These charges are only allegations which may be contested by the licensee in an administrative hearing.

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

IN THE MATTER OF JOSEPH OLIVIERI, M.D.	STATEMENT OF CHARGES

JOSEPH OLIVIERI, M.D., the Respondent, was authorized to practice medicine in New York State on or about December 5, 1974, by the issuance of license number 122622 by the New York State Education Department. Respondent is a family medicine practitioner, and rendered care and treatment to Patients A though G from on or about 2013 through on or about January 2018 (the identities of the patients are contained in the annexed appendix).

FACTUAL ALLEGATIONS

A. Patient A came under the care and treatment of Respondent from on or about December 2013 through on or about November 2017. Respondent deviated from the standard of care by:

1. Inappropriate prescribing of controlled substances to Patient A.
2. Inadequate assessment, REMS[1], and monitoring of Patient A's drug therapy.

[1] A Risk Evaluation and Mitigation Strategy (REMS) is a drug safety program that the U.S. Food and Drug Administration (FDA) can require for certain medications with serious safety concerns to help ensure the benefits of the medication outweigh its risks. REMS are designed to reinforce medication use behaviors and actions that support the safe use of that medication. REMS are designed to help reduce the occurrence and/or severity of certain serious risks, by informing and/or supporting the execution of the safe use conditions described in the medication's FDA-approved prescribing information. (https://fda.gov)

3. Failing to provide contextual details in the medical records regarding potential aberrant behavior of Patient A.
4. Escalating dosages of controlled substances without explanation in the medical records.
5. Lack of imaging studies or other objective studies to justify the high doses of opioids used to treat Patient A's pain complaints.

B. Patient B came under the care and treatment of Respondent from on or about April 2014 through on or about June 2017. Respondent deviated from the standard of care by:

1. Inappropriate prescribing of controlled substances to Patient B.
2. Inadequate assessment, REMS, and monitoring of Patient B's drug therapy.
3. Escalating dosages of controlled substances without explanation in the medical records.
4. Lack of imaging studies or other objective diagnostic studies to justify the high doses of opioids used to treat Patient B's pain complaints.

C. Patient C came under the care and treatment of Respondent from the spring of 2014 through on about December 2017. Respondent deviated from the standard of care by:

1. Inappropriate prescribing of controlled substances to Patient C.
2. Inadequate REMS regarding prescribing high doses of controlled substances used in Patient C's care.
3. Inadequate monitoring and re-evaluation regarding the treatment of Patient C's pain, anxiety and ADHD.

D. Patient D came under the care and treatment of Respondent from on or about April 2015 through on or about January 2018. Respondent deviated from the standard of care by:

1. Inappropriate prescribing of controlled substances to Patient D.
2. Prescribing daily benzodiazepine therapy with inadequate assessment, REMS, and monitoring of the drug therapy.

E. Patient E came under the care and treatment of Respondent from on or about September 2014 through on or about November 2017. Respondent deviated from the standard of care by:

1. Inappropriate prescribing of controlled substances to Patient E.
2. Inadequate assessment, REMS, and monitoring of Patient E's drug therapy.
3. Lack of imaging studies or other objective diagnostic studies to justify the high doses of opioids used to treat Patient E's pain complaints.

F. Patient F came under the care and treatment of Respondent from on or about October 2013 through on or about June 2017. Respondent deviated from the standard of care by:

1. Inappropriate prescribing of controlled substances to Patient F.
2. Inadequate reassessment of both the safety and oversight of continuing the use of controlled substances in Patient F's care.
3. Inadequate REMS regarding the oversight of the high doses of controlled substances used in Patient F's care.

G. Patient G came under the care and treatment of Respondent from on or about August 2013 through on or about November 2017. Respondent deviated from the standard of care by:

1. Inappropriate prescribing of controlled substances to Patient G.
2. Inadequate REMS regarding the oversight of the high doses of controlled substances used in Patient G's care.

3. Inadequate monitoring and re-evaluation regarding the treatment of Patient G's pain, anxiety and ADHD.
4. Lack of imaging studies or other objective findings to support the use of high opioid doses in the management of Patient G's pain complaints.

H. Respondent's medical records for Patients A through G were incomplete and inadequate, which included but is not limited to, notations of dosages of controlled substances that were escalated without explanation, as well as illegible entries in the handwritten medical records.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

1. Paragraphs A. and A.1. and A.2. and A.3. and A.4. and A.5.
2. Paragraphs B. and B.1. and B.2. and B.3. and B.4.
3. Paragraphs C. and C.1. and C.2. and C.3.
4. Paragraphs D. and D.1. and D.2.
5. Paragraphs E. and E. 1. And E.2. and E.3.
6. Paragraphs F. and F.1 and F.2. and F.3.
7. Paragraphs G. and G.1 and G.2. and G.3. and G.4.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

8. Paragraphs A. and A.1. and A.2. and A.3. and A.4. and A.5.

9. Paragraphs B. and B.1. and B.2. and B.3. and B.4.

10. Paragraphs C. and C.1 and C.2. and C.3.

11. Paragraphs D. and D.1. and D.2.

12. Paragraphs E. and E. 1. And E.2. and E.3.

13. Paragraphs F. and F.1 and F.2. and F.3.

14. Paragraphs G. and G.1 and G.2. and G.3. and G.4.

THIRD SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

15. Paragraph H.

DATE: August 16, 2019
New York, New York

[redacted]

HENRY S. WEINTRAUB
Chief Counsel
Bureau of Professional Medical Conduct