NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
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HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

October 8, 2019

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Anna Lewis, Esq.
Bureau of Professional Medical Conduct
NYS Department of Health
90 Church Street
New York, New York 10007

Joseph Olivieri, M.D.
[redacted]

RE: In the Matter of Joseph Olivieri, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 19-254) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

[redacted]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: cmg
Enclosure

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

IN THE MATTER OF JOSEPH OLIVIERI, M.D.	DETERMINATION AND ORDER 19-254

A Notice of Hearing and Statement of Charges, both dated August 16, 2019, were personally served upon **JOSEPH OLIVIERI, M.D.** (Respondent). **MICHAEL IANNUZZI, M.D.**, Chairperson, **STEVEN M. LAPIDUS, M.D.**, and **RICHARD S. GOLDBERG, ESQ.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) of the Public Health Law of the State of New York (Public Health Law). Administrative Law Judge **WILLIAM J. LYNCH, ESQ.**, served as the Administrative Officer.

The Department of Health, Office of Professional Medical Conduct (Petitioner or the Department) appeared by **RICHARD J. ZAHNLEUTER**, General Counsel, by **ANNA LEWIS, ESQ.**, of Counsel. Respondent failed to file a written answer or appear at the hearing on the date specified in the Notice of Hearing, and the hearing proceeded in his absence. Pursuant to Public Health Law § 230(10)(e), the allegations and charges contained in the Statement of Charges were deemed admitted. Evidence was received, the Department's witness was sworn and heard, and transcripts of the proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Notice of Hearing Served:	August 22, 2019
Pre-Hearing Conference:	September 20, 2019
Hearing Dates:	September 26, 2019
Witness for Petitioner:	Marie Affriany, R.N. Investigator
Deliberations Held:	September 26, 2019

STATEMENT OF CASE

The Statement of Charges contains three specifications of professional misconduct, as defined in Education Law § 6530. These charges and the allegations were deemed admitted because the Respondent failed to submit an answer. The Department recommends that Respondent's license to practice medicine be revoked. A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. All findings and conclusions set forth below are the unanimous determinations of the Hearing Committee unless otherwise indicated. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding.

Having heard the testimony and considered the documentary evidence presented by Petitioner, the Hearing Committee hereby makes the following findings of fact:

1. Respondent was authorized to practice medicine in New York State on or about December 5, 1974, by the issuance of license number 122622. (Dept. Ex. 4.)

2. 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:

a. Inappropriate prescribing of controlled substances to Patient A;

b. Inadequate assessment, REMS[1], and monitoring of Patient A's drug therapy;

c. Failing to provide contextual details in the medical records regarding potential aberrant behavior of Patient A;

d. Escalating dosages of controlled substances without explanation in the medical records; and

e. Lack of imaging studies or other objective studies to justify the high doses of opioids used to treat Patient A's pain complaints. (Dept. Ex. 2; Appendix I.)

3. 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:

a. Inappropriate prescribing of controlled substances to Patient B;

b. Inadequate assessment, REMS, and monitoring of Patient B's drug therapy;

c. Escalating dosages of controlled substances without explanation in the medical records; and

d. Lack of imaging studies or other objective diagnostic studies to justify the high doses of opioids used to treat Patient B's pain complaints. (Dept. Ex. 2; Appendix I.)

4. 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:

a. Inappropriate prescribing of controlled substances to Patient C;

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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)

b. Inadequate REMS regarding prescribing high doses of controlled substances used in Patient C's care; and

c. Inadequate monitoring and re-evaluation regarding the treatment of Patient C's pain, anxiety and ADHD. (Dept. Ex. 2; Appendix I.)

5. 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:

a. Inappropriate prescribing of controlled substances to Patient D; and

b. Prescribing daily benzodiazepine therapy with inadequate assessment, REMS, and monitoring of the drug therapy. (Dept. Ex. 2; Appendix I.)

6. 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:

a. Inappropriate prescribing of controlled substances to Patient E;

b. Inadequate assessment, REMS, and monitoring of Patient E's drug therapy; and

c. Lack of imaging studies or other objective diagnostic studies to justify the high doses of opioids used to treat Patient E's pain complaints. (Dept. Ex. 2; Appendix I.)

7. 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:

a. Inappropriate prescribing of controlled substances to Patient F;

b. Inadequate reassessment of both the safety and oversight of continuing the use of controlled substances in Patient F's care; and

c. Inadequate REMS regarding the oversight of the high doses of controlled substances used in Patient F's care. (Dept. Ex. 2; Appendix I.)

8. 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:

a. Inappropriate prescribing of controlled substances to Patient G;

b. Inadequate REMS regarding the oversight of the high doses of controlled substances used in Patient G's care;

c. Inadequate monitoring and re-evaluation regarding the treatment of Patient G's pain, anxiety and ADHD; and

d. 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. (Dept. Ex. 2; Appendix I.)

9. 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. (Dept. Ex. 2; Appendix I.)

CONCLUSIONS OF LAW

As required by PHL § 230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Statement of Charges were more probable than not. The Department offered into evidence the written medical opinion of Joel Kent, M.D., regarding Respondent's care of Patients A through G. Doctor Kent concluded that Respondent lacked the required knowledge and skill to safely conduct the management of controlled substances and that Respondent's prescribing practices increased the likelihood of problems such as unintended lethal overdose, medication diversion and addiction.

The Department also offered into evidence an agreement dated May 2, 2019 which Respondent entered into with the United States Attorney for the Southern District of New York in a pending criminal

action. This agreement sets forth the basis for acceptance of Respondent's guilty plea to violating 21 U.S.C. § 846, "by participating in a conspiracy to distribute and dispense, possess with intent to distribute and dispense, and cause to be distributed and dispensed, controlled substances outside the scope of professional practice and not for a legitimate medical purpose." The Department indicated that Respondent's plea has been entered, but that sentencing has been delayed until October 17, 2019.

Having considered the complete record in this matter, the Hearing Committee concludes that the Department has established the three specifications contained in the Statement of Charges. The Hearing Committee made these conclusions of law pursuant to the factual findings listed above, and all conclusions resulted from a unanimous vote of the Hearing Committee.

The First Specification charged Respondent with professional misconduct for practicing medicine with negligence on more than one occasion in his care of Patients A through G, in violation of New York Education Law § 6530(3). Negligence is defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances and involves a deviation from acceptable medical standards in the treatment of patients.

The Second Specification charged Respondent with professional misconduct for practicing medicine with incompetence on more than one occasion in his care of Patient A through G, in violation of New York Education Law § 6530(5). Incompetence is the lack of the requisite skill to practice medicine safely. Dhabuwala v State Board for Professional Medical Conduct, 225 AD2d 609 (3d Dept. 1996).

The Third Specification charged Respondent with professional misconduct for failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in violation of Education Law § 6530(32). A medical record needs to convey objectively meaningful medical information concerning a patient treated to other physicians. Maglione v New York State Dept. of Health, 9 AD3d 522 (3d Dept. 2004).

The Hearing Committee unanimously concludes that the record establishes these specifications of misconduct. The evidence of the Department's medical expert establishes that Respondent lacks the required knowledge and skill to safely conduct the management of controlled substances and that Respondent's prescribing practices increased the likelihood of problems such as unintended lethal overdose, medication diversion and addiction. In addition, Respondent has admitted in a pending criminal court action that he participated in a conspiracy to distribute and dispense controlled substances outside the scope of professional practice and not for a legitimate medical purpose.

DETERMINATION AS TO PENALTY

The Hearing Committee considered the full spectrum of penalties available pursuant to statute, including revocation, suspension, probation, censure, and the imposition of civil penalties. Physicians must comply with the highest ethical standards, and integrity is as important to the practice of medicine as medical competence. The Hearing Committee concludes that Respondent's practice of medicine poses a danger to his patients and has contributed to current opioid crisis. Accordingly, the Hearing Committee concurs with the Department's recommendation that Respondent's license must be revoked.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The First through Third Specifications of professional misconduct, as set forth in the Statement of Charges are SUSTAINED;

2. Respondent's license to practice medicine is revoked;

3. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at his last known address and such service shall be effective upon receipt

or seven days after mailing, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: New York, New York
October 7, 2019

[redacted]

MICHAEL IANNUZZI, M.D. (CHAIR)

STEVEN M. LAPIDUS, M.D.
RICHARD S. GOLDBERG, ESQ.

TO: Anna Lewis, Esq.
Associate Counsel
Bureau of Professional Medical Conduct
NYS Department of Health
90 Church Street
New York, New York 10007

Joseph Olivieri, M.D.
[redacted]

APPENDIX I

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