.

7. Investigator Carter reviewed the short patient record for A.S.C. and was unable to find any demographic record. The notes were handwritten and difficult to read.

8. Investigator Carter contacted all of the OTP's in Tulsa to determine if directly refer their patients to Defendant. He learned that none of the OTP's in Tulsa specifically refer their patients to Defendant. Two of the programs confirmed they had patients seeing Defendant for behavioral care, but both of those medical directors expressed concerns about Defendant's prescribing of high doses of Xanax and other similar drugs when treating patients known to have a history of substance abuse, and who are simultaneously taking large doses of Methadone.

9. Investigator Carter subpoenaed ten (10) additional patient charts, which were subsequently delivered to William Tankersley, M.D. for expert review.

10. On June 20, 2018, expert review was tendered to Investigator Carter from Dr. Tankersley, who had determined that the records would not meet an academic standard of care for documentation. It was determined that there were deficits in patients' histories, objective criteria for diagnoses, treatments, proper use of PMP records, discussions of alternatives to controlled substances, monitoring for side effects, plans of care and medical necessity.

11. Overall, Defendant does not always sufficiently justify the use of high dose benzodiazepine or his clinical decision making in his documentation. He appears to be willing to use higher than standard doses of Xanax frequently rather than as an exception for treatment resistant patients. He uses quick titrations to higher dose ranges as part of his initial treatment plan as opposed to documenting failure of a lower dose regimen to justify high dose use. There is a willingness to use these high risk doses in patients with a substance history who are higher risk for abuse, misuse, and diversion potential. He also demonstrates a willingness to use higher dose Xanax in combination with opiates or a second in class medication (benzodiazepines), which increases adverse event risk and overdose potential.

12. Defendant also appears to be comfortable using high dose Xanax in combination with higher than standard doses of stimulant medications. Several of the charts also had concerns for abuse, misuse, and diversion with the co-administered stimulant. While there is data to support higher dose stimulant use in treatment resistant patients, Defendant's typical dose regimen for adult ADHD patients were 2-3 times the recommended dose. Again, he used aggressive titration to higher than typical doses as the initial plan rather than documenting failure of lower doses to justify use of the higher

dose range. Documentation of a failed lower dose stimulant trial and trial of failed lower dose plus an augmentation agent would be standard of care before pursuing high dose treatment.

13. Evidence determined through expert review, that the specific patient records included the following:

a. Patient T.A.C.:

While the initial assessment was difficult to follow, it appeared to establish a previous history of diagnosis of ADHD and treatment with stimulant and benzodiazepine. The assessment also indicates patient suffers from panic/agoraphobia and transient depression, but does not establish diagnostic criteria to confirm these diagnoses. There is no indication of screening for substance history. There is no documentation of a discussion of risks/benefits of the medications. The charts from 2012-2013 include no discussion of why an SSRI, as a first line treatment, was not considered for the depressive and anxiety components of the patient's care. The Adderall dosage is ultimately titrated to higher than typical dose ranges.

The patient's Xanax dose was increased from 1mg TID to 2 mg TID with weak clinical documentation to support the increase. In 2016, the patient notes indicate a diagnosis change to bipolar and ADHD without clinical symptoms or appropriate description of the patient's level of functioning presented to support the diagnosis change. On five occasions in 2016, the Defendant is provided a 90 day refill of alprazolam either one or two months early. There is no documentation that PMP was checked or of discussions regarding the early refills of Xanax. There is no documentation of abuse screening with these multiple early refills, and refills begin being mailed out rather than picked up in person. The frequency of visits is decreased when there is the possibility of more significant symptomatology. The patient's medication regimen is not on first line standard of care treatment for bipolar with concern of mania symptoms which would include a mood stabilizer.

There are significant issues with documentation and management of care. Defendant continued to provide controlled substances to a patient during a 6 month period without follow-up visits in which there were multiple early refills.

b. Patient C.B.C.:

The initial intake indicated a diagnosis of paranoid schizophrenia and a history of ADHD, with documentation that patient is no longer on ADHD medications. However, there was no screening for substance history or an indication of attempts to obtain medical records or coordinate care with the transferring provider. From December of 2015 to December of 2016, the treatment notes document fluctuations in the patient's level of psychosis and antipsychotic medications are titrated and changed. There is a period where hospitalization is considered due to the level of psychosis, but the chart indicates the patient

eventually became stable on a consistent medication regimen. However, there is no documentation that the PMP was checked prior to Xanax refills. In 2017, the patient's visits are reduced from monthly to 6 month follow-up visits on a patient with chronic mental illness that has been difficult to stabilize.

c. Patient J.B.C:

The initial intake note indicates patient was transferring care from the VA, however there is no indication of attempt to obtain records or coordinate care. A substance history screen documents "excessive alcohol use" and "daily vodka multiple drinks per day." The notes document a history of manic episodes, panic attacks and ADHD, but the level of symptom documentation to support diagnosis is weak. Diagnoses of Bipolar, Panic and ADHD are given. The patient is prescribed Lamictal 100mg, Zoloft 100mg, Adderall 30mg TID and Xanax 1.5mg QID. There is documentation that the patient been on the Xanax for a year without clarification on whether the other medications are a continuation from the transferring provider or are new medications. Benzodiazepine use in a patient with known alcohol use disorder is unsafe and can lead to injury or overdose death. The note does not document a consideration of these issues or that these risks were discussed with the patient. On 8/14/15 there is documentation of the PMP being checked and a mention of methamphetamine, however, there are no entries in the PMP prior to 8/19/16, and there are no other documentation of checking the PMP in the chart.

Overall, the notes lack structure and legibility and the documentation lacked medical or psychiatric symptoms, making it difficult to justify the patient's treatment course and level of functioning. Several notes mention concern for mania, however, there is no documentation of consideration of the high dose stimulant contributing to mania. There are multiple issues in the chart raising concern for this patient's high abuse potential and being at significant risk for diversion or misuse of medications, which should have prompted increased frequency of visits, reduction in the number of refills, not providing refills unless cancelled visits are rescheduled, drug testing, and encouraged involvement in 12 step peer support group.

d. Patient B.C.C:

The Defendant has a lengthy therapeutic relationship with this patient. The initial intake includes a substance abuse screen with history of alcoholism with daily drinking and a medical history of chronic pain. Patient is diagnosed with depression and started on an SSRI. The notes continue to document significant depression, irritability and anxiety with titration of Xanax to 2mg QID. Benzodiazepine use in a patient with known alcohol use disorder is high risk for abuse, misuse and unsafe co-administration with alcohol lead to injury or overdose death. The notes do not document a consideration of these issues or that these risks were discussed with the patient. There is no charting of a discussion of the increased risk of overdose with the combination of opiate and benzodiazepine

with the patient starting pain management. The patient, who has a history of substance abuse, is seen for many years at six month intervals while still being provided refills of controlled substances. There is no documentation that PMP was checked prior to Xanax refills.

e. Patient M.D.C.:

The initial intake note lacks structure and is difficult to follow, but indicates a transfer of care from another state with no documentation of attempts to obtain records or coordinate care with the previous provider. The patient is inherited on higher than standard doses of controlled substance and there is no documentation of effort to confirm the patient's report of doses, and 10mg of daily Xanax is prescribed when the patient disclosed daily dose of 5-7mg. The quality of the follow-up notes are poor and focus on the patient's life stressors rather than documenting mood, anxiety or ADHD symptoms. There are multiple red flags that the patient is misusing or abusing controlled substances. However, refills are provided for controlled substances for 6 months without a face-to-face visit and early refills are attempted.

In 2013, the pharmacy calls to advise that patient has tried to fill an Adderall script that is a photo copy and Defendant documents checking the PMP. The follow-up note indicates that the patient's sister tried to fill the script, and Defendant charts, "pt dependable reliable," and Xanax is prescribed with 5 refills. Beginning in 2014, the PMP indicates multiple early refills of Xanax and that the patient is using multiple pharmacies in order to fill Xanax early, while the Defendant charts checking the PMP with no concerns. Beginning in 2016, the patient is moved to annual appointments when there have been many red flags for diversion, misuse, and abuse of medications.

Court records from 2013 to 2015 indicate that Defendant was convicted of Burglary and Possession of Methamphetamine in Creek County case no CF-13-489, which also included probation violations and drug testing issues.

f. Patient K.E.C:

High dose benzodiazepine use is continued at a similar dose from transferring physician; however, there is no charting that the PMP was checked or an attempt to obtain records or coordinate care. The patient is on a combination of high dose Xanax and an opiate and is receiving controlled substances from multiple providers. The titration of the patient's stimulant increase was extreme and there was no discussion of possible use of an SSRI as first line treatment for panic disorder.

g. Patient A.L.C:

Charting has structure and legibility concerns making the intake note difficult to follow. A diagnosis of MDD, Panic disorder and Adult ADHD are given, where a PTSD screen would have been indicated due to the patient's trauma history.

There is no documentation that the PMP was checked, which would have shown a history of opiate prescriptions from multiple providers. When increasing Xanax into the high dose range, there is increased concern with co-administration with Ambien and opiates being obtained from other providers and no notes addressing these issues. The only follow-up substance screening mentions marijuana use.

h. Patient A.S.C.:

The Defendant's initial intake diagnosis is panic disorder and ADHD. Patient is prescribed Xanax 1mg QID and Strattera. Patient is then changed from Strattera to Adderall without evidence of a face-to-face visit. The patient's Xanax prescription was later increased to 2mg QID. The note documents, "review med: {illegible} misuse or stealing." If this was meant to document a PMP check, it would have been the only PMP check documented for this patient. This patient was stepped down to less frequent visits more quickly than seen with the other charts.

This is the patient Defendant admitted he knew was in an OTP Program. Is this reflected anywhere in the charts, and are there discussions of the risks involving combination of Xanax and Methadone?

i. Patient L.S.C.:

The initial intake indicates that the patient is on Xanax 1mg QID and transferring care from another physician, although there is no indication of attempt to obtain records or coordinate care. There is a negative screening for substance use disorders and alcohol documented, however the notes indicate that the patient has attended a methadone clinic for one year and is on 100mg/day of methadone for chronic pain. Attending a methadone clinic strongly indicates substance use disorder. Opiate use disorder is not included on his initial diagnosis. The combination of Xanax and methadone has a significant overdose risk. There is no documentation of discussion of the increased risk of the combination of these medications until 6 months into treatment. Use of high dose controlled substances on a patient with substance use disorder requiring opiate agonist treatment prior to documenting failure of trials of first line non-controlled substance alternative would not be considered standard of care and exposes the patient to significant overdose and relapse risk.

j. Patient D.W.C.:

This chart starts earlier than most of the charts reviewed, and evidences that earlier in his practice Defendant appeared to have made more of an effort to meet standard of care practice and provide more detailed documentation. A 2003 follow-up note documented that the patient is challenged to try SSRI's rather than benzodiazepine monotherapy. The patient was also challenged when there is concern of misuse and the number of refills are reduced and the frequency of visits are increased. However, as treatment progresses, the quality of symptom documentation in the chart decreases. Follow-up visits focus more social issues

than psychiatric or medical symptoms. There is no charting of checking of the PMP. As with many other patients, placing the patient on six month follow-up visits would be questionable due to a history of safety concerns.

Additionally, this patient is approaching the geriatric age range, and there is no documentation of re-evaluation of treatment due to the added safety risks with high dose benzodiazepine use as the patient ages. Several of the SSRI trials have titrations to the maximum dose, which is dangerous considering the patient's significant history of adverse reactions to this class of medications. However, those side effects could have been avoided with slower titrations or would have resolved after a few doses had the medication not been abandoned so quickly. All of which could have been worked through with patient education.

14. A review of the PMP records for these patients revealed that the Defendant never checked the PMP for T.A.C, C.B.C., J.B.C., A.L.C., or D.W.C. For patients B.C.C., M.D.C., and K.E.C., and L.S.C., the Defendant only checked the PMP approximately once a year beginning in late 2016.

II. VIOLATIONS

15. Based on the foregoing, the Defendant is guilty of professional misconduct as follows:

a. Dishonorable or immoral conduct likely to deceive, defraud, or harm the public in violation of 59 O.S. 2011, § 509(8) and Okla. Admin. Code §§ 435:10-7-4(11),

b. Prescribing or administering a drug or treatment without sufficient examination and the establishment of a valid physician-patient relationship in violation of 59 O.S. 2011, § 509(12),

c. Prescribing, dispensing or administering of controlled substances or narcotic drugs in excess of the amount considered good medical practice, or prescribing, dispensing or administering controlled substances or narcotic drugs without medical need in accordance with published standards in violation of 59 O.S. 2011, § 509 (16) and Okla. Admin. Code § 435:10-7-4(2),

d. Failure to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient in violation of 59 O.S. 2011, § 509 (18),

e. Failure to provide a proper and safe medical facility setting and qualified assistive personnel for a recognized medical act, including but not limited to an initial in-person patient examination, office surgery, diagnostic service or any other medical procedure or treatment. Adequate medical records to support diagnosis, procedure, treatment or prescribed medications must be produced and maintained in violation of 59 O.S. 2011, § 509 (20) and Okla. Admin. Code § 435:10-7-4(41),

f. Violating the criminal laws of this State, including 63 O.S. § 2-309D(G)(2)(a), when such act is connected with the physician's practice of medicine, in violation of 59 O.S. 2011, § 509(9) and Okla. Admin. Code § 435:10-7-4(27),

g. Indiscriminate or excessive prescribing, dispensing or administering of controlled or narcotic drugs in violation of Okla. Admin. Code § 435:10-7-4(1),

h. Dispensing, prescribing or administering a controlled substance or narcotic drug without medical need in violation of and Okla. Admin. Code § 435:10-7-4(6),

i. Except as otherwise permitted by law, prescribing, selling, administering, distributing, ordering or giving a habitue or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug in violation of and Okla. Admin. Code § 435:10-7-4(25),

j. Improper management of medical records in violation of Okla. Admin. Code § 435:10-7-4(36).

III. CONCLUSION

Given the foregoing, the undersigned requests the Board conduct a hearing, and, upon proof of the allegations contained herein, impose such disciplinary action as authorized by law, up to and including suspension or revocation and any other appropriate action with respect to the Defendant's professional license, including an assessment of costs and attorney's fees incurred in this action as provided by law.

Marc S. Pate, OBA #10567
Assistant Attorney General
313 N.E. 21st Street
Oklahoma City, Oklahoma 73105
405/522-3921

VERIFICATION

I, Larry Carter, under penalty of perjury, under the laws of the State of Oklahoma, state as follows:

1. I have read the above Complaint regarding the Defendant, Dominic Losacco, M.D.; and

2. The factual statements contained therein are true and correct to the best of my knowledge and belief.

Larry Carter, Investigator
OKLAHOMA STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION

Date: 15 Feb 2019

Oklahoma County
Place of Execution