

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
PATRICK J. DEROSA, M.D.

STATEMENT
OF
CHARGES

PATRICK J. DEROSA, M.D., the Respondent, was authorized to practice medicine in New York State on or about November 12, 1976 by the issuance of license number 129321 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about and between September 29, 2008, and September 20, 2010, Respondent DeRosa and [REDACTED], a physician assistant, treated Patient A, a 32 year old male at Respondent DeRosa's office located at 1101 Stewart Avenue, Garden City, New York. (Patient A and the other patients in the Statement of Charges are identified in Appendix.) Respondent DeRosa diagnosed Patient A, a 32 year old male, with a left shoulder Hills-Sachs lesion, SLAP lesion, labrum tear with avulsion and an osteochondral fracture. On or about January 12, 2010 Respondent DeRosa performed arthroscopy on Patient A's left shoulder. During the post-operative period, Respondent DeRosa deviated from medically accepted standards in that:

1. On or about January 13, 2010 he inappropriately prescribed Patient A Oxycontin, 40 mg, Q6 hours, 120 pills, a dose significantly above what either Respondent had previously prescribed.
2. On multiple occasions Respondent wrote prescriptions of Oxycontin with instructions to take the medication at inappropriate time intervals, including instructing the patient to take the medication on an as needed ("PRN") basis.
3. On or about May 25, 2010 Respondent violated Public Health Law Section 3332(3) by prematurely issuing additional prescription of the schedule II controlled substance, Oxycontin. Section 3332(3) provides that "No additional prescriptions

for a controlled substance may be issued by a practitioner to an ultimate user within thirty days of the date of any prescription previously issued unless and until the ultimate user has exhausted all but a seven day supply of the controlled substance provided by any previously issued prescription." Respondent issued additional prescriptions of Oxycontin before Patient A exhausted all but a seven day supply from a prescription issued on May 13, 2010.

4. Respondent failed to appropriately evaluate for addiction/diversion risk factors.
5. Respondent failed to appropriately coordinate Patient A's care with another health care provider who concurrently treated the patient with opiate medication.

B. On or about and between June 11, 2007, and April 30, 2010, Respondent DeRosa and [REDACTED] treated Patient B for right knee pain. Respondent De Rosa operated on Patient B's right knee in July 2007. Respondent De Rosa's treatment of Patient B with opiate medication deviated from medically accepted standards in that:

1. Respondent failed to take and/or note an adequate personal and family history regarding issues that might affect the Patient's risk of addiction and/or misuse of opiate medication
2. Respondent inappropriately escalated the dosage of opiate medication on or about and between January 17, 2008 and January 19, 2009, and/or failed to document reasons for the increases.
3. On multiple occasions Respondent wrote prescriptions of Oxycontin with instructions to take the medication at inappropriate time intervals, including instructing the patient to take the medication on an as needed ("PRN") basis.
4. Respondent failed to appropriately evaluate for addiction/diversion risk factors.
5. Respondent failed to appropriately coordinate Patient B's care with another health care provider who concurrently treated the Patient with opiate medication.

C. On or about and between April 30, 2008, and December 6, 2010, the Respondent DeRosa and [REDACTED] treated Patient C, a 43 year old male at the onset of treatment. Patient C complained of pain related to problems with his left knee and hip. Respondent DeRosa deviated from medically accepted standards in that:

1. At the initial visit he prescribed Patient Can inappropriately high dose of opiate medication, Oxycontin 40 mg. Q6h, 120 pills.
2. At the initial visit and at multiple follow up visits Respondent wrote prescriptions of Oxycontin with instructions to take the medication at inappropriate time intervals, including instructing the patient to take the medication on an as needed ("PRN") basis.
3. Respondent failed to maintain a record that accurately reflects the evaluation and treatment, including failing to maintain an accurate record of the amounts of prescribed opiate medication.
4. Respondent failed to periodically assess the Patient for addiction risk factors and/or possible drug diversion.

D. On or about April 15, 2011, the Office of Professional Medical Conduct ("OPMC") sent a letter to Respondent DeRosa requesting a copy of the complete medical record for Patient D. According to the record that Respondent submitted to the OPMC, on or about and between December 22, 2008, and November 24, 2010, both Respondent DeRosa and [REDACTED] treated Patient D for back pain which reportedly was caused by a work related accident. On or about and between December 2009 and September 2010 Respondent DeRosa submitted medical records to the Geico Insurance Company to support no-fault insurance claims for ten office visits. The records submitted to Geico were not included in Respondent DeRosa's submission to OPMC. Respondent De Rosa:

1. Failed to provide OPMC with a complete copy of the medical record in response to a written request.
2. With respect to the records submitted to the Geico insurance company, Respondent DeRosa knowingly and falsely represented on a New York State Motor Vehicle No-Fault insurance form NF-3 and in the note of the office visit

dated December 15, 2009, that Patient D's symptoms first appeared on the date of the motor vehicle accident, September 25, 2009. Respondent intended to deceive.

3. Respondent DeRosa concealed, with the intent to deceive OPMC, that in or about and between January 2010 and September 2010 Patient D had ten office visits for treatment related to a motor vehicle accident. Respondent DeRosa also concealed that during the same period of time Patient D was prescribed twice as much Percocet as had previously been prescribed.

E. On or about and between August 4, 2003, and May 11, 2009, Respondent DeRosa treated Patient F for low back pain and an Achilles tendon tear. During the course of treatment the Respondent prescribed opioid analgesics, NSAIDs, alprazolam and physical therapy. Respondent:

1. Failed to periodically assess the Patient for addiction risk factors and/or possible drug diversion.
2. Inappropriately prescribed multiple instant release opioids for concurrent use.
3. Inappropriately prescribed alprazolam, up to 8 mg a day, and/or failed to document an adequate justification for the prescriptions.
4. Failed to maintain a record that accurately reflects the evaluation and treatment of the Patient, including on multiple occasions failing to note pill counts and/or dosing instructions for prescribed opiate medication.

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, B, C, and E and their respective subparagraphs.

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:

2. Paragraphs A, B, C, and E and their respective subparagraphs.

THIRD THROUGH SIXTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

3. Paragraph A and its subparagraphs.
4. Paragraph B and its subparagraphs.
5. Paragraph C and its subparagraphs.
6. Paragraph E and its subparagraphs.

SEVENTH THROUGH TENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

7. Paragraph A and its subparagraphs.
8. Paragraph B and its subparagraphs.
9. Paragraph C and its subparagraphs.
10. Paragraph E and its subparagraphs.

ELEVENTH AND TWELFTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

11. Paragraphs D and D2.
12. Paragraphs D and D3.

THIRTEENTH AND FOURTEENTH SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

13. Paragraphs D and D2.
14. Paragraphs D and D3.

FIFTEENTH 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. Paragraphs C3 and E4.

SIXTEENTH SPECIFICATION

OPMC RECORD REQUEST

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(28) by failing to respond within thirty days to written communications from the Department of Health and to make available any relevant records to an inquiry or complaint, as alleged in the facts of:

16. Paragraphs D and D1.

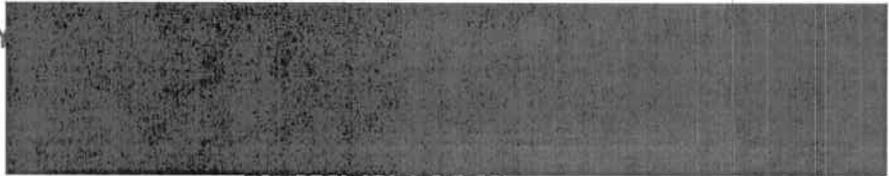
SEVENTEENTH SPECIFICATION

VIOLATING ARTICLE 33 of the PUBLIC HEALTH LAW

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(16) by a willful or gross negligent failure to comply with substantial provisions of federal, state or local laws, rules or regulations governing the practice of medicine (to wit: Article 33 of the Public Health Law and regulations promulgated pursuant to the authority thereof) as alleged in the facts of:

17. Paragraphs A and A3.

DATE: April 3, 2013
New York, New York



ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct