STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

CASE NO.: 2009-06572

ROMAN MOSAI, M.D.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

Petitioner, the Department of Health, by and through its undersigned counsel, files this Administrative Complaint before the Board of Medicine against Respondent, Roman Mosai, M.D., and in support alleges:

1. Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed physician within the State of Florida, having been issued license number ME 40999, and was Board Certified in Emergency Medicine.

3. Respondent's address of record is 9112, Dollanger Court Orlando, Florida 32819-4064.

4. At all times material hereto, between November 11, 2008 and June 3, 2010 (the treatment period), Respondent, while practicing medicine in the State of Florida treated three (3) patients for pain management, they are referred to throughout by their initials as WR, CP and MW.

5. During the treatment period, Respondent prescribed to these three (3) patients the following controlled substance; Lortab 10 milligrams.

6. Lortab is a brand name for the formulation of hydrocodone and acetaminophen (Tylenol). Lortab is prescribed to treat pain. According to Section 893.03(3), Florida Statutes, hydrocodone, in the dosages found in hydrocodone/APAP is a Schedule III controlled substance that has a potential for abuse less than the substances in Schedules I and II and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to moderate or low physical dependence or high psychological dependence.

FACTS SPECIFIC TO PATIENT WR

7. Respondent treated WR between November 11, 2008 and February 10, 2009 (the treatment period).

8. WR, an undercover police officer, posed as a patient seeking pain relief medication without medical justification, his office visits to Respondent were filmed and audio taped using hidden surveillance equipment.

9. WR presented to Respondent as a self-referred, cash paying male patient with a vague history of lower back pain subsequent to a motor vehicle accident in 2004, he reported to Respondent that he had been treated with Tylenol and Ibuprophen (OTC) prior to meeting Respondent.

10. During the treatment period Respondent immediately prescribed Lortab for the management of WR's pain.

11. The surveillance tape transcripts of WR's encounters with Respondent also show that Respondent ignored statements from WR indicating that he was not compliant with the use of his medications. Specifically, the transcripts document WR as making the following statements to Respondent:

A. 11/6/08: Lortab hit's the spot and makes him feel good.....his back feels fine after sitting in the waiting room chair for so long.

B. 12/3/08: "I was hoping to get some more of those Lortab. Like before, really nothing (when asked by Respondent where are you hurting,) just would like to get some of those Lortabs....You know my friends told me to come in....like the way Lortab makes me feel, that's why I like to get them...The last ones were gone in 10 days!"

C. 1/7/09: "...and Lortab for you? I had a couple (Xanax) left over.."

12. Respondent failed to evaluate WR's chronic "lower back pain," until 2/10/09 at which time he requested WR to obtain a lumbar MRI Scan which was never performed.

13. Respondent's diagnosis of "lower back pain," is vague and non-specific. Respondent's physical examination of WR consistently demonstrated "tenderness lumbar sacral with decreased range of motion." Respondent documented reduced range of motion (no quantification), spasm, and no neuro-vascular abnormalities in the lower extremity. However, his physical examination lacks further orthopedic testing, including provocative testing to identify the primary pain generator.

14. Respondent failed to make a referral of WR to an orthopedic surgeon, physiatrist, neurologist, neurosurgery, or pain medicine physician for further consultation.

15. During the treatment period Respondent's medical records fail to show in his evaluation of the patient and in his treatment of WR one or more of the following:

a) A complete medical history and physical examination that was conducted and documented in the medical record;

b) Documentation of neurologic findings, specific ranges of motion, reflex testing, documentation of a functional exam such as for activities of daily living, squatting, straight leg raising, or other appropriate diagnostic tests to assess radiculopathy or neurologic deficit.

c) Appropriate diagnostic testing for illicit drug use and drug diversion of opioids such as Urine drug testing, pill counts pharmacy profiles.

d) A basis in the medical record to justify the amount and frequency of Lortab that Respondent prescribed to WR.

FACTS SPECIFIC TO PATIENT CP

16. Respondent's medical records state that he treated Patient CP for left knee pain between December 12, 2008 and April 4, 2009 (the treatment period).

17. CP a female 31 year old undercover police officer also posed as a patient seeking pain relief medication without medical justification and her office visits to Respondent were filmed and audio taped using hidden surveillance equipment.

18. CP initially presented to Respondent as WR's girlfriend as a self-referred cash paying patient with a vague and remote history of left knee pain aggravated by running. CP's past medical history and medication were unremarkable. CP indicated to Respondent that she did not utilize opiates or other Controlled Substances prior to her initial consultation with Respondent.

19. Hydrocodone is available in multiple strengths (2.5, 5, 7.5, and 10 mg). Respondent elected to prescribe Lortab 10 mg, without medical records justifying this course of treatment or why he chose to use the highest strength, 10 mg, in this opiate naive patient.

20. Respondent's physical examination was unremarkable except for tender left knee with decreased range of motion." He diagnosed CP with "arthralgia of left knee." Respondent requested that CP obtain a left knee MRI Scan on January 10, 2009, three (3) months after her initial consultation, is never obtained.

21. Respondent failed to refer CP to an orthopedic surgeon for evaluation of her primary orthopedic complaint and also failed to refer CP to physical therapy, instead CP received Lortab on a monthly basis for the management of her left knee pain during the remainder of the treatment period.

22. Respondent ignored documented and recorded statements from CP indicating that she was seeking to obtain Controlled Substances. Specifically, the transcripts document CP as making the following statements to Respondent:

A. 12/10/08: "....every once in a while when I run it will aggravate me....it's not aggravating me now, but it does when I run." Dr. Mosai: "Lortab,", CP: "yeah like the ones he (WR) has." Dr. Mosai: "Lortab l0...we don't give more than 60 usually." "...can you give me 80..? Dr. Mosai:.."we don't give more than 60, but I had already written 100, so I

didn't change it."

B. 1/7/09:..."yeah I take the medication, it makes it easy to forget."

23. Respondent failed to monitor CP's compliance with the use of Controlled Substances and failed to obtain random urine samples for urine drug testing, perform pill counts, or obtain pharmacy profiles in order to determine CP's compliance. In addition, he failed to have a signed controlled substances agreement within the medical records.

24. Respondent obtained a history and performed a physical examination during each of CP's office visits, but the pain focused history was of poor quality and he failed to document the aggravating and alleviating factors, past medical treatments, previous consultations of this left knee pain and physical examination lacked further orthopedic testing.

25. During the treatment period respondent's medical records fail to show in his evaluation of the patient and in his treatment of CP one or more of the following:

a) A complete medical history and physical examination that was conducted and documented in the medical record;

b) Justification for the extent of controlled substances being prescribing, and or an appropriate diagnoses to warrant the prescriptions that are written;

c) Appropriate diagnostic testing for illicit drug use/diversion of opioids;

d) Documentation of neuromuscular function, reflex testing and specific ranges of motion, signs or symptoms of radiculopathy, neurologic deficit or other functional levels of activity;

e) Documentation in the physical examinations or medical records to support the amount of controlled substances;

f) The nature and intensity of the pain is not accurately discussed.

26. The physical examinations Respondent performed were non-pain focused and non-orthopedic or musculoskeletal in nature. The follow-up physical examinations fail to note physical and objective findings, there is no documentation of neuromuscular function, reflex testing, specific ranges of motion, signs or symptoms of radiculopathy, neurologic deficit or other functional levels of activity.

27. Respondent's treatment of CP was limited to the prescribing of

a controlled substance. There are no instances where other modalities or treatments were tried. No pain management procedures, local injections, physical therapy, aquatic therapy, or other board certified specialties have ever been involved in CP's treatment.

FACTS SPECIFIC TO PATIENT MW

28. Between March 2, 2009 and June 3, 2010 (the treatment period) Respondent treated MW for pain.

29. MW is a 56 year old male with a history of poly-arthralgias (hips, knees, and shoulder) and lower back pain. His past medical history was significant for asthma emphysema and hypertension and as a result MW was on disability.

30. Respondent was MW's primary care physician and prescribed Advair and Albuterol (both are bronchodilators for the management of asthma), Claritin, Ibuprophen, Lisinopril (for the management of hypertension), and Lortab 10 mg.

31. MW initially presented to Respondent with complaints of neck pain arising from moderate degenerative changes in the cervical spine with a diffuse disc bulge at C5-C6 with mild impingement on the spinal cord with moderate bilateral intervertebral neural foraminal stenosis.

32. During the treatment period Respondent failed to adequately monitor MW for compliance, failed to have a completed controlled substances agreement in his medical documentation and failed to note the medical records to demonstrate that pill counts, pharmacy profiles or urine drug testing was performed to demonstrate compliance.

33. During the treatment period, Respondent's medical records fail to show in his evaluation of MW one or more of the following:

a) Medical records to justify prescribing Lortab 10 mg;

b) Detailed physical examination findings other than the superficial entries such as "tender knees, shoulders, and finger joints, and thoraco-lumbar spine tenderness";

c) Comments on the range of motion, specific finger joints affected (i.e. left first distal interphalangeal joint, right second proximal interphalangyeal joint. etc.), presence or absence of joint effusions, erythematic and warmth;

d) Specific orthopedic tests (Faber's maneuver, straight leg raises, etc.);

e) The efficacy of the use of opiates for the management of MW's pain, measurement of reduction of pain on a visual analogue scale,

improved ability to perform activities of daily living, working, improved sleep, were also absent from the medical documentation.

34. Respondent's periodic physical examinations were extremely cursory and show limited information; there is no competent review of individual musculoskeletal systems, common neurologic testing, or even basic documentations of range of motion; while the physical examinations document tenderness and pain, there are no specific diagnoses other than generalized pain that are ever mentioned.

COUNT ONE

35. Petitioner reincorporates and realleges paragraphs 1 through 34 as if fully set forth herein.

36. Section 458.331(1)(nn), Florida Statutes (2008 and 2009), provides that violating any provision of chapters 456 or 458, Florida Statutes (2008 and 2009), or any rules adopted pursuant thereto, is grounds for discipline by the Board of Medicine.

37. Rule 64B8-9.013(3), Florida Administrative Code, provides as follows in pertinent part:

> The Board has adopted the following standards for the use of controlled substances for pain control:

(a) Evaluation of the Patient. A complete medical history and physical examination must be conducted and documented in the medical record.

38. Respondent violated Rule 64B8-9.013(3), Florida Administrative Code, by prescribing Lortab 10 mg during the treatment period without conducting or documenting complete medical histories or physical examinations on Patients WR, CP, and MW.

39. Based on the foregoing, Respondent has violated Section 458.331(1) (nn), Florida Statutes (2008 and 2009), by violating Rule 64B8-9.013(3), Florida Administrative Code.

COUNT TWO

40. Petitioner reincorporates and realleges paragraphs 1 through 34 as if fully set forth herein.

41. Chapter 64B8-9.013(3), Florida Administrative Code, as more particularly set forth in paragraph 37 herein is adopted and realleged as if fully set forth.

42. Section 458.331(1)(t), Florida Statutes (2008 and 2009), provides that the gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar

conditions and circumstances is grounds for discipline by the Board of Medicine.

43. Respondent failed to practice medicine with that level of care, skill and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances in treating Patient WR, in one or more of the following ways:

a) By failing to order urine drug testing and undertake steps to ensure compliance such as pill counts and pharmacy profiles in view of the statements made by WR indicating that he was not compliant with the Lortab 10 mg that was prescribed to him.

b) By violating the standards for the use of controlled substances for pain control provided by the Board of Medicine in Rule 64B8-9.013(3), Florida Administrative Code;

c) By failing to make a referral of WR to an orthopedic surgeon, physiatrist, neurologist, neurosurgery, or pain medicine physician for further consultation;

d) By prescribing an excessive and inappropriate amount of a controlled substance.

44. Respondent failed to practice medicine with that level of care, skill and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances in the treatment of Patient CP in one or more of the following ways:

a) By violating the standards for the use of controlled substances for pain control provided by the Board of Medicine in Rule 64B8-9.013(3), Florida Administrative Code;

b) By failing to refer CP to an orthopedic surgeon for evaluation of her primary orthopedic complaint and also failed to refer CP to physical therapy order diagnostic testing in view of the high dosages of opioids prescribed;

c) By failing to order urine drug testing and undertake steps to ensure compliance such as pill counts and pharmacy profiles in view of the statements made by CP indicating that she was not compliant with the Lortab 10 mg that was prescribed to her;

d) By prescribing inappropriate and or excessive quantities of Lortab 10 mg;

e) By failing to perform appropriate physical examinations.

45. Respondent failed to practice medicine with that level of care, skill and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances in the treatment of Patient MW in one or more of the following ways:

a) By prescribing inappropriate and or excessive quantities of Lortab 10 mg;

b) By violating the standards for the use of controlled substances for pain control provided by the Board of Medicine in Rule 64B8-9.013(3), Florida Administrative Code;

c) By failing to monitor compliance, order urine drug testing and take steps to ensure compliance such as pill counts and pharmacy profiles and by failing to have a completed controlled substances agreement in his medical documentation in light of his prescribing Lortab 10 mg;

d) By failing to undertake competent and detailed physical examination.

46. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes (2008 and 2009).

COUNT THREE

47. Petitioner reincorporates and realleges paragraphs 1 through 34 as if fully set forth herein.

48. Chapter 64B8-9.013(3), Florida Administrative Code, as more particularly set forth in paragraph 37 herein is adopted and realleged.

49. Section 458.331(1)(m), Florida Statutes (2008 and 2009), subjects a licensee to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

50. During the treatment period Respondent failed to perform a legal obligation placed upon him as a physician contained within Rule 64B8-9.013(3), Florida Administrative Code, by prescribing Lortab 10mg to patients WR, CP and MW in the quantities described without documenting conducting or complete medical histories or physical examinations.

51. During the treatment period Respondent's medical records fail to show in his evaluation of the patient and in his treatment of WR one or more of the following:

a) A complete medical history and physical examination that was conducted and documented in the medical record;

b) Documentation of neurologic findings, specific ranges of motion, reflex testing, documentation of a functional exam such as for activities of daily living, squatting, straight leg raising, or other appropriate diagnostic tests to assess radiculopathy or neurologic deficit.

c) Appropriate diagnostic testing for illicit drug use and drug diversion of opioids such as Urine drug testing, pill counts and pharmacy profiles.

d) A basis in the medical record to justify the amount and frequency of Lortab 10 mg that Respondent prescribed to WR.

52. During the treatment period respondent's medical records fail to show in his evaluation of the patient and in his treatment of CP one or more of the following:

a) A complete medical history and physical examination that was conducted and documented in the medical record;

b) Justification for the extent of Lortab 10 mg being prescribing, and or an appropriate diagnoses to warrant the prescriptions that were written;

c) Appropriate diagnostic testing for illicit drug use/diversion of opioids;

d) Documentation of neuromuscular function, reflex testing and specific ranges of motion, signs or symptoms of radiculopathy, neurologic deficit or other functional levels of activity;

e) Documentation in the physical examinations or medical records to support the amount of controlled substances;

f) The nature and intensity of the pain is not accurately discussed.

g) The physical examinations Respondent performed were non-pain focused and non-orthopedic or musculoskeletal in nature. The followup physical examinations fail to note physical and objective findings, there is no documentation of neuromuscular function, reflex testing, specific ranges of motion, signs or symptoms of radiculopathy, neurologic deficit or other functional levels of activity.

53. During the treatment period Respondent's medical records fail

to show in his evaluation of the patient and in his treatment of MW one or more of the following:

a) Medical records to justify prescribing Lortab 10 mg.;

b) Detailed physical examination findings other than the superficial entries such as "tender knees, shoulders, and finger joints, and thoraco-lumbar spine tenderness";

c) Specific comments on the range of motion, specific finger joints affected (i.e. left first distal interphalangeal joint, right second proximal interphalangyeal joint. etc.), presence or absence of joint effusions, erythematic and warmth;

d) Specific orthopedic tests (Faber's maneuver, straight leg raises, etc.);

e) The efficacy of the use of opiates for the management of MW's pain, measurement of reduction of pain on a visual analogue scale, improved ability to perform activities of daily living, working, improved sleep, were also absent from the medical documentation.

f) Physical examinations were extremely cursory and show limited information; there is no competent review of individual musculoskeletal systems, common neurologic testing, or even basic

documentations of range of motion; while the physical examinations document tenderness and pain, there are no specific diagnoses other than generalized pain that are ever mentioned.

g) By failing to keep medical records during the treatment period that justify the course of treatment of MW.

60. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2008 and 2009), by violating Rule 64B8-9.013(3), Florida Administrative Code.

COUNT FOUR

61. Petitioner reincorporates and realleges paragraphs 1 through 34 and paragraph 37 as if fully set forth herein.

62. Section 458.331(1)(q), Florida Statutes (2008 and 2009), provides as follows: prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice is grounds for discipline by the Board of Medicine. For purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is

not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his intent.

63. During the treatment period, Respondent prescribed Lortab 10 mg to patients WR, CP and MW inappropriately and or in excessive or inappropriate quantities.

64. Based on the foregoing, Respondent has violated Section 458.331(1)(q), Florida Statutes (2008 and 2009).

WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, Placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 5th day of June, 2012.

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DATE 6-5-2012

RAM/sdw

PCP Members: S. Rosenberg, Winchester, Pardue
PCP: 6-5-2012

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or his behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.

ROMAN MOSAI CASE NO.: 2009-06572