BEFORE THE NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE

IN THE MATTER OF THE COMPLAINT

AGAINST

JIM Y. WANG, D.O.

RESPONDENT.

Case No.: AD-05-29-907

Filed: 9-1-05

Executive Director

COMPLAINT

Pursuant to the provisions of Chapter 633 of the Nevada Revised Statutes, and by virtue of the authority vested in it by said chapter, the Investigative Board Member of the Nevada Board of Osteopathic Medicine, having a reasonable basis to believe that JIM Y. WANG, D.O. hereinafter referred to as "Respondent," has violated the provisions of said chapter, hereby issues its formal Complaint, stating the Investigative Board Member's charges and allegations, as follows:

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

2. That NRS 633.511(1) provides that unprofessional conduct is grounds for the initiation of disciplinary proceedings.

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3. That NRS 633.131(1) defines "Unprofessional conduct" as follows:

(f) Engaging in any:

(1) Professional conduct which is intended to deceive or which the board by regulation has determined is unethical;

(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.

(g) Administering, dispensing or prescribing any controlled substance or any dangerous drug as defined in chapter 454 of NRS, otherwise than in the course of legitimate professional practice or as authorized by law.

4. Pursuant to NAC 633.350, a licensee engages in unethical conduct if he:

(5) Fails to generate or create medical records relating to the diagnosis, treatment and care of a patient.

(6) Prescribes a controlled substance in a manner or an amount that the board determines is excessive.

(9) Engages in any other conduct that the Board determines constitutes unfitness to practice osteopathic medicine.

COUNT ONE

(Patient A - Excessive Prescribing)

5. The allegations set forth in paragraphs 1 through 4 are incorporated herein by reference, as though set forth in full.

6. Respondent treated Patient A on four (4) occasions, spanning the period from January 24, 2005 through May 4, 2005.

7. On January 24, 2005, Patient A presented to Respondent, as a new patient, complaining of moderate lumbar pain, tenderness of the right knee and bronchitis and seeking a refill of an Oxycontin prescription, a dangerous and highly addictive controlled substance. Patient A requested this refill without providing Respondent with any documentation or proof to suggest that he had previously been prescribed this medication by any other physician.

8. Despite the fact that Respondent made no abnormal findings as to Patient A's lumbar spine and right knee and characterized Patient A's pain as moderate, and had no proof to suggest that Patient A had previously received a prescription for Oxycontin,
Respondent refilled Patient A's Oxycontin prescription at a dosage of 80 milligrams, twice per day, for a period of thirty (30) days. Such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient A's pain level, experience with Oxycontin, or level of drug resistance.


10. Again, Respondent made no abnormal findings as to Patient A's lumbar spine and shoulder and noted that Patient A "feels worse", without further elaboration or investigation. Respondent then refilled Patient A's Oxycontin prescription at a dosage of 80 milligrams, twice per day; another potentially life-threatening decision as Respondent still had no awareness of Patient A's pain level, experience with Oxycontin, or level of drug resistance.

11. On March 31, 2005, Patient A again presented to Respondent, complaining of lumbar pain and seeking a refill of his Oxycontin prescription

12. Again, Respondent made no abnormal findings as to Patient A's lumbar spine and then refilled Patient A's Oxycontin prescription at a dosage of 80 milligrams, twice per day; another potentially life-threatening decision as Respondent still had no awareness of Patient A's pain level, experience with Oxycontin, or level of drug resistance.

13. On May 4, 2005, Patient A presented to Respondent, complaining of lumbar spine and shoulder pain and seeking a refill of his Oxycontin prescription

14. Again, Respondent made no abnormal findings as to Patient A's lumbar spine or shoulder and then refilled Patient A's Oxycontin prescription at a dosage of 80 milligrams, twice per day; yet another potentially life-threatening decision as Respondent still had no awareness of Patient A's pain level, experience with Oxycontin, or level of drug resistance.

15. A dosage of 80 milligrams of Oxycontin, twice per day is usually administered to patients presenting in severe pain and/or patients who have built up considerable tolerance to pain medication.

16. Patient A satisfied neither of these criteria at the time the Respondent issued the above-referenced prescriptions.
17. Oxycontin is a dangerous and highly addictive controlled substance and is classified as a "Schedule II" narcotic pursuant to NAC 453.520. Thus, Respondent's prescription of Oxycontin in his treatment of Patient A during the time period and under the circumstances alleged above, is excessive and is a violation of NAC 633.350(6) and NRS 633.131(f)(1). Respondent's actions also constitute unprofessional conduct and provide grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT TWO

(Patient A – Administering A Controlled Substance To Patients Without Justification Is Conduct Detrimental To The Public Health)

18. The allegations set forth in paragraphs 1 through 17 are incorporated herein by reference, as though set forth in full.

19. On four (4) occasions, spanning the period from January 24, 2005 through May 4, 2005, Respondent prescribed Oxycontin to Patient A at a dosage of 80 milligrams, twice per day. Under these circumstances, Respondent's four (4) prescriptions of Oxycontin could have been life threatening since Respondent had no awareness of Patient A's pain level, experience with Oxycontin, or level of drug resistance.

20. Respondent prescribed the dosage of 80 milligrams, twice a day (the maximum possible Oxycontin dosage) for Patient A, without objectively investigating the cause or nature of Patient A's symptoms, or whether such a massive dosage was appropriate for that patient.

21. In prescribing Oxycontin for Patient A in the dosages described herein and under the circumstances set forth above, Respondent has engaged in conduct that is harmful to his patients or is detrimental to the public health, safety and morals. Such conduct is a violation of NRS 633.131(f)(2) and constitutes grounds for disciplinary action pursuant to NRS 633.511(1).

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COUNT THREE

(Patient A – Failure To Document Prescribed Medications And The
Clinical Observations Which Justify These Prescriptions Is Unprofessional Conduct)

22. The allegations set forth in paragraphs 1 through 21 are incorporated herein by
reference, as though set forth in full.

23. Respondent treated Patient A on four (4) occasions, spanning the period from
January 24, 2005 through May 4, 2005.

24. On January 24, 2005, Patient A presented to Respondent, complaining of
moderate lumbar pain, tenderness of the right knee and bronchitis and seeking an Oxycontin
refill, a dangerous and highly addictive controlled substance. Patient A requested this refill
without providing Respondent with any documentation or proof to suggest that he had
previously been prescribed this medication by any other physician.

25. At Patient A's request, Respondent prescribed Oxycontin at a dosage of 80
milligrams, twice per day. There is no documentation in the medical records for this visit of any
physical findings to justify a prescription of this nature. Such a dose of Oxycontin could have
been life threatening since Respondent had no awareness of Patient A's pain level,
experience with Oxycontin, or level of drug resistance.

26. During this same visit, despite Patient A's request for an Oxycontin refill, the
medical records for this visit erroneously reflect Patient A's “current medications” as “none”.

27. On March 1, 2005, Patient A again presented to Respondent, complaining of
lumbar spine and shoulder pain, and seeking an Oxycontin refill.

28. Again, at Patient A's request, Respondent prescribed Oxycontin to Patient A at a
dosage of 80 milligrams, twice per day. There is no documentation in the medical records for
this visit of any physical findings to justify a prescription of this nature. Again, such a dose of
Oxycontin could have been life threatening since Respondent had no awareness of Patient
A's pain level, experience with Oxycontin, or level of drug resistance.

29. During this same visit, despite Patient A's request for an Oxycontin refill, the
medical records for this visit again erroneously reflect Patient A's “current medications” as

31. Again, at Patient A’s request, Respondent prescribed Oxycontin to Patient A at a dosage of 80 milligrams, twice per day. There is no documentation in the medical records for this visit of any physical findings to justify a prescription of this nature. Again, such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient A’s pain level, experience with Oxycontin, or level of drug resistance.

32. During this same visit, despite Patient A’s request for an Oxycontin refill, the medical records for this visit again erroneously reflect Patient A’s “current medications” as “none”.


34. Again, at Patient A’s request, Respondent prescribed Oxycontin to Patient A at a dosage of 80 milligrams, twice per day. There is no documentation in the medical records for this visit of any physical findings to justify a prescription of this nature. Again, such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient A’s pain level, experience with Oxycontin, or level of drug resistance.

35. During this same visit, despite Patient A’s specific request for an Oxycontin refill, the medical records for this visit again erroneously reflect Patient A’s “current medications” as “none”.

36. As a result of the four (4) visits Patient A made to Respondent, Respondent failed to generate or create medical records relating to the diagnosis, treatment and care of his patient.

37. Such conduct is unprofessional conduct pursuant to NRS 633.131(f), and NAC 633.350(5). Such conduct is grounds for disciplinary action pursuant to NRS 633.511(1).
COUNT FOUR

(Patient B - Excessive Prescribing)

38. The allegations set forth in paragraphs 1 through 37 are incorporated herein by reference, as though set forth in full.

39. Respondent treated Patient B on one (1) occasion, on February 16, 2005.

40. On February 16, 2005, Patient B presented to Respondent, as a new patient, complaining of moderate lumbar pain, tenderness of the right knee, loss of appetite, seeking an annual check-up and a refill of an Oxycontin prescription, a dangerous and highly addictive controlled substance. Patient A requested this refill without providing Respondent with any documentation or proof to suggest that he had previously been prescribed this medication by any other physician.

41. Despite the fact that Respondent made no abnormal findings as to Patient B's lumbar spine and right knee and failed to investigate the nature and possible causes of Patient B's pain, Respondent refilled Patient A's Oxycontin prescription at a dosage of 80 milligrams, twice per day for a period of thirty (30) days. Such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient A's pain level, experience with Oxycontin, or level of drug resistance.

42. A dosage of 80 milligrams of Oxycontin, twice per day is usually administered to patients presenting in severe pain and/or patients who have built up considerable tolerance to pain medication.

43. Patient B satisfied neither of these criteria at the time the Respondent issued the above-referenced prescription.

44. Oxycontin is a dangerous and highly addictive controlled substance and is classified as a "Schedule II" narcotic pursuant to NAC 453.520. Thus, Respondent's prescription of Oxycontin in his treatment of Patient B during the time period and under the circumstances alleged above, is excessive and is a violation of NAC § 633.350(6) and NRS 633.131(f)(1). Respondent's actions also constitute unprofessional conduct and provide grounds for disciplinary action pursuant to NRS 633.511(1).
COUNT FIVE

(Patient B – Administering A Controlled Substance To Patients Without
Justification Is Conduct Detrimental To The Public Health)

45. The allegations set forth in paragraphs 1 through 44 are incorporated herein by reference, as though set forth in full.

46. On February 16, 2005, Respondent prescribed Oxycontin to Patient B at a dosage of 80 milligrams, twice per day for thirty (30) days. Under these circumstances, Respondent’s prescription of Oxycontin could have been life threatening since Respondent had no awareness of Patient B’s pain level, experience with Oxycontin, or level of drug resistance.

47. Respondent prescribed the dosage of 80 milligrams, twice a day (the maximum possible Oxycontin dosage) for thirty (30) days for Patient B, without objectively investigating the cause or nature of Patient B’s symptoms, or whether such a massive dosage was appropriate for that patient.

48. In prescribing Oxycontin for Patient B in the dosage described herein and under the circumstances set forth above, Respondent has engaged in conduct that is harmful to his patients or is detrimental to the public health, safety and morals. Such conduct is a violation of NRS 633.131(f)(2) and constitutes grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT SIX

(Patient B – Failure To Document Prescribed Medications And The Clinical Observations Which Justify These Prescriptions Is Unprofessional Conduct)

49. The allegations set forth in paragraphs 1 through 48 are incorporated herein by reference, as though set forth in full.


51. On that date, Patient B presented to Respondent complaining of moderate lumbar pain, tenderness of the right knee, loss of appetite, seeking an annual check-up and an Oxycontin refill, a dangerous and highly addictive controlled substance. Patient B
requested this refill without providing Respondent with any documentation or proof to suggest that he had previously been prescribed this medication by any other physician.

52. At Patient B’s request, Respondent prescribed Oxycontin to Patient B at a dosage of 80 milligrams, twice per day for thirty (30) days. There is no documentation in the medical records for this visit of any physical findings to justify a prescription of this nature. Such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient B’s pain level, experience with Oxycontin, or level of drug resistance.

53. During this same visit, despite Patient B’s specific request for an Oxycontin refill, the medical records for this visit erroneously reflect Patient B’s “current medications” as “none”.

54. As a result of the visit Patient B made to Respondent, Respondent failed to generate or create medical records relating to the diagnosis, treatment and care of his patient.

55. Such conduct is unprofessional conduct pursuant to NRS 633.131(f), and NAC 633.350(5). Such conduct is grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT SEVEN

(Patient C - Excessive Prescribing)

56. The allegations set forth in paragraphs 1 through 55 are incorporated herein by reference, as though set forth in full.

57. Respondent treated Patient C on three (3) occasions, spanning the period from January 5, 2005 through March 4, 2005.


59. Despite the fact that Respondent made no abnormal findings as to Patient C’s lumbar spine and characterized Patient C’s pain as moderate, Respondent issued an Oxycontin prescription to Patient C at a dosage of 80 milligrams, twice per day, for a period of thirty (30) days. Such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient C’s pain level, experience with Oxycontin, or level of drug resistance.
60. On February 9, 2005, Patient C again presented to Respondent, complaining of lumbar spine and cystic acne, and seeking a refill of his Oxycontin prescription.

61. Again, Respondent made no abnormal findings as to Patient C's lumbar spine and failed to investigate the nature and possible causes of Patient C's pain. Respondent then refilled Patient C's Oxycontin prescription at a dosage of 80 milligrams, twice per day, for thirty (30) days. This was another potentially life threatening decision as Respondent still had no awareness of Patient C's pain level, experience with Oxycontin, or level of drug resistance.


63. Again, Respondent made no abnormal findings as to Patient C's lumbar spine and then refilled Patient C's Oxycontin prescription at a dosage of 80 milligrams, twice per day for thirty (30) days. This was another potentially life threatening decision as Respondent still had no awareness of Patient C's pain level, experience with Oxycontin, or level of drug resistance.

64. A dosage of 80 milligrams of Oxycontin, twice per day is usually administered to patients presenting in severe pain and/or patients who have built up considerable tolerance to pain medication.

65. Patient C satisfied neither of these criteria at the time the Respondent issued the above-referenced prescriptions.

66. Oxycontin is a dangerous and highly addictive controlled substance and is classified as a "Schedule II" narcotic pursuant to NAC 453.520. Thus, Respondent's prescription of Oxycontin in his treatment of Patient C during the time period and under the circumstances alleged above, is excessive and is a violation of NAC § 633.350(6) and NRS 633.131(f)(1). Respondent's actions also constitute unprofessional conduct and provide grounds for disciplinary action pursuant to NRS 633.511(1).
COUNT EIGHT

(Patient C – Administering A Controlled Substance To Patients Without Justification Is Conduct Detrimental To The Public Health)

67. The allegations set forth in paragraphs 1 through 66 are incorporated herein by reference, as though set forth in full.

68. On three (3) occasions, spanning the period from January 5, 2005 through March 4, 2005, Respondent prescribed Oxycontin to Patient C at a dosage of 80 milligrams, twice per day for thirty (30) days each. Under these circumstances, Respondent's three (3) prescriptions of Oxycontin could have been life threatening since Respondent had no awareness of Patient A's pain level, experience with Oxycontin, or level of drug resistance.

69. Respondent prescribed the dosage of 80 milligrams, twice a day (the maximum possible Oxycontin dosage) for Patient C, without objectively investigating the cause or nature of Patient C's symptoms, or whether such a massive dosage was at all appropriate for that patient.

70. In consistently prescribing Oxycontin for Patient C in the dosages described herein and under the circumstances set forth above, Respondent has engaged in conduct that is harmful to his patients or is detrimental to the public health, safety and morals. Such conduct is a violation of NRS 633.131(f)(2) and constitutes grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT NINE

(Patient C – Failure To Document Prescribed Medications And The Clinical Observations Which Justify These Prescriptions Is Unprofessional Conduct)

71. The allegations set forth in paragraphs 1 through 70 are incorporated herein by reference, as though set forth in full.

72. Respondent treated Patient C on three (3) occasions, spanning the period from January 5, 2005 through March 4, 2005.

74. After examining Patient C, Respondent prescribed Oxycontin to Patient C at a
dosage of 80 milligrams, twice per day. The medical records for this visit contain no
documentation of this prescription, nor do these records contain any physical findings to justify
a prescription of this nature. Such a dose of Oxycontin could have been life threatening since
Respondent had no awareness of Patient C’s pain level, experience with Oxycontin, or level of
drug resistance.

75. The medical records for this visit erroneously reflect Patient C’s “current
medications” as “none”.

76. On February 9, 2005, Patient C again presented to Respondent, complaining of
lumbar spine and cystic acne, and seeking an Oxycontin refill.

77. Again, Respondent made no abnormal findings as to Patient C’s lumbar spine
and failed to investigate the cause or nature of Patient C’s pain. Respondent then refilled
Patient C’s Oxycontin prescription at a dosage of 80 milligrams, twice per day for thirty (30)
days. There is no documentation in the medical records for this visit of any physical findings
to justify a prescription of this nature. Again, such a dose of Oxycontin could have been life
threatening since Respondent had no awareness of Patient A’s pain level, experience with
Oxycontin, or level of drug resistance.

78. During this same visit, despite Patient C’s specific request for an Oxycontin refill,
the medical records for this visit again erroneously reflect Patient C’s “current medications” as
“none”.

79. On March 4, 2005, Patient C again presented to Respondent, complaining of
lumbar pain and seeking an Oxycontin refill.

80. Again, Respondent made no abnormal findings as to Patient C’s lumbar spine
and then refilled Patient C’s Oxycontin prescription at a dosage of 80 milligrams, twice per
day. There is no documentation in the medical records for this visit of any physical findings to
justify a prescription of this nature. Again, such a dose of Oxycontin could have been life
threatening since Respondent had no awareness of Patient C’s pain level, experience with
Oxycontin, or level of drug resistance.
81. During this same visit, despite Patient C's specific request for an Oxycontin refill, the medical records for this visit again erroneously reflect Patient A's "current medications" as "none".

82. As a result of the three (3) visits Patient C made to Respondent, Respondent failed to generate or create medical records relating to the diagnosis, treatment and care of his patient.

83. Such conduct is unprofessional conduct pursuant to NRS 633.131(f), and NAC 633.350(5). Such conduct is grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT TEN

(Patient D - Excessive Prescribing)

84. The allegations set forth in paragraphs 1 through 83 are incorporated herein by reference, as though set forth in full.


86. On March 28, 2005, Patient D presented to Respondent, complaining of lumbar pain, allergies and seeking a refill of an Oxycontin prescription, a dangerous and highly addictive controlled substance. Patient D requested this refill without providing Respondent with any documentation or proof to suggest that he had previously been prescribed this medication by any other physician.

87. Respondent made no abnormal findings as to Patient D's lumbar spine and shoulder and noted that Patient D "feels worse", without further elaboration or investigation. Respondent then refilled Patient D's Oxycontin prescription at a dosage of 80 milligrams, twice per day, for a period of thirty (30) days. Such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient D's pain level, experience with Oxycontin, or level of drug resistance.

88. A dosage of 80 milligrams of Oxycontin, twice per day is usually administered to patients presenting in severe pain and/or patients who have built up considerable tolerance to pain medication.
89. Patient D satisfied neither of these criteria at the time the Respondent issued the above-referenced prescriptions.

90. Oxycontin is a dangerous and highly addictive controlled substance and is classified as a “Schedule II” narcotic pursuant to NAC 453.620. Thus, Respondent’s prescription of Oxycontin in his treatment of Patient D during the time period and under the circumstances alleged above, is excessive and is a violation of NAC § 633.350(6) and NRS 633.131(f)(1). Respondent’s actions also constitute unprofessional conduct and provide grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT ELEVEN

(Patient D – Administering A Controlled Substance To Patients Without Justification Is Conduct Detrimental To The Public Health)

91. The allegations set forth in paragraphs 1 through 90 are incorporated herein by reference, as though set forth in full.

92. On March 28, 2005, Respondent prescribed Oxycontin to Patient D at a dosage of 80 milligrams, twice per day, for thirty (30) days. Under these circumstances, Respondent’s prescription of Oxycontin could have been life threatening since Respondent had no awareness of Patient D’s pain level, experience with Oxycontin, or level of drug resistance.

93. Respondent prescribed the dosage of 80 milligrams, twice a day (the maximum possible Oxycontin dosage) for Patient D, without objectively investigating the cause or nature of Patient D’s symptoms, or whether such a massive dosage was appropriate for that patient.

94. In prescribing Oxycontin for Patient D in the dosages described herein and under the circumstances set forth above, Respondent has engaged in conduct that is harmful to his patients or is detrimental to the public health, safety and morals. Such conduct is a violation of NRS 633.131(f)(2) and constitutes grounds for disciplinary action pursuant to NRS 633.511(1).
COUNT TWELVE

(Patient D – Failure To Document Prescribed Medications And The Clinical Observations Which Justify These Prescriptions Is Unprofessional Conduct)

95. The allegations set forth in paragraphs 1 through 94 are incorporated herein by reference, as though set forth in full.


97. On December 28, 2004, Patient D presented to Respondent, complaining of moderate lumbar pain, allergies and seeking an Oxycontin refill, a dangerous and highly addictive controlled substance. Patient D requested this refill without providing Respondent with any documentation or proof to suggest that he had previously been prescribed this medication by any other physician.

98. Despite Patient D’s request for an Oxycontin refill, the medical records for this visit erroneously reflect Patient D’s “current medications” as “none”.

99. Additionally, the medical records for this visit contain handwritten indications that Respondent did, in fact, refill Patient D’s Oxycontin prescription. However, nowhere else in the records for this visit, can this prescription be substantiated.

100. On March 25, 2005, Patient D again presented to Respondent, complaining of moderate lumbar pain, allergies and seeking an Oxycontin refill.

101. At Patient D’s request, Respondent prescribed Oxycontin to Patient D at a dosage of 80 milligrams, twice per day. There is no documentation in the medical records for this visit of any physical findings to justify a prescription of this nature. Such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient D’s pain level, experience with Oxycontin, or level of drug resistance.

102. During this same visit, despite Patient D’s request for an Oxycontin refill, the medical records for this visit again erroneously reflect Patient D’s “current medications” as “none”.

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103. As a result of the two (2) visits Patient D made to Respondent, Respondent failed to generate or create medical records relating to the diagnosis, treatment and care of his patient.

104. Such conduct is unprofessional conduct pursuant to NRS 633.131(f), and NAC 633.350(5). Such conduct is grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT THIRTEEN

(Patient E - Excessive Prescribing)

105. The allegations set forth in paragraphs 1 through 104 are incorporated herein by reference, as though set forth in full.


107. On February 22, 2005, Patient E presented to Respondent, as a new patient, complaining of bronchitis, moderate pain in his left knee, acne, as well as allergies.

108. Despite the fact that Respondent made no abnormal findings as to Patient E's left knee pain and characterized Patient E's pain as moderate, Respondent issued an Oxycontin prescription to Patient E at a dosage of 80 milligrams, twice per day for thirty (30) days. Such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient E's pain level, experience with Oxycontin, or level of drug resistance.


110. Again, Respondent made no abnormal findings as to Patient E's right knee pain and failed to investigate the nature and possible causes of Patient E's pain. Respondent then refilled Patient E's Oxycontin prescription at a dosage of 80 milligrams, twice per day for thirty (30) days; another potentially life-threatening decision as Respondent still had no awareness of Patient E's pain level, experience with Oxycontin, or level of drug resistance.

111. On April 21, 2005, Patient E again presented to Respondent, complaining of right shoulder pain, bilateral knee pain, and seeking a refill of his Oxycontin prescription.
112. Again, Respondent made no abnormal findings as to Patient E's right shoulder or knees and then refilled Patient C's Oxycontin prescription at a dosage of 80 milligrams, twice per day for thirty (30) days; yet another potentially life threatening decision as Respondent still had no awareness of Patient E's pain level, experience with Oxycontin, or level of drug resistance.


114. Again, Respondent made no abnormal findings as to Patient E's shoulders or knees and then refilled Patient C's Oxycontin prescription at a dosage of 80 milligrams, twice per day, for thirty (30) days; yet another potentially life threatening decision as Respondent still had no awareness of Patient E's pain level, experience with Oxycontin, or level of drug resistance.

115. A dosage of 80 milligrams of Oxycontin, twice per day is usually administered to patients presenting in severe pain and/or patients who have built up considerable tolerance to pain medication.

116. Patient E satisfied neither of these criteria at the time the Respondent issued the above-referenced prescriptions.

117. Oxycontin is a dangerous and highly addictive controlled substance and is classified as a "Schedule II" narcotic pursuant to NAC 453.520. Thus, Respondent's prescription of Oxycontin in his treatment of Patient E during the time period and under the circumstances alleged above, is excessive and is a violation of NAC § 633.350(6) and NRS 633.131(f)(1). Respondent's actions also constitute unprofessional conduct and provide grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT FOURTEEN

(Patient E – Administering A Controlled Substance To Patients Without Justification Is Conduct Detrimental To The Public Health)

118. The allegations set forth in paragraphs 1 through 117 are incorporated herein by reference, as though set forth in full.
119. On four (4) occasions, spanning the period from February 22, 2005 through May 24, 2005, Respondent prescribed Oxycontin to Patient E at a dosage of 80 milligrams, twice per day for thirty (30) days.

120. Respondent prescribed the dosage of 80 milligrams, twice a day (the maximum possible Oxycontin dosage) for thirty (30) days, for Patient E, without objectively investigating the nature of Patient E's symptoms, or whether such a massive dosage was at all appropriate for that patient.

121. In consistently prescribing Oxycontin for Patient E in the dosages described herein and under the circumstances set forth above, Respondent has engaged in conduct that is harmful to his patients or is detrimental to the public health, safety and morals. Such conduct is a violation of NRS 633.131(f)(2) and constitutes grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT FIFTEEN

(Patient E – Failure To Document Prescribed Medications And The Clinical Observations Which Justify These Prescriptions Is Unprofessional Conduct)

122. The allegations set forth in paragraphs 1 through 121 are incorporated herein by reference, as though set forth in full.

123. Respondent treated Patient E on four (4) occasions, spanning the period from February 22, 2005 through May 24, 2005.


125. After examining Patient E, Respondent prescribed Oxycontin to Patient E at a dosage of 80 milligrams, twice per day for thirty (30) days (the maximum possible Oxycontin dosage). The medical records for this visit contain no physical findings to justify a prescription of this nature. Such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient E's pain level, experience with Oxycontin, or level of drug resistance.

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127. Again, Respondent made no abnormal findings as to Patient E's right knee pain and failed to investigate the nature and possible causes of Patient E's pain. Respondent then refilled Patient E's Oxycontin prescription at a dosage of 80 milligrams, twice per day for thirty (30) days. There is no documentation in the medical records for the visit of any physical findings to justify a prescription of this nature. Again, such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient E's pain level, experience with Oxycontin, or level of drug resistance.

128. During this same visit, despite Patient E's request for an Oxycontin refill, the medical records for this visit erroneously reflect Patient E's "current medications" as "none".

129. On April 21, 2005, Patient E again presented to Respondent, complaining of right shoulder pain, bilateral knee pain, and seeking a refill of his Oxycontin prescription.

130. Again, Respondent made no abnormal findings as to Patient E's right shoulder or knees and then refilled Patient E's Oxycontin prescription at a dosage of 80 milligrams, twice per day for thirty (30) days. There is no documentation in the medical records for this visit of any physical findings to justify a prescription of this nature. Again, such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient E's pain level, experience with Oxycontin, or level of drug resistance.

131. During this same visit, despite Patient E's request for an Oxycontin refill, the medical records for this visit again erroneously reflect Patient E's "current medications" as "none".


133. Again, Respondent made no abnormal findings as to Patient E's shoulders or knees and then refilled Patient E's Oxycontin prescription at a dosage of 80 milligrams, twice per day for thirty (30) days. There is no documentation in the medical records for this visit of any physical findings to justify a prescription of this nature. Such a dose of Oxycontin could
have been life threatening since Respondent had no awareness of Patient E's pain level, experience with Oxycontin, or level of drug resistance.

134. During this same visit, despite Patient E's specific request for a refill of an Oxycontin prescription, the medical records for this visit again erroneously reflect Patient E's "current medications" as "none".

135. As a result of the four (4) visits Patient E made to Respondent, Respondent failed to generate or create medical records relating to the diagnosis, treatment and care of his patient.

136. Such conduct is unprofessional conduct pursuant to NRS 633.131(f), and NAC 633.350(5). Such conduct is grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT SIXTEEN

(Patient F - Excessive Prescribing)

137. The allegations set forth in paragraphs 1 through 136 are incorporated herein by reference, as though set forth in full.

138. Respondent treated Patient F on three (3) occasions, spanning the period from February 25, 2005 through April 22, 2005.


140. Despite the fact that Respondent made no abnormal findings as to Patient F's lumbar spine and characterized Patient F's pain as moderate, Respondent issued an Oxycontin prescription to Patient F at a dosage of 80 milligrams, twice per day for thirty (30) days. Such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient F's pain level, experience with Oxycontin, or level of drug resistance.


142. Again, Respondent made no abnormal findings as to Patient F's lumbar spine and failed to investigate the nature and possible causes of Patient F's pain. Respondent then refilled Patient F's Oxycontin prescription at a dosage of 80 milligrams, twice per day for thirty
Such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient F's pain level, experience with Oxycontin, or level of drug resistance.

143. On April 22, 2005, Patient F again presented to Respondent, complaining of lumbar and right shoulder pain and seeking a refill of an Oxycontin prescription.

144. Again, Respondent made no abnormal findings as to Patient F's lumbar spine or right shoulder and then refilled Patient F's Oxycontin prescription at a dosage of 80 milligrams, twice per day for thirty (30) days. Such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient F's pain level, experience with Oxycontin, or level of drug resistance.

145. A dosage of 80 milligrams of Oxycontin, twice per day for thirty (30) days is usually administered to patients presenting in severe pain and/or patients who have built up considerable tolerance to pain medication.

146. Patient F satisfied neither of these criteria at the time the Respondent issued the above-referenced prescriptions.

147. Oxycontin is a dangerous and highly addictive controlled substance and is classified as a "Schedule II" narcotic pursuant to NAC 453.520. Thus, Respondent's prescription of Oxycontin in his treatment of Patient C during the time period and under the circumstances alleged above, is excessive and is a violation of NAC § 633.350(6) and NRS 633.131(f)(1). Respondent's actions also constitute unprofessional conduct and provide grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT SEVENTEEN

(Patient F – Administering A Controlled Substance To Patients Without Justification Is Conduct Detrimental To The Public Health)

148. The allegations set forth in paragraphs 1 through 147 are incorporated herein by reference, as though set forth in full.

149. On three (3) occasions, spanning the period from February 25, 2005 through April 22, 2005, Respondent prescribed Oxycontin to Patient F at a dosage of 80 milligrams, twice per day for thirty (30) days. Under these circumstances, Respondent's three (3)
prescriptions of Oxycontin could have been life threatening since Respondent had no awareness of Patient F’s pain level, experience with Oxycontin, or level of drug resistance.

150. Respondent prescribed the dosage of 80 milligrams, twice a day for thirty (30) days (the maximum possible Oxycontin dosage) for Patient F, without objectively investigating the objective cause or nature of Patient F’s symptoms, or whether such a massive dosage was at all appropriate for that patient.

151. In consistently prescribing Oxycontin for Patient F in the dosages described herein and under the circumstances set forth above, Respondent has engaged in conduct that is harmful to his patients or is detrimental to the public health, safety and morals. Such conduct is a violation of NRS 633.131(f)(2) and constitutes grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT EIGHTEEN

(Patient F – Failure To Document Prescribed Medications And The Clinical Observations Which Justify These Prescriptions Is Unprofessional Conduct)

152. The allegations set forth in paragraphs 1 through 151 are incorporated herein by reference, as though set forth in full.

153. Respondent treated Patient F on three (3) occasions, spanning the period from February 25, 2005 through April 22, 2005.


155. After examining Patient F, Respondent refilled his Oxycontin prescription at his request, at a dosage of 80 milligrams, twice per day. The medical records for this visit contain no physical findings to justify a prescription of this nature. Such a dose of Oxycontin could have bee life threatening since Respondent had no awareness of Patient F’s pain level, experience with Oxycontin, or level of drug resistance.

156. The medical records for this same visit erroneously reflect Patient F’s “current medications” as “none”.

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158. Again, Respondent made no abnormal findings as to Patient F’s lumbar spine and failed to investigate the nature and possible causes of Patient F’s pain. Respondent then refilled Patient F’s Oxycontin prescription at a dosage of 80 milligrams, twice per day, for thirty (30) days. Again, such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient A’s pain level, experience with Oxycontin, or level of drug resistance.

159. During this same visit, despite Patient F’s request for an Oxycontin refill, the medical records for this visit again erroneously reflect Patient F’s “current medications” as “none”.

160. On April 22, 2005, Patient F again presented to Respondent, complaining of lumbar and right shoulder pain and seeking an Oxycontin refill.

161. Again, Respondent made no abnormal findings as to Patient F’s lumbar spine or right shoulder and then refilled Patient C’s Oxycontin prescription at a dosage of 80 milligrams, twice per day. There is no documentation in the medical records for this visit of any physical findings to justify a prescription of this nature. Again, such a dose of Oxycontin could have been life threatening since Respondent had no awareness of Patient A’s pain level, experience with Oxycontin, or level of drug resistance.

162. During this same visit, despite Patient F’s request for an Oxycontin refill, the medical records for this visit again erroneously reflect Patient F’s “current medications” as “none”.

163. As a result of the three (3) visits Patient F made to Respondent, Respondent failed to generate or create medical records relating to the diagnosis, treatment and care of his patient.

164. Such conduct is unprofessional conduct pursuant to NRS 633.131(f), and NAC 633.350(5). Such conduct is grounds for disciplinary action pursuant to NRS 633.511(1).
COUNT NINETEEN
(Summary Suspension)

165. The allegations set forth in paragraphs 1 through 164 are incorporated herein as if set out in full.

166. That the public health, safety, and welfare imperatively require action and summary suspension of Respondent’s license to practice medicine in the state of Nevada pending a hearing on the Complaint. That the continuing practice of medicine or the continuing ability to practice medicine by Respondent during the pendency of the time necessary for a hearing on this Complaint would endanger the health, safety, and welfare of his patients.

COUNT TWENTY
(Pattern of Unethical Conduct Which Constitutes
Unfitness To Practice Osteopathic Medicine)

167. The allegations set forth in paragraphs 1 through 166 are incorporated herein as if set out in full.

168. That the Respondent has engaged in a pattern of prescribing Oxycontin, a dangerous and highly addictive controlled substance which is classified as a “Schedule II” narcotic pursuant to NAC 453.520, in amounts and to an extent which falls outside the guidelines for prescribing which are observed by osteopathic medicine practitioners in the State of Nevada.

169. That the Respondent’s prescriptions of Oxycontin for Patients A, B, C, D, E, and F, as described herein, were excessive and irresponsible in light of the Respondent’s failure to investigate or document the facts and circumstances which warranted the issuance of these prescriptions.

170. That, taken as a whole, Respondent’s conduct constitutes a pattern of conduct which renders Respondent unfit to practice Osteopathic medicine.
WHEREFORE, the Investigative Member of the Board of Osteopathic Medicine prays as follows:

1. That the Nevada State Board of Osteopathic Medicine schedule an emergency hearing and affirmatively find that the public health, safety, and welfare imperatively require emergency action and summarily suspend Respondent's license to practice Osteopathic Medicine in the state of Nevada pending a hearing on the Complaint pursuant to NRS 633.591;

2. That the Nevada State Board of Osteopathic Medicine conduct a hearing on this Complaint as provided by statute;

3. That, pursuant to NRS 633.651, Respondent, JIM Y. WANG, D.O. be publicly reprimanded and/or the license of Respondent, JIM Y. WANG, D.O., be revoked, suspended, limited to a specified branch of osteopathic medicine, or placed on probation with conditions and terms as the Nevada State Board of Osteopathic Medicine may deem just and proper and which are not inconsistent with law;

4. That RESPONDENT, JIM Y. WANG, D.O., be ordered to pay reasonable attorney's fees and costs of the investigation and the administrative and disciplinary proceedings.

DATED this __ day of September, 2005.

By: [Signature]

DANIEL CURTIS, D.O.,
Investigating Member of the Nevada Board of Osteopathic Medicine

Submitted by:

BRIAN SANDOVAL
Attorney General

By: [Signature]

Richard I. Dretzer
Deputy Attorney General
555 E. Washington Avenue, Suite 3900
Las Vegas, Nevada 89101
(702) 486-3165
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4. That RESPONDENT, JIM Y. WANG, D.O., be ordered to pay reasonable attorney's fees and costs of the investigation and the administrative and disciplinary proceedings.

DATED this 1 day of September, 2005.

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

Submitted by:

BRIAN SANDOVAL
Attorney General

By: Richard I. Dreitzer
Deputy Attorney General
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