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STATE OF NEW JERSEY
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF LAW
STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF THE SUSPENSION OR REVOCATION OF THE LICENSE OF **JOEL GLASS, M.D.** **LICENSE NO. 25MA02629200** TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF NEW JERSEY	Administrative Action **COMPLAINT VERIFIED AS TO COUNTS I AND II.**

Christopher S. Porrino, Attorney General of the State of New Jersey ("Attorney General"), by Kate Calendar, Deputy Attorney General, with offices located at 124 Halsey Street, P.O. Box 45029, Newark, New Jersey 07101, by way of Verified Complaint says:

GENERAL ALLEGATIONS

1. Complainant, Christopher S. Porrino, the Attorney General of New Jersey, is charged with enforcing the laws of the State of New Jersey pursuant to N.J.S.A. 52:17A-4(h), and is empowered to initiate administrative disciplinary proceedings against persons licensed by the New Jersey State Board of Medical Examiners ("Board") pursuant to N.J.S.A. 45:1-14 et seq.

2. The Board is charged with the duty and responsibility of regulating the practice of medicine and surgery in the State of New Jersey pursuant to N.J.S.A. 45:9-1 et seq.

3. Pursuant to N.J.S.A. 45:1-22, the Board may enter an order of temporary suspension pending a plenary hearing on an Administrative Complaint upon a finding of clear and imminent danger to the public health, safety and welfare.

4. Joel B. Glass, M.D. ("Respondent"), is a 74 year-old physician, who, at all times relevant hereto, has been licensed to practice medicine in the State of New Jersey with License Number 25MA02629200. Respondent's license is currently "Active".

5. Respondent is a psychiatrist and currently maintains a practice at 925 Route 73 North – Suite E, Marlton, NJ 08053. Respondent is Board certified by the American Board of Neurology and Psychiatry. Respondent represents himself on his letterhead as practicing: General Psychiatry, Psychoanalytic Psychotherapy, Forensic Psychiatry, Psychosomatic Medicine, Family Psychiatry, Marital Therapy, Hypnosis and Chronic Pain Rehabilitation.

6. The Enforcement Bureau of the Division of Consumer Affairs opened an investigation into the Respondent based upon a referral from another government agency. On December 20, 2016, during an inspection of his medical practice, the Attorney General served Respondent with a Subpoena Duces Tecum. The Subpoena demanded that Respondent produce, among other records, the records of A.T. and N.M. [1]

7. Among the Controlled Dangerous Substances ("CDS") that Respondent prescribed for the two patients discussed below were Oxycodone and Diazepam.

8. These CDS drugs, as the descriptions below from the United States Food and Drug Administration approved package inserts and/or the Physician's Desk Reference ("PDR")

[1] Pursuant to Board policy, patient initials are being used throughout this Verified Complaint to preserve confidentiality. The identities of the patients are known to Respondent.

establish, are dangerous medications with habit forming potential to be utilized cautiously. The descriptions follow:

a. Oxycodone/Roxicodone are common names for oxycodone hydrochloride which is an opioid analgesic. It is used for management of moderate to severe acute and chronic pain. During all times relevant hereto, Oxycodone has been a Schedule II CDS as defined in N.J.S.A. 24:21-6.

b. Diazepam, also known as Valium or Diastat, is used to treat muscle spasms and seizures, as well as relieve anxiety. Diazepam is a benzodiazepine and at all times relevant hereto has been a Schedule IV CDS as defined by N.J.S.A. 24:21-8.

9. Pursuant to N.J.S.A. 45:1-44 et. seq., the New Jersey Division of Consumer Affairs (the "Division") maintains the New Jersey Prescription Monitoring Program ("PMP") The PMP is a statewide database that collects prescription data on CDS and Human Growth Hormone dispensed in outpatient settings in New Jersey, and by out-of-State pharmacies dispensing into New Jersey. Upon information and belief, beginning in the Fall of 2011 prescribers could register and have access to PMP data to perform lookups on all prescriptions issued to their patients.

10. Effective November 7, 2016, all prescribers must conduct PMP lookups every three months for any existing patient to whom they prescribe Schedule II CDS for acute or chronic pain. N.J.A.C. 13:45A-35.9(a).

11. Respondent first submitted a registration for the PMP on January 13, 2015. (Certification of Acting PMP Administrator Matthew Wetzel attached to the Certification of Deputy Attorney General Kate Calendar ("Calendar Cert.") as Exhibit 1 (herein "Wetzel Cert.").

12. On July 17, 1990, the Board entered a Final Order in the matter of Joel B. Glass, M.D. The factual basis for the Final Order was Respondent's guilty plea to one count of Medicaid Fraud. Upon finding that Respondent's guilty plea established multiple violations of the rules governing the practice of medicine, the Board imposed, in part, a three year suspension from practice effective December 2, 1988. The entire period of suspension was stayed and served as a period of probation.

COUNT I
Patient N.M.

13. The General Allegations are repeated and re-alleged as if set forth in detail herein.

14. N.M. is a 42 year old male who has been Respondent's patient since 2007. (Patient Record of N.M., attached as Exhibit 2 to Calendar Cert., Bates Stamp Numbers NM1-210). N.M. suffered a workplace injury to his foot and developed reflex sympathetic dystrophy (RSD). (Id. at NM177).

15. Respondent prescribed highly addictive narcotics and benzodiazepines without a coherent treatment plan, failing to record and follow through with objectives and goals for pain management and/or opioid use. Respondent also failed to adequately monitor N.M's use of, and response to, Oxycodone. Illustrative of Respondent's prescribing of Oxycodone and Diazepam to N.M. is reflected in the following chart:

Date[2]:	**Drug:**	**Quantity:**	**Location where prescription was filled**
1/10/15	Diazepam 10mg	180	Morrisville, Vermont
	Oxycodone 30mg	86	Morrisville, Vermont
1/13/15	Oxycodone 30mg	544	Morrisville, Vermont
2/6/15	Diazepam 10mg	180	Morrisville, Vermont

[2] Date listed is the date the medication was sold according to the Kinney Drug pharmacy profile. (See NM211-229).

2/8/15	Oxycodone 30mg	607	Morrisville, Vermont
3/6/15	Diazepam 10mg	180	Morrisville, Vermont
	Oxycodone 30mg	630	Morrisville, Vermont
4/5/15	Oxycodone 30mg	630	Morrisville, Vermont
	Diazepam 10mg	180	Morrisville, Vermont
5/3/15	Oxycodone 30mg	630	Morrisville, Vermont
	Diazepam 10mg	180	Morrisville, Vermont
5/30/15	Oxycodone 30mg	70	Morrisville, Vermont
	Diazepam 10mg	180	Morrisville, Vermont
6/1/15	Oxycodone 30mg	560	Morrisville, Vermont
6/28/15	Diazepam 10mg	180	Morrisville, Vermont
7/26/15	Oxycodone 30mg	130	Morrisville, Vermont
8/4/15	Diazepam 10mg	180	Morrisville, Vermont
8/23/15	Diazepam 10mg	180	Morrisville, Vermont
	Oxycodone 30mg	48	Morrisville, Vermont
8/24/15	Oxycodone 30mg	582	Morrisville, Vermont
9/17/15	Oxycodone 30mg	630	Morrisville, Vermont
10/14/15	Oxycodone 30mg	188	Morrisville, Vermont
	Diazepam 10mg	180	Morrisville, Vermont
	Oxycodone 30mg	422	Morrisville, Vermont
11/12/15	Oxycodone 30mg	630	Morrisville, Vermont
	Diazepam 10mg	180	Morrisville, Vermont
12/9/15	Diazepam 10mg	180	Morrisville, Vermont
	Oxycodone 30mg	70	Morrisville, Vermont
12/11/15	Oxycodone 30mg	560	Morrisville, Vermont
1/7/16	Oxycodone 30mg	630	Morrisville, Vermont
	Diazepam 10mg	180	Morrisville, Vermont
2/3/16	Diazepam 10mg	180	Morrisville, Vermont
	Oxycodone 30mg	630	Morrisville, Vermont
2/28/16	Diazepam 10mg	180	Morrisville, Vermont
	Oxycodone 30mg	630	Morrisville, Vermont
3/22/16	Oxycodone 30mg	630	Morrisville, Vermont
3/29/16	Diazepam 10mg	180	Morrisville, Vermont
4/15/16	Oxycodone 30mg	630	Morrisville, Vermont
4/25/16	Diazepam 10mg	180	Morrisville, Vermont
5/10/16	Oxycodone 30mg	630	Morrisville, Vermont
5/20/16	Diazepam 10mg	180	Morrisville, Vermont
6/8/16	Oxycodone 30mg	630	Morrisville, Vermont
6/22/16	Diazepam 10mg	180	Morrisville, Vermont
7/5/16	Oxycodone 30mg	630	Morrisville, Vermont
7/15/16	Diazepam 10mg	180	Morrisville, Vermont
7/27/16	Oxycodone 30mg	630	Walgreens Mail Service
8/4/16	Diazepam 10mg	180	Walgreens Mail Service
8/27/16	Oxycodone 30mg	630	Morrisville, Vermont
9/22/16	Oxycodone 30mg	630	Morrisville, Vermont

10/17/16	Diazepam 10mg	180	Walgreens Mail Service
10/26/16	Oxycodone 30mg	630	Morrisville, Vermont
11/23/16	Diazepam 10mg	180	Morrisville, Vermont
	Oxycodone 30mg	630	Morrisville, Vermont
12/23/16	Diazepam 10mg	540	Walgreens Mail Service
12/27/16	Oxycodone 30mg	441	Walgreens Mail Service
1/24/17	Oxycodone 30mg	392	Morrisville, Vermont
2/14/17	Oxycodone 30mg	560	Morrisville, Vermont
3/13/17	Oxycodone 30mg	630	Morrisville, Vermont
4/7/17	Oxycodone 30mg	630	Morrisville, Vermont
Total Dosage Units Diazepam 10mg		**4,680**	
Total Dosage Units Oxycodone 30mg		**17,860**	

(Prescription Records of N.M., attached as Exhibit 3 to Calendar Cert., Bates Stamps NM 211-234).

16. In 2013, Respondent prescribed Oxycodone 30 mg monthly to N.M. in quantities of 630 units, totaling 7,560 Oxycodone 30 mg in one year. (Calendar Cert., Ex. 3, NM212-216). Respondent prescribed the Oxycodone 30 mg along with 240 dosage units of Diazepam monthly. (Ibid.). For all of this prescribing, Respondent's notes for all of 2013 do not show one physical examination and total less than five (5) pages of handwritten notes. (Calendar Cert., Ex. 2, NM106-110). In fact, there are absolutely no notes for October and November of that year. (Id. at NM 109-110).

17. Respondent continued to prescribe an extremely high level of Oxycodone despite other doctors indicating the dosage was inappropriate. On January 11, 2013, Dr. Alan Mirasol, a Physical Medicine and Rehabilitation Physician, conducted a Peer Review of Respondent's prescribing to N.M. The matter was referred from a PBM Clinical Escalation Alert. Dr. Mirasol reviewed some of the Respondent's office notes as well as a Medication Report but his attempt to contact the Respondent was unsuccessful. The Peer Review recommended that N.M. should be weaned to 120 MED or less given that his MED level of 1002

was "dangerously high" and "at this dosage the patient [was] at an extremely high risk of morbidity and mortality." (Calendar Cert., Ex. 2, NM 178). This physician also stated that the dose of Oxycodone was not medically appropriate and N.M.'s past medical history caused concerns about drug dependency. (Ibid.). It was also noted that opioids are not "significantly effective for neuropathic pain" like RSD which N.M. suffered from and opioid treatment is often discouraged in these instances given concerns about ineffectiveness and potential for addiction. (Id.).

18. The reviewing physician further commented that when a medication review was previously performed in 2012, Respondent stated he "will not discuss weaning with the patient 'because he would be crippled without these medications'" and confirmed that N.M. had not signed an opioid agreement or had any urine drug tests. (Id. at 177). Respondent ignored these recommendations and continued prescribing 630 Oxycodone 30 mg monthly.

19. In 2014, Respondent continued to prescribe 630 Oxycodone 30 mg. (Calendar Cert., Ex. 3, NM 216-220). N.M. filled 13 prescriptions for Oxycodone 30 mg in 2014, all in dosage units of 630, for an annual dosage unit of 8,190. (Ibid.). N.M. had a pain management consultation on March 12, 2014. Dr. Vannette Perkins stated that she would not take on N.M.'s care as she disagreed with the current medication regimen. She said "[a]t the doses of narcotic prescribed, *which far exceeds any patient I have ever seen in more than 20 years of experience as a Pain Management Specialist*, the medication regimen needs to be addressed and immediately but gradually weaned." (Calendar Cert., Ex. 2, NM155)(emphasis added). Dr. Perkins also stated that she recommended weaning N.M. off "the current regimen gradually as an outpatient or in an inpatient rehabilitation facility" and noted that it was "concerning that this level of narcotic tolerance was allowed in a young now 39 yr old male." (Ibid.). Despite this

warning from a pain management doctor, Respondent immediately continued his typical prescribing; N.M. filled a prescription written by the Respondent for 630 Oxycodone 30 mg on April 7, 2014, May 5, 2014 and May 30, 2014. (Calendar Cert., Ex. 3, NM217-18).

20. Respondent did not conduct physical examinations on N.M. yet prescribed large doses of Oxycodone 30 mg to him for over 10 years. From only January 2015 through March 2017, the Respondent prescribed N.M. close to 18,000 tablets of Oxycodone 30 mg. N.M. was prescribed Oxycodone 30 mg, three (3) tablets, every three (3) hours, totaling 630 tablets every 30 days. Oxycodone 30 mg should not be taken more frequently than every four (4) hours. (Calendar Cert., Ex. 4, Expert Report of Anthony Sifonios, M.D. ("Sifonios Report")).

21. Respondent, in blatant disregard of laws and regulations in New Jersey as well as CDC recommendations, regularly exceeds 90 morphine milligram equivalent per day ("MME"). (Calendar Cert., Ex. 5, Sifonios Report).

22. Respondent's attempts to wean N.M. off of his large dosage have been at best, negligible. As early as July 2012, Respondent noted that N.M. felt he "could not face taper[ing] Oxycodone." (Calendar Cert., Ex. 2, NM 103). At that time, Respondent did not elaborate on any plan to attempt tapering, discuss the need to, or indicate he felt it was necessary, he simply drew an arrow to a note higher up on the page to indicate he was refilling N.M.'s monthly prescription of 630 Oxycodone 30 mg. (Ibid.). Respondent then continued to prescribe this dosage of Oxycodone 30 mg for the next five (5) years.

23. On April 3, 2015, N.M.'s wife called the Respondent and told him that she believed N.M. was using other drugs and abusing Oxycodone for six (6) months. (Calendar Cert., Ex. 2, NM115). Despite this serious concern, Respondent seemingly ignored the warning and prescribed N.M. 630 tablets of Oxycodone 30 mg *the next day*, without conducting a urine

drug screen. (Id.). This is a gross deviation from the standard of care. (See Calendar Cert., Ex. 4, Sifonios Report).

24. On August 27, 2015 and October 27, 2016, Respondent was notified by Helios High-Risk Profiling service[3] that N.M.'s case had been identified as having possible clinical concerns. (Calendar Cert., Ex. 2, NM34-38). In the first correspondence Helios noted that N.M.'s opioid regimen exceeded "the recommended maximum daily morphine equivalent dose of 100mg" and given this fact, it was recommended under current guidelines that he be followed by a pain management specialist. (Id. at NM70). It was noted in both the August and October letters that N.M. was receiving short-acting opioids without any long-acting analgesics, and it is recommended that a baseline of pain treatment be established using a long-acting opioid if the use of short-acting medications has been unsuccessful. (Id. at NM36, 70). Respondent replied to the initial correspondence indicating that he found the information "not useful." (Id. at NM68).

25. N.M.'s patient records also reveal that the Respondent received notifications from PSMI's Drug Testing and Monitoring Service, which N.M. was enrolled in by his workers' compensation payor. (Calendar Cert., Ex. 2, NM142). On January 16, 2015, the PMSI Drug Testing and Monitoring Quarterly Summary Report noted that "[a]lthough the presence of oxycodone, noroxycodone, and oxymorphone in the patient's urine could be adequately explained by PMSI workers' compensation prescription records, due to the lack of response from Dr. Glass, the lower-than-expected level of these analytes detected could not be adequately explained." (Id. at N145). Dr. Glass did not change his prescribing methods after this report, nor does the record show he contacted PSMI. Despite this report indicating possible diversion of the Oxycodone he prescribed, Respondent does not have any notes indicating he saw N.M. until

[3] Helios is a Workers' Compensation Pharmacy Benefit Management company. (See Calendar Cert., Ex. 2, NM64). N.M. received payment for his medications through this company.

three months later, but did continue to prescribe for the months in between. (Id. at NM 114-115, Calendar Cert., Ex. 3, NM 220-221).

26. Respondent prescribed to N.M. even after N.M. said he would find a physician closer to his home in Vermont and Respondent was informed that he was not authorized to treat N.M. pursuant to a workers' compensation settlement. On April 2, 2016, Respondent noted that N.M. would have to stop coming to him pursuant to his workers' compensation case settlement. (Calendar Cert, Ex. 2, NM119). Respondent's next note, on April 19, 2016, says that N.M. will follow up with him until he moved to Maine as was planned. (Id. at NM120). Respondent has no notes for May 2016, despite N.M. filling a prescription that month. (Calendar Cert., Ex. 2 at NM120; Ex. 3 at NM225). On June 7, 2016, Respondent notes that N.M.'s primary care physician refused to prescribe Oxycodone. (Calendar Cert., Ex. 2, NM120). Respondent also noted that Maine would limit the opioid prescriptions. (Ibid.) Respondent did not even attempt to decrease N.M.'s prescriptions. On July 28, 2016, Respondent noted that N.M. "will need PCP to auth[orize] Oxycodone in ME" unless the workers' compensation continues it. (Id.).

27. On December 7, 2016, Respondent was informed that he was not authorized to conduct further treatment for N.M.'s workers' compensation claim. (Id. at NM28). N.M., pursuant to a settlement order entered on April 16, 2016, was to treat with a physician or facility located in his state of residence. (Ibid.). Despite this, Respondent continued to treat N.M. and prescribe him copious amounts of Oxycodone. N.M. filled a prescription written by Respondent for 630 Oxycodone 30mg as recently as April 8, 2017. (Calendar Cert., Ex. 3, NM228).

28. In addition to excessive amounts of Oxycodone, Respondent prescribed N.M. large doses of Diazepam. Respondent prescribed 10 mg of Diazepam every 4 hours. This

medication should not be prescribed more than every 6 hours. (Calendar Cert., Ex. 4, Sifonios Report).

29. Prescribing a benzodiazepine like Diazepam with an opioid like Oxycodone can pose a potentially life threatening risk to the patient. Both medications depress the central nervous system and can decrease respiratory drive. (Calendar Cert., Ex. 4, Sifonios Report). Respondent continually, over a period of years, concurrently prescribed Diazepam and Oxycodone to N.M., despite the fact that this put him at greater risk for a potentially fatal overdose. (Ibid.).

30. There is no pain management agreement in the records provided. However, according to a PMSI Drug Testing and Monitoring Quarterly Summary Report, Dr. Glass indicated that such a contract was in place. (Calendar Cert., Ex. 2, NM146).

31. Despite the quantities of Schedule II CDS Respondent was prescribing to N.M. he did not perform a PMP lookup until November 11, 2015. (Calendar Cert., Ex.1, Wetzel Cert. at 2). PMP records further reveal that, despite ongoing prescribing of Schedule II CDS to N.M. for chronic pain after November 7, 2016, Respondent did not perform mandatory quarterly PMP reviews. (Ibid). Respondent's last PMP lookup for N.M. occurred on December 19, 2016, yet his prescribing of Oxycodone continued to at least April 8, 2017. (Calendar Cert., Ex. 1, Wetzel Cert. at 2; Calendar Cert. Exhibit 3 at NM228).

32. Respondent's actions described herein constitute gross negligence which endangered the life, health, welfare, safety or property of a person in violation of N.J.S.A. 45:1-21(c); repeated acts of negligence in violation of N.J.S.A. 45:1-21(d); professional or occupational misconduct in violation of N.J.S.A. 45:1-21(e); failure to comply with the provisions of an act or regulation administered by the Board in violation of N.J.S.A. 45:1-21(h)

(Specifically, preparation of a patient record in violation of N.J.A.C. 13:35-6.5 and failure to properly examine a patient prior to issuing a prescription in violation of N.J.A.C. 13:35-7.1A); failure to comply with certain limitations on prescribing controlled substances and failure to reevaluate treatment plans in violation of N.J.A.C. 13:35-7.6, and the prescription of controlled dangerous substances indiscriminately, without good cause, at a time when Respondent knew or should have known that the substances were to be used for unauthorized consumption or distribution in violation of N.J.S.A. 45:1-21(m).

33. Respondent's prescribing of Schedule II pain medication to N.M. after November 16, 2016 without performing quarterly PMP lookups constitutes a violation of N.J.A.C. 13:45A-35.9(a)(2). As such Respondent has engaged in Professional Misconduct pursuant to N.J.A.C. 13:45A-35.11(a) and N.J.S.A. 45:1-21 (e).

34. Respondent's conduct as alleged herein palpably demonstrates that his continued practice of medicine and/or surgery in New Jersey presents a clear and imminent danger to the public health, safety, and welfare warranting the immediate temporary suspension of his license pursuant to N.J.S.A. 45:1-22.

COUNT II
PATIENT A.T.

35. The General Allegations and those of the prior count are repeated and re-alleged as if set forth at length herein.

36. A.T., a 43 year old female, has been a patient of the Respondent since 2011. (Calendar Cert., Exhibit 5, Patient Record of A.T., Bates Stamp AT 1-162). Respondent treated A.T. for her chronic pain in addition to providing psychiatric services. (Id.).

37. According to Respondent's patient records A.T. has a history of chronic lower back pain and procedures to fix the same. (Calendar Cert., Ex. 1, AT74). There are no imaging studies found in Respondent's records that support a diagnosis of back pain and no evidence of the operations. (See Calendar Cert. Exhibit 4, Sifonios Report). There is no evidence in A.T.'s patient record that Respondent spoke to her prior treating physician. Respondent's patient record is also devoid of any previous medical records for A.T.

38. Over the course of his treatment of A.T., Respondent routinely prescribed Oxycodone 30 mg in dramatically high quantities. Despite regular prescribing of a narcotic pain medication, Respondent failed to document any physical examinations or diagnostic tests. (Calendar Cert., Ex. 4, Sifonios Report).

39. Over the course of Respondent's treatment of A.T., the quantities of Oxycodone she received remained extremely high despite the dearth of evidence supporting these prescriptions. Illustrative of Respondent's recent prescribing of Oxycodone to A.T. is the following chart:

Date:	**Drug:**	**Quantity:**
January 22, 2015	Oxycodone 30mg	336
February 4, 2015	Oxycodone 30mg	336
February 18, 2015	Oxycodone 30mg	336
March 4, 2015	Oxycodone 30mg	336
March 19, 2015	Oxycodone 30mg	336
April 2, 2015	Oxycodone 30mg	294
April 16, 2015	Oxycodone 30mg	252
May 5, 2015	Oxycodone 30mg	252
May 15, 2015	Oxycodone 30mg	252
June 2, 2015	Oxycodone 30mg	252
June 11, 2015	Oxycodone 30mg	252
June 25, 2015	Oxycodone 30mg	252
July 8, 2015	Oxycodone 30mg	252
July 22, 2015	Oxycodone 30mg	252
August 5, 2015	Oxycodone 30mg	252
August 20, 2015	Oxycodone 30mg	252
September 2, 2015	Oxycodone 30mg	252

September 16, 2015	Oxycodone 30mg	252
September 30, 2015	Oxycodone 30mg	252
October 14, 2015	Oxycodone 30mg	252
October 29, 2015	Oxycodone 30mg	242
November 11, 2015	Oxycodone 30mg	252
November 24, 2015	Oxycodone 30mg	252
December 9, 2015	Oxycodone 30mg	252
December 22, 2015	Oxycodone 30mg	252
January 6, 2016	Oxycodone 30mg	252
January 20, 2016	Oxycodone 30mg	252
February 1, 2016	Oxycodone 30mg	252
February 16, 2016	Oxycodone 30mg	252
February 29, 2016	Oxycodone 30mg	252
March 15, 2016	Oxycodone 30mg	252
March 28, 2016	Oxycodone 30mg	252
April 12, 2016	Oxycodone 30mg	230
April 26, 2016	Oxycodone 30mg	200
May 23, 2016	Oxycodone 30mg	200
June 6, 2016	Oxycodone 30mg	200
June 20, 2016	Oxycodone 30mg	200
July 2, 2016	Oxycodone 30mg	180
July 15, 2016	Oxycodone 30mg	180
July 30, 2016	Oxycodone 30mg	180
August 12, 2016	Oxycodone 30mg	180
August 25, 2016	Oxycodone 30mg	180
September 8, 2016	Oxycodone 30mg	180
September 22, 2016	Oxycodone 30mg	180
October 6, 2016	Oxycodone 30mg	180
October 20, 2016	Oxycodone 30mg	180
November 2, 2016	Oxycodone 30mg	180
November 17, 2016	Oxycodone 30mg	180
November 30, 2016	Oxycodone 30mg	180
December 14, 2016	Oxycodone 30mg	180
December 28, 2016	Oxycodone 30mg	180
January 12, 2017	Oxycodone 30mg	140
January 25, 2017	Oxycodone 30mg	70
February 2, 2017	Oxycodone 30mg	140
February 15, 2017	Oxycodone 30mg	140
March 1, 2017	Oxycodone 30mg	130
March 14, 2017	Oxycodone 30mg	130
March 29, 2017	Oxycodone 30mg	130
April 11, 2017	Oxycodone 30mg	130
Total Dosage Units of Oxycodone 30mg prescribed over an approximately 27 month period.		**13,076**

(Prescription Profile of A. T., attached as Exhibit 6 to Calendar Cert., Bates Stamps AT163-168).

40. Respondent continuously prescribed CDS to A.T. in excessive quantities for three or more months without documenting a treatment plan with objectives and goals for pain management or opioid use and without making reasonable efforts to prescribe alternative medications or alternative treatments to alleviate the pain. A.T.'s average daily prescribed Oxycodone intake was over 15 pills per day, or on average, 450 mg of Oxycodone per day. This dosage is concerning for possible abuse and/or diversion by the patient. (Calendar Cert., Ex. 4, Sifonios Report). In March 2017 alone, Respondent wrote A.T. prescriptions for a total of 390 Oxycodone 30 mg.

41. On November 29, 2011, A.T.'s first documented visit to the Respondent's office, there is no diagnosis provided and no physical examination conducted. (Calendar Cert., Ex. 5, AT81-85). According to Respondent's notes, A.T. had been provided 450 tablets of Oxycodone 30 mg by another physician. Respondent did not conduct a physical examination to verify the reported pain, did not conduct a base line urine screen and did not contact A.T.'s pharmacy to review her prescription profile. There is also no evidence that Respondent requested that A.T. show him her current Oxycodone pill bottle to verify she was taking the medication. Rather, Respondent's medical record confirms that he just provided A.T. with a prescription continuing her on the dosage she claimed was set by her previous physician. (Id. at AT84).

42. In 2012, Respondent prescribed 450 dosage units of Oxycodone 30 mg to A.T. every two weeks. This resulted in a monthly total of 900 dosage units of Oxycodone 30 mg and an annual total of 10,800 dosage units. At no point in 2012 is there evidence of any physical examination; use of alternative medication or interventional pain management procedures; urine

screen; pain contract; pill count; review of the PMP; referral for diagnostic testing; referral to a pain management specialist; or referral for alternate modalities such as physical therapy. (Calendar Cert., Ex. 5, AT87-102).

43. In 2013, Respondent prescribed 450 tablets of Oxycodone 30 mg to A.T. every two weeks through July 23, 2013. (Calendar Cert., Ex. 6). On July 23, 2013, A.T. filled a prescription for 450 Oxycodone 15 mg. Four days later she filled a prescription for 225 Oxycodone 30 mg. (Id.). Respondent's note for July 22, 2013 does not indicate any change in medication and there is nothing to explain the July 27, 2013 prescription. One week later, on August 5, 2013, A.T. filled a prescription for 168 Oxycodone 30 mg. (Calendar Cert., Ex. 6). Respondent notes indicate that A.T. "wants to try [to decrease] Oxycodone" and he provided her with two prescriptions for 168 Oxycodone 30 mg. (Calendar Cert., Ex. 5, AT 110). Respondent continued to prescribe 168 Oxycodone every 5-7 days, resulting in a monthly total of 672 dosage units through the end of 2013. (Calendar Cert., Ex. 6). At no point in 2013 is there evidence of any physical examination; use of alternative medication or interventional pain management procedures; urine screen; pain contract; pill count; review of the PMP; referral for diagnostic testing; referral to a pain management specialist; or referral for alternate modalities such as physical therapy. (See Calendar Cert., Ex. 5).

44. In 2014, Respondent prescribed A.T. a total of 672 dosage units per month for the entire year, totaling 8,064 Oxycodone 30 mg in a single year. During January to April 2014, Respondent prescribed A.T. 168 dosage units of Oxycodone 30 mg every 5-7 days. Starting on April 1, 2014, A.T. began receiving her prescriptions bimonthly, filling prescriptions written by the Respondent for 336 Oxycodone 30 mg approximately every two weeks. (Calendar Cert., Ex. 6). There is no indication in the record why Respondent changed from giving A.T. two

prescriptions per visit to one for the same total dosage. (Calendar Cert., Ex. 5, AT118). At no point in 2014 is there evidence of any physical examination; use of alternative medication or interventional pain management procedures; urine screen; pain contract; pill count; review of the PMP; referral for diagnostic testing or referral for alternate modalities such as physical therapy.

45. By his own admission in 2015, as reflected in A.T.'s patient record, Respondent never tried other medications to treat A.T.'s condition. He cited the fact that a previous doctor had kept her on high quantities as the sole justification for his indiscriminate prescribing *four years after* he took over her care. (Calendar Cert., Ex. 5, AT28). Respondent also indicated that a lower dose was ineffective. (Id. at AT29). However, when Respondent claimed this in June 2015, he had never tried A.T. on a dosage lower than the one she was currently on. (See Calendar Cert., Ex. 6).

46. In June 2015 Respondent claimed on a Pharmacy Prior Authorization Form that he was "slowly tapering [the] dose." Despite this assertion, A.T. was maintained on 252 Oxycodone every 14 days through March 2016, nine months after he said he would taper her. (Calendar Cert., Ex. 5, AT28). Respondent decreased A.T. from 252 Oxycodone 30 mg every two weeks to 180 Oxycodone 30 mg every two weeks between March 2016 and July 2016. On April 11, 2016, Respondent noted that A.T. "hopes to d/c" and is "ready to [decrease] medicine (Oxycodone) [decrease] by 30 mg/week." Respondent noted that he was prescribing 230 Oxycodone 30 mg for April 21 and 200 dosage units for April 25. (Calendar Cert., Ex 5, AT 136). However, on May 9, 2016, Respondent noted that A.T. had sweats, withdrawal and loss of appetite from decreasing Oxycodone. (Ibid.). That day Respondent gave A.T. two prescriptions for 200 Oxycodone 30 mg each. Beginning in July 2016, A.T. received 180 tablets of Oxycodone 30 mg every two weeks.

47. On December 1, 2016, Respondent's patient record for A.T. indicates that she was "due to decrease oxycodone shortly." (Id. at AT19). Respondent did decrease the amount of Oxycodone prescribed per visit however, the total number of Oxycodone A.T. received per month quickly rose again. In December 2016, A.T. received prescriptions for 360 tablets of Oxycodone 30 mg. In January 2017, A.T. received prescriptions totaling 210 Oxycodone 30 mg; in February 2017, A.T. received prescriptions totaling 280 Oxycodone 30 mg and in March 2017, A.T. received prescriptions totaling 390 Oxycodone 30 mg. (See Calendar Cert., Ex. 6).

48. Various pharmacies and insurance providers contacted Respondent regarding A.T.'s dose, yet he ignored any suggestions his prescribing was indiscriminate and continued to prescribe in excessive amounts. As early as February 2013 Respondent was asked to verify A.T.'s prescription following concerns raised by a pharmacist. (Calendar Cert., Ex. 5, AT66). On February 28, 2013 and December 2, 2013, Respondent sent a letter to a pharmacy attempting to justify A.T.'s prescriptions. (Id. at AT74). On June 10, 2014, Respondent received notice that A.T.'s insurance drug plan limitations had been exceeded and her Oxycodone "exceeds controlled substance fill limit." (Id. at AT59). On November 12, 2014, CVS Caremark contacted Respondent and stated that A.T. had been identified as "having unusual medication utilization patterns which may indicate possible drug over-utilization." (Id. at AT55). On December 12, 2014, the pharmacy where A.T. regularly fills her prescriptions sent Respondent a letter requesting increased documentation to accompany her prescriptions. (Calendar Cert., Ex. 6). In 2015, Respondent was asked to complete a Prior Authorization Request for A.T.'s Oxycodone prescription. (Id. at AT46). In each instance Respondent provided to these entities a justification for his prescribing and continued his unabated Oxycodone prescribing to A.T.

49. Respondent continued to prescribe massive quantities of Oxycodone despite A.T. reporting that she worked out at a gym, shoveled snow, went sledding with her children and attended a spin class. (Calendar Cert., Ex. 5, AT 107, 111, 116, 127, 137).

50. Respondent also continued to prescribe to A.T. after she began working in a pain management medical practice. (Id. at AT132). A.T. began getting trigger point injections from her employers, who are pain management specialists. (Id. at AT134, 139). Respondent failed to coordinate A.T.'s treatment with these pain management physicians, and did not review any of A.T.'s patient records from this practice, he merely continued to prescribe A.T. excessive and ongoing amounts of Oxycodone.

51. Respondent failed to enter into a Controlled Substances Agreement with A.T. until April 2015, four years, and 28,000 dosage units, after he began prescribing her opioid medications. (Calendar Cert., Ex. 5, AT35-36). Respondent also failed to monitor A.T.'s drug use through the PMP until January 18, 2016. (Calendar Cert., Ex. 1, Wetzel Cert., at 2). Only three checks of the PMP are evidenced in Respondent's records and all occurred in 2016, years after Respondent began providing A.T. with Oxycodone 30 mg. (Calendar Cert., Ex. 5, AT 142-148). A search of Respondent's request history for A.T. through the NJPMP identifies only seven (7) requests, four (4) of which were conducted on the same day. (Calendar Cert., Ex. 1, Wetzel Cert., at 2). On December 1, 2016, Respondent indicated that he was not performing urine drug screens on A.T. as she was unable to afford them. (Id. at AT18). Despite prescribing A.T. as many as 450 tablets of Oxycodone for a two week supply, there is not one urine drug screen present in Respondent's records. (Calendar Cert., Ex. 4, Sifonios Report).

52. Although Respondent began prescribing large quantities of Oxycodone to A.T. in 2011, the first PMP lookup of A.T. by Respondent occurred on January 18, 2016. (Calendar

Cert., Ex.1, Wetzel Cert.). PMP records further reveal that despite ongoing prescribing of Schedule II CDS to A.T. for chronic pain after November 7, 2016, Respondent did not perform the required quarterly review of her PMP. (Ibid.). Respondent's last PMP lookup for A.T. was on December 16, 2016, yet his prescribing of Oxycodone continues to at least April 11, 2017. (Calendar Cert., Ex.1, Wetzel Cert. at 2; Calendar Cert. Exhibit 6 at AT168).

53. In his management of A.T., Respondent grossly deviated from the standard of care by failing to perform a physical examination, continuing to prescribe with no imaging study to support the clinical diagnosis in the medical record, no urine drug screens and the indiscriminate prescribing of astronomical amounts of Oxycodone 30 mg. (Calendar Cert., Ex. 4, Sifonios Report).

54. Respondent's actions described herein constitute gross negligence that endangered the life, health, welfare or safety of A.T. in violation of N.J.S.A. 45:1-21(c); repeated acts of negligence in violation of N.J.S.A. 45:1-21(d); professional or occupational misconduct in violation of N.J.S.A. 45:1-21(e); failure to comply with the provisions of an act or regulation administered by the Board in violation of N.J.S.A. 45:1-21(h), specifically, failure to perform an appropriate history, physical examination and formulate a treatment plan prior to issuing a prescription in violation of N.J.A.C. 13:35-7.1A; failure to comply with certain limitations on prescribing controlled substances and failure to reevaluate treatment plans in violation of N.J.A.C. 13:35-7.6, and the issuing of prescriptions for controlled dangerous substances indiscriminately or without good cause in violation of N.J.S.A. 45:1-21(m).

55. Respondent's prescribing of Schedule II pain medication to A.T. without performing quarterly PMP lookups constitutes a violation of N.J.A.C. 13:45A-35.9(a)(2). As

such Respondent has engaged in Professional Misconduct pursuant to N.J.A.C. 13:45A-35.11(a) and N.J.S.A. 45:1-21 (e).

56. Respondent's indiscriminate prescribing of CDS to A.T. demonstrates such appalling medical judgment that his continued practice places the public's health, safety, and welfare in clear and imminent danger and warrants the temporary suspension of his license pursuant to N.J.S.A. 45:1-22.

COUNT III
(PATIENTS D.B., J.G., W.L)

55. The General Allegations and Counts I and II are repeated and re-alleged as if set forth in detail herein.

56. Respondent has been treating D.B. since 2013. In November 2016 alone, Respondent prescribed D.B. 112 dosage units of alprazolam, 56 dosage units of Adderall XE 20 mg, and 112 dosage units of Oxycodone 30 mg. As recently as February 27, 2017, D.B. filled a prescription for 112 Oxycodone 30 mg written by the Respondent.

57. Respondent continuously prescribed CDS to D.B. in excessive quantities for three or more months without a physical examination, documenting a treatment plan with objectives and goals for pain management or opioid use, making reasonable efforts to prescribe alternative medications or alternative treatments to alleviate the pain. Respondent also failed to adequately monitor D.B.'s use of, and response to, Oxycodone.

58. Respondent has been treating J.G. since 2013. As recently as March 6, 2017, J.G. filled a prescription for 168 Oxycodone 30 mg written by the Respondent. In December 2016, Respondent prescribed J.G. 112 Lorazepam 1mg; 336 Oxycodone 30 mg; 30 Lexapro 20 mg; 28 Adderall XR 30 mg.

59. Respondent continuously prescribed CDS to J.G. in excessive quantities for three or more months without a physical examination, documenting a treatment plan with objectives and goals for pain management or opioid use, making reasonable efforts to prescribe alternative medications or alternative treatments to alleviate the pain. Respondent also failed to adequately monitor J.G.'s use of, and response to, Oxycodone.

60. Respondent has been treating W.L. since 2009. As recently as February and March 2017, W.L. filled a prescription for 112 OxyContin 80 mg, as well as 84 Oxycodone 30 mg.

61. Respondent continuously prescribed CDS to W.L. in excessive quantities for three or more months without a physical examination, documenting a treatment plan with objectives and goals for pain management or opioid use, making reasonable efforts to prescribe alternative medications or alternative treatments to alleviate the pain. Respondent also failed to adequately monitor W.L.'s use of, and response to, Oxycodone.

62. Respondent's actions described herein constitute gross negligence which endangered the life, health, welfare, safety or property of a person in violation of N.J.S.A. 45:1-21(c); repeated acts of negligence in violation of N.J.S.A. 45:1-21(d); professional or occupational misconduct in violation of N.J.S.A. 45:1-21(e); failure to comply with the provisions of an act or regulation administered by the Board in violation of N.J.S.A. 45:1-21(h) (Specifically, preparation of a patient record in violation of N.J.A.C. 13:35-6.5 and failure to properly examine a patient prior to issuing a prescription in violation of N.J.A.C. 13:35-7.1A); failure to comply with certain limitations on prescribing controlled substances and failure to reevaluate treatment plans in violation of N.J.A.C. 13:35-7.6, and the prescription of controlled dangerous substances indiscriminately, without good cause, at a time when Respondent knew or

should have known that the substances were to be used for unauthorized consumption or distribution in violation of N.J.S.A. 45:1-21(m).

WHEREFORE, Complainant demands the entry of an Order:

1. Temporarily suspending Respondent's license to practice medicine and surgery in the State of New Jersey pending the conclusion of a plenary hearing in this matter, pursuant to N.J.S.A. 45:1-22;

2. Suspending or revoking Respondent's license to practice medicine and surgery in the State of New Jersey following a plenary hearing;

3. Assessing enhanced civil penalties against Respondent for each and every separate unlawful act as set forth in the individual counts above, pursuant to N.J.S.A. 45:1-25(a);

4. Requiring Respondent to pay costs, including investigative costs, attorney's fees and costs, expert and fact witness fees and costs, costs of trial, and transcript costs, pursuant to N.J.S.A. 45:1-25; and

5. Ordering such other and further relief as the Board shall deem just and appropriate under the circumstances.

CHRISTOPHER S. PORRINO
ATTORNEY GENERAL OF NEW JERSEY

By: Kate Calendar
Kate J. Calendar
Deputy Attorney General

Dated: May 4, 2017
Newark, New Jersey