

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

FILED

JUL 10 2009

STATE OF OKLAHOMA
EX REL. THE OKLAHOMA BOARD
OF MEDICAL LICENSURE
AND SUPERVISION,

Plaintiff

v.

LEONARDO HERMAN CLARAVALL, M.D.,
LICENSE NO. 10412,

Defendant.

OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE & SUPERVISION

Case No. 09-03-3705

COMPLAINT

COMES NOW the plaintiff, the State of Oklahoma ex rel. the Oklahoma State Board of Medical Licensure and Supervision (the "Board"), by and through its attorney, Elizabeth A. Scott, Assistant Attorney General, and for its Complaint against the Defendant, Leonardo Herman Claravall, M.D., Oklahoma license no. 10412, alleges and states as follows:

1. The Board 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 pursuant to 59 Okla. Stat. §480 *et seq.*
2. Defendant, Leonardo Herman Claravall, M.D., holds Oklahoma license no. 15171.

PRIOR DISCIPLINARY ACTION

3. On or about January 23, 1998, the Board entered a Voluntary Submittal to Jurisdiction and Agreed Order whereby Defendant's license was **SUSPENDED** for a period of **SIXTY (60) DAYS**, to be followed by a **FIVE (5) YEAR** term of **PROBATION** due to a finding that he prescribed a drug without sufficient examination and the establishment of a valid physician/patient relationship, he aided or abetted the unlicensed practice of medicine, he engaged in gross or repeated negligence, he allowed another person to use his physician's license to practice medicine and that he failed to maintain effective controls against the diversion of controlled dangerous substances. Specifically, Defendant allowed his sisters, as well as his

brother-in-law to examine patients, dispense controlled drugs to the patients, and to hold themselves out as licensed physicians when they were not in fact licensed in any state. These actions occurred primarily when Defendant was not on the premises. Defendant's probation ended March 23, 2003.

CURRENT UNPROFESSIONAL CONDUCT ALLEGATIONS

VIOLATION OF DEA AND OBN REGISTRATION LAWS

4. On or about December 1, 2004, Defendant's registration to prescribe controlled dangerous substances with the Oklahoma Bureau of Narcotics and Dangerous Drugs expired due to Defendant's failure to renew his registration.

5. On or about August 31, 2008, Defendant's registration to prescribe controlled dangerous substances with the Drug Enforcement Agency expired due to his failure to renew his registration.

6. Throughout the period of time when Defendant's DEA and OBN registrations had expired, Defendant continued to prescribe controlled dangerous substances to his patients. A review of the Prescription Monitoring Program revealed that Defendant has written or authorized over three-thousand (3000) prescriptions for controlled dangerous substances for the period February 1, 2008 through February 1, 2009 during which time he did not possess both a DEA and OBN registration.

7. On or about January 23, 2009, OBN Agent Mark Stewart confronted Defendant about his continued prescribing of controlled dangerous substances while failing to possess valid OBN and DEA permits. Defendant admitted to Agent Stewart that he had written prescriptions for controlled dangerous substances without valid OBN and DEA permits. Defendant agreed with Agent Stewart that he would not prescribe any controlled dangerous substances until he obtained valid OBN and DEA permits.

8. On or about March 17, 2009, Agent Stewart and Board Investigator Steve Washbourne confronted Defendant about new claims that Defendant had continued to prescribe controlled dangerous substances after his meeting with Agent Stewart on January 23, 2009 but before he obtained both OBN and DEA permits. Defendant admitted that he had in fact prescribed controlled dangerous substances during this time based upon the fact that he had submitted his application and a check for an OBN permit. Defendant admitted that he had not received any OBN registration certificate confirming that he was allowed to prescribe controlled dangerous substances.

PRESCRIBING VIOLATIONS

9. From February 20, 2007 until February 21, 2009, Defendant wrote or authorized one-hundred forty-two (142) prescriptions for controlled dangerous drugs to Patient GRW for alleged back pain and depression. These prescriptions include eighty-nine (89) prescriptions for

Phendimetrazine, Hydrocodone and Acetaminophen/Codeine, Schedule III controlled dangerous drugs, for a total of 6,484 dosage units, and fifty-three (53) prescriptions for Soma, Alprazolam and Phentermine, Schedule IV controlled dangerous drugs, for a total of 2,428 dosage units, for an average of **12.17 dosage units per day of controlled dangerous drugs**. Defendant's chart on this patient reveals that he performed only a minimal physical examination on this patient at the first appointment and for the next two (2) years, no adequate physical examination prior to prescribing the controlled dangerous drugs other than recording vital signs, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. The majority of Defendant's chart on this patient reflects numerous visits with no documentation other than a listing of drugs prescribed and vital signs. Defendant's chart reflects multiple visits without any physical findings.

10. From January 11, 2007 until February 27, 2009, Defendant wrote or authorized two-hundred fifteen (215) prescriptions for controlled dangerous drugs to Patient CCW for alleged back pain and weight loss. These prescriptions include one-hundred thirty-five (135) prescriptions for Phendimetrazine and Hydrocodone, Schedule III controlled dangerous drugs, for 7,095 dosage units, and eighty (80) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 2,400 dosage units, for an average of **12.20 dosage units per day of controlled dangerous drugs**. Defendant's chart on this patient reveals that he failed to perform any physical examination on this patient during this time prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart during this time reflects numerous visits with no documentation other than a listing of drugs prescribed. Defendant's chart reflects multiple visits without any physical findings.

11. From April 18, 2008 until February 4, 2009, Defendant wrote or authorized fifty-five (55) prescriptions for controlled dangerous drugs to Patient SDW for weight loss. These prescriptions include thirty-six (36) prescriptions for Phendimetrazine, Acetaminophen/Codeine and Tussionex Susp., Schedule III controlled dangerous drugs, for 2,632 dosage units, and nineteen (19) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for a total of 510 dosage units, for an average of **10.76 dosage units per day of controlled dangerous drugs**. Defendant's chart on this patient reveals that he performed only a minimal physical examination on this patient at the first appointment and for the next year, no adequate physical examination prior to prescribing the controlled dangerous drugs other than recording vital signs, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. The majority of Defendant's chart on this patient reflects numerous visits with no documentation other than a listing of drugs prescribed and vital signs. Defendant's chart reflects multiple visits without any physical findings.

12. From March 3, 2007 until January 10, 2009, Defendant wrote or authorized one-hundred thirty-six (136) prescriptions for controlled dangerous drugs to Patient PDW for weight loss. These prescriptions include twenty-four (24) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 850 dosage units, and one-hundred twelve (112) prescriptions for Ambien, Soma, Xanax, Phentermine and Zolpidem, Schedule IV controlled dangerous drugs, for 4,590 dosage units, for an average of **8.01 dosage units per day of controlled dangerous drugs**. Defendant's chart on this patient reveals that he performed little to no complete physical examinations other than on the first visit other than recording vital signs, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. The majority of Defendant's chart on this patient reflects numerous visits with no documentation other than a listing of drugs prescribed and vital signs. Defendant's chart additionally reflects multiple visits without any physical findings. **Patient PDW died on February 13, 2009 due to prescription drug overdose.** A review of the PMP reveals that Patient PDW was receiving controlled dangerous substances from numerous physicians in addition to Defendant during this time period.

13. From January 11, 2007 until February 23, 2009, Defendant wrote or authorized sixty-three (63) prescriptions for controlled dangerous drugs to SFW for weight control. These prescriptions include thirty-nine (39) prescriptions for Phendimetrazine and twenty-four (24) prescriptions for Hydrocodone, Schedule III controlled dangerous drugs, for 5,098 dosage units. Defendant's chart on this patient reveals that while he performed a physical examination on the patient when he first treated her in 1995, he failed to perform complete physical examinations thereafter other than recording vital signs, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects little justification for the prolonged use of Hydrocodone. The majority of Defendant's chart on this patient reflects numerous visits with no documentation other than a listing of drugs prescribed and vital signs. Defendant's chart additionally reflects multiple visits without any physical findings.

14. From October 10, 2007 until January 31, 2009, Defendant wrote or authorized thirty-one (31) prescriptions for controlled dangerous drugs to Patient RJW for alleged muscle and shoulder pain. These prescriptions include fifteen (15) prescriptions for Hydrocodone and Phendimetrazine, Schedule III controlled dangerous drugs, for 746 dosage units, and sixteen (16) prescriptions for Phentermine and Xanax, Schedule IV controlled dangerous drugs, for 840 dosage units. Defendant's chart on this patient reveals that while he performed a physical examination on the patient when he first treated her in 1996, he failed to perform complete physical examinations thereafter other than recording vital signs, that he did not establish a legitimate medical need for the medications, that he did not order appropriate tests, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. The majority of Defendant's chart on this patient reflects numerous visits with no documentation other than a listing of drugs prescribed and vital signs. Defendant's chart additionally reflects multiple visits without any physical findings.

15. Defendant is guilty of unprofessional conduct in that he:
- A. Engaged in dishonorable or immoral conduct which is likely to deceive, defraud or harm the public in violation of 59 O.S. § 509 (8) and OAC 435:10-7-4 (11).
 - B. Engaged in practice or other behavior that demonstrates an incapacity or incompetence to practice medicine and surgery in violation of OAC 435:10-7-4(18).
 - C. Violated any provision of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board in violation of 59 O.S. §509 (13) and OAC 435:10-7-4(39).
 - D. Failed 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. §509 (18) and OAC 435:10-7-4(41).
 - E. Violated any state or federal law or regulation relating to controlled substances in violation of OAC 435:10-7-4(27).
 - F. Prescribed or administered a drug or treatment without sufficient examination and the establishment of a valid physician patient relationship in violation of 59 O.S. §509 (12).
 - G. Prescribed, dispensed or administered a controlled substance or narcotic drugs in excess of the amount considered good medical practice, or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standards in violation of 59 O.S. 509(16).
 - H. Engaged in the indiscriminate or excessive prescribing, dispensing or administering of controlled or narcotic drugs in violation of OAC 435:10-7-4(1).
 - I. Prescribed, dispensed or administered controlled substances or narcotic drugs in excess of the amount considered good medical practice or prescribed, dispensed or administered controlled substances or narcotic drugs without medical

need in accordance with published standard in violation of OAC 435:10-7-4(2) and (6).

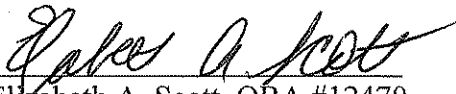
- J. Confessed to a crime involving the violation of the antinarcotic or prohibition laws and regulations of the federal government or the laws of this state in violation of 59 O.S. 509(7).
- K. Is physically or mentally unable to practice medicine and surgery with reasonable skill and safety in violation of OAC 435:10-7-4(17).

Conclusion

WHEREFORE, plaintiff requests that 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 the revocation or suspension of the Defendant's license to practice as a physician and surgeon in the State of Oklahoma, the assessment of costs and fees incurred in this action, and any other appropriate action with respect to Defendant's license to practice as a physician and surgeon in the State of Oklahoma.

Dated this 10th day of July, 2009 at 9:00 a.m.

Respectfully submitted,


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Attorney for the State of Oklahoma ex rel.
Oklahoma State Board of Medical
Licensure and Supervision