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

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

Plaintiff,

v.

KOTESWAR SUREDDI, M.D.
LICENSE NO. 11978,

Defendant.

VOLUNTARY SURRENDER OF LICENSE
IN LIEU OF PROSECUTION

State of Oklahoma )
) Case No. 11-08-4402
Oklahoma County )

I, Koteswar Sureddi, M.D., being of lawful age and after first being duly sworn, depose and state as follows:

1. I hereby voluntarily surrender my Oklahoma medical license no. 11978.

2. The surrender of my license is freely and voluntarily made. I have not been subject to any coercion or duress, and I am fully aware of the consequences of the surrender of my license.

3. I am the subject of a Complaint filed by the Oklahoma State Board of Medical Licensure and Supervision involving allegations that if proven, would constitute grounds for disciplinary action by the Board.

4. The allegations to which I have plead guilty are as follows:

5. Defendant, Koteswar Sureddi, M.D., holds Oklahoma license no. 11978 and practiced as a physician in Durant, Oklahoma at the time of the events at issue.
OVERPRESCRIBING CONTROLLED DANGEROUS DRUGS

6. Patient BJL-12 years old

A. On or about February 12, 2010, Defendant began treating Patient BJL, a twelve (12) year old male. Patient BJL complained of a sore throat and Defendant prescribed a Z-Pak to him.

B. A review of the PMP reveals that one (1) year later, beginning February 14, 2011 and continuing until July 13, 2011, Defendant issued nine (9) prescriptions for a total of 465 dosage units of Hydrocodone 7.5 mg and 10 mg to Patient BJL, who was now only 13 years old. During this time, the patient chart does not reflect any office visits or patient examinations, nor does it reflect any of the prescriptions issued by Defendant to this child.

C. After having received these nine (9) undocumented prescriptions, Patient BJL returned to Defendant’s office on August 4, 2011 for a sports physical and alleged Osgood-Schlatter’s disease. After that visit, Defendant authorized two (2) more prescriptions for Hydrocodone 7.5 mg, for an additional 110 dosage units to the child for alleged pain.

D. A review of Defendant's chart on this patient reveals that he failed to perform any physical examination on this patient prior to prescribing the first nine (9) prescriptions for controlled dangerous drugs and that the examination thereafter was insufficient, that he did not order appropriate tests, that he did not obtain any PMPs or drug screens, that he did not establish a legitimate medical need for the medications, that he did not maintain a readily retrievable record of all controlled dangerous drugs prescribed to this patient, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

E. When asked by Board investigators why all of these prescriptions for controlled dangerous to Patient BJL were not noted in the patient chart, Defendant admitted that the patient’s mother would call him on the weekends or after hours and request the drugs. He stated that he would call in the prescriptions but would forget to chart them in the medical record. Defendant also admitted that since the patient’s mother was a nurse, he had asked her to write down what he called in for her and her children and just give the note to him at her next appointment.
7. **Patient AJL-13 years old**

A. On or about April 22, 2009, Defendant began treating Patient AJL, a thirteen (13) year old male, who is also the brother of Patient BJL set forth above. Patient AJL complained of a sore throat and knee pain.

B. A review of the PMP reveals that beginning that day, April 22, 2009 and continuing until August 19, 2011, Defendant issued twenty-two (22) prescriptions for Hydrocodone, a Schedule III controlled dangerous substance for a total of 950 dosage units, and one (1) prescription for Dextroamphetamine, a Schedule II controlled dangerous substance, for 30 dosage units, for a grand total of 980 dosage units to Patient AJL, who was now only 15 years old. During this time, the patient chart reflects only three (3) office visits, for a sore throat and ear pain. Of the twenty-three (23) prescriptions for controlled dangerous substances, only one (1) prescription for Hydrocodone is noted in the patient chart. The remaining twenty-two (22) prescriptions are undocumented.

C. On or about September 8, 2011, Board investigators interviewed Defendant and subpoenaed numerous patient charts, including the chart of Patient AJL. After that interview, Defendant continued to prescribe controlled dangerous substances to this child when he authorized two (2) more prescriptions for Hydrocodone 7.5 mg. and 10 mg., for an additional 108 dosage units to the child, again for no documented medical reason.

D. A review of Defendant's chart on this patient reveals that he failed to perform a sufficient physical examination, that he did not order appropriate tests, that he did not obtain any PMPs or drug screens, that he did not establish a legitimate medical need for the medications, that he did not maintain a readily retrievable record of all controlled dangerous drugs prescribed to this patient, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

E. When asked by Board investigators why all of these prescriptions for controlled dangerous were not noted in the patient chart, Defendant admitted that the patient’s mother would call him on the weekends or after hours and request the drugs. He stated that he would call in the prescriptions but would forget to chart them in the medical record. Defendant also admitted that since the patient’s
mother was a nurse, he had asked her to write down what he called in for her and her children and just give the note to him at her next appointment.

8. **Patient TJL—mother of Patients BJL and AJL**

A. Beginning on or around April 3, 2008 and continuing through August 30, 2011, Defendant treated Patient TJL, the mother of Patients BJL and AJL above, for alleged chronic pain and insomnia.

B. A review of the PMP reveals that during this approximate two and one-half (2 ½) year period of time, Defendant issued seventy-three (73) prescriptions for controlled dangerous substances to Patient TJL. Prescriptions include thirty-two (32) prescriptions for Hydrocodone, a Schedule III controlled dangerous substance for a total of 2069 dosage units, and forty-one (41) prescriptions for Xanax, Ambien, Soma, Ativan and Restoril, Schedule IV controlled dangerous substances, for a total of 1981 dosage units, for a grand total of 4050 dosage units. Of these seventy-three (73) prescriptions, forty-three (43) are not reflected anywhere in the patient record.

C. The patient chart reflects numerous references to possible abuse by the patient, including (i) notification by the insurance company that the patient was obtaining the same drugs from multiple providers; (ii) the patient asking for medications for her mother; (iii) the patient claiming that her purse was stolen and asking for more drugs; (iv) the patient's inability to cut down her use of controlled dangerous substances despite repeated requests; and (v) PMP showing more than one doctor giving the patient the same medications. Despite all of these indications, Defendant continued to prescribe controlled dangerous substances to this patient.

D. A review of Defendant's chart on this patient reveals that he failed to perform a sufficient physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that although he did obtain a PMP, he ignored it and continued to prescribe controlled dangerous substances to the patient, that he did not establish a legitimate medical need for the medications, that he did not maintain a readily retrievable record of all controlled dangerous drugs prescribed to this patient, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient with chronic pain medications.
E. When asked by Board investigators why all of these prescriptions for controlled dangerous were not noted in the patient chart, Defendant admitted that the patient would call him on the weekends or after hours and request the drugs. He stated that he would call in the prescriptions but would forget to chart them in the medical record. Defendant also admitted that since the patient was a nurse, he had asked her to write down what he called in for her and her children and just give the note to him at her next appointment.

9. **Patient JBL**

A. From at least June 10, 2011 until July 9, 2011, Defendant treated Patient JBL. When Board investigators subpoenaed the patient chart, they were advised that no patient chart exists.

B. The PMP reflects that from June 10, 2011 until July 9, 2011, Patient JBL received three (3) prescriptions for Hydrocodone 7.5 mg for a total of 145 dosage units.

C. Since there is no patient chart on this patient, the justification for the prescriptions is unknown.

D. According to the pharmacist where the prescriptions were filled, Defendant called in the last two (2) prescriptions on weekends and Patient TJL, as set forth above in para. 5, picked up the prescriptions for Patient JBL. On the following Monday, the pharmacist called Defendant’s office to confirm the authenticity of the prescriptions and was advised by Defendant’s staff that Patient JBL was not a patient of record.

E. When subsequently questioned by Board investigators, Defendant admitted that he had called in these prescriptions at the patient’s request, that he had not seen him as a patient in his clinic for approximately ten (10) years, and that he kept no record of the prescriptions.

F. A review of Defendant’s records reveals no patient record for Patient JBL, and as such, that he did not establish a legitimate need for the medications, that he did not document the type and amount of controlled dangerous substances being prescribed at each visit as required by narcotics laws, that he did not document any physical examination or obtain any patient history during the time that he treated this patient, that he did not order any 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 with narcotic pain medication.

10. **Patient JFL**

A. From at least June 9, 2011 until July 7, 2011, Defendant treated Patient JFL. When Board investigators subpoenaed the patient chart, they were advised that **no patient chart exists**.

B. The PMP and pharmacy records reflect that from June 9, 2011 until July 7, 2011, Patient JFL received four (4) prescriptions: Oxycodone #60 and Xanax #90 on June 9, 2011, and Oxycodone #40 and Xanax #75 on July 7, 2011.

C. Since there is no patient chart on this patient, the justification for the prescriptions is unknown.

D. A review of Defendant’s records reveals **no** patient record for Patient JFL, and as such, that he did not establish a legitimate need for the medications, that he did not document the type and amount of controlled dangerous substances being prescribed at each visit as required by narcotics laws, that he did not document any physical examination or obtain any patient history during the time that he treated this patient, that he did not order any 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 with narcotic pain medication.

11. **Patient ARL**

A. Beginning on or around February 14, 2011 and continuing through September 2, 2011, Defendant treated Patient ARL for neuropathy caused by recent IV Methamphetamine use.

B. A review of Patient ARL’s chart reflects that Defendant treated the patient’s neuropathy (caused by prior illegal drug use) with Oxycodone and Ativan. During this approximate seven (7) month period of time, Defendant issued twelve (12) prescriptions for controlled dangerous substances to Patient ARL. Prescriptions include ten (10) prescriptions for Oxycodone, a Schedule II controlled dangerous substance for a total of **972 dosage units**, and two (2) prescriptions for Ativan, a Schedule IV controlled dangerous substance, for a total of **90 dosage units**, for a grand total of **1062 dosage units**.
C. The patient chart reflects numerous notations that the patient is to make his own arrangements to see various specialists, yet it is never done. The patient additionally claimed that his Oxycodone was stolen and requested more. Defendant gave a new prescription without any substantiation of the patient’s claim.

D. The patient chart additionally reflects that in May 2011, the patient was hospitalized for intentional/accidental drug overdose. The patient chart additionally reflects that a drug test at the hospital showed Patient ARL positive for Methamphetamine, Benzodiazepines, Opiates, Marijuana and Tricyclics. Four (4) days after the patient’s overdose, he returned to Defendant and was again prescribed Oxycodone 20 mg. #100.

E. A review of Defendant's chart on this patient reveals that he failed to order appropriate tests, that he prescribed controlled dangerous drugs to a known addict, 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 with chronic pain medications.

12. **Patient BBL-9 years old**

A. On or about April 27, 2011, Defendant began treating Patient BBL, a nine (9) year old male, for alleged pain from a car wreck. From April 27, 2011 until August 25, 2011, Patient BBL received five (5) prescriptions for Hydrocodone, a Schedule III controlled dangerous substance, for 210 dosage units. One (1) of the prescriptions for Hydrocodone is not noted anywhere in the patient chart.

B. The patient chart contains no prior medical records, no labs, no PMP, no drug tests, no x-rays and no referrals.

C. A review of Defendant's chart on this patient reveals that he failed to perform a sufficient physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain a PMP, that he did not establish a legitimate medical need for the medications, that he did not maintain a readily retrievable record of all controlled dangerous drugs prescribed to this patient, and that he did not maintain an office record which accurately reflects the evaluation, treatment
and medical necessity of treatment of the patient with chronic pain medications.

13. **Patient RPL**

A. A review of the PMP reveals that beginning on October 20, 2010 and then again on November 17, 2010, Defendant began treating Patient RPL when he prescribed Xanax #60 to her on both of these dates. The patient chart makes no reference to either of these prescriptions for Xanax and reflects the first actual patient visit as two (2) months later on January 19, 2011.

B. Since there are no patient records related to these prescriptions, the justification for the prescriptions is unknown.

C. On or about January 19, 2011, Patient RPL presented for her initial examination by Defendant. According to the patient chart, this twenty-three (23) year old female claimed that she suffered from Crohn's disease which had allegedly been diagnosed over ten (10) years ago. Defendant did not obtain any prior medical records to support this diagnosis, nor did he obtain any tests or labs to confirm this alleged diagnosis. Instead, he prescribed Xanax #60 and Lortab 10 mg. #90 on her first visit.

D. A review of the patient chart and the PMP reveals that from January 19, 2011 until August 16, 2011, Defendant issued twenty-three (23) prescriptions for controlled dangerous substances to Patient RPL. Prescriptions include nine (9) prescriptions for Oxycodone, a Schedule II controlled dangerous substance for a total of 650 dosage units, two (2) prescriptions for Hydrocodone, a Schedule III controlled dangerous substance for a total of 100 dosage units, and twelve (12) prescriptions for Xanax, a Schedule IV controlled dangerous substances, for a total of 919 dosage units, for a grand total of 1669 dosage units. Of these twenty-three (23) prescriptions, two (2) are not reflected anywhere in the patient record.

E. Throughout Defendant's treatment of Patient RPL, there were indications that she was diverting the medications prescribed by Defendant. According to the patient chart, Patient RPL was seen by Defendant on June 8, 2011 and received prescriptions for Oxycodone and Xanax on that date. The patient returned to Defendant's office one (1) day later claiming that her prescriptions had been stolen and Defendant gave her new ones without any proof of the theft. One month later, on July 5, 2011, Patient RPL
was seen by Defendant and received prescriptions for Oxycodone and Xanax on that date. The patient returned to Defendant’s office two (2) days later, this time claiming that her sister-in-law stole her medications and Defendant gave her new prescriptions without any further proof. Additionally, Patient RPL repeatedly failed to show up for appointments, yet Defendant continued to call in prescriptions for her. When asked by Board investigators as to why he would continue to prescribe to her despite her repeated stories that her medications were lost, he stated that he is simply more sympathetic to pain than other doctors.

F. When questioned by Board investigators on how he diagnosed Patient RPL with Crohn’s disease when there were no other physician records in his files, Defendant stated that he simply relied on what the patient told him.

FRAUDULENT PRESCRIPTIONS
PATIENTS RPL AND JFL

11. As set forth above, on June 8, 2011, Patient RPL obtained two (2) prescriptions from Defendant: Oxycodone #60 and Xanax #90. These prescriptions are reflected on the PMP as having been filled on June 8, 2011.

12. The following day, June 9, 2011, Patient RPL returned to Defendant’s office claiming that her medications had been stolen at Wal-Mart. According to Patient RPL’s patient chart, Defendant gave her new prescriptions for Oxycodone #60 and Xanax #90. However, these prescriptions do not show up on the PMP as having ever been filled in the name of Patient RPL.

13. An examination of the PMP does reveal that on this same day, June 9, 2011, the following prescriptions written by Defendant were filled in the name of Patient JFL (the brother of Patient RPL): Oxycodone #60 and Xanax #90. Pharmacy records reflect that when these prescriptions were presented to be filled, the pharmacist called Defendant and confirmed that the prescriptions in the name of Patient JFL were legitimate. However, when Board investigators later subpoenaed the patient chart for Patient JFL, Defendant denied knowing anyone by that name and stated that there was no such patient chart for Patient JFL.

14. On July 5, 2011, Patient RPL obtained two (2) more prescriptions from Defendant: Oxycodone #60 and Xanax #80. These prescriptions are reflected on the PMP as having been filled on July 5, 2011.
15. Two (2) days later, on July 7, 2011, Patient RPL returned to Defendant’s office claiming that a portion of her medications had been stolen by her sister-in-law. Defendant’s chart reflects that he gave her new prescriptions for Oxycodone #40 and Xanax #75. However, these prescriptions do not show up on the PMP as having ever been filled in the name of Patient RPL.

16. An examination of the pharmacy records does reveal that on this same day, July 7, 2011, Defendant issued the following prescriptions in the name of Patient JFL (the brother of Patient RPL): Oxycodone #40 and Xanax #75. According to pharmacy records, the Xanax prescription was called in by Defendant and the Oxycodone prescription was written by Defendant. However, when Board investigators later subpoenaed the patient chart for Patient JFL, Defendant denied knowing anyone by that name and stated that there was no such patient chart for Patient JFL.

17. The State submits that contrary to what Defendant wrote in Patient RPL’s medical record, he did not issue her new prescriptions on June 9, 2011 and July 7, 2011, but instead issued fraudulent prescriptions in the name of Patient JFL for the intended use of his sister, Patient RPL.

18. 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. Failed to maintain adequate medical records to support diagnosis, procedure, treatment or prescribed medications in violation of 59 O.S. § 509 (20).

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. Procured, aided or abetted a criminal operation in violation of 59 O.S. § 509 (1).

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 violation of the antinarcotic or prohibition laws and regulations of the federal government and the laws of this state in violation of 59 O.S. §509 (7).

K. Committed any act which is a violation of the criminal laws of any state when such act is connected with the physician’s practice of medicine in violation of 59 O.S. §509(9).

L. Wrote a false or fictitious prescription for any drugs or narcotics declared by the laws of this state to be controlled or narcotic drugs in violation of 59 O.S. 509(11).

M. Engaged in the improper management of medical records in violation of OAC 435:10-7-4(36).

N. Engaged in the use of any false, fraudulent, or deceptive statement in any document connected with the practice of medicine and surgery in violation of OAC 435:10-7-4(19).

O. Violated a state or federal law or regulation relating to controlled substances in violation of OAC 435:10-7-4(27).
P. Except as otherwise permitted by law, prescribed, sold, administered, distributed, ordered, or gave to a habitué 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 OAC 435:10-7-4(25).

Q. Failed to establish a physician/patient relationship prior to providing patient-specific medical services, care or treatment, except in a clearly emergent, life threatening situation in violation of OAC 435:10-7-4(49).

1. I hereby submit my wallet card and wall certificate as evidence of my intent to surrender my license.

2. As a condition to accepting my surrender of license in lieu of prosecution, I acknowledge that the Board may require me to pay all costs expended by the Board for any legal fees and costs, and any investigation, probation and monitoring fees, including but not limited to staff time, salary and travel expense, witness fees and attorney fees.

DATED this 27 day of February, 2014.

Koteswar Suretti, M.D.

Subscribed and sworn before me this 27 day of February, 2014.

Notary Public

My commission expires on 06/12/16.

ACCEPTED:

Gerald C. Zumwalt, M.D.
Secretary, Oklahoma State Board of Medical Licensure and Supervision

Date: 3-1-14

RECEIVED
MAR 13 2014
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION