

1 **BEFORE THE NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE**

2 IN THE MATTER OF THE COMPLAINT **BOARD OF**
OSTEOPATHIC MEDICINE

3 AGAINST

4 SUSAN MIKO, D.O.

5 RESPONDENT.

Case No.: AD0808066

Filed:

Catrina Kelly Executive
Executive Director *Administrator*

AUG 01 2008
FILED

7 **COMPLAINT**

8 Pursuant to the provisions of Chapter 633 of the Nevada Revised Statutes, and by
9 virtue of the authority vested in it by said chapter, the Investigative Board Member of the
10 Nevada Board of Osteopathic Medicine, having a reasonable basis to believe that SUSAN
11 MIKO, D.O., hereinafter referred to as "Respondent" or "Dr. Miko," has violated the provisions
12 of said chapter, hereby issues its formal Complaint, stating the Investigative Board Member's
13 charges and allegations, as follows:

14 **I.**

15 **General Allegations**

16 1. That Respondent is licensed in active status to practice medicine in the state of
17 Nevada, and at all times alleged herein, was so licensed by the Board of Osteopathic
18 Medicine of the State of Nevada pursuant to the provisions of Chapter 633 of the Nevada
19 Revised Statutes.

20 2. That NRS 633.511(1) provides that unprofessional conduct is a ground for the
21 initiation of disciplinary proceedings.

22 3. That NRS 633.511(5) provides that professional incompetence is a ground for the
23 initiation of disciplinary proceedings.

24 4. That NRS 633.131(1) defines "Unprofessional conduct," in part, as follows:

- 25 (f) Engaging in any:
26 (1) Professional conduct which is intended to deceive or
27 which the board by regulation has determined is unethical;
28 (2) Medical practice harmful to the public or any conduct
detrimental to the public health, safety or morals which does
not constitute gross or repeated malpractice or professional
incompetence.

- 1 (g) Administering, dispensing or prescribing any controlled
- 2 substance or any dangerous drug as defined in chapter 454
- 3 of NRS, otherwise than in the course of legitimate
- 4 professional practice or as authorized by law.
- 5 (f) Habitual drunkenness or habitual addiction to the use of a
- 6 controlled substance. . . .
- 7 (m) Failure of a licensee to maintain timely, legible, accurate
- 8 and complete medical records relating to the diagnosis,
- 9 treatment and care of a patient.

10 5. Pursuant to NAC 633.350, a licensee engages in unethical conduct if she:

- 11 (5) Fails to generate or create medical records relating to the
- 12 diagnosis, treatment and care of a patient.
- 13 (6) Prescribes a controlled substance in a manner or an amount
- 14 that the board determines is excessive.
- 15 (7) Fails to comply with the terms of an agreement with a
- 16 diversion program approved by the Board.
- 17 (8) Fails to comply with an order of the Board; and
- 18 (9) Engages in any other conduct that the Board determines
- 19 constitutes unfitness to practice osteopathic medicine.

20 6. A complaint was filed by the Fremont Medical Center on or about May 18, 2007,
21 alleging that Susan Miko, D.O., had received two thousand (2,000) "pills of Hydrocodone
22 w/apap 10/325." Fremont Medical Center alleged that she was not authorized to utilize that
23 "facility for this order as we do not even carry this medication in" that facility. A statement was
24 also provided by individuals at the Fremont Medical Center stating that Dr. Miko's explanation
25 for the order was that she ordered it for her husband and that he requires up to 30 pills a day
26 and that she ordered such a large quantity to save money. Dr. Miko has no reliable medical
27 records, if any at all, to evidence the treatment of the family member. Additionally, the
28 individuals at the Fremont Medical Center indicated that she actually paid more for the 2,000
pills ordered than she would have had to pay as a co-payment on her insurance policy.
According to the individuals at Fremont Street Medical Center, Dr. Miko indicated that she
would appreciate it if the medical center kept this order "confidential."

7. Dr. Miko responded to that complaint in December 2007; and shortly thereafter, Dr.
Miko provided a copy of the report dated January 8, 2008, from the Nevada State Board of

1 Pharmacy, concerning the purchase of 2,000 Hydrocodone and a copy of her husband's
2 medical records. It is noted that Respondent's husband is not a patient of Fremont Medical
3 Center.

4 8. As a result of the large purchase of Hydrocodone and the possible drug addiction
5 and/or excessive prescribing, Dr. Miko was referred to the Nevada Health Professionals
6 Assistance Foundation ("diversion program"). A contract between Dr. Miko and the diversion
7 program was finally entered into on or about April 15, 2008.

8 9. As part of the anticipated diagnosis and/or treatment, Dr. Miko also agreed to enter
9 into the Betty Ford Clinic ("clinic"). This admission occurred in February, 2008. The clinic
10 noted in its discharge summary that they "are usually suspicious, or at least surprised, when
11 physicians claim that they were unaware that prescribing controlled substance (on anything
12 other than an emergency basis) to a family member is frowned upon or in some states,
13 illegal." These were the claims made by Dr. Miko. The clinic also noted that they did not
14 possess sufficient information to indicate that Dr. Miko herself was misusing the controlled
15 substance. The recommendations pursuant to the discharge summary included: (1) that Dr.
16 Miko complete courses in prescription ethics and addiction/pain management; (2) that Dr.
17 Miko undergo an independent neuropsychological evaluation to assure that her cognitive
18 functioning is in keeping with the demands for her profession; (3) that Dr. Miko abstain from all
19 psychoactive substances that are not properly prescribed for her by a physician for a period of
20 one year and that her abstinence be monitored by the diversion program in Las Vegas; and
21 (4) that she be followed up within three months from the date of the report and within one
22 year.

23 10. Upon receipt of additional information from the diversion program, the clinic
24 prepared a subsequent discharge summary, bearing a narrative date of March 31, 2008.
25 Therein, it indicated that Dr. Miko used poor judgment in subsequently using Hydrocodone
26 without informing the diversion program while under scrutiny and that her actions "significantly
27 raises the possibility that she may meet criteria for a diagnosis of Opioid Abuse" and that
28 the "possibility that she may have developed dependence on opioids can not, of course, be

1 ignored." The clinic recommended that "Dr. Miko voluntarily suspend her practice of medicine
2 and enroll in the [diversion program]. Her suitability to return to the practice of medicine
3 should be determined according to her compliance" with various recommendations.

4 11. A psychological evaluation performed by the clinic in February 2008 noted as
5 follows:

6 It is interesting to note that after two prescriptions for hydrocodone and acetaminophen
7 #40, 10 mg/650 mg on January 5, 2007 and January 14, 2007, and a 4 mg strength
8 #40 prescription for hydromorphone on January 6th followed by one prescription in
9 February of 2007 for #40 hydrocodone and acetaminophen and one in March for Lortab
10 7.5 mg/500, #40, that no outside prescriptions are noted. The next prescription is
11 recorded on June 19, 2007 and this three month period includes the month of April in
12 which Dr. Miko had placed the order for the #2000 hydrocodone.

13 12. The psychological evaluation performed by the clinic in February 2008 also noted
14 that there were "some perplexing inconsistencies and/or omissions in the information provided
15 by Dr. Miko, which become especially evident when prescription data are reviewed for both
16 her and her husband for hydrocodone over the period of 2005 through 2008." It continued
17 that the "prescription history does not appear consistent with the apparent need for
18 medications that Dr. Miko reported her husband had, and certainly would not reflect a use
19 pattern that would correspond to the #2000 pills being required to treat headaches over the
20 course of 8-12 months dependent on severity and frequency." It continued that a review of
21 the pharmacy records that "#150 pills were dispensed to Dr. Miko [during a certain time
22 period]. This number appears to be more pills dispensed than she reported taking for active
23 pain at the time . . . these numbers would suggest that the pills, if indeed they were being
24 taken, were either being given to her husband or taken by Dr. Miko and her husband. A
25 question then arises as to the exact length of time Dr. Miko had been treating her husband."

26 13. On July 2, 2008, Dr. Peter Mansky of the diversion program informed the board
27 that Dr. Miko "resigned from" their program. Dr. Mansky's report also indicated that Dr. Miko's
28 employment records were finally received from Dr. Miko and/or her employers; and that they
were compared with Dr. Miko's prescription information. He noted that the prescription
information for November 2007 indicated that she was using "30 pills within three days or 10

1 pills per day." He also indicated that in March, 2008, she rendered medical treatment to
2 patients within twenty-four (24) hours of imbibing in the controlled substance Hydrocodone.

3 **II.**

4 **Unprofessional Conduct**

5 14. The allegations contained in paragraphs 1 through 13 of Section I, General
6 Allegations, of this Complaint are incorporated herein by reference, as though each such
7 allegation was more specifically set forth in full herein.

8 15. The dosages being utilized by Dr. Miko and/or being prescribed by Dr. Miko for the
9 family member is excessive and possibly indicative of a habitual addiction, especially in light
10 of the fact that these two do not have general family physicians and that Dr. Miko is engaged
11 in the self-prescribing and dispensing; and such acts are not consistent with the standard of
12 care in the medical community as such dispensing and/or prescribing may be harmful to the
13 public and detrimental to the public health and safety. Pursuant to NRS 633.131(1)(f),
14 discipline is warranted.

15 16. Dr. Miko prescribed the Hydrocodone to herself and her husband not as physician-
16 patient in a clinic setting; and furthermore, Dr. Miko failed to maintain and retain accurate
17 records pertaining to any alleged treatment of herself and her husband. These acts are
18 unprofessional conduct pursuant to NRS 633.131(1)(g) and (m), for which discipline is
19 warranted.

20 **III.**

21 **Unethical Conduct**

22 17. The allegations contained in paragraphs 1 through 13 of Section I, General
23 Allegations, and Section II, Unprofessional Conduct, of this Complaint are incorporated herein
24 by reference, as though each such allegation was more specifically set forth in full herein.

25 18. Respondent's self-prescribing and dispensing the amounts of Hydrocodone
26 mentioned herein is excessive and is a violation of an osteopathic physician's ethical conduct,
27 i.e., a violation of NAC 633.350(6) and NRS 633.131(f)(1) and (2).

28 16. Respondent's actions of failing to maintain accurate records pertaining to the

1 treatment of herself and her husband is a violation of NAC 633.350(5), i.e., an unethical
2 conduct, for which discipline is warranted.

3 17. Respondent's withdrawal from treatment from the Board-ordered treatment from
4 the diversion program, breaching the written agreement, is an unethical conduct of an
5 osteopathic physician pursuant to NAC 633.350(7) and (8) for which discipline is warranted.

6 18. Respondent's rendering medical services to patients while under the influence of
7 excessive amounts of Hydrocodone, i.e., within 24 hours of taking the same, is an unfitness to
8 practice osteopathic medicine pursuant to NAC 633.350(9) for which discipline is warranted.

9 **IV.**

10 **Summary Suspension**

11 19. The allegations contained in paragraphs 1 through 13 of Section I, General
12 Allegations; Section II, Unprofessional Conduct; and Section III, Unethical Conduct, of this
13 Complaint are incorporated herein by reference, as though each such allegation was more
14 specifically set forth in full herein.

15 20. That the public health, safety, and welfare imperatively require action and
16 summary suspension of Respondent's license to practice medicine in the state of Nevada
17 pending a hearing on the Complaint pursuant to NRS 233B.127(3). That the continuing
18 practice of medicine or the continuing ability to practice medicine by Respondent during the
19 pendency of the time necessary for a hearing on this Complaint would endanger the health,
20 safety, and welfare of her patients.

21 WHEREFORE, the Investigative Member of the Board of Osteopathic Medicine prays
22 as follows:

23 1. That the Nevada State Board of Osteopathic Medicine schedule an emergency
24 hearing pursuant to NRS 233B.127(3) and affirmatively find that the public health, safety, and
25 welfare imperatively require emergency action and summarily suspend Respondent's license
26 to practice Osteopathic Medicine in the State of Nevada pending a hearing on the Complaint
27 pursuant to NRS 633.591;

28 2. That the Nevada State Board of Osteopathic Medicine conduct a hearing on this


1 Complaint as provided by statute;

2 3. That, pursuant to NRS 633.651, Respondent, SUSAN MIKO, D.O., be publicly
3 reprimanded and/or the license of Respondent, SUSAN MIKO, D.O., be revoked, suspended,
4 limited, or placed on probation with conditions and terms as the Nevada State Board of
5 Osteopathic Medicine may deem just and proper and which are not inconsistent with law; and

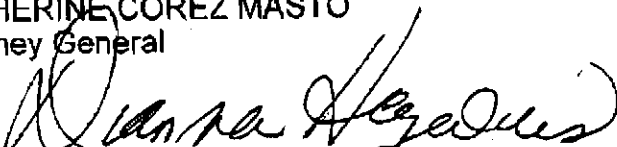
6 4. That Respondent SUSAN MIKO, D.O., be ordered to pay reasonable attorney's fees
7 and costs of the investigation and the administrative and disciplinary proceedings.

8 DATED this 31 day of July, 2008.

9 NEVADA STATE BOARD OF
10 OSEOPATHIC MEDICINE

11 By: 
12 DANIEL CURTIS, D.O.,
13 Investigating Member of the
14 Nevada Board of Osteopathic Medicine

14 Submitted by:
15 CATHERINE COREZ MASTO
16 Attorney General

17 By: 
18 Dianna Hegeduis, # 5616
19 Sr. Deputy Attorney General
20 555 E. Washington Avenue, Suite 3900
21 Las Vegas, Nevada 89101
22 (702) 486-3894
23
24
25
26
27
28

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101