BEFORE THE WEST VIRGINIA BOARD OF OSTEOPATHIC MEDICINE

WEST VIRGINIA BOARD OF OSTEOPATHIC MEDICINE

Complainant,

v. **Complaint No. 2015-11**

SANJAY MEHTA, D.O.,

Respondent.

STATEMENT OF CHARGES

The West Virginia Board of Osteopathic Medicine (hereinafter identified as the "Board") has considered the above-styled complaint alleging that Sanjay Mehta, D.O. (hereinafter referenced as the "Respondent") has engaged in unprofessional and unethical conduct. After review of the facts alleged and information uncovered in the course of its investigation, the Board finds that there is probable cause to believe that the Respondent has engaged in conduct, practices, and acts that constitute professional negligence, violations of the rules of the Board and a willful department from accepted standards of professional conduct.

The specific amended charges are as follows:

1. The Respondent, Sanjay Mehta, D.O., is a licensee of the Board and holds license number 1754 to practice medicine and surgery in the State of West Virginia.

2. Under state and federal law, a "controlled substance" is a drug, substance or an immediate precursor of a drug or substance that appears on a list or schedule of substances defined by statute, and that may only be possessed, created, manufactured or transferred under restricted conditions.

3. The schedules for Controlled Substances range from Schedule I to Schedule V, where the substances listed in Schedule I carry the highest potential for abuse and those in Schedule V are deemed to have the lowest potential for abuse.

4. The Board received a complaint on or around February 5, 2015, from the West Virginia Controlled Substances Monitoring Program pursuant to W. Va. Code § 60A-9-5(b). The complaint alleged Respondent's improper controlled substance prescribing practices resulted in the death of five patients from July 2013 through December 2013.

5. The Licensee's response received August 17, 2015, by his attorney denied all wrongdoing.

6. During all times pertinent to this complaint, the Respondent practiced at the Hope Clinic in Beaver, West Virginia.

7. The Board sought and received an extension of time pursuant to W. Va. Code § 30-1-5(c) on October 7, 2015.

COUNT I

DEVIATION FROM ACCEPTED STANDARDS OF PRACTICE

8. The board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1 through 7.

9. Patient 1 began his treatment at the Hope Clinic on or around April 12, 2011. He failed several drug screens. A note in his medical record indicates that he was called for a pill count on June 27, 2012. Patient 1 indicated that his medication had been stolen and he had no pills to be counted. These facts are indicative of diversion of controlled substances.

10. The Respondent first treated Patient 1 on November 6, 2012. The Respondent prescribed Patient 1 oxycodone hydrochloride, 30 milligrams, 150 pills.

11. The patient assessment form for patient 1 for May 20, 2013 is blank, as are several other assessment forms in the medical records. A report from the West Virginia Board of Pharmacy shows that the Respondent prescribed the same medication to Patient 1 on a monthly basis. However, the assessment form allowed Patient 1 to request to skip actually seeing the doctor on each visit.

12. On July 15, 2013, Patient 1 was treated at the Hope Clinic. He requested to skip seeing the doctor. Other than a check mark indicating "Continue present regimen", the assessment form is essentially blank. However, Patient 1 received a prescription written by the Respondent on this date for Oxycodone hydrochloride 30 milligrams, 150 pills. A report from the West Virginia Board of Pharmacy indicates that this prescription was intended to last 25 days.

13. This shows that oxycodone 30 milligrams would be taken 6 times daily for a total of 180 milligrams of oxycodone per day. This is an unusually high daily dose for the treatment of chronic non-cancer pain.

14. Medical records for Patient 1 also show that he was receiving a prescription from another physician for diazepam 10 milligrams, to be taken twice daily.

15. Patient 1 died on July 18, 2013 from combined oxycodone, alprazolam, diazepam, hydroxyzine and gabapentin intoxication.

16. During the period that he treated Patient 1, the Respondent had reason to know, and should have known that this patient obtained a controlled substance from another physician, in addition to the controlled substance that the Respondent prescribed, and he failed to alter the patient's treatment accordingly.

17. In the course of treating Patient 1, the Respondent repeatedly prescribed a controlled substance to the patient without taking reasonable and prudent precautions to prevent misuse and abuse.

18. The Respondent's failure to take reasonable and prudent precautions in the treatment of Patient 1 was a contributing cause to this patient's death.

19. In his treatment of Patient 1, the Respondent has departed from, and failed to conform to the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, § 18.1.j.

COUNT II

DEVIATION FROM ACCEPTED STANDARDS OF PRACTICE

20. The board hereby reasserts, and incorporates by reference all matters asserted in paragraphs 1 through 7.

21. Patient 2 began his treatment at Hope Clinic on March 21, 2012. He was initially prescribed Morphine 30 milligrams, quantity of 30 and Roxicodone 15 milligrams, quantity of 120.

22. The Respondent first prescribed medication to Patient 2 on January 9, 2013. Prior to this, on August 8, 2012, Patient 2 signed a form admitting to doctor shopping. Patient 2 failed multiple drug screens. A report from the West Virginia Board of Pharmacy showed that Patient 2 filled a prescription for oxycodone written by another physician.

23. On March 7, 2013, a drug screen performed was positive for hydrocodone. Patient 2 had no prescription for hydrocodone. On July 9, 2013, a drug screen for Patient 2 was positive for hydrocodone, oxycodone and buprenorphine. Patient 2 only had a prescription for oxycodone. On October 14, 2013, a drug screen was negative for the patient's prescribed oxycodone. All of these results are indicative of possible drug diversion.

23. Patient 2 was seen at the Hope Clinic on December 5, 2013. The assessment sheet for this visit is not signed by the patient and is blank. There is no physician

signature. However, Patient 2 received a prescription from the Respondent for oxycodone hydrochloride 15 milligrams, 90 pills.

24. Patient 2 died on December 6, 2013 from oxycodone and hydrocodone intoxication. The death certificate for Patient 2 describes the injury as an "over-use of prescribed oxycodone in the setting of doctor shopping."

25. The Respondent treated Patient 2 from January 9, 2013 through the time of his death. During this period, the Respondent had reason to know, and should have known, that this patient obtained controlled substances from other physicians, in addition to those prescribed by the Respondent, and he failed to alter the patient's treatment accordingly.

26. In the course of treating Patient 2, the Respondent repeatedly prescribed controlled substances to the patient without taking reasonable and prudent precautions to prevent their misuse and abuse.

27. The Respondent's failure to take reasonable and prudent precautions in the treatment of Patient 2 was a contributing cause of his death. In his treatment of Patient 2, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, § 18.1.j.

COUNT III

DEVIATION FROM ACCEPTED STANDARDS OF PRACTICE

28. The board hereby reasserts, and incorporates by reference all matters asserted in paragraphs 1 through 7.

29. Patient 3 was seen only once by the Respondent. He was treated by the Respondent on October 15, 2013. At that time, a drug screen was positive for diazepam, morphine and oxycodone. A report from the West Virginia Board of Pharmacy showed that Patient 3 received his last prescription for these medications on August 22, 2013 from another physician.

30. At this visit, the Respondent prescribed Patient 3 morphine 100 milligrams, 90 pills and Roxicodone, 30 milligrams, 270 pills.

31. Patient 3 died on October 24, 2013 from combined oxycodone, morphine and diazepam intoxication.

32. The Respondent's failure to take reasonable and prudent precautions in the treatment of Patient 3 was a contributing cause of his death. In his treatment of Patient 3, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, § 18.1.j.

COUNT IV

DEVIATION FROM ACCEPTED STANDARDS OF PRACTICE

33. The board hereby reasserts, and incorporates by reference all matters asserted in paragraphs 1 through 7.

34. Patient 4 began treatment at the Hope Clinic on October 22, 2012. She was first treated by the Respondent at Hope Clinic on December 19, 2012. The Respondent prescribed Roxicodone 30 milligrams, 90 pills and Roxicodone 15 milligrams, 60 pills.

35. The Respondent's prescriptions equal 120 milligrams daily of oxycodone which is an excessively high dose for chronic musculoskeletal type pain. Patient 4 continued to receive the same prescriptions from the Respondent through July 27, 2013.

36. Patient 4 died on August 3, 2013 from combined oxycodone, alprazolam, diazepam and gabapentin intoxication. In the course of treating Patient 4, the Respondent repeatedly prescribed controlled substances to the patient without taking reasonable and prudent precautions to prevent their misuse and abuse.

37. The Respondent's failure to take reasonable and prudent precautions in the treatment of Patient 4 was a contributing cause of her death. In his treatment of Patient 4, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, § 18.1.j.

COUNT V

DEVIATION FROM ACCEPTED STANDARDS OF PRACTICE

38. The board hereby reasserts, and incorporates by reference all matters asserted in paragraphs 1 through 7.

39. Patient 5 began treatment at the Hope Clinic on May 8, 2012. She was first treated by the Respondent on November 20, 2012. By this time, Patient 5 had failed two drug screens.

40. The Respondent prescribed oxycodone 30 milligrams, 90 pills on multiple occasions. Patient 5 was at high risk for abuse of narcotic medications due to her multiple failed drug screens.

41. Patient 5 was last treated at Hope Clinic on October 29, 2013 where she received another prescription for oxycodone. Patient 5 died on November 13, 2013 from oxycodone, hydrocodone and alprazolam intoxication.

42. In the course of treating Patient 5, the Respondent repeatedly prescribed controlled substances to the patient without taking reasonable and prudent precautions to prevent their misuse and abuse.

43. The Respondent's failure to take reasonable and prudent precautions in the treatment of Patient 5 was a contributing cause of her death. In his treatment of Patient 5, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, § 18.1.j.

CONCLUSION

Based upon all of the foregoing, the West Virginia Board of Osteopathic Medicine finds that there is probable cause to believe that the Respondent has engaged in unprofessional conduct and has engaged in conduct, practices and acts that constitute a departure from accepted standards of professional conduct in the practice of osteopathic medicine and surgery.

WEST VIRGINIA BOARD OF OSTEOPATHIC MEDICINE

by: Ernest Miller DO

Ernest Miller, D.O.
President

Date: 7/29/16