

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



**IN THE MATTER OF:**  
**Thomas Rocco M.D.**  
**License number MD 09898**  
**Complaint number C 180785, 180819**

**CONSENT ORDER**

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

**FINDINGS OF FACT**

1. Respondent has been a licensed physician in the State of Rhode Island since September 2<sup>nd</sup>, 1998. Respondent has multiple offices located at Newport Hospital Wound Clinic, 11 Friendship Street, 6<sup>th</sup> Floor, Newport, Rhode Island, Brain Spine Neurological Institute in Johnston, Rhode Island, and B&B Medical Marijuana Evaluation Center and Medical His specialty is Surgery. He graduated from Chicago Medical School June 1<sup>st</sup>, 1993.
2. The Board received two complaints regarding Respondent and his prescribing of opioids for his patients. Steere House, a Certified Nursing Facility is required to report allegations of Misappropriation / Exploitation. The complainant had knowledge that Patient A (alias) was being prescribed opioids, specifically oxycodone 30 mg, 150 per month. A physician assistant at Steere house who took care of Patient A, noted that

Patient A revealed to her that Respondent was a family friend and did not see Respondent in his office. Additionally, it is noted that Patient A shared the oxycodone 30 mg intended for Patient A with her son, who was also a patient of Respondent. Complainant avers they contacted Respondent's office and was informed Patient A was not seen there in the most recent 2 years. Complainant also avers that Patient A told them that her son fills the prescriptions for her and he was the one actually taking the oxycodone.

3. Respondent was the attending physician for Patient A who is 72 years old and has been treating for multiple medical problems since 2012 including back pain at the Brain Spine Neurological Institute in Johnston, as well as wound care at Newport Hospital Wound Clinic.
4. Patient A was being treated with multiple medications including some controlled substances such as; oxycodone (an opioid) 30 mg five times a day.
5. Respondent was the attending physician for Patient B, son of Patient A.
6. Respondent treated Patient B for back pain. Patient B was treated with monthly epidural steroid injections as well as medications. Patient B was prescribed multiple medications including oxycodone 30 mg, five times a day as well as alprazolam, a benzodiazepine.
7. Respondent is the attending physician for Patient C.
8. Respondent treated patient C with hydromorphone for pain related to wounds secondary to venous stasis. Respondent treated Patient C with multiple medications as well as overall wound care. The medications included hydromorphone, an opioid as well as trazadone, a psychotropic.
9. The Investigative Committee reviewed the medical records of Patient A, B, C, D, E and F provided by Respondent. The Investigative Committee concluded the medical records

did not contain adequate documentation of a treatment plan, specifically, there was not documentation of what objectives were used to determine treatment success, or pain relief, or changes in physical or psychosocial function, or diagnostic evaluations or other planned treatments. The assessments and plans were often brief and vague and included phrases such as continue meds, or pain. It was not always clear from review of the medical record which condition was specifically being treated with an opioid, nor if there was improvement. Additionally, the Investigative Committee noted, Patient A was not seen at the Brain Spine Neurological Institute in Johnston since December 18<sup>th</sup>, 2015. Patient A was seen at Newport Hospital Wound clinic, yet there was no mention of Patient A taking oxycodone in those medical records.

10. The Investigative Committee reviewed the medical records of Patient A, B, C, D, E and F provided by Respondent. The Investigative Committee concluded the medical records did not contain adequate documentation of educating the patient about the adverse risk of taking alcohol, or other psychoactive medications, specifically benzodiazepines, or tolerance, addiction, overdose or death. There was no documentation that it was the patient's responsibility to safeguard the medication and keep in a secure location. There was no documentation of educating the patient about safe disposal options.
11. Respondent was the attending physician for Patient A, B, C, D, E and F who all were prescribed various opioids, including oxycodone and hydromorphone at various doses for greater than 90 consecutive days.
12. The Investigative Committee reviewed the medical records of Patient A, B, C, D, E and F provided by Respondent, and concluded the medical records did not contain written patient treatment agreements.

13. Respondent was the attending physician for Patient A, B, C, D, E and F who was prescribed opioids, including oxycodone and hydromorphone for greater than 12 months at varying doses.
14. The Investigative Committee reviewed the medical record for Patient A, B, C, D, E and F as supplied by Respondent and did not see documentation of Patient A, B, C, D, E and F adherence with any medication treatment plan; specifically, if pain, function, or quality of life have improved or diminished using objective evidence; and if continuation or modification of medications for pain management treatment is necessary based on the practitioner's evaluation of progress towards treatment objectives. It was also noted that Respondent did not check the Prescription Drug Monitoring Program as required.
15. The Investigative Committee reviewed the above referenced complaint and the previously referenced medical records, as well as facts and circumstances relevant to the complaint and prescribing pattern
16. Respondent was the attending physician for Patient A and Patient B. Respondent prescribed Oxycodone 30 mg five times a day to each patient, which is a daily morphine milligram equivalent (MME) of 225 MME to Patient A and Patient B for several years.
17. Respondent is the attending physician for Patient D who was prescribed hydromorphone 8 mg, 10 tablets a day. This is a MME of 400mg/day.
18. Respondent is the attending physician for Patient F who was prescribed oxycodone ER and short acting oxycodone IR that yields 500 MME/day.
19. The Investigative Committee did not see documentation in the medical record of consideration of referral to a pain management physician as required.
20. The Investigative Committee reviewed the above referenced complaint and the

previously referenced medical records, as well as facts and circumstances relevant to the complaint and prescribing pattern

21. Respondent was the attending physician for Patient A and Patient B.
22. Respondent was prescribing oxycodone 30 mg 5 times a day to each patient.
23. After Respondent learned of the complaints from the Board regarding Patient A and Patient B, Respondent met with both patients.
24. Respondent summarily discharged both patients from his practice and gave each patient a tapering dose of opioids and list of physicians who treat pain. Respondent did not complete a safe transition of care and have a practitioner to practitioner conversation as required in the regulation.
25. Respondent was the attending physician for Patient E.
26. Patient E was treated with fentanyl which is a long acting opioid.
27. The Investigative Committee reviewed the medical record for Patient E and did not see documentation of compliance with the above regulation, specifically there was no documentation of requirements to education patient about: *(1) Serious life-threatening or even fatal respiratory depression may occur; (2) Methadone treatment may initially not provide immediate pain relief, and patient needs to be aware of overdose potential if taken in excess of dose, as prescribed; (3) Accidental consumption of long-acting opioids especially in children, can result in fatal overdose; (4) Long-term opioid use can result in physical addiction to opiates and abrupt stopping of medication may cause withdrawal symptoms including, but not limited to: runny eyes, runny nose, insomnia, diarrhea, vomiting, restlessness, nausea, weakness, muscle aches, leg cramps and hot flushes.*
28. Respondent was attending physician for Patient A, B, C, D, E and F.

29. Respondent prescribed each patient various doses of opioids, including oxycodone and hydromorphone.
30. Respondent had a pattern of not checking the Prescription drug monitoring program for his patients. Respondent did not obtain urine drug screens to verify these patients were taking the prescribed opioids. Respondent did not conduct pill counts or engage in any effort to see if patients were actually taking their medications.
31. The Investigative Committee concluded Respondent did not maintain minimum standards to prevent diversion of a controlled substance.
32. Respondent violated the *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), 3.6 (Written Patient Treatment Agreement), 3.7 Periodic Review and 3.9 (Multidisciplinary Approach to Treatment of Chronic Pain) 3.10 Transition of Care on Long-term opioid therapy, 3.12 Long Acting Opioids and RIGL § 5-37.5.1 (19) *Incompetent, negligent, or willful misconduct in the practice of medicine which includes the rendering of medically unnecessary services, and any departure from, or the 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. The board does not need to establish actual injury to the patient in order to adjudge a physician or limited registrant guilty of the unacceptable medical practice in this subdivision;*

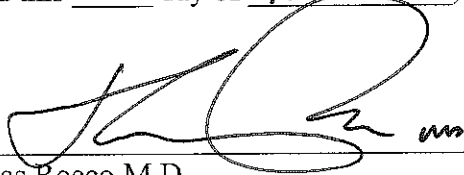
**Based on the foregoing, the parties agree as follows:**

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.

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 upon ratification of this Consent Order an administrative fee to the Board with a check for \$1700.00 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 in controlled substance prescribing, such as the Vanderbilt course.
7. Respondent shall engage a Board approved monitor commencing within 30 days of ratification of this order, to review the content and medical decision making of 10 of Respondent's 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 Respondent shall insure that the Board approved monitor provides a monthly report to the Board at [DOH.PRCOMPLIANCE@health.ri.gov](mailto:DOH.PRCOMPLIANCE@health.ri.gov), no later than the 15<sup>th</sup> day of the month following the month reviewed.
8. If any term of this Consent Order is violated, the Director of the Department of Health shall have the discretion to impose further disciplinary action including

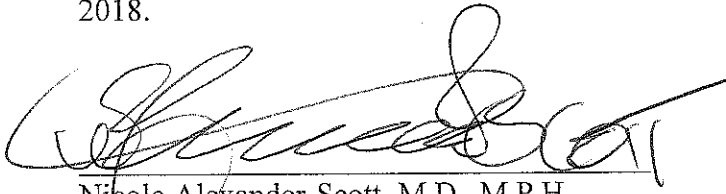
immediate suspension of Respondent's license to practice medicine. If the Director imposes further disciplinary action, Respondent shall be given notice and shall have the right to request an administrative hearing within twenty (20) days of the suspension and/or further discipline.

Signed this 17<sup>th</sup> day of November, 2018.



Thomas Rocco M.D.

Ratified by the Board of Medical Licensure and Discipline on the 12<sup>th</sup> day of December 2018.



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