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

FILED

SEP 06 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.	)

AMENDED 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 Amended 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. During the relevant time at issue, Defendant employed numerous chiropractors, including but not limited to Steve Sweeney, Kris Wilson, Bradley Cockings, Robert Harvey, Ron Brown and Kristi Farrell.

4. Although he never physically practiced there, Defendant and Dr. Litchfield also had an office in Del City known as the Mid-Del branch of the Pain Management and Rehabilitation Clinic.

5. The chiropractors employed at the Mid-Del Clinic have admitted that when patients came to the Mid-Del Clinic for an initial evaluation or follow-up treatment, when narcotics were requested, the customary procedure was for the chiropractor to call the Defendant or Dr. Litchfield directly to obtain authorization for the ordering of the narcotics. The

chiropractors have admitted that this was done prior to the patient ever seeing the physician and that some patients even received refills of their narcotics without having ever seen the physician.

6. On May 17, 2001, July 3, 2001, October 17, 2001 and November 30, 2001, Patient AHW, an employee of Defendant received prescriptions for 60 dosage units of Percocet 5 mg., a Schedule II controlled dangerous drug, 60 dosage units of Valium, a Schedule IV controlled dangerous drugs, another 60 dosage units of Valium, and 40 dosage units of Percocet 10 mg., a Schedule II controlled dangerous drug, respectively. The October 17, 2001 prescription was called in and all of the remaining prescriptions do not contain an original signature but instead contain the stamped signature of Defendant. A review of Defendant's records reveals that Defendant kept no chart on Patient AHW, that he did not perform 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 did not maintain any office record which accurately reflected the evaluation, treatment and medical necessity of treatment of the patient.

7. 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, a 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.

8. Beginning February 18, 2002 and continuing through June 11, 2002, Patient TRW was seen and treated in the Mid-Del Clinic by Ron Brown, D.C. and Kristi Farrell, D.C. On March 6, 2002, he received treatment at the Mid-Del Clinic and received a prescription for 60 dosage units of Lortab 7.5 mg., a Schedule III controlled dangerous drug. On April 5, 2002, patient TRW received a prescription for 30 dosage units of Lortab 7.5 mg., and on April 16, 2002, he received a prescription for 60 dosage units of Lortab 7.5 mg. These prescriptions were given pursuant to the verbal authorization of Defendant and were called in to the pharmacy pursuant to his directions. Defendant did not at that time nor has he at any time since then ever treated Patient TRW at any location. Patient TRW continued to receive treatment from chiropractors at the Mid-Del Clinic through June 11, 2002. A review of Defendant's records reveals that he did not perform 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 did not maintain any office record which accurately reflected the evaluation, treatment and medical necessity of treatment of the patient.

9. On or about April 8, 2002, Patient BBW was seen and treated in the Mid-Del Clinic by Ron Brown, D.C. Although the Defendant owned the clinic, neither he nor any other licensed medical doctor was practicing at that location on that date or on any other date. At that

time and at the Mid-Del Clinic, Patient BBW received prescriptions for 60 dosage units of Lortab, a Schedule III controlled dangerous drug and for 60 dosage units of Soma, a Schedule IV controlled dangerous drug. These prescriptions were given pursuant to the verbal authorization of Defendant and were called in to the pharmacy pursuant to his directions. Defendant did not at that time nor has he at any time since then ever treated Patient BBW at any location. Patient BBW continued to receive treatment from a chiropractor at the Mid-Del Clinic through May 15, 2002. A review of Defendant's records reveals that he did not perform 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 did not maintain any office record which accurately reflected the evaluation, treatment and medical necessity of treatment of the patient.

10. On or about March 28, 2002, Patient DCW was seen and treated in the Mid-Del Clinic by Ron Brown, D.C. Although the Defendant owned the clinic, neither he nor any other licensed medical doctor was practicing at that location on that date or on any other date. At that time and at the Mid-Del Clinic, Patient DCW received a prescription for 60 dosage units of Lortab, a Schedule III controlled dangerous drug. This prescription was given pursuant to the verbal authorization of Defendant and was called in to the pharmacy pursuant to his directions. Defendant did not at that time nor has he at any time since then ever treated Patient DCW at any location. Patient DCW continued to receive treatment from a chiropractor at the Mid-Del Clinic through April 17, 2002. A review of Defendant's records reveals that he did not perform 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 did not maintain any office record which accurately reflected the evaluation, treatment and medical necessity of treatment of the patient.

11. On or about January 4, 2002, Patient DMW was seen and treated in the Mid-Del Clinic by Robert Harvey, D.C. Although the Defendant owned the clinic, neither he nor any other licensed medical doctor was practicing at that location on that date or on any other date. At that time and at the Mid-Del Clinic, Patient DMW received a prescription for 60 dosage units of Lortab 7.5 mg., a Schedule III controlled dangerous drug. This prescription was given pursuant to the verbal authorization of Defendant and was called in to the pharmacy pursuant to his directions. Defendant did not at that time nor has he at any time since then ever treated Patient DMW at any location. Patient DMW continued to receive treatment from a chiropractor at the Mid-Del Clinic through February 15, 2002. A review of Defendant's records reveals that he did not perform 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 did not maintain any office record which accurately reflected the evaluation, treatment and medical necessity of treatment of the patient.

12. On or about January 4, 2002, Patient RMW was seen and treated in the Mid-Del Clinic by Robert Harvey, D.C. Although the Defendant owned the clinic, neither he nor any other licensed medical doctor was practicing at that location on that date or on any other date. At that time and at the Mid-Del Clinic, Patient RMW received a prescription for 60 dosage units of Lortab 7.5 mg., a Schedule III controlled dangerous drug. This prescription was given pursuant

to the verbal authorization of Defendant and was called in to the pharmacy pursuant to his directions. Defendant did not at that time nor has he at any time since then ever treated Patient RMW at any location. Patient RMW continued to receive treatment from a chiropractor at the Mid-Del Clinic through February 15, 2002. A review of Defendant's records reveals that he did not perform 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 did not maintain any office record which accurately reflected the evaluation, treatment and medical necessity of treatment of the patient.

13. Beginning October 18, 1999 and continuing through July 25, 2002, Patient PSW received 101 prescriptions for Oxycontin 10 mg. and 20 mg., a Schedule II controlled dangerous drug and Lortab 7.5 mg., a Schedule III controlled dangerous drug for a total of 9,380 dosage units for an average of **9.28 dosage units per day of controlled dangerous drugs.** A review of Defendant's records reveals Defendant never performed a physical examination on this patient until April 25, 2002, after Board investigators had contacted Defendant, 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 did not maintain any office record which accurately reflected the evaluation, treatment and medical necessity of treatment of the patient. The records also reflect that after Board investigators contacted Defendant, he or his staff at his direction changed or supplemented Patient PSW's chart.

14. 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.

15. 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.

16. 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.

17. 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.

18. 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.

19. 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.

20. 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.

21. 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.

22. 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.

23. 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.

24. 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.

25. 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.

26. 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.

27. For the past three (3) years, Defendant and his staff have utilized a stamped signature on his prescriptions, including those for Schedule II controlled dangerous drugs. 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. A review of the records of one (1) Eckerd's pharmacy location in the Oklahoma City area reveals that on August 8, 2001, September 13, 2001 and September 21, 2002, Defendant issued three (3) separate prescriptions for Oxycontin, a Schedule II controlled dangerous drug on prescriptions which did not contain his original signature, but instead contained his stamped signature. Other than the stamped signature, the writing on the prescriptions is not that of Defendant, but is that of the office receptionist, Andrea Hallman, or the actual prescription, including the drug, dosage and instructions, is also stamped.

28. A review of the records of Pan Med Pharmacy in Oklahoma City, OK reveals numerous other stamped prescriptions for Schedule III through IV controlled dangerous drugs. Other than the stamped signature, the writing on the prescriptions is not that of the Defendant, but is that of the office receptionist, Andrea Hallman, or in some instances, the actual prescription, including the drug, dosage and instructions, is also stamped.

29. Defendant's records reveal that subsequent to being contacted by Board investigators, he or his office staff at his direction changed or supplemented patient charts.

30. 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).

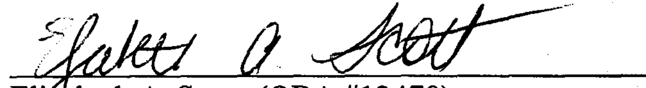
M. Engaged in the use of any false, fraudulent, or deceptive statement in any document connected with the practice of medicine and surgery in violation of OAC 435:10-7-4(19).

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

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,



Elizabeth A. Scott (OBA #12470)
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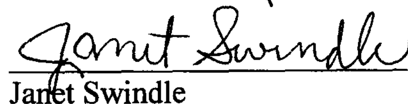
Attorney for the Plaintiff

CERTIFICATE OF MAILING

I certify that on the 6 day of September, 2002, I mailed a true and correct copy of the Amended Complaint by mailing the same, postage prepaid, to R. Brown Wallace, Spradling, Alpern & Gum, 101 Park Avenue, Suite 700, Oklahoma City, OK 73102-7283.



Janet Swindle