

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

**IN THE MATTER OF:**  
**Vincent Montemarano, M.D.**  
**License number MD 05077**  
**Complaint number C18-0052**

### **CONSENT ORDER**

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

### **FINDINGS OF FACT**

1. Respondent has been a licensed physician in the State of Rhode Island since August 25<sup>th</sup>, 1976. Respondent's office is located at 27 East Avenue, Westerly, Rhode Island and his primary specialty is General Surgery.
2. The Board received a complaint from a physician who reported he had reason to believe a mutual patient (Patient A) was diverting opioids prescribed by Respondent. The complainant contacted Respondent to alert Respondent to the possibility of diversion of prescribed opioids. Complainant reports respondent did not take appropriate steps to prevent diversion and filed this complaint to protect the public, since diverted opioids can cause harm to the public.
3. Respondent was the attending physician for Patient A.
4. Patient A was being treated with oxycodone (an opioid) at varying doses on multiple occasions for several years, as well as co-prescribing alprazolam (a benzodiazepine).

Respondent avers the oxycodone was prescribed for chronic back pain. Respondent avers the alprazolam was prescribed for anxiety.

5. The Investigative Committee reviewed the medical records of Patient A provided by Respondent, and concluded the medical records did not contain adequate documentation of *"the patient's health history and physical examination in the health record prior to treating for chronic pain."*
6. The Investigative Committee also concluded the medical records did not contain adequate documentation of a treatment plan, specifically, there was not documentation what objectives were used to determine treatment success, or pain relief, or changes in of physical or psychosocial function, or diagnostic evaluations or other panned treatments.
7. The Investigative Committee also 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 also no documentation that it was the patient's responsibility to safeguard the medication and keep in a secure location. There was also documentation of educating the patient about safe disposal options.
8. Respondent initiated this patient on opioids, specifically oxycodone.
9. Respondent did not check the PMP.
10. Respondent prescribed Patient A an opioid, oxycodone for greater than 90 consecutive days and in total greater than 12 months. The Investigative Committee concluded the medical records did not contain a written patient treatment agreement. Respondent in his appearance on March 28, 2018, acknowledged he did not know what a written patient treatment agreement was and did not have such an agreement with Patient A.
11. The Investigative Committee also concluded after review of the medical record for Patient A, there was inadequate documentation of Patient A's 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.

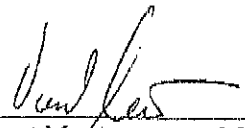
12. Respondent prescribed Patient A oxycodone on multiple occasions where the daily MME exceed 120 MME.
13. After review of the medical record as supplied by Respondent, the Investigative Committee concluded Respondent's medical record did not meet the minimum standards.
14. Respondent violated the *Rules and Regulations for Pain Management, Opioid Use and the Registration of Distributors of Controlled Substances in Rhode Island* [R21-28-CSD] sections 3.1, 3.4, 3.7 and the *Rules and Regulations for the Licensure and Discipline of Physicians* {R-5-27-MD/DO} section 11.4 (Medical Records).

**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 upon ratification of this Consent Order an administrative fee to the Board with a check for \$850.00 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 Medical Records, Respondent shall send evidence of completing the course to [DOH.PRCCompliance@health.ri.gov](mailto:DOH.PRCCompliance@health.ri.gov).
- 7. Respondent shall not prescribe any schedule 2-5 controlled substances effective close of business 10 August 2018. Respondent shall not renew his controlled substance registration in the future and shall surrender the existing controlled substance registration effective 10 August 2018.
- 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 9<sup>th</sup> day of July, 2018.

  
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 Vincent Montemarano, M.D.

Ratified by the Board of Medical Licensure and Discipline on the 11<sup>th</sup> day of JULY, 2018.

  
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 Nicole Alexander-Scott, M.D., M.P.H. *Acting Director*  
 Director  
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 Providence, Rhode Island 02908