IN THE MATTER OF:
Frank Maggiacomo, D.O.
License Number DO 00383
BMLD Case Number C15-545, C16-488, C170532

CONSENT ORDER

Frank Maggiacomo D.O. (hereinafter "Respondent") is licensed as a physician in Rhode Island. The Board of Medical Licensure and Discipline (hereinafter the "Board") makes the following:

FINDINGS OF FACT

1. Respondent has been a licensed physician in the State of Rhode Island since June 14th, 1989. Respondent's office is located at 1681 Cranston Street, Suite D, Cranston, Rhode Island, and his primary specialty is Internal Medicine, in which he has been board certified since 2006.

2. Respondent agreed in paragraph 6 of a Consent Order ratified by the Board on May 11th, 2016 to "*attend within 9 months of ratification of this order The CPEP: Prescribing Controlled Drugs: Critical Issues and Pitfalls©.*"

3. Respondent sent correspondence to the Board dated November 30, 2016 stating "*...Enclosed herein Please find certificate of credits for classes my client has attended that were required by the consent order he signed in May of 2016.*" Respondent attached certificates for completion of 5.75 credit hours of CME from primed.

4. Respondent was sent correspondence from the Board Chief Administrator December 8th, 2016 stating that the attached certificates did not satisfy the conditions of the ratified Consent Order.

5. The required course was offered June and December of 2016. Respondent did not register

for those courses. Respondent did not notify the Board that he was not able to register for a course until after receiving the letter from December 8, 2016 from the Board Chief Administrator.

6. Respondent did not take the agreed upon course within the agreed upon time stipulated in the ratified consent order.

7. Respondent's controlled substance registration was suspended March 15th, 2017 for failure to comply with the terms of the Consent Order.

8. Respondent subsequently took the agreed-upon course and his controlled substance registration was reinstated May 25th, 2017.

9. In a separate matter, the Board received a complaint regarding care by Respondent of Patient A. The complaint came from a pharmacist who was concerned about a prescription for Patient A for fentanyl.

10. Respondent is the physician for "Patient A" who has multiple medical problems and was treated with a fentanyl patch.

11. Respondent initiated opioid therapy to Patient A with fentanyl, Patient A did not have evidence of a recent prior opioid prescription and was opioid naïve. The initial prescription written and filled in March of 2016 was for fentanyl patch 25ug/hour.

12. Respondent was questioned by a pharmacist in April 2016 about the dose regarding this prescription. Respondent did not change the prescription nor review the Prescription drug monitoring plan.

13. The Board retained an expert to review the complaint and medical records. The Board expert noted the medical record appeared incomplete however was able to make some observations based on the available information. Patient A was an 83-year-old patient who was not tolerant to opioids. Patient A was also taking other medications that can cause sedation including Meclizine, Zanaflex (Tizanidine), Fioricet, Amitriptyline, and Ambien. Patient A had other chronic medical problems including obesity and there was no evidence Patient A was evaluated for sleep apnea. The expert opined that since the patient was 83 years old and so more susceptible to the sedating effects of multiple

medications, the fact that she was simultaneously prescribed several other potentially sedating medications would make the addition of an opioid medication equivalent to 33 mg of oral Oxycodone per day a source for concern. The expert also noted Patient A had generalized edema and a history of urticarial and the expert opined that this medical condition could render the absorption of the Fentanyl quite variable, depending upon the placement of the patch and the degree of edema at that site. Between the diagnoses of urticaria and generalized edema, a transdermal medication was probably not the best place to start with regard to opioid maintenance."

14. The Board expert also noted the dose of the medication was increased from 25ug per hour to 50ug per hour although it was not clear whether or not Respondent saw the patient before increasing Patient A's dose to 50 mic/hour.

15. The Investigative committee issued a subpoena for the complete medical records in the above referenced complaint. The medical records supplied by Respondent were not complete.

16. Respondent prescribed fentanyl which is an opioid and a controlled substance. Respondent's medical record did not reflect documentation of a treatment plan, nor evidence of patient education/consent, nor did Respondent check the PDMP prior to starting this opioid.

17. Respondent prescribed Patient A fentanyl 50 ug/hour which is equivalent to 120 milligrams MED per day. It appears Respondent may not have documented in the medical record consideration of referral to a pain management physician.

18. Fentanyl 25 ug/hour and 50 ug/hour are long-acting opioids. Respondent prescribed both of these opioids to Patient A. Respondent did not document in the medical record evidence of providing patient education regarding the risks involved with a long acting opioid. Respondent did not document evidence of closely monitoring fentanyl use before conducting a dose increase of this long acting opioid.

19. The board received a separate complaint from a physician assistant (PA) regarding inappropriate supervision. The complainant reported that while Respondent's Controlled

substance registration (CSR) was suspended, she was asked to write controlled substance prescriptions for patients she had not seen or evaluated. Respondent assured complainant PA could do this because Respondent had been assured by his previous attorney that this was acceptable.

20. Respondent did not have a valid CSR at the time and therefore was not allowed to supervise the PA and the PA required supervision from a prescriber with a valid CSR.

Respondent has violated Rhode Island General Laws § 5-37-5.1 *(24) Violating any provision or provisions of this chapter or the rules and regulations of the board or any rules or regulations promulgated by the director or of an action, stipulation, or agreement of the board.* Additionally, Respondent has violated Rhode Island General Laws, specifically, § 5-37-5.1 *(19) ... failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board....;* Additionally, Respondent has violated § 5-37-5.1 *(23) Failing to furnish the board, its chief administrative officer, investigator or representatives, information legally requested by the board*; Additionally Respondent has violated Rules and Regulations for Pain management, Opioid use and the Registration of Distributors of controlled substances in Rhode Island R21-28-CSD sections 3.2 Documentation of Treatment Plan, 3.4 Patient Education/Consent, 3.5 Prescription Drug Monitoring plan 3.9 Multidisciplinary Approach to treatment of Pain and 3.12 Long-Acting Opioids.

Based on the foregoing, the parties agree as follows:

1. Respondent admits to the jurisdiction of the Board.
2. Respondent has agreed to this Consent Order and understands that it is subject to final approval of the Board, and this Consent Order is not binding on Respondent until final ratification by the Board.
3. If ratified by the Board, Respondent hereby acknowledges and waives:
   a. The right to appear personally or by counsel or both before the Board;
   b. The right to produce witnesses and evidence on his behalf at a hearing;

c. The right to cross examine witnesses;

d. The right to have subpoenas issued by the Board;

e. The right to further procedural steps except for those specifically contained herein;

f. Any and all rights of appeal of this Consent Order; and

g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review.

h. Any objection that this Consent Order will be reported to the National Practitioner Date Bank, Federation of State Medical Boards as well as posted on the department's public web site.

4. Respondent agrees to pay within (60) days of the ratification of this Consent Order an administrative fee to the Board with a check for $4500.00 dollars made payable to the Rhode Island General Treasurer for costs associated with investigating the above-referenced complaint.

5. Respondent hereby agrees to this reprimand on his physician license.

6. Respondent agrees to take within six (6) months of the ratification of this order a Board approved CME from CPEP of at least 8 hours duration in topics related to; appropriate prescribing of controlled substances.

7. Respondent's controlled substance registration is suspended for 3 years, although the suspension is stayed if Respondent complies with the terms of this order. Respondent agrees to follow the requirements set forth in the Rules and Regulations for **216-RICR-20-20-4** Pain Management, Opioid Use and the Registration of Distributors of Controlled Substances in Rhode Island. Respondent also agrees to engage Affiliated Monitors to review 10 medical records monthly for 12 months for compliance with the regulations.

8. In the event that any term of this Consent Order is violated, after it is signed and accepted, the Director of the Department of Health shall have the discretion to

impose further disciplinary action. If the Director imposes further disciplinary action, Respondent shall be given notice and shall have the right to request an administrative hearing within twenty (20) days of the suspension and/or further discipline. The Director of the Department of Health shall also have the discretion to request an administrative hearing after notice to Respondent of a violation of any term of this Consent Order. The Administrative Hearing Officer may suspend Respondent's license, or impose further discipline, for the remainder of Respondent's licensing period if the alleged violation is proven by a preponderance of evidence.

Signed this 10 day of October, 2017.

Frank Maggiacomo D.O.

Ratified by the Board of Medical Licensure and Discipline on the 11th day of October 2017.

Nicole Alexander-Scott, M.D., M.P.H.
Director
Rhode Island Department of Health
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Providence, Rhode Island 02908