

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



IN THE MATTER OF:
Joseph Guarnaccia M.D.
License Number MD 10454
Case # C16-999

CONSENT ORDER

Joseph Guarnaccia, M.D. (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 is a licensed physician in Rhode Island and was issued his license on October 19th, 2000. Respondent's specialty is neurology. His Practice is located at the MS Center of New England, 1351 South County Trail, East Greenwich, Rhode Island.
2. The Board received a notice from the Board of Pharmacy that Respondent was not monitoring the PDMP and duplicate prescriptions were filled for Patient A for April, May and June of 2016.
3. Respondent is the attending physician for Patient A. Respondent treated Patient A for multiple medical problems including multiple sclerosis, headache, anxiety, depression and chronic pain.

4. Respondent prescribed multiple medications for Patient A including multiple strengths of oxycodone, alprazolam, zolpidem and Adderall, all of which are controlled substances.
5. Respondent did not have sufficient office practices in place to monitor controlled substance prescribing in his office, and Patient A received duplicate prescriptions for oxycodone and Adderall for April, May and June of 2016. Any patient for whom Respondent wrote prescriptions for opioid narcotics was seen no less than every three months. At these visits, patients received three hand signed prescriptions on security prescription pads with the current date and consecutive fill dates, 30 days apart. The prescriptions were photocopied and placed in the patient's chart. This procedure was followed on Patient A's January 14, 2016 visit. The patient returned to the clinic to review MRI scans on February 25, 2016, prior to her regularly scheduled March visit. At that time, she received prescriptions for April and May for oxycodone and Adderall. However, for reasons that could not be determined, copies of these prescriptions were not placed in the patient's chart. When the patient presented for her regular three-month visit on March 17, 2016, that information was missing, and the patient inadvertently was given duplicate prescriptions for April and May for oxycodone and Adderall. These duplicate prescriptions were filled by her friend, who paid in cash, at a pharmacy not typically utilized by Patient A.

At Patient's A June 16, 2016 appointment, prescriptions were written for three months in the manner described above. However, the patient's pharmacist called to inform Respondent's office that Patient A could fill her prescriptions a day earlier than had been written as a fill date on the prescription. Patient A was instructed to return the prescriptions to Respondent's office, and they would be replaced.

On or about June 20, 2016, Patient A's daughter came to Respondent's office to pick up the rewritten prescriptions dated June 17, 2016, but she did not have the prescriptions dated June 16th. The patient's daughter came in early in the morning, before Respondent or his medical assistant had arrived. The receptionist retrieved the rewritten prescriptions and provided them to Patient's daughter. Respondent's medical assistant called Patient A later that same day to retrieve the prescriptions dated June 16, 2016. The patient told Respondent's medical assistant that she had forgotten to give her daughter the prescriptions but would mail them in. The replacement scripts for oxycodone and Adderall were filled on June 24, 2016 through the patient's regular pharmacy. Apparently, on June 26, 2016, a Sunday, Patient A's friend attempted to have the June 16th prescriptions for oxycodone and Adderall filled at a different pharmacy. The pharmacist checked the RI PDMP and refused to fill the prescriptions, because they were filled two days earlier. She also left a message on Respondent's office's answering machine that Sunday, apprising them of the situation. Meanwhile, the friend had the prescriptions filled at another pharmacy using cash. When Respondent learned of the pharmacist's message, he contacted her immediately and instructed her not to fill any further prescriptions for Patient A. The same day, Patient A's daughter returned the June 16th scripts for oxycodone and Adderall, which had fill dates of July and August, to Respondent's office.

6. The Board also found that the Respondent's signature on the prescriptions was too simple and therefore, potentially, easily forged.
7. The Board found that Respondent has violated Rhode Island Rules and Regulations R21-28-CSD sections 3.4 (inadequate documentation of oral patient education

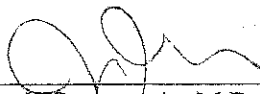
communications), 3.5 (not checking the PDMP), 3.6 (not having a written pain agreement). Respondent has also violated RIGL 5.37.5.1 section (26) for civil violation of state laws concerning standards of practice and prescribing of controlled substances.

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 Data 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 \$850 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 successfully complete within six (6) months of the ratification of this order a The Vanderbilt prescribing course.
7. 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 board 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 21 day of August, 2017.



Joseph Guarnaccia, M.D.

Board of Medical Licensure & Discipline
Joseph Guarnaccia M.D., C16-1173

Ratified by the Board of Medical Licensure and Discipline on the 15th day of September 2017.



Nicole Alexander-Scott, M.D., M.P.H.
Director
Rhode Island Department of Health
3 Capitol Hill, Room 401
Providence, Rhode Island 02908

Board of Medical Licensure & Discipline
Joseph Guarnaccia M.D., C16-1173