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

FILED
MAR 24 2015
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION

STATE OF OKLAHOMA, *ex rel.* THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff,	)	
vs.	)	**Case No. 14-08-5033**
TAMERLANE ROZSA, M.D. LICENSE NO. MD 17499	)	
Defendant.	)	

COMBINED VERIFIED COMPLAINT AND MOTION FOR EMERGENCY HEARING

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

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 holds Oklahoma medical license number 17499. The acts and omissions complained of herein were made while Defendant was acting as a physician pursuant to her medical license conferred upon her by the State of Oklahoma. Such acts and omissions occurred within the physical territory of the State of Oklahoma.

I. ALLEGATIONS OF PROFESSIONAL MISCONDUCT

3. On August 21, 2014, Investigator S.W. investigated Defendant's prescribing practices and lack of documentation to justify those prescriptions. The Board received numerous complaints from several sources claiming that Defendant was staying overnight at her office and seeing patients at bizarre hours, sometimes into the late night hours. It was also reported that Defendant was prescribing large amounts of Controlled Dangerous Substances (CDS) without medical necessity and without sufficient, and in some cases without any, charting or recording. Reports also indicated that Defendant was keeping an office that was unsanitary to an unhealthy level, that patients tell Defendant what they want rather than Defendant telling them what is medically necessary, and numerous other acts of unprofessional conduct. Further investigation reveals that for the years 2012, 2013 and 2014, Defendant is #1 in Milliliters prescribed of Promethazine with codeine in

Oklahoma, and is # 1 for the years 2013 and 2014 in number of prescriptions written. In addition, she was consistently in the top five for the years 2010 and 2012.

4. On August 26, 2014, Investigator S.W. travelled to Defendant's office and served a subpoena for patient records. He interviewed Defendant after knocking on her private office door located within the clinic. It took Defendant approximately 8 minutes to open the door and she looked like she had just woken up. Defendant was wearing a stained sweat shirt and her overall appearance was unkempt. The office was exceedingly dirty, and there were two patients in the waiting room.

5. Investigator S.W. asked Defendant why she prescribes so many of her patients promethazine with codeine. Defendant stated that most patients are ex-smokers that need it, and other patients use it to alleviate their allergies. On November 10, 2014, Investigator S.W. received multiple reports from J.G., of the Tulsa Police Department, which showed patients and associates of Defendant involved in unlawful prescription sales. Further investigation revealed a high percentage of Defendant's patients have been arrested and convicted of CDS violations.

6. The Board Staff commissioned an expert review of nine (9) patient charts. The expert's opinion is that Defendant's prescription management and habits are harmful and dangerous to her patients and potentially lethal. The expert further opined that Defendant's care and conduct is unprofessional and does not conform to the standard of care expected.

7. On February 12, 2015, Investigator S.W. received a phone call from D.J., a registered nurse, the father of A.J. A.J. is a patient of Defendant and, according to D.J., is also an addict. D.J. stated that A.J. has overdosed twice from CDS that she obtains from Defendant. He stated that he called Defendant's office in July 2014 and told them that A.J. is an addict and had overdosed. D.J. further stated that the staff said, "we know, they all are." Investigation of prescribing records shows that A.J. has been receiving Oxycodone 30 MG #145 and Clonazepam .5 MG #40 every 25 days and has been since October 3, 2012 from Defendant.

8. On February 19, 2015, Investigator S.W. spoke with J.W., MD. J.W. informed Investigator S.W. that Defendant was discharged from St. John's Hospital on February 18, 2015, and was admitted on or around February 11, 2015. J.W. stated that Defendant was brought in by EMSA, she had urinated on herself, and was found to have been sleeping on an air mattress in her medical office. J.W. stated that Defendant had a high BAC and was checked for a personality disorder.

9. On February 20, 2015, Board Investigators S.W. and R.R. went to St. John's hospital in Tulsa and obtained the medical record for Defendant's February 2015 hospital stay. The lab results were positive for alcohol and opiates.

10. On February 20, 2015, Investigators S.W. and R.R. travelled to Defendant's medical office located at 2301 S. Sheridan. They knocked several times before anyone answered

and after some preliminaries with other people in the office, Investigators spoke with Defendant. During questioning Defendant said she was in hospital for six days, she had diabetes along with pneumonia, and she self-diagnosed gout. Defendant denied drinking alcohol prior to being taken to St. John's but admitted to self-medicating with Tussinex, which contains Hydrocodone, three to four times due to her pneumonia. Defendant obtained the Tussinex from a friend. She did not have a prescription for it. Investigators noted that the office smelled of urine and it was very filthy. Her air mattress, where Defendant sleeps, was located in the waiting area of the office. Investigator S.W. asked Defendant to explain her prescribing of Promethazine with codeine. Defendant stated that "it's a very popular drug among the black population, which is who I prescribe to People refer to it as my cough syrup." Investigators presented Defendant with a letter of agreement not to practice, which she refused to sign.

11. Pictures of the office show the exam room full of trash and clutter. It is apparent that Defendant has gone from staying in her office on occasion to staying there all, or at least most, of the time and it has been reported that she is seeing patients from her bed which is in the waiting room of her clinic.

12. St. John's medical records show that Cornell Miller is making decisions on who can visit Defendant. He permitted employees EW and GM to see Defendant and he has unfettered access to her. On the February 20, 2015, visit to Defendant's office, employee CM was observed accepting service of the Board's subpoena and retrieving the patient charts. Defendant stated that CM was working off his office visit charges. Defendant was observed in a wheelchair with her legs propped up with a prescription pad in her lap. She was observed writing CDS prescriptions for a female patient. When asked about those prescriptions, Defendant said the patient was going out of town and needed her prescription. Upon further investigation it was discovered that the patient received five (5) prescriptions for CDS. She then filled three (3) prescriptions on February 20, 2015, and the other two (2) on February 23, 2015, calling into question the veracity of the statement that she was going out of town.

13. Investigator S.W. subpoenaed the medical records of patients CM, EW and GM from Defendant. These records, as well as one other, were reviewed by an expert. That expert concluded the documentation in each was inadequate, the quantities of CDS prescribed could be potentially lethal, and the provider's prescription management and habits are harmful and dangerous to her patients and potentially lethal. It is the expert's professional opinion Defendant's care and conduct is unprofessional and does not conform to current standards or care.

14. Two (2) C-II CDS prescriptions were written on February 12, 2015, and February 13, 2015. Defendant was admitted to St. John's hospital on those days. When presented with a prescription written for L.R. for Oxycodone, Defendant stated that L.R. is not a patient and this is a forged prescription. She went on to say that this has happened before. Further, Cornell Miller, who is Defendant's caretaker, employee and patient, has a very lengthy criminal record. Most of Mr. Miller's convictions are for obtaining CDS by fraud, obtaining CDS by forged prescriptions, possession of CDS, and most recently,

carrying a firearm after conviction of a felony. On February 26, 2015, Investigator S.W. presented Defendant with an agreement not to write CDS prescriptions. Defendant refused to execute the agreement stating that she knew better than the Board when she is healthy enough to prescribe CDS to her patients.

15. Numerous Walgreens and CVS pharmacies in the Tulsa area have refused to fill Defendant's CDS prescriptions due to the amounts and combinations of CDS being prescribed. In addition, the Tulsa County Health department has received complaints that Defendant's office was full of medical waste, was filthy and that Defendant was using her office as her residence. Investigator C.S., of the County Health Department, attempted to inspect her office on March 17, 2015, and observed that Defendant was lying in a hospital bed which is located in the waiting room. Patients were walking up to Defendant asking to be seen. C.S. was denied access to an inspection of the office by Defendant.

16. In March 2015, Investigator SW spoke with CM, a former patient and the mother of a current patient, and AH, who is a current patient. They both stated that Defendant lives at her office and that Cornell Miller gives her sponge baths and makes the decisions on who gets on the list to see Defendant. They further stated that no exams were actually being performed. They stated that Defendant was simply writing prescriptions. Both stated they gave Defendant $100 up front to be put on the list to see Defendant.

II. VIOLATIONS

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

a. Engaging in the 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);

b. Violating, or attempting to violate, directly or indirectly, any of the provisions of the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act, either as a principal, accessory or accomplice, or aiding or abetting the practice of medicine by an unlicensed person, in violation of 59 O.S. 2011, § 509(13) and Okla. Admin. Code § 435:10-7-4(21);

c. Prescribing, dispensing or administering CDS in a manner prohibited by:

i. 59 O.S. 2011, § 509(12),

ii. 59 O.S. 2011, § 509(16),

iii. Okla. Admin. Code § 435:10-7-4(1),

iv. Okla. Admin. Code § 435:10-7-4(2),

v. Okla. Admin. Code § 435:10-7-4(6),

vi. Okla. Admin. Code § 435:10-7-4(7),

vii. Okla. Admin. Code § 435:10-7-4(24),

viii. Okla. Admin. Code § 435:10-7-4(26),

ix. Okla. Admin. Code § 435:10-7-4(27), and

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

d. Failing to provide a proper and safe medical facility setting and qualified assistive personnel for a recognized medical act, in violation of 59 O.S. 2011, § 509(20) and Okla. Admin. Code § 435:10-7-4(41);

e. Failing 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);

f. Failing to maintain adequate medical records to support diagnosis, procedure, treatment or prescribed medications, in violation of 59 O.S. 2011, § 509(20) and Okla. Admin. Code § 435:10-7-4(41);

g. Engaging in the improper management of medical records, in violation of Okla. Admin. Code § 435:10-7-4(36);

h. Allowing another person or organization to use the Defendant's license to practice medicine, in violation of Okla. Admin. Code 435:10-7-4(22);

i. Prescribing or administering CDS to herself, in violation of Okla. Admin. Code § 435:10-7-4(5), (27) and 63 O.S. 2011, § 2-304(A)(8);

j. Failing to maintain effective controls against diversion of CDS, in violation of 63 O.S. 2011, § 2-303(A)(1) and 21 CFR § 1301.71(a);

k. Failing to establish a physician-patient relationship and performing a sufficient examination prior to administering treatment, in violation of 59 O.S. 2011, § 509(12);

l. Engaging in gross or repeated negligence in the practice of medicine and surgery, in violation of Okla. Admin. Code § 435:10-7-4(15);

m. Possessing the inability to practice medicine with reasonable skill and safety to patients by reason of age, illness, drunkenness, excessive use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, in violation of 59 O.S. 2011, § 509(15); and

n. Receiving a fee, commission, or other compensation for professional services not actually rendered, in violation of Okla. Admin. Code § 435:10-7-4(30).

III. MOTION FOR EMERGENCY SUSPENSION HEARING

18. Paragraphs one through seventeen are incorporated herein by reference.

19. This Verified Complaint establishes significant acts of professional misconduct, including indiscriminate and excessive prescribing, lethal prescribing practices, failing to establish legitimate physician-patient relationship before prescribing CDS, failing to guard against diversion, failing to manage patients in any way, failing to keep appropriate records to support diagnoses or treatment, and failing to provide a safe and proper clinical setting and qualified assistive personnel. Defendant lives in her office, which is in a state of utter filth and disarray. She rests in a bed when seeing patients in the waiting room. She conducts no examinations of any kind; Defendant merely writes CDS prescriptions that patient's request.

20. This Verified Complaint establishes Defendant has been self-administering CDS, yet no CDS shows up on her prescription record. Defendant also ingested alcohol with CDS in her system. She was admitted into hospital after being found unresponsive in her bed (in her clinic's waiting room) lying in urine. The Complaint establishes Defendant is incapable of practicing medicine and has repeatedly engaged in gross negligence in the practice of medicine. Defendant is not in control of her medical practice.

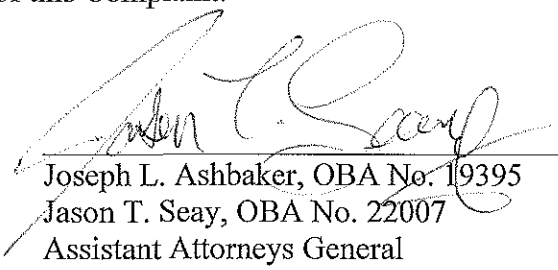
21. The findings of the investigation are so extreme that Board investigators offered Defendant an agreement not to practice until the Board's investigation and adjudication of the complaint could be concluded. Defendant refused to execute the agreement. In an effort to try to protect the safety of patients but compromise with Defendant, Board investigators subsequently offered an agreement to Defendant whereby she would agree to stop prescribing CDS, but still be able to practice medicine, until the Board's investigation and adjudication of the complaint could be concluded. Again, Defendant refused to execute the agreement.

22. Defendant has ignored the pleas of Board investigators to stop her dangerous conduct. She has refused to voluntarily cease her dangerous practices. As such, there is no recourse to protect the public other than an emergency hearing to determine if the Defendant's license should be immediately suspended pending final resolution of the Complaint.

23. Pursuant to 59 O.S. 2011, § 503.1, the undersigned counsel request the Board Secretary confer with the President of the Board regarding this matter to determine whether an emergency exists for which the immediate suspension of a license is imperative for the public health, safety and welfare. Further, the undersigned counsel requests the Board Secretary set this matter for immediate hearing pursuant to 75 O.S. 2011, § 314(C)(2) to determine if Defendant's license to practice medicine should be summarily suspended.

IV. CONCLUSION

Defendant is in no condition mentally or physically to practice medicine at this time. It is clear that there are no patient exams taking place. Defendant has no control over her clinic and employees. Defendant is prescribing large quantities of CDS without establishing any medical necessity and without adequate records. Defendant admits to taking CDS without a prescription from a physician and she states that she knows what's best for her when it comes to self-diagnosing. Defendant refuses to take St. John's recommendation for skilled nursing. Defendant's prescription pads are being taken from her and used unlawfully. Defendant has a security guy, who is a convicted felon, telling patients who can come in or not. Cash is the form of payment Defendant accepts. Defendant is not taking care of her hygiene and the office smells of urine. Defendant lives in her office but there is no bath or shower. Further, the expert analysis of records states clearly that types and combinations of CDS being prescribed by Defendant are potentially lethal. 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. The undersigned also request this matter be set for an emergency hearing to determine if Defendant's license should be immediately suspended pending final resolution of this Complaint.



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VERIFICATION

I, Stephen Washbourne, 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, Tamerlane Rozsa, M.D.; and

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

Stephen Washbourne
Stephen Washbourne, Investigator for OSBMLS

Date: 3-24-15

Oklahoma County
Place of Execution