Public

BPMC No. 13-198

STATE OF NEW YORK DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

**IN THE MATTER**

**OF**

**JAMES COCORES, M.D.**
**CO-13-02-0877-A**

**COMMISSIONER'S SUMMARY ORDER**

TO: JAMES COCORES, M.D.
REDACTED

The undersigned, Nirav R. Shah, M.D., M.P.H., Commissioner of Health, pursuant to New York Public Health Law §230, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, has determined that the duly authorized professional disciplinary agency of another jurisdiction, the State of Florida, Department of Health, has made a finding substantially equivalent to a finding that the practice of medicine by **JAMES COCORES, M.D.**, Respondent, New York license number 158815, in that jurisdiction, constitutes an imminent danger to the health of its people, as is more fully set forth in the Order of Emergency Suspension of License, dated February 18, 2013, attached, hereto, as Appendix "A," and made a part, hereof.

It is, therefore:

ORDERED, pursuant to New York Public Health Law §230(12)(b), that effective immediately, **JAMES COCORES, M.D.,** shall not practice medicine in the State of New York or in any other jurisdiction where that practice is predicated on a valid New York State license to practice medicine.

**ANY PRACTICE OF MEDICINE IN THE STATE OF NEW YORK IN VIOLATION OF THIS ORDER SHALL CONSTITUTE PROFESSIONAL MISCONDUCT WITHIN THE MEANING OF NEW YORK EDUCATION LAW §6530(29) AND MAY CONSTITUTE UNAUTHORIZED MEDICAL PRACTICE, A FELONY DEFINED BY NEW YORK EDUCATION LAW §6512.**

This Order shall remain in effect until the final conclusion of a hearing which shall commence within thirty (30) days after the final conclusion of the disciplinary proceeding in Florida.

The hearing will be held pursuant to the provisions of New York Public Health Law §230, and New York State Administrative Procedure Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on a date and at a location to be set forth in a written Notice of Referral Proceeding to be provided to the Respondent after the final conclusion of the New Hampshire proceeding. Said written Notice may be provided in person, by mail, or by other means. If Respondent wishes to be provided said written notice at an address other than that set forth above, Respondent shall so notify, in writing, both the attorney whose name is set forth in this Order, and the Director of the Office of Professional Medical Conduct, at the addresses set forth below.

**RESPONDENT SHALL NOTIFY THE DIRECTOR OF THE OFFICE OF PROFESSIONAL MEDICAL CONDUCT, NEW YORK STATE DEPARTMENT OF HEALTH, RIVERVIEW CENTER, 150 BROADWAY – SUITE 355, ALBANY, NEW YORK 12204-2719, VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED OF THE FINAL CONCLUSION OF THE PROCEEDING IMMEDIATELY UPON SUCH CONCLUSION.**

**THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.**

DATE: Albany, New York
6/20 , 2013

REDACTED

Nirav R. Shah, M.D., M.P.H.
Commissioner of Health
New York State Department of Health

Inquires should be directed to:

Michael G. Bass
Assistant Counsel
Bureau of Professional Medical Conduct
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Albany, New York 12237
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# Appendix A

Final Order No. DOH-13-0367-EGO -MQA
FILED DATE FEB 21 2013
Department of Health
By REDACTED
Deputy Agency Clerk

**STATE OF FLORIDA**
**DEPARTMENT OF HEALTH**

IN RE: The Emergency Suspension of the License of
James Alexander Cocores, M.D.
License Number: ME 76635
Case Number: 2011-08787

## ORDER OF EMERGENCY SUSPENSION OF LICENSE

John H. Armstrong, MD, FACS, State Surgeon General and Secretary of Health, ORDERS the Emergency Suspension of the license of James Alexander Cocores, M.D. (Dr. Cocores) to practice as a physician in the State of Florida. Dr. Cocores holds license number ME 76635. His address of record is 5301 North Federal Highway, Suite 200, Boca Raton, Florida 33487. The following Findings of Fact and Conclusions of Law support the Emergency Suspension of Dr. Cocores's license to practice as a physician in the State of Florida.

## INTRODUCTION

In February 2011, the Palm Beach Sheriff's Office (PBSO) received information that, while practicing at Southcoast Psycoptherapy & Education Associates, Inc. (Southcoast), Dr. Cocores was prescribing pain medication to patients without examining them. Around May 2011, Dr. Cocores left his employment with Southcoast and set up his own medical practice a few office suites away from Southcoast. In August 2011, L.D., an undercover agent

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from the PBSO Multi-Agency Diversion Taskforce, presented to Dr. Cocores while posing as a patient with psychiatric issues and a pre-existing back injury. Between August 2011 and April 2012, L.D. presented to Dr. Cocores for a total of nine visits, during which Dr. Cocores prescribed controlled substances to L.D. without appropriate evaluation or medical justification.

FINDINGS OF FACT

1. The Department is the state agency charged with regulating the practice of medicine, pursuant to Chapters 20, 456, and 458, Florida Statutes (2011-2012). Section 456.073(8), Florida Statutes (2012), empowers the State Surgeon General to summarily suspend Dr. Cocores's license to practice as a physician in the State of Florida in accordance with Section 120.60(6), Florida Statutes (2012).

2. At all times material to this Order, Dr. Cocores was licensed to practice as a physician in the State of Florida, pursuant to Chapter 458, Florida Statutes (2011-2012), but was not board-certified in any specialty.

3. At all times material to this Order, Dr. Cocores was employed at Southcoast, in Boca Raton, Florida, and/or his own medical practice located a few office suites away from Southcoast.

4. On or about August 10, 2011, L.D. presented for an initial visit with Dr. Cocores. She informed Dr. Cocores that her brother recently passed away and she felt "numb" and felt that she was "going through...[the] motions." L.D. then stated that she fell off a horse in February 2011 and had been receiving treatment from Dr. J.C., a chiropractor and pain management physician. Dr. Cocores asked L.D., when Dr. J.C. "gives you oxycodone, are they 15s or 30s?" L.D. told Dr. Cocores that Dr. J.C. prescribed oxycodone 30 mg, oxycodone 15 mg and Xanax 1 mg to her. She added that she did not fill her most recent prescription for oxycodone 15 mg and that she took only one Xanax 1 mg each night, despite Dr. J.C. prescribing additional Xanax.

5. Oxycodone is commonly prescribed to treat pain. According to Section 893.03(2), Florida Statutes (2011-2012), oxycodone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical used in treatment in the United States. Abuse of oxycodone may lead to severe psychological or physical dependence.

6. Xanax is the brand name for alprazolam and is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes (2011-2012),

alprazolam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States. Abuse of alprazolam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

7. After L.D. stated that she injured her back, Dr. Cocores conducted no physical examination on L.D. and reviewed no diagnostic test results or other medical records regarding L.D.'s condition. However, Dr. Cocores suggested, "So you have a thoracic disc degeneration? It's probably two or three of them at least." L.D. informed Dr. Cocores that she had disc bulges, not degeneration. L.D. stated that she had X-rays done at her chiropractor's office. Dr. Cocores did not ask to see the X-rays and did not ask L.D. to undergo any further diagnostic studies.

8. During this visit, L.D. and Dr. Cocores also discussed L.D.'s sleep problems. Dr. Cocores explained to L.D. that Ambien and Lunesta both cause brain damage. He stated that he would rather have L.D. "take an extra Xanax," if she "can get [her] doctor to dispense it." He also stated that he would dispense it, but "now-a-days if you get oxy and you get Xanax from another doctor, they think you are doctor shopping."

9. Ambien is the brand name for the drug zolpidem, prescribed to treat insomnia. According to Title 21, Section 1308.14, Code of Federal Regulations, zolpidem is a Schedule IV controlled substance. Zolpidem can cause dependence and is subject to abuse. However, Ambien is not a scheduled substance according to Florida Statutes.

10. Lunesta is the brand name for eszopiclone and is a hypnotic used to treat insomnia. Lunesta is a legend drug, but is not a controlled substance.

11. Dr. Cocores did not conduct any type of physical examination or drug screening on L.D. and did not prescribe any medications to L.D. during this visit.

12. On or about September 7, 2011, L.D. returned for a follow-up visit with Dr. Cocores. Dr. Cocores began the visit by again discussing the death of L.D.'s brother and her guilt associated with that loss. L.D. stated that she called Dr. J.C.'s office a few times about getting more Xanax, but then she found out that law enforcement shut down Dr. J.C.'s office. L.D. stated that she ran out of Xanax a few weeks ago but was using her husband's Ambien along with oxycodone 15 mg she had left over from

previous prescriptions. Dr. Cocores did not address the fact that L.D. admitted to using Ambien from a prescription that was not issued to her.

13. L.D. then asked Dr. Cocores whether he would prescribe Xanax to her. He stated, "Well, Xanax I can do" and "One of the reasons [Dr. J.C.] might have gotten busted is because he was giving out psych meds with pain meds and you aren't supposed to do that unless you are a psychiatrist." He further explained that law enforcement had investigated Dr. Cocores's practice, but that he had "changed his ways" and was "mainly a psychiatrist."

14. L.D. and Dr. Cocores then discussed L.D.'s pain medications. Dr. Cocores stated that he would "rather avoid" Percocet as it is "oxycodone 10," but that he would prefer to prescribe Vicodin 10 mg to L.D.. Dr. Cocores asked L.D., "Do you want to take a gamble with Vicodin 10s?". She replied in the affirmative. Dr. Cocores then stated that L.D. needed to "get a copy of an MRI [Magnetic Resonance Imaging scan] for the next time; although it's not as crucial with the Vicodin."

15. Vicodin and Lorcet are brand names for hydrocodone/APAP. Hydrocodone/APAP contains hydrocodone and acetaminophen, or Tylenol, and is prescribed to treat pain. According to Section 893.03(3), Florida Statutes (2011-2012), 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. Abuse of the substance may lead to moderate or low physical dependence or high psychological dependence.

16. Dr. Cocores prescribed 120 dosage units of Vicodin 10/325 mg and 30 dosage units of Xanax 1 mg to LD. He conducted no physical examination or drug screening on L.D. and reviewed no diagnostic test results or medical records before prescribing the medication. Dr. Cocores told L.D. to call if she needed to come in for a follow-up visit during the next three months. He added, "Hopefully, the place won't be closed down."

17. On or about November 10, 2011, L.D. returned for a follow-up visit with Dr. Cocores. She informed Dr. Cocores that she ran out of Xanax and explained that she did not like the Lorcet she received when she filled the September 2011 prescription from Dr. Cocores for Vicodin 10/325 mg. Dr. Cocores stated "we can't do oxy; it's too highly scrutinized, but we can do Percocets." Dr. Cocores spent the remainder of the visit talking to L.D. about his personal problems, including his relationship with his mother, his business ventures other than practicing medicine and providing financial support for

his daughter and his ex-wife. He then prescribed 30 dosage units of Xanax 1 mg and an unknown quantity of Percocet 10/325 mg to L.D. without conducting any type of physical examination or drug screening on her. The quantity of Percocet is unknown because Dr. Cocores failed to document it. Dr. Cocores failed to ask L.D. about the MRI report he requested during L.D.'s last visit.

18. Percocet is a brand name for oxycodone/APAP, which contains oxycodone and acetaminophen, or Tylenol. According to Section 893.03(2), Florida Statutes (2011-2012), oxycodone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States. Abuse of oxycodone may lead to severe psychological or physical dependence.

19. On or about December 8, 2012, L.D. returned for a follow-up visit with Dr. Cocores. Dr. Cocores began the visit by discussing religion and why L.D.'s dietary habits are making her nauseous. Dr. Cocores's only mention of L.D.'s pain occurred when he asked, "Your pain? How's that going?" Once again, Dr. Cocores prescribed 30 dosage units of Xanax 1 mg and 120 dosage units of Percocet 10/325 mg to L.D. without conducting any physical

examination or drug screening on L.D. and without reviewing any of L.D.'s previous medical records or diagnostic test results.

20. On or about January 4, 2012, L.D. returned for a follow-up visit with Dr. Cocores. When she arrived late for her appointment, Dr. Cocores stated, "We will try to get what you need in the few minutes that we have. Are you mainly needing your pills?" L.D. asked Dr. Cocores whether he could prescribe oxycodone to her. He stated that he would not, but once again prescribed Percocet and Xanax to L.D. without any physical examination or drug screening and without reviewing any medical records or diagnostic test results. Dr. Cocores did not document the quantity of medications that her prescribed to L.D. L.D. and Dr. Cocores spent the remainder of the visit discussing what Dr. Cocores did for New Years, L.D.'s upcoming vacation, and the self-centered nature of people in South Florida.

21. On or about February 29, 2012, L.D. returned for a follow-up visit with Dr. Cocores. L.D. told Dr. Cocores that the Percocet was bothering her stomach and that she wished to take oxycodone instead. Dr. Cocores asked L.D., "Is that what you want to do?" She told him yes. He quickly changed the subject to topics that were unrelated to L.D.'s health concerns, wrote prescriptions for Xanax and Percocet, and scheduled a follow-up

appointment for L.D. Dr. Cocores failed to conduct any physical examination or drug screen on L.D. and failed to review any medical records or diagnostics test results before prescribing controlled substances to L.D.

22. L.D. left Dr. Cocores's office and returned to the patient waiting room before realizing that Dr. Cocores had given a prescription for Percocet to her. She returned to his office and asked for oxycodone instead of Percocet. Without asking L.D. any further questions or conducting any examination, Dr. Cocores took the Percocet prescription from her, wrote a prescription for 75 dosage units of oxycodone 15 mg pills and handed that prescription to L.D. instead. Dr. Cocores failed to document the quantity of Xanax that he prescribed to L.D.

23. On or about March 28, 2012, L.D. returned for a follow-up visit with Dr. Cocores. Dr. Cocores began the visit by confirming that L.D. switched from Percocet to oxycodone and asking whether L.D. was able to fill the prescription for oxycodone. L.D. informed Dr. Cocores that she was able to fill the prescription at Walgreens. Dr. Cocores then stated to L.D. that he needed "an updated MRI or else" he could not prescribe oxycodone anymore because "they are getting very strict with that stuff." He did not specify who he meant by "they". L.D. stated that she had an MRI less than one year ago.

Dr. Cocores asked L.D. to bring a copy of the MRI report to her next visit. He then wrote prescriptions for 30 dosage units of Xanax 1 mg and 75 dosage units of oxycodone 15 mg and provided them to L.D. without examining her, drug testing her or reviewing any of L.D.'s medical history.

24. On or about April 25, 2012, L.D. returned for a follow-up visit with Dr. Cocores. Dr. Cocores began the visit by asking, "How are the medications working for you?" He then changed the course of the conversation and discussed matters unrelated to the treatment of L.D.'s pain. Dr. Cocores concluded the visit by providing L.D. with prescriptions for Xanax and oxycodone and a follow-up appointment for the following month. Dr. Cocores did not examine or drug test L.D., did not review any of L.D.'s previous medical records and did not mention the MRI he asked about during L.D.'s previous visit. Dr. Cocores also failed to document the quantity of medications that he prescribed to L.D.

25. At no time during L.D.'s visits did Dr. Cocores complete any type of physical exam on L.D., take L.D.'s vital signs, or monitor L.D. for compliance in taking her medications as prescribed. Dr. Cocores also failed to ask L.D. about her medical history, with the exception of information regarding medications that Dr. J.C. prescribed to L.D., failed to review any of

L.D.'s previous medical records and failed to review any MRIs or other diagnostic tests.

26. At no time during L.D.'s visits did Dr. Cocores document any medical justification for prescribing controlled substances to L.D., document a complete medical history or physical examination for L.D. or document treatment objectives for L.D. Dr. Cocores also failed, on at least four occasions, to document the medications that he prescribed to L.D. L.D. paid Dr. Cocores between $100 and $325 for each of her nine visits to him.

27. The Department retained an independent medical expert who is an anesthesiologist and pain management physician as well as a diplomate of the American Academy of Pain Management. The Department's expert opined that Dr. Cocores had "no business" treating L.D. in the manner in which he did and that his treatment of L.D. failed to meet the applicable standard of care. He explained that Dr. Cocores basically "chatted" with L.D. and then provided her with prescriptions for controlled substances.

28. The Department's expert stated that Dr. Cocores prescribed controlled substances commonly known to treat pain to L.D. while "ignoring the most basic guidelines for prescription of controlled substances." The expert noted that Dr. Cocores failed to perform a history and physical

examination of L.D. at any time during the patient's treatment and failed to complete an appropriate diagnostic work-up of the patient. He opined that in every visit, with the exception of the first visit, Dr. Cocores engaged in "social conversation" with L.D. and then provided her with prescriptions for pain medications.

29. The expert stated that Dr. Cocores failed to "establish sound clinical grounds to justify the need for the therapy . . . initiated," and instead prescribed pain medication to L.D. because she informed him that her previous pain clinic was closed and she needed a "replacement supplier for her prescriptions."

30. The expert opined that Dr. Cocores failed to establish a treatment plan delineating the objectives that he would use to determine treatment success, including pain relief and improved function.

31. The expert stated that Dr. Cocores failed to employ any other treatment modalities in his treatment of L.D., such as interventional techniques, and failed to refer L.D. for consultations with other specialists, including a pain specialist or surgeon.

32. The Department's expert further opined that Dr. Cocores failed "in the most egregious way" to prevent drug abuse or diversion by L.D. He

pointed out that Dr. Cocores never drug tested L.D. or conducted a pill count. The expert concluded that Dr. Cocores could not possibly have known whether L.D. was taking the medication that he prescribed to her or diverting the medication. The Department's expert ultimately stated that Dr. Cocores was providing L.D. with medically unjustifiable prescriptions in exchange for money, rather than performing the functions of a medical doctor.

33. Physicians who liberally prescribe controlled substances without following the minimum standards of care applicable to the prescribing of those drugs pose a serious danger to the public health, welfare and safety. This is so because the controlled substances prescribed by these physicians are often potentially addictive and the misuse or abuse of these drugs can cause serious and lasting medical injury and death.[1]

34. The facts recited above support the conclusion that Dr. Cocores is using his medical license to prescribe controlled substances without following the minimum standards of care applicable to the prescribing of those drugs, without any proper determination that prescribing those drugs is medically necessary and without any regard for the health, safety and well-being of the individuals receiving these addictive and potentially lethal drugs. Dr.

[1] The Proliferation of Pain Clinics in South Florida, November 19, 2009, Broward County Grand Jury report.

Cocores's acts manifest such a pattern and propensity to practice below the appropriate standard of care that a continuation of this practice poses an immediate serious danger to the public health, safety, or welfare.

35. A physician licensed in the State of Florida is one of a small number of licensed professionals allowed to prescribe, administer, and dispense controlled substances. The Legislature has vested a trust and confidence in these licensed professionals by permitting them to prescribe drugs with a high potential for abuse and harm. Inappropriate prescribing of highly addictive controlled substances to patients presents a danger to the public health, safety, or welfare, and does not correspond to that level of professional conduct expected of one licensed to practice medicine in this state.

36. In addition to Dr. Cocores's distribution of drugs to patients in violation of state law, Dr. Cocores consistently violated the standards governing the practice of medicine in Florida by performing no physical exams and failing to monitor L.D. for signs of drug dependency and diversion. Dr. Cocores's below-standard practice of medicine evidences his inability or unwillingness to comply with the professional and medical standards that govern physicians in the State of Florida.

37. Dr. Cocores acted with indifference to the health of patients by prescribing the most highly addictive drugs to L.D. with no demonstration of medical need and in contravention of the well-known warnings, dangers, and contraindications pertaining to the drugs.

38. Illegal activity by a physician necessarily affects that physician's ability to practice medicine as a physician's professional judgment and ethical standards are all implicated in these activities. Dr. Cocores's involvement in providing prescriptions in exchange for money manifests a lack of the professional judgment and ethical standards that are necessary to practice medicine in the State of Florida. Dr. Cocores's willingness to practice medicine below the minimum standards of care and to endanger the lives of patients also demonstrate a lack of the good moral character required for licensure as a physician in the State of Florida.

39. Dr. Cocores's professional and medical incompetence, his lack of good moral character, his willingness to use his medical license to facilitate the distribution of drugs in violation of state law, his indifference to the safety of patients and his unwillingness to carry out even the most basic functions required of physicians in the State of Florida, when taken together, demonstrate that Dr. Cocores is incapable of, or unwilling to, practice

medicine safely and that his continued practice of medicine poses an immediate serious danger to the public health, safety, or welfare.

40. Dr. Cocores's moral turpitude and unwillingness to practice within the standard of care makes obvious that his unsafe practice of medicine is likely to recur and that a less restrictive sanction, such as an emergency restriction order preventing Dr. Cocores from prescribing controlled substances, would not be sufficient to protect the public from the immediate serious danger posed by Dr. Cocores's continued practice as a medical doctor. Dr. Cocores's actions in this case are not the result of carelessness or ignorance on his part; instead, Dr. Cocores's actions demonstrate his willingness to violate the laws, regulations, and standards that govern the practice of medicine in the State of Florida. Nothing short of the immediate suspension of Dr. Cocores's license to practice medicine would be sufficient to protect the public from the danger of harm presented by Dr. Cocores.

## CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the State Surgeon General concludes as follows:

1. The State Surgeon General has jurisdiction over this matter pursuant to Sections 20.43 and 456.073(8), Florida Statutes (2011-2012), and Chapter 458, Florida Statutes (2011-2012).

2. Section 120.60(6), Florida Statutes (2011-2012), authorizes the Department to suspend a physician's license if the Department finds that the physician presents an immediate, serious danger to the public health, safety or welfare.

3. Section 458.331(1)(t)1, Florida Statutes (2011-2012), subjects a physician to discipline, including suspension, for committing medical malpractice as defined in Section 456.50, Florida Statutes (2011-2012). "Medical malpractice" is defined by Section 456.50(1)(g), Florida Statutes (2011-2012), as "the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure." Section 456.50(1)(e), Florida Statutes (2011-2012), provides that the "level of care, skill, and treatment recognized in general law related to health care licensure" means the standard of care that is specified in Section 766.102(1), Florida Statutes (2011-2012), which states:

> The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is

recognized as acceptable and appropriate by reasonably prudent similar health care providers.

Section 458.331(1)(t)1., Florida Statutes (2011-2012), directs the Board of Medicine to give "great weight" to Section 766.102, Florida Statutes (2011-2012).

4. Dr. Cocores failed to meet the prevailing standard of care in one or more of the following manners:

a. By failing to conduct a history and physical examination on L.D. at any time;

b. By failing to order appropriate diagnostic or objective tests for L.D.;

c. By prescribing controlled substances to L.D. without medical justification;

d. By prescribing inappropriate quantities of controlled substances to L.D.;

e. By failing to establish a treatment plan for the treatment of L.D.'s pain;

f. By failing to employ other modalities for the treatment of L.D.'s pain;

g. By failing to request consultations with other specialists for the treatment of L.D.'s pain; and/or

h. By failing to monitor L.D. for drug abuse and/or diversion of the medications which he prescribed to her.

5. Section 458.331(1)(q), Florida Statutes (2011-2012), subjects a physician to discipline, including suspension, for 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. For the purposes of this subsection, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including 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 the physician's intent.

6. Dr. Cocores prescribed, dispensed, administered, mixed, or otherwise prepared a legend drug, other than in the course of his professional practice, in one or more of the following manners:

a. By excessively prescribing controlled substances to L.D.; and/or

b. By inappropriately prescribing controlled substances to L.D.

7. Section 453.331(1)(m), Florida Statutes (2011-2012), subjects a physician to discipline, including suspension, for failing to keep legible medical records 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 or hospitalizations.

8. Dr. Cocores failed to keep legible medical records that justify the course of treatment of L.D. in one or more of the following manners:

a. Failing to document any medical justification for prescribing controlled substances to L.D.;

b. Failing to document a complete medical history;

c. Failing to document a physical examination for L.D.;

d. Failing to document treatment objectives for L.D.; and/or

e. Failing to document the medications that he prescribed to L.D.

9. Dr. Cocores's continued practice as a physician constitutes an immediate serious danger to the health, safety, and welfare of the public,

and this summary procedure is fair under the circumstances to adequately protect the public.

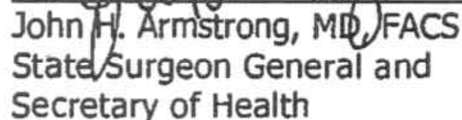
In accordance with Section 120.60(6), Florida Statutes (2012), it is

**ORDERED THAT:**

1. The license of James Alexander Cocores, M.D., license number ME 76635, is hereby immediately suspended.

2. A proceeding seeking formal suspension or discipline of the license of James Alexander Cocores, M.D., to practice as a physician will be promptly instituted and acted upon in compliance with Sections 120.569 and 120.60(6), Florida Statutes (2012).

**DONE and ORDERED** this 18th day of February, 2013.



John H. Armstrong, MD, FACS
State Surgeon General and
Secretary of Health

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## NOTICE OF RIGHT TO JUDICIAL REVIEW

Pursuant to Sections 120.60(6), and 120.68, Florida Statutes, this Order is judicially reviewable. Review proceedings are governed by the Florida Rules of Appellate Procedure. Proceedings are commenced by filing a Petition for Review, in accordance with Florida Rule of Appellate Procedure 9.100, with the District Court of Appeal, accompanied by a filing fee prescribed by law, and a copy of the Petition with the Agency Clerk of the Department of Health, within thirty (30) days of the date this Order is filed.

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**STATE OF FLORIDA**
**DEPARTMENT OF HEALTH**

**DEPARTMENT OF HEALTH,**

**PETITIONER,**

**v.** **CASE NO.: 2011-08787**

**JAMES ALEXANDER COCORES, M.D.,**

**RESPONDENT.**

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## ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Medicine against the Respondent, JAMES ALEXANDER COCORES, M.D., and in support thereof alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine, pursuant to Chapters 20, 456, and 458, Florida Statutes (2011-2012).

2. At all times material to this Complaint, Respondent was licensed to practice as a physician in the State of Florida, pursuant to Chapter 458, Florida Statutes (2011-2012), having been issued license number ME 76635.

3. Respondent's address of record is 5301 North Federal Highway, Suite 200, Boca Raton, Florida 33487.

4. At all times material to this Complaint, Respondent was authorized to prescribe controlled substances classified under schedules two through five of Section 893.03, Florida Statutes (2011-2012), to patients.

5. At all times material to this Complaint, Respondent was employed at Southcoast Psychotherapy & Education Associates, Inc. (Southcoast) in Boca Raton, Florida or his own medical practice located a few office suites away from Southcoast.

6. On or about August 10, 2011, L.D., an undercover agent from the PBSO Multi-Agency Diversion Taskforce, presented to Respondent while posing as a patient experiencing psychiatric issues.

7. L.D. informed Respondent that her brother recently passed away and she felt "numb" and felt that she was "going through...[the] motions."

8. L.D. then stated that she fell off a horse in February 2011 and had been receiving treatment from Dr. J.C., a chiropractor and pain management physician.

9. L.D. told Respondent that Dr. J.C. prescribed oxycodone 30 mg, oxycodone 15 mg and Xanax 1 mg to her. She added that she did not fill her most recent prescription for oxycodone 15 mg and that she took only one Xanax 1 mg each night, despite Dr. J.C. prescribing additional Xanax.

10. Oxycodone is commonly prescribed to treat pain. According to Section 893.03(2), Florida Statutes (2011-2012), oxycodone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States. Abuse of oxycodone may lead to severe psychological or physical dependence.

11. Xanax is the brand name for alprazolam and is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes (2011-2012), alprazolam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States. Abuse of alprazolam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

12. After L.D. stated that she injured her back, Respondent

conducted no physical examination or drug testing on L.D. and reviewed no diagnostic test results or other medical records regarding L.D.'s condition.

13. L.D. stated that she had X-rays done at her chiropractor's office. Respondent did not ask to see the X-rays and did not ask L.D. to undergo any further diagnostic studies.

14. On or about September 7, 2011, L.D. returned for a follow-up visit with Respondent. Respondent began the visit by again discussing the death of L.D.'s brother and her guilt associated with that loss.

15. L.D. stated that she called Dr. J.C.'s office a few times about getting more Xanax, but then she found out that law enforcement shut down Dr. J.C.'s office. L.D. stated that she ran out of Xanax a few weeks ago but was using her husband's Ambien along with oxycodone 15 mg she had left over from previous prescriptions.

16. Respondent did not address the fact that L.D. admitted to using Ambien from a prescription that was not issued to her.

17. Ambien is the brand name for the drug zolpidem, prescribed to treat insomnia. According to Title 21, Section 1308.14, Code of Federal Regulations, zolpidem is a Schedule IV controlled substance. Zolpidem can

cause dependence and is subject to abuse. However, Ambien is not a scheduled substance according to Florida Statutes.

18. Respondent prescribed 120 dosage units of Vicodin 10/325 mg and 30 dosage units of Xanax 1 mg to LD.

19. Respondent also asked that L.D. undergo a magnetic resonance imaging (MRI) and bring the report of that screening with her to her next visit.

20. Vicodin and Lorcet are brand names for hydrocodone/APAP. Hydrocodone/APAP contains hydrocodone and acetaminophen, or Tylenol, and is prescribed to treat pain. According to Section 893.03(3), Florida Statutes (2011-2012), 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. Abuse of the substance may lead to moderate or low physical dependence or high psychological dependence.

21. Respondent conducted no physical examination or drug screening on L.D. and reviewed no diagnostic test results or medical records before prescribing the medication.

22. On or about November 10, 2011, L.D. returned for a follow-up visit with Respondent.

23. She informed Respondent that she ran out of Xanax and explained that she did not like the Lorcet she received when she filled the September 2011 prescription from Dr. Cocores for Vicodin 10/325 mg.

24. Respondent then prescribed 30 dosage units of Xanax 1 mg and an unknown quantity of Percocet 10/325 mg to L.D. without conducting any type of physical examination or drug screening on her. The quantity of Percocet is unknown because Respondent failed to document it.

25. Percocet is a brand name for oxycodone/APAP, which contains oxycodone and acetaminophen, or Tylenol. According to Section 893.03(2), Florida Statutes (2011-2012), oxycodone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States. Abuse of oxycodone may lead to severe psychological or physical dependence.

26. Respondent failed to ask L.D. about the MRI report he requested during L.D.'s last visit.

27. On or about December 8, 2012, L.D. returned for a follow-up visit with Respondent.

28. Once again, Respondent prescribed 30 dosage units of Xanax 1 mg and 120 dosage units of Percocet 10/325 mg to L.D. without conducting any physical examination or drug screening on L.D. and without reviewing any of L.D.'s previous medical records or diagnostic test results.

29. On or about January 4, 2012, L.D. returned for a follow-up visit with Respondent.

30. L.D. asked Respondent whether he could prescribe oxycodone to her. He stated that he would not, but once again prescribed Percocet and Xanax to L.D. without any physical examination or drug screening and without reviewing any medical records or diagnostic test results. Respondent did not document the quantity of medications that her prescribed to L.D.

31. On or about February 29, 2012, L.D. returned for a follow-up visit with Respondent. L.D. told Respondent that the Percocet was bothering her stomach and that she wished to take oxycodone instead.

32. Respondent wrote prescriptions for Xanax and Percocet, and scheduled a follow-up appointment for L.D.

33. Respondent failed to conduct any physical examination or drug screen on L.D. and failed to review any medical records or diagnostics test results before prescribing controlled substances to L.D.

34. Respondent prescribed 30 dosage units of Xanax 1 mg and 120 dosage units of Percocet 10/325 mg to L.D. without conducting any physical examination or drug screening on L.D. and without reviewing any of L.D.'s previous medical records or diagnostic test results.

35. L.D. left Respondent's office and returned to the patient waiting room before realizing that Respondent had given a prescription for Percocet to her. She returned to his office and asked for oxycodone instead of Percocet.

36. Without asking L.D. any further questions or conducting any examination, Respondent took the Percocet prescription from her, wrote a prescription for 75 dosage units of oxycodone 15 mg pills and handed that prescription to L.D. instead.

37. Respondent failed to document the quantity of Xanax that he prescribed to L.D.

38. On or about March 28, 2012, L.D. returned for a follow-up visit with Respondent.

39. Respondent stated to L.D. that he needed an MRI report or he could not prescribe oxycodone to her any longer.

40. Respondent then wrote prescriptions for 30 dosage units of Xanax 1 mg and 75 dosage units of oxycodone 15 mg and provided them to L.D. without examining her, drug testing her or reviewing any of L.D.'s medical history.

41. On or about April 25, 2012, L.D. returned for a follow-up visit with Respondent.

42. Respondent provided L.D. with prescriptions for Xanax and oxycodone and a follow-up appointment for the following month.

43. Respondent did not examine or drug test L.D., did not review any of L.D.'s previous medical records and did not mention the MRI he asked about during L.D.'s previous visit.

44. Respondent also failed to document the quantity of medications that he prescribed to L.D.

45. At no time during L.D.'s visits did Respondent document any medical justification for prescribing controlled substances to L.D.,

document a complete medical history or physical examination for L.D. or document treatment objectives for L.D.

46. Respondent also failed, on at least four occasions, to document the medications that he prescribed to L.D.

47. Respondent failed to establish a treatment plan delineating the objectives that he would use to determine treatment success, including pain relief and improved function.

48. Respondent failed to employ any other treatment modalities in his treatment of L.D., such as interventional techniques, and failed to refer L.D. for consultations with other specialists, including a pain specialist or surgeon.

## COUNT I

49. Petitioner realleges and incorporates paragraphs 1 through 48 as if fully set forth herein.

50. Section 458.331(1)(t)1, Florida Statutes (2011-2012), subjects a physician to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes (2011-2012). "Medical malpractice" is defined by Section 456.50(1)(g), Florida Statutes (2011-2012), as "the failure to practice medicine in accordance with the level of care, skill, and

treatment recognized in general law related to health care licensure." Section 456.50(1)(e), Florida Statutes (2011-2012), provides that the "level of care, skill, and treatment recognized in general law related to health care licensure" means the standard of care that is specified in Section 766.102(1), Florida Statutes (2011-2012), which states:

> The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

Section 458.331(1)(t)1., Florida Statutes (2011-2012), directs the Board of Medicine to give "great weight" to Section 766.102, Florida Statutes (2011-2012).

51. Respondent failed to meet the prevailing standard of care in one or more of the following manners:

a. By failing to conduct a history and physical examination on L.D. at any time;

b. By failing to order appropriate diagnostic or objective tests for L.D.;

c. By prescribing controlled substances to L.D. without medical justification;

d. By prescribing inappropriate quantities of controlled substances to L.D.;

e. By failing to establish a treatment plan for the treatment of L.D.'s pain;

f. By failing to employ other modalities for the treatment of L.D.'s pain;

g. By failing to request consultations with other specialists for the treatment of L.D.'s pain; and/or

h. By failing to monitor L.D. for drug abuse and/or diversion of the medications which he prescribed to her.

52. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2011-2012), by committing medical malpractice.

**COUNT II**

53. Petitioner realleges and incorporates paragraphs 1 through 48 as if fully set forth herein.

54. Section 458.331(1)(q), Florida Statutes (2011-2012), subjects a physician to discipline for 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. For the purposes of this subsection, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including 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 the physician's intent.

55. Respondent prescribed, dispensed, administered, mixed, or otherwise prepared a legend drug, other than in the course of his professional practice, in one or more of the following manners:

a. By excessively prescribing controlled substances to L.D.; and/or

b. By inappropriately prescribing controlled substances to L.D.

56. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2011-2012), by prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of Respondent's professional

practice.

## COUNT III

57. Petitioner realleges and incorporates paragraphs 1 through 48 as if fully set forth herein.

58. Section 453.331(1)(m), Florida Statutes (2011-2012), subjects a physician to discipline for failing to keep legible medical records 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 or hospitalizations.

59. Respondent failed to keep legible medical records that justify the course of treatment of L.D. in one or more of the following manners:

a. Failing to document any medical justification for prescribing controlled substances to L.D.;

b. Failing to document a complete medical history;

c. Failing to document a physical examination for L.D.;

d. Failing to document treatment objectives for L.D.; and/or

e. Failing to document the medications that he prescribed to L.D.

60. Based on the foregoing, Respondent violated Section

458.331(1)(m), Florida Statutes (2011-2012), by failing to keep legible medical records that justify the course of treatment.

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 of Medicine deems appropriate.

SIGNED this 8th day of March, 2013.

John H. Armstrong, MD, FACS
State Surgeon General and
Secretary of Health

REDACTED

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PCP: March 8, 2013
PCP Members: Dr. S. Rosenberg; Dr. El Sanadi

DOH V. JAMES ALEXANDER COCORES, M.D. Case No. 2011-08787

## 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 her 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 any other discipline imposed.**