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

FILED

JUL 10 2002

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION

STATE OF OKLAHOMA EX REL. THE OKLAHOMA BOARD OF MEDICAL LICENSURE AND SUPERVISION,	
Plaintiff,	
v.	**Case No. 02-04-2491**
TROY ANTHONY TORTORICI, M.D., LICENSE NO. 19410,	
Defendant.	

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, Troy Anthony Tortorici, M.D., 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, Troy Anthony Tortorici, M.D., holds Oklahoma license no. 19410.

3. Defendant practices at the Pain Management and Rehabilitation Center in Oklahoma City, Oklahoma with Lonnie Litchfield, M.D. and also employs two (2) licensed chiropractors, Steve Sweeney and Kris Wilson.

4. On March 8, 1998, January 12, 1999 and February 11, 2002, Defendant wrote four (4) prescriptions to Lonnie Litchfield, M.D., his partner at the Pain Management and Rehabilitation Clinic in Oklahoma City, Oklahoma. These prescriptions were for Hydrocodone, a Schedule III controlled dangerous drug, and Lorazipam, Schedule IV controlled dangerous drug. A review of Defendant's records reveals that he failed to perform any physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not establish a legitimate medical need for the medications, that he did not establish a valid physician patient relationship prior to prescribing the medications, and that he failed to keep any record of the prescription written February 11, 2002.

5. Beginning January 2, 2001 and continuing through February 19, 2002, Patient BEW was seen and treated in Defendant's office on at least fourteen (14) separate occasions. During this same period of time, Defendant received prescriptions for Lortab and Soma on at least twelve (12) separate occasions. Some of the prescriptions were written on prescription pads not containing Defendant's original signature, but instead contained a stamped signature. Patient BEW admits that during this fourteen (14) month period he was being treated in Defendant's office and receiving prescriptions stamped with Defendant's signature, that he was never treated by Defendant, but instead received his treatment and prescriptions for controlled dangerous drugs from Steve Sweeney, a licensed chiropractor employed by Defendant. Defendant's chart on this patient reveals no indication that Defendant ever performed a physical examination on this patient, that he did not establish a legitimate medical need for the medical treatment, that he did not establish a valid physician patient relationship prior to prescribing the medications, and that he failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

6. On or about October 23, 2001, Defendant wrote a prescription for Ultram to Patient PRW. Defendant's signature on the prescription is not his original signature, but instead is a stamped signature. A review of Defendant's records reveals no indication that Defendant ever performed any physical examination on this patient prior to prescribing the medications, that he did not establish a legitimate medical need for the medications, that he failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient, and that he did not establish a valid physician patient relationship prior to prescribing the medications.

7. On or about February 28, 2001, Patient CCW was seen and treated in Defendant's office. A review of Defendant's records reveals no indication that Defendant ever performed any physical examination on this patient, that he did not establish a legitimate need for medical treatment, that he did not establish a valid physician patient relationship prior to administering treatment, and that he failed to maintain an office record which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient.

8. On or about February 20, 2002, Patient MCW was examined and treated at Defendant's office. A review of Defendant's records reveals that although the Patient was prescribed Lortab, a Schedule III controlled dangerous drug, and although a treatment plan was prescribed, there is no indication that a physician ever examined the Patient. The records reveal that Defendant failed to perform any physical examination on this patient, that he did not establish a legitimate need for the medical treatment, that he did not establish a valid physician patient relationship prior to administering treatment and prescribing drugs, and that he failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

9. On or about February 28, 2002, Defendant prescribed Lortab, a Schedule III controlled dangerous drug, to Patient SPW. A review of Defendant's records reveals no indication that Defendant ever performed any physical examination on this patient, that he did not establish a legitimate medical need for the medical treatment, that he did not establish a valid

physician patient relationship prior to prescribing the medications, and that he failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

10. Beginning on or around August 23, 2001 and continuing through December 2001, Patient RAW was seen and treated in Defendant's office. During this same period of time, Defendant prescribed Oxycontin, a Schedule II controlled dangerous drug, Lortab, a Schedule III controlled dangerous drug, and Soma, a Schedule V controlled dangerous drug to Patient RAW. A review of Defendant's records reveals no indication that Defendant ever performed a physical examination on this patient, that he did not establish a legitimate medical need for the medical treatment, that he did not establish a valid physician patient relationship prior to prescribing the medications, and that he failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

11. Beginning on or around September 13, 2001 and continuing until November 13, 2001, Patient JDW was seen and treated in Defendant's office on twenty-five (25) separate occasions. During this same period of time and continuing through at least March 25, 2002, Patient JDW received prescriptions for Lortab on twenty-three (23) separate occasions. A review of Defendant's records reveals no indication that Defendant ever performed a physical examination on this patient, that he did not establish a legitimate medical need for the medical treatment, that he did not establish a valid physician patient relationship prior to prescribing the medications, and that he failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

12. Beginning on or around January 2, 2002 and continuing until February 19, 2002, Patient MDW was seen and treated in Defendant's office on at least thirteen (13) separate occasions. During this same period of time, Patient MDW received prescriptions for Percocet, Lortab and Darvocet on six (6) separate occasions. A review of Defendant's records reveals no indication that Defendant ever performed a physical examination on this patient, that he did not establish a legitimate medical need for the medical treatment, that he did not establish a valid physician patient relationship prior to prescribing the medications, and that he failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

13. Beginning on or around October 11, 2001 and continuing until January 2, 2002, Patient CHW was seen and treated in Defendant's office on at least nineteen (19) occasions. During this same period of time, Patient CHW received at least eight (8) prescriptions for Lortab on written prescriptions not containing Defendant's original signature, but instead containing his stamped signature. A review of Defendant's records reveals no indication that Defendant ever performed a physical examination on this patient, that he did not establish a legitimate medical need for the medical treatment, that he did not establish a valid physician patient relationship prior to prescribing the medications, and that he failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

14. On June 14, 2001 and on February 21, 2002, Patient DDW was seen and treated in Defendant's office. A review of Defendant's records reveals no additional visits to Defendant's office. From June 18, 2001 through April 11, 2002, Patient DDW received twenty-one (21) prescriptions for Lortab. A review of Defendant's records reveals no indication that Defendant ever performed a physical examination on this patient, that he did not establish a legitimate medical need for the medical treatment, that he did not establish a valid physician patient relationship prior to prescribing the medications, and that he failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

15. Beginning May 18, 1999 and continuing through October 15, 1999, Patient RCW was seen and treated in Defendant's office. Patient RCW was prescribed various non-controlled medications by Defendant at this time. Patient RCW was subsequently seen in Defendant's office on November 16, 2000. Subsequently, on January 10, 2002, Patient RCW received prescriptions for Ultram, Oxycontin 5 mg., and Oxycontin 20 mg. from Defendant. A review of Defendant's records reveals no indication that Defendant ever performed a physical examination on this patient on any of these occasions, that he did not establish a legitimate medical need for the medical treatment, that he did not establish a valid physician patient relationship prior to prescribing the medications, and that he failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

16. Beginning October 11, 2001 and continuing through October 29, 2001, Patient EFW was seen and treated in Defendant's office on seven (7) separate occasions. A review of Defendant's records reveals no indication that Defendant ever performed a physical examination on this patient, that he did not establish a legitimate medical need for the medical treatment, and that he failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

17. Defendant has admitted to a Board investigator that the practice with respect to treatment of the above-referenced patients as well as other patients seen at the Pain Management and Rehabilitation Center was for Steve Sweeney, the chiropractor, to examine, diagnose and treat the patients, after which time the chiropractor would sometimes, but not always, call Defendant on the telephone. The Defendant would then call the chiropractor and prescribe the controlled dangerous substances to the patient. The Defendant allowed the chiropractor to give the patients prescriptions which were pre-signed or that contained a stamped signature. In some instances, pre-signed or stamped prescriptions were given to patients without the chiropractor ever contacting Defendant. Defendant admitted that it was possible for patients to receive controlled dangerous substances without having ever seen either him or his partner, Dr. Litchfield.

18. Defendant has admitted to a Board investigator that for the past three (3) years, he has utilized a stamped signature on his prescriptions. He admits that three (3) years ago he was contacted by a pharmacy and advised that stamped signatures could not be used on prescriptions, but that his office nevertheless continued to utilize them throughout at least 2001 for patients including, but not limited to, Patients RVW, LIW, LHW, LRW, TBW and CHW.

19. 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(9) and OAC 435:10-7-4(11).

B. 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(14) and OAC 435:10-7-4(39).

C. Aided or abetted, directly or indirectly, the practice of medicine by any person not duly authorized under the laws of this state in violation of 59 O.S. §509(15) and OAC 435:10-7-4(21).

D. Prescribed a drug without sufficient examination and establishment of a valid physician patient relationship in violation of 59 O.S. §509(13).

E. Confessed to a crime involving a violation of the anti-narcotic laws of the federal government or the laws of this state in violation of 59 O.S. §509(8), 63 O.S. §2-404, OAC 475:25-1-3 and OAC 475:30-1-4.

F. Committed an 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(10).

G. 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(19) and 435:10-7-4(41).

H. Violated a state or federal law or regulation relating to controlled substances in violation of OAC 435:10-7-4(27), 63 O.S. §2-404 and OAC 475:25-1-3.

I. 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(17).

J. Engaged in the indiscriminate or excessive prescribing, dispensing or administering of controlled or narcotic drugs in violation of OAC 435:10-7-4(1).

K. 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).

L. Engaged in the delegation of authority to another person for the signing of prescriptions for either controlled or non-controlled drugs in violation of OAC 435:10-7-4(7).

Conclusion

WHEREFORE, the Plaintiff respectfully 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 suspension or revocation and any other appropriate action with respect to Defendant's medical license, and an assessment of costs and attorney's fees incurred in this action as provided by law.

Respectfully submitted,

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Attorney for the Plaintiff