State of Rhode Island
Department of Health
Board of Medical Licensure & Discipline

IN THE MATTER OF:
John Corsi D.O.
License number D.O. 00371
Complaint number C190010

CONSENT ORDER

The Rhode Island Board of Medical Licensure and Discipline (hereinafter "Board") has reviewed and investigated the above referenced complaint pertaining to Dr. John Corsi (hereinafter "Respondent") through its Investigative Committee.

FINDINGS OF FACT

1. Respondent has been a licensed physician in the State of Rhode Island since June 8th, 1988. Respondent's office is located at 466 Putnam Pike, Smithfield, Rhode Island. His specialty is Internal Medicine. He graduated from University of New England College of Osteopathic Medicine June 1, 1984.
2. The Board received a complaint from the father of Patient A (*alias*), who was a patient under the care of Respondent.
3. Respondent was the attending physician for Patient A who is 39 years old and has been treating Patient A for multiple medical problems including Huntington's Disease, anxiety, depression, abdominal pain and other medical problems.
4. Patient A was being treated with multiple medications including some controlled substances such as; oxycodone twice a day (an opioid), clonazepam (a benzodiazepine),

dextroamphetamine (a stimulant). Patient A was also taking other medications, including trazodone, venlafaxine and other medications. Respondent states that the medications were having a positive effect for the patient and, further, that many of the medication regimens had been initiated by other providers in other specialties.

5. The Investigative Committee reviewed the medical records of Patient A provided by Respondent. The Investigative Committee could not determine from the medical record why Patient A was taking pain medication (oxycodone). The Investigative Committee was of the opinion the medical records were very brief and did not include a meaningful History of Present Illness or Review of Systems at every visit. The Investigative committee noted that throughout the medical record, although the patient was treated for depression and anxiety, there was no documentation of assessment of whether patient was ever a threat to self or others, there was no assessment if Patient A was making progress or regressing in the management of Patient A's depression or anxiety. Respondent asserts that Patient A never behaved in a manner that suggested he was a threat to himself or others and, further, that the treatments were having the intended effect. Respondent also notes that over time he reduced the dosage of medications for the patient, including Oxycodone. Respondent also notes that when his practice transferred to his new employer, some of the prior records may not have been completely transferred to the new electronic record, which caused the records provided to the Board to be incomplete.

6. Patient A does see a psychiatrist, yet Respondent does prescribe clonazepam 1 mg three times a day, although the Committee felt it is not evident from the medical record why Patient A is taking clonazepam (clonazepam is a benzodiazepine and is commonly

prescribed for anxiety as well as other medical problems) Additionally, in the progress notes, it is not evident there is a mental status exam or assessment of patient's treatment progress based on the prescribed clonazepam. Patient A does have anxiety and depression, the progress notes typically state patient will continue current medications. There is no documented assessment if Patient A is improving, getting worse or having issues with anxiety or depression in any of the progress notes. Respondent asserts that such assessments were being done, however he concedes they may not have been consistently documented in a thorough manner.

7. Respondent notes in his response to the Board he was treating Patient A with oxycodone for abdominal pain secondary to colitis. Respondent reports this treatment was started by another physician who was a gastroenterologist and taken over by Respondent, several years ago. After review of the medical record, the Investigative committee could not determine why Patient A was taking oxycodone or what was the cause of the abdominal pain. It was also not clear to the Investigative Committee if the oxycodone, improved Patient A's abdominal pain or made it worse. Respondent explained that the oxycodone in fact was improving patient A's pain, as Patient A had been on a steady dose for an extended period of time. Respondent acknowledges this may not have been documented in a thorough manner.
8. The Investigative committee concluded the documentation in the medical record and management of Patient A did not meet the minimum standard of care. Additionally, the lack of documented justification for prescribing Patient A an opioid and a benzodiazepine was below the standard of care.

9. The Investigative Committee reviewed the medical records of Patient A provided by Respondent. The Investigative Committee concluded the medical records did not contain sufficient information to justify the course of treatment for pain, anxiety or depression, or an adequate History of Present Illness to document the progress or regression Patient A may have been experiencing with any of their medical problems. The Investigative committee noted there were medical records maintained in a paper format from 2006-2017 which are illegible and therefore the Committee could not determine if the records contained meaningful information about Patient A and their overall treatment. Respondent acknowledges that documentation at times was not legible or as thorough as desired, however he also asserts that the actual assessments were thorough and the medication decisions were proper for this patient.
10. Respondent was the attending physician for Patient A who was prescribed an opioid type medication, oxycodone 15 mg, 60 tablets twice a day.
11. The Investigative Committee reviewed the medical records of Patient A provided by Respondent and concluded the medical records did not document an appropriate patient evaluation, specifically noting the patients' health history was not adequately documented in the medical record to justify the course of treatment.
12. The Investigative Committee reviewed the medical record for Patient A, as supplied by Respondent and did not see documentation of Patient A's condition reflecting any change in pain relief, or if there was documentation of any change in physical or psychosocial function. While Respondent acknowledges that documentation issues existed, he also asserts that the pain management was working well for this patient.
13. The Investigative committee concluded the standard set forth in the regulation was not

met.

14. Respondent avers he educated Patient A about the applicable risk and benefits of opioids as well as safe storage.

15. The Investigative Committee reviewed the medical record for Patient A, as supplied by Respondent and did not see documentation that indicated Patient A had received any counseling, education or advice about prescription opioids as the above regulation requires. The Investigative committee noted, it was not possible to read much of the medical record prior to Respondent's usage of an electronic health record, additionally, even in the electronic version, the Committee was unable to determine why Patient A was taking a prescription opioid. Respondent did appear before the Investigative committee and stated he thought his care and the medical records met the applicable standard. The Respondent indicated he did counsel the patient about prescription opioids, including the use of pain contracts. The Investigative committee did not agree with Respondent's assertions that his actions were sufficient.

16. Upon review of the medical record, the Investigative committee did not see documentation of evidence of appropriate periodic review. Respondent did see Patient A at an acceptable frequency, yet there was inadequate documentation that the standards set forth in the above regulation were met, such as assessing patient's adherence to the treatment plan, if pain or quality of life have improved, therefore the Investigative committee determined the standard of the regulation was not met.

17. The Board has determined Respondent has violated RIGL §5-37.5.1 (19).

18. The Board has determined Respondent has violated Rules and Regulations for Licensure and Discipline of Physicians [216-RICR-40-05-1] section D, *"Medical Records shall be legible and contain the identity of the physician or physician extender and supervising physician by name and professional title who is responsible*

for rendering, ordering, supervising or billing each diagnostic or treatment procedure. The records must contain sufficient information to justify the course of treatment, including, but not limited to: active problem and medication lists; patient histories; examination results; test results; records of drugs prescribed medical records.

19. The Board has determined Respondent has violated the *Rules and Regulations for Pain Management, Opioid Use and the Registration of Distributors of Controlled Substances in Rhode Island* [216-RICR-20-20-4] sections A *The practitioner shall obtain, evaluate and document the patient's health history and physical examination in the health record prior to treating for chronic pain.* Patient Evaluation, B. *"Documentation in the medical record for chronic pain shall state the objectives that will be used to determine treatment success and shall include, at a minimum:*

    1. *Any change in pain relief;*

    2. *Any change in physical and psychosocial function; and*

    3. *Additional diagnostic evaluations or other planned treatments."*

20. The Board has determined Respondent has violated the *Rules and Regulations for Pain Management, Opioid use and the Registration of Distributors of controlled substances in Rhode Island* [216-RICR-20-20-4] section D Patient Education.

21. The Board has determined Respondent has violated the *Rules and Regulations for Pain management, Opioid use and the Registration of Distributors of controlled substances in Rhode Island* [216-RICR-20-20-4] section G Periodic Review. *"Periodic reviews, including an in-person visit, shall take place at intervals not to exceed six (6) months.*

Based on the foregoing, the parties agree as follows:

1. Respondent admits to the jurisdiction of the Board.
2. Respondent acknowledges that these are the findings of the Investigative Committee and 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 no later than 5 business days after ratification of this Consent Order an administrative fee to the Board with a check for $1230.00 dollars made payable to the Rhode Island General Treasurer for costs associated with investigating the above-referenced complaint. Respondent will send notification and copy of check to DOH.PRCompliance@health.ri.gov and mail the actual check to the Rhode Island Department of Health, Room 205, 3 Capitol Hill, Providence, RI 02908-5097.

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

6. Respondent agrees to take within twelve (12) months of the ratification of this order a Board approved CME in Medical Records as well as a Board approved course in Controlled substance prescribing, such as the Vanderbilt course. Evidence of completion of these courses will be sent no later than 12 months after ratification of this order to DOH.PRCompliance@health.ri.gov .

7. Respondent agrees that commencing within 30 days of ratification of this order, a Board approved monitor will review the content and medical decision making of 10 (ten) of Respondents medical records for patients receiving prescriptions for controlled substances. These reviews will continue monthly for a period of 12 months following the ratification of this order. The Board approved monitor will provide a monthly report to the Board at DOH.PRCompliance@health.ri.gov. Report will be sent to the above email address no later than 15 calendar days after the preceding month has ended.

8. If 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 including immediate suspension of Respondent's license to practice medicine. 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 a hearing after notice to Respondent of a violation of any term of this Consent Order. After hearing thereon, the Board may suspend Respondent's license, or impose further discipline, for the remainder of Respondent's licensing period if any alleged violation is proven by a preponderance of evidence.

Signed this 7 day of July, 2019.

John Corsi D.O.

Ratified by the Board of Medical Licensure and Discipline on the 10th day of July 2019.

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