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

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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.	)	

VOLUNTARY SUBMITTAL TO JURISDICTION

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 for the State of Oklahoma and the staff of the Board, as represented by the Secretary of the Board, Gerald C. Zumwalt, M.D., and the Executive Director of the Board, Lyle Kelsey, and the Defendant, Troy Anthony Tortorici, M.D., Oklahoma license no. 19410, who appears in person and through counsel, R. Brown Wallace, offer this Agreement effective November 21, 2002 for acceptance by the Board *en banc* pursuant to Section 435:5-1-5.1 of the Oklahoma Administrative Code ("OAC").

AGREEMENT AND ACKNOWLEDGMENT BY DEFENDANT

By voluntarily submitting to jurisdiction and entering into this Order, Defendant pleads guilty to the allegations in the Amended Complaint filed herein on September 6, 2002, and further acknowledges that hearing before the Board would result in some sanction under the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act (the "Act").

Defendant, Troy Anthony Tortorici, M.D., states that he is of sound mind and is not under the influence of, or impaired by, any medication or drug and that he fully recognizes his right to appear before the Board for evidentiary hearing on the allegations made against him. Defendant hereby voluntarily waives his right to a full hearing, submits to the jurisdiction of the Board and agrees to abide by the terms and conditions of this Order. Defendant acknowledges that he has read and understands the terms and conditions stated herein, and that this Agreement has been reviewed and discussed with him and his legal counsel.

PARTIES' AGREEMENT AND STIPULATIONS

Plaintiff, Defendant and the Board staff stipulate and agree as follows:

Findings of Fact

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 practiced there only on a very limited basis, seeing only a few patients, 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, if neither physician were in the office, was for the chiropractor to call the Defendant or Dr. Litchfield directly to obtain authorization for the prescribing of the narcotics. The chiropractors have admitted that, on occasions, 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 to show (a) that he performed a physical examination on this patient, (b) that he established a legitimate medical need for the medical treatment, and (c) that he established a valid physician patient relationship prior to prescribing the medications. Defendant 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 kept no chart on Lonnie Litchfield to show (a) that he performed a physical examination on this patient prior to prescribing the controlled dangerous drugs, (b) that he established a legitimate medical need for the medications, and (c) that he established a valid physician patient relationship prior to prescribing the medications. Defendant kept no 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, Patient TRW 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 by seeing the patient in a face-to-face medical encounter. 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 has no patient medical chart to establish (a) that he conducted a personal allopathic physical examination on this patient, (b) that he established a legitimate allopathic medical need for the allopathic medical treatment, and (c) that he established a valid physician patient relationship, through a face-to-face medical encounter, prior to prescribing the medications. Defendant did not maintain an office record which accurately reflected his personal allopathic evaluation, treatment and the allopathic 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 shares of stock in the Oklahoma corporation that owned the clinic, neither he nor any other licensed medical doctor was practicing at that location on that 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 by seeing the patient in a face-to-face medical encounter. 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 has no patient medical chart to establish (a) that he conducted a personal allopathic physical examination on this patient, (b) that he established a legitimate allopathic medical need for the allopathic medical treatment, and (c) that he established a valid physician patient relationship, through a face-to-face medical encounter, prior to prescribing the medications. Defendant failed to maintain an office record which accurately reflected his personal allopathic evaluation, treatment and the allopathic 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 shares of stock in the Oklahoma corporation that owned the clinic, neither he nor any other licensed medical doctor was practicing at that location on that 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 by seeing the patient in a face-to-face medical encounter. 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 has no patient medical chart to establish (a) that he conducted a personal allopathic physical examination on this patient, (b) that he established a legitimate allopathic medical need for the allopathic medical treatment, and (c) that he established a valid physician patient relationship, through a face-to-face medical encounter, prior to prescribing the medications. Defendant failed to maintain an office record which accurately reflected his personal allopathic evaluation, treatment and the allopathic 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 shares of stock in the Oklahoma corporation that owned the clinic, neither he nor any other licensed medical doctor was practicing at that location on that 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 by seeing the patient in a face-to-face medical encounter. 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 has no patient medical chart to establish (a) that he conducted a personal allopathic physical examination on this patient, (b) that he established a legitimate allopathic medical need for the allopathic medical treatment, and (c) that he established a valid physician patient relationship, through a face-to-face medical encounter, prior to prescribing the medications. Defendant failed to maintain an office record which accurately reflected his personal allopathic evaluation, treatment and the allopathic 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 shares of stock in the Oklahoma corporation that owned the clinic, neither he nor any other licensed medical doctor was practicing at that location on that 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 by seeing the patient in a face-to-face medical encounter. 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 has no patient medical chart to establish (a) that he conducted a personal allopathic physical

examination on this patient, (b) that he established a legitimate allopathic medical need for the allopathic medical treatment, and (c) that he established a valid physician patient relationship, through a face-to-face medical encounter, prior to prescribing the medications. Defendant failed to maintain an office record which accurately reflected his personal allopathic evaluation, treatment and the allopathic 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 that, although he had a patient chart, the chart had no entries by Defendant, personally, to establish (a) that he performed an allopathic physical examination on this patient until April 25, 2002, after Board investigators had contacted Defendant, (b) that he established a legitimate medical need for the medical treatment, (c) that he established a valid physician patient relationship prior to prescribing the medications, and (d) that he maintained any office record which accurately reflected the evaluation, treatment and medical necessity of treatment of the patient. After Board investigators contacted Defendant, his office staff, at his direction, supplemented Patient PSW's chart by adding a single sheet prescription log which summarized the prescriptions given to Patient PSW.

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 not on all occasions seen by Defendant, in a face-to-face medical encounter, but instead received his treatment and was handed prescriptions for controlled dangerous drugs by Steve Sweeney, a licensed chiropractor employed by Defendant. A review of Defendant's records reveals that he has no patient medical chart to establish (a) that he ever personally performed an allopathic physical examination on this patient, (b) that he established a legitimate allopathic medical need for the allopathic medical treatment, and (c) that he established a valid physician patient relationship, through a face-to-face medical encounter, prior to prescribing the medications. Defendant did not maintain an office record which accurately reflects his personal allopathic evaluation, treatment and the 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 (a) personally performed any allopathic physical examination on this patient prior to prescribing the medications, (b) established a legitimate allopathic medical need for the medications, (c) maintained an office record which accurately reflects the allopathic evaluation, treatment and medical necessity of treatment of the patient, nor that he (d) established a valid

physician patient relationship, through a face-to-face medical encounter, 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 (a) personally performed any allopathic physical examination on this patient, (b) established a legitimate need for allopathic medical treatment, (c) established a valid physician patient relationship, with a face-to-face medical encounter, prior to administering treatment, nor that he (d) maintained an office record which accurately reflects the allopathic 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 in the patient chart that a physician ever personally performed an allopathic physical examination of the Patient. The records fail to reflect that Defendant (a) personally performed any allopathic physical examination on this patient, (b) established a legitimate need for the allopathic medical treatment, and (c) established a valid physician patient relationship, with a face-to-face medical encounter, prior to administering allopathic treatment and prescribing drugs. Defendant failed to maintain an office record which accurately reflects the allopathic evaluation, treatment and the allopathic 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 (a) personally performed any allopathic physical examination on this patient, (b) established a legitimate medical need for the allopathic medical treatment, (c) established a valid physician patient relationship, with a face-to-face medical encounter, prior to prescribing the medications, nor that he (d) maintained an office record which accurately reflects the allopathic 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 (a) personally performed an allopathic physical examination on this patient, (b) established a legitimate medical need for the allopathic medical treatment, (c) established a valid physician patient relationship, with a face-to-face medical encounter, prior to prescribing the medications, nor that he (d) maintained an office record which accurately reflects the allopathic 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 (a) personally performed an allopathic physical examination on this patient, (b) established a legitimate medical need for the allopathic medical treatment, (c) established a valid physician patient relationship, with a face-to-face medical encounter, prior to prescribing the medications, nor that he (d) maintained an office record which accurately reflects the allopathic 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 (a) personally performed an allopathic physical examination on this patient, (b) established a legitimate medical need for the allopathic medical treatment, (c) established a valid physician patient relationship, with a face-to-face medical encounter, prior to prescribing the medications, nor that he (d) maintained an office record which accurately reflects the allopathic 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 (a) personally performed an allopathic physical examination on this patient, (b) established a legitimate medical need for the allopathic medical treatment, (c) established a valid physician patient relationship, with a face-to-face medical encounter, prior to prescribing the medications, nor that he (d) maintained an office record which accurately reflects the allopathic 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 (a) personally performed an allopathic physical examination on this patient, (b) established a legitimate medical need for the allopathic medical treatment, (c) established a valid physician patient relationship, with a face-to-face medical encounter, prior to prescribing the medications, nor that he (d) maintained an office record which accurately reflects the allopathic 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 (a) personally performed an allopathic physical examination on this patient on any of these occasions, (b) established a

legitimate medical need for the allopathic medical treatment, (c) established a valid physician patient relationship, with a face-to-face medical encounter, prior to prescribing the medications, nor that he (d) maintained an office record which accurately reflects the allopathic 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 (a) personally performed an allopathic physical examination on this patient, (b) established a legitimate medical need for the allopathic medical treatment, nor that he (c) maintained an office record which accurately reflects the allopathic 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 patients seen at the Pain Management and Rehabilitation Center was for Steve Sweeney, the chiropractor, to examine, diagnose and treat the patients. If the chiropractor believed that pain medication might be required, and the Defendant was not in the office, Sweeny would call Defendant on the telephone. The Defendant would then call to discuss the patient with the chiropractor to decide whether to prescribe the controlled dangerous substances to the patient. The Defendant allowed the chiropractor to give the patients prescriptions for controlled dangerous substances which contained a stamped signature. Stamped prescriptions or called in prescriptions were given to patients on some occasions where Defendant has no recollection of ever having been contacted by a chiropractor for authority. Defendant admitted that it was possible for patients to receive prescriptions for controlled dangerous substances without having ever seen either him or his partner, Dr. Litchfield for a face-to-face medical encounter.

27. For the past three (3) years, Defendant and his staff have utilized a stamped signature on some, but not all, 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, 2001, 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, his office staff, at his direction, supplemented patient charts by adding a single sheet prescription log which summarized the prescriptions given to patients. In some instances,

Defendant reviewed patient charts and added his initials to pre-existing notes in the 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. 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).

F. 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.

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

H. 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).

I. 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).

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

Conclusions of Law

1. The Board has jurisdiction and authority over the Defendant and subject matter herein pursuant to the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act (the "Act") and its applicable regulations. The Board is authorized to enforce the Act as necessary to protect the public health, safety and welfare.

2. Based on the foregoing facts, Defendant, Troy Anthony Tortorici, Oklahoma license 19449, is guilty of the unprofessional conduct set forth below:

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. 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).

F. 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.

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

H. 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).

I. 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).

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

Order

IT IS THEREFORE ORDERED by the Oklahoma State Board of Medical Licensure and Supervision as follows:

1. The Board *en banc* hereby adopts the agreement of the parties in this Voluntary Submittal to Jurisdiction.

2. The license of Defendant, Troy Anthony Tortorici, M.D., Oklahoma license no. 19410, is hereby **SUSPENDED** beginning November 21, 2002 for a period of one hundred eighty (180) days.

3. Defendant shall complete two-hundred forty (240) hours of **COMMUNITY SERVICE** under Jane Fitch, M.D., Chair of the University of Oklahoma Health Sciences Center Department of Anesthesiology. Defendant shall complete the community service on or before November 21, 2003.

4. Defendant's license shall be **RESTRICTED** in that he shall not be allowed to practice outside of a hospital based anesthesiology practice, nor shall he be allowed to prescribe any controlled dangerous substances outside of a hospital based anesthesiology practice, without the prior express approval of the Board.

5. If the Board ever modifies the restriction on Defendant's Oklahoma medical license, it shall be under terms of **PROBATION** to be determined at the time of modification.

6. Defendant shall allow the Board or its designee to monitor his practice to verify that the terms of the Voluntary Submittal to Jurisdiction are being followed by Defendant.

7. Promptly upon receipt of an invoice for such charges, Defendant shall pay all costs of this action authorized by law, including without limitation, legal fees and investigation costs.

8. Defendant's suspended license shall not be reinstated unless Defendant has reimbursed the Board for all taxed costs.

Dated this 12 day of ~~November~~ December, 2002.

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

AGREED AND APPROVED:

Troy Anthony Tortorici, M.D.
License No. 19410

R. Brown Wallace
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405/848-6841

Attorney for the Oklahoma State Board
of Medical Licensure and Supervision

CERTIFICATE OF MAILING

I certify that on the 12th day of December, 2002, I mailed a via first class mail, postage prepaid, a true and correct copy of this Voluntary Submittal to Jurisdiction to R. Brown Wallace, 101 Park Ave. Suite 700 Oklahoma City, Ok 73102.

Janet Swindle, Secretary