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,	)	
v.	)	**Case No. 17-02-5441**
MOHEB HALLABA, M.D., LICENSE NO. MD 13018,	)	
Defendant.	)	

VERIFIED COMPLAINT

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

I. JURISDICTION

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 no. 13018, which was issued on February 17, 1981.

3. The acts and omissions complained of herein occurred while Defendant was acting as a physician pursuant to the medical license conferred upon him by the State of Oklahoma. Such acts and omissions occurred within the physical territory of the State of Oklahoma.

II. BACKGROUND

4. This Complaint arises out of an investigation into allegations of overprescribing by the Defendant, while he was working at the Robison Clinic located at 1415 N. Watts, Sayre, Oklahoma. This case was initially brought to the Board by the Drug Enforcement Administration (DEA), where it was believed that Defendant was issuing prescriptions for schedule II medications to patients without establishing a valid physician-patient relationship.

5. Eighteen patient charts were gathered, among which there were four patient deaths from suspected drug overdoses since coming under Defendant's care.

6. On March 7, 2017, Board Investigator Larry Carter, DEA Diversion Investigator (DI) Ginger Schickendanz, DEA Group Supervisor John Kushnir, and OBN Agent Elsa Castro interviewed the Defendant in his office.

7. Defendant has been practicing medicine for approximately sixty (60) years, and until the early 2000s, he specialized in vascular surgery and is board certified in general surgery. Defendant began working at the Robison Clinic in the fall of 2015. Defendant did not have a background in pain management, and by his own admission, he simply tried to fit into the ongoing practice at the clinic.

8. When he was first employed at the clinic, Defendant did not see or treat any patients. Defendant stated the nurse practitioners ("NP") saw all the new and established patients and he signed prescriptions for schedule II prescriptions without reviewing the patient's medical records. At times, Defendant estimated he was brought around fifty (50) to one hundred (100) prescriptions each work day for him to sign. Most, if not all, of these prescriptions were for schedule II drugs.

9. Around April 2016, Dr. Robison sold or leased the clinic to Quartz Mountain, LLC, which prompted the implementation of a new policy beginning December 1, 2016 that Defendant was to change his practice of signing prescriptions without actually seeing a patient. However, the time with each patient was only extended when the patient indicated the drugs were not working, or requested a new or different type of medication. If the patient said the medicine was still effective, the patient's schedule II prescriptions are filled out by the NP and he merely signs them. Defendant stated he did not conduct patient examinations and that there is no way he could see every patient. Defendant confirmed that this was still the practice as of the date of the interview.

10. When confronted with a summary of the quantities of controlled dangerous substances ("CDS") Defendant prescribed in October 2015, which showed that Defendant prescribed well in excess of 30,000 dosage units throughout the month, Defendant appeared to be concerned that the number was so large. Defendant was also shown another summary for the month of January 2016, after Defendant had been at the clinic for only three months. This summary showed that Defendant had an increase in prescribing of approximately 300%. Defendant indicated he was unaware of that dramatic increase in his prescribing.

11. When asked about his use of the Oklahoma PMP system, Defendant told the investigators that he was unfamiliar with this system, and pointed out that he did not even have a computer in his office. When shown a patient PMP report, Defendant stated he had never seen any such document before.

12. Defendant had 779 separate patients who had no record of Defendant checking the PMP system since September 2016 as required by Title 63 § 2-309D(G)(2)(a). Investigator Carter checked ten of these patients, and found that six had been checked by a NP at the

Robison Clinic during that time, indicating that employees at the clinic were aware of the statutory requirement, and were loosely complying with the statutory requirement.

13. Defendant told investigators that patients were occasionally dismissed from the practice; however, Defendant had no real input on these decisions, and the final decision was made by someone in the front office.

14. Defendant was unsure as to whether or not he was the supervising physician for any mid-level practitioners employed at the Robison Clinic. However, according to the Oklahoma Board of Nursing records, the Defendant was listed at the time as the only supervising physician for at least two NPs affiliated with the Robison Clinic, LM and ES. Defendant was also one of two supervising physicians listed for a former employee of the clinic, JZ.

15. On March 31, 2017, Investigator Carter, Investigator Schickendanz and Agent Castro interviewed JZ, NP, at the OBN office regarding her knowledge and association with the Robison Clinic and Defendant.

16. JZ began work at the Robison Clinic around August 2014 and stated the majority of their patients were treated by NPs. When a new patient came to the clinic, they were usually seen by a NP first, who would conduct the initial examination and prepare a treatment plan. If schedule II drugs were included in the drug therapy, the NP would consult with either Dr. Robison or Defendant, who would review the patient chart and discuss the needs with the NP. The doctors did not meet every new patient face-to-face and the Defendant did not perform examinations on patients.

17. Around the time the Defendant started working at the clinic, JZ overheard Dr. Robison say that he hired Defendant because he had a "clean" DEA number. Dr. Robison also indicated that he needed Defendant to help supervise the mid-level practitioners at the clinic because Dr. Robinson could no longer do so.

18. JZ said that it was rare for Defendant to see a patient who was brand new to the clinic, and that Defendant "stressed out" his nurses because he did not know how to use a computer. It was much more common for the NPs to see patients, print prescriptions, and then present them to Defendant for his signature.

19. JZ explained that Defendant was unfamiliar with the demands of working at a busy clinic, and also recalled the Defendant making a comment that he needed to quit this job over concerns about the high volume of prescriptions that were being issued.

20. On April 6, 2017, Agent Schickendanz and Agent Castro obtained four (4) prescriptions written by Defendant and filled at the City Pharmacy located in the same building as the clinic in which Defendant works. These prescriptions were written by Defendant and filled as follows:

    a. 3/10/2016 Audrey Hallaba Spouse Zolpidem 10 mg #30 (Schedule IV)

    b. 3/11/2016 Audrey Hallaba Spouse Robitussin AC 240ml

c. 1/18/2017 Moheb Hallaba Self Diazepam 5 mg #30 (Schedule IV)

d. 3/2/2017 Audrey Hallaba Spouse Methylphenidate 5 mg #20 (Schedule II)

21. Staff Pharmacist Cindy Miller stated she was familiar with Defendant's signature, and confirmed that all of the above prescriptions were signed by Defendant.

22. Investigators interviewed former Robison Clinic patient, LV, on April 25, 2017:

a. LV was referred to the clinic in 2014 and states he subsequently became an addict because he could get any kind of medication from the clinic. LV would typically leave the clinic with eight or more prescriptions written by Dr. Robison and subsequently Defendant.

b. LV was dismissed from pain management on one occasion by NP JZ for a positive urinalysis, only to be put back on pain management the following month by Dr. Robison. At one point, LV was obtaining 75 extended release and 60 regular narcotic pain medications, for a total of 135 tablets a month.

c. When LV first saw Defendant, Defendant merely looked at LV's patient chart and did not perform an examination. On another visit, Defendant mentioned there was no MRI in his chart, but continued to prescribe him the pain medication.

d. On LV's May 7, 2016 visit, Defendant told LV that he was breaking the law by giving him 2mg of Xanax in addition to his pain medication. However, Defendant still wrote the prescriptions, including OxyContin.

23. Review of patient charts and prescription history for overdose patient deaths include the following:

a. **Patient LK**: patient's monthly Oxycodone prescriptions written after December 2015 were all signed by Defendant, yet there was not a signed note by the Defendant in the chart. There are inconsistent urine drug screens, such as positive results for drugs not prescribed, including THC and Methamphetamine, and negative results for medications that were prescribed. Patient died on 5/19/2017 of acute Oxycodone toxicity.

b. **Patient DS**: patient's monthly prescriptions for Fentanyl and Hydrocodone written after October 2015 were all signed by Defendant, yet there was not a signed note by the Defendant in the chart for a large number of these visits. There was no entry in the chart for the patient's prescription on the last visit on 9/22/2016 and the patient died 9/28/2016 of suspected Fentanyl toxicity.

c. **Patient CH**: Defendant signed patient's prescriptions for OxyContin and Oxycodone equaling MME of 300mg filled six days before the patient died of acute Oxycodone toxicity on 11/9/2015. There was no chart entry for that visit and no indication anywhere that Defendant ever saw the patient or the chart. There were also multiple inconsistent urine drug screens.

III. VIOLATIONS

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

a. Violation of any provision(s) of the medical practice act or the rules and regulations of the Board, in violation of 59 O.S. 2011, § 492(C)(2)(3) and Okla. Admin. Code § 435:10-7-4(39).

b. Engaging in dishonorable or immoral conduct which is 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);

c. 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) and Okla. Admin. Code § 435:10-7-4(49);

d. Aiding or abetting the practice of medicine and surgery by an unlicensed person, in violation of 59 O.S. 2011, § 509(14) and Okla. Admin. Code § 435:10-7-4(21);

e. 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);

f. 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) and Okla. Admin. Code § 435:10-7-11(6);

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. Allowing another person or organization to use a physician's license to practice medicine and surgery, in violation of Okla. Admin. Code § 435:10-7-4(22);

i. Purchasing or prescribing any regulated substance in Schedule I through V, as defined by the Uniform Controlled Dangerous Substances Act, for the physician's personal use, in violation of Okla. Admin. Code § 435:10-7-4(5);

j. Prescribing, selling, administering, distributing, ordering, or giving any drug legally classified as a controlled substance or recognized as an addictive dangerous drug to a family member or to himself or herself. Provided that this paragraph shall not apply to family members outside the second degree of consanguinity or affinity, in violation of Okla. Admin. Code § 435:10-7-4(26);

k. Violating any state or federal law or regulation relating to controlled substances, in violation of 59 O.S. 2011, § 509(9), Okla. Admin. Code §§ 435:10-7-4(27) and 435:10-7-11(7):

i. Title 63 § 2-309D(G)(2)(a) requires prescribers or their staff to check the PMP system at least once every six months when prescribing opioids, benzodiazepines, or carisoprodol in order to assess medical necessity and the possibility that the patient may be unlawfully obtaining prescription drugs. It also requires the medical provider to note in the patient file that the PMP has been checked.

IV. 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 Defendant's Oklahoma professional healthcare license, including an assessment of costs and attorney's fees incurred in this action as provided by law.

Respectfully submitted,

Rachel Rogers

Rachel A. Rogers, OBA No. 31206
Assistant Attorney General
OKLAHOMA STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION
101 N.E. 51st Street
Oklahoma City, Oklahoma 73105
405/962.1400
405/962.1499 – Facsimile

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 Defendant, Moheb Hallaba, 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: 18 Dec 2017

Oklahoma
County, State of Execution