BEFORE THE NEVADA STATE
BOARD OF OSTEOPATHIC MEDICINE

IN THE MATTER OF THE COMPLAINT AGAINST GARY LUTZ, D.O. RESPONDENT.	Case No.: **AD-04-327** Filed: 4-11-05 Executive Director

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER REVOCATING MEDICAL LICENSE

This matter came on for hearing on March 8 and 9, 2005, before Rudy Manthei, D.O., Chairman, and members of the Nevada State Board of Osteopathic Medicine ("Board"), noticed in accordance with Nevada's Open Meeting laws and NRS and NAC Chapters 633. The investigating member of the Board, Dr. Gary Mono, was represented by Charlotte Bible, Chief Deputy Attorney General, and Deanne Rymarowicz, Deputy Attorney General. Respondent, Gary Lutz, D.O., was represented by John V. Spilotro, Esq. The Board's findings, conclusions of law, and order, as well as a discussion of the testimony and evidence presented, are set forth as follow:

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Statement of the Case

A Complaint was filed with the Board against Gary Lutz, D.O., on or about February 12, 2004 concerning two patients. On February 13, 2004, the medical license of Dr. Lutz was suspended pursuant to an emergency action by the Board. On or about October 4, 2004, an Amended Complaint was filed against Dr. Lutz, concerning a total of four patients, alleging malpractice, excessive prescribing of controlled substance, and falling below the community standard of care and treatment of patients for a Doctor of Osteopathic medicine.

Prior to the presentation of the case, Dr. Lutz, through counsel, admitted all allegations of the Amended Complaint concerning Patients B, C, and D. (Transcript (hereafter "Tr.") of March 8, 2005 hearing, p. 6.) Therefore, Counts 2, 3, 4, 5, 6, and 7 of the Amended Complaint were admitted.

Discussion of Testimony and Evidence

The Investigating Member presented two witnesses in support of the Amended Complaint; namely, Dr. Robert Kessler, as an expert witness, and John Hambrick as investigator for the Board. Dr. Kessler testified in detail concerning Dr. Lutz's care and treatment of Patients A, B, C, and D; and the medical records concerning Patients A, B, C, and D were offered into evidence. Such records were relied upon during Dr. Kessler's examination and cross-examination.

Concerning Patient A, Dr. Kessler testified that this patient's medical records indicated that the patient expressed suicidal ideology; yet, Dr. Lutz failed to refer the patient to a psychiatrist or a medical facility (Tr. 3-8-05, p. 20-3), although he did talk to Patient A about a previously attempted suicide. It was Dr. Kessler's opinion that Dr. Lutz over-prescribed medication for this patient as well, without adequate workup. Ultimately, this patient committed suicide. Dr. Kessler also expressed his opinion that the care and treatment rendered by Dr. Lutz to Patient A did not meet the standard of care ordinarily exercised by osteopathic physicians in good standing in this community. (Tr. 3-8-05, p. 27.)

On cross-examination, Dr. Kessler did agree that other physicians were also prescribing medication for this patient, and such was evident from the autopsy report. Dr. Kessler also admitted that he has seen situations were a patient is losing insurance and had prescriptions refilled at an earlier date while coverage was still available. (Tr. 3-8-05, p. 82.) The Board also questioned Dr. Kessler about Patient A, the possibility that the patient was selling drugs (Tr. 3-8-05, p. 125, 127), the requirement that a patient enter into a contract concerning controlled substance, and the notations made when additions are made to a medical record.

Concerning Patient B, Dr. Kessler expressed his opinion that Dr. Lutz over-prescribed for this patient as well. The medications prescribed included, but are not limited to, OxyFast, Lortab, OxyContin, Norco, Morphine, Methadone, Soma, Dilaudid, and Dexedrine (Tr. 3-8-05, p. 28-30), without an adequate workup. Dr. Kessler also noted that this patient was instructed to utilize a different pharmacy to apparently avoid the pharmacist from noticing any over-

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prescribing and/or too frequent of filling prescriptions. (Tr. 3-8-05, p. 38-9.) According to Dr. Kessler, the maximum dosage of Tylenol is 4,000 milligrams; and that the most common cause of drug overdose is due to Tylenol as it causes liver damage. (Tr. 3-8-05, p. 39.) Although most physicians try to keep the Tylenol dosage to less than 3,000 milligrams per day, this patient was receiving approximately 3,600 milligrams per day. (Tr. 3-8-05, p. 40.) Inadequate workup and/or examination of this patient were also noted by Dr. Kessler (Tr. 3-8-05, p. 41); and in his opinion, the care and treatment of this patient fell below the appropriate standard (Tr. 3-8-05, p. 45-6).

On cross-examination, Dr. Kessler was questioned whether this second pharmacy may be the result of a change in insurance carrier.

Concerning Patient C, Dr. Kessler testified that over-prescribing was noted in this patient's records as well. For example, Dr. Kessler noted that this patient was prescribed Actiq, Hydrocodone, Soma, Zanax, Percocet, OxyContin, Tenuate, Phentermine, Zoloft, Lexapro, Klonopin, Mobic, Provigil, Lortab, Ambien, and Valium (Tr. 3-8-05, p. 48-50). This witnesses was of the opinion that Dr. Lutz engaged in over-prescribing medication for this patient, without proper documentation of the pain source; and that the care and treatment of this patient fell below the standard of care for an osteopathic physician (Tr. 3-8-05, p. 56).

Concerning Patient D, Dr. Kessler noted the following prescribed medications: Lortab, Klonopin, Desyrel, Dyazide, Soma, Percocet, Methadone, Bextra, Arthrotec, Lexapro, Benicar, Viagra, AndroGel, Ritalin, Neurontin, Actiq, Wellbutrin, Dexedrine, and Vicodin (Tr. 3-8-05, p. 57-9). Dr. Kessler expressed concern that this patient was a forklift driver while under such heavy medication (Tr. 3-8-05, p. 60). Dr. Kessler was also critical of Dr. Lutz in his failure to do a physical examination and the inadequacy of the history from this patient (Tr. 3-8-05, p. 61). Dr. Kessler expressed his concern that this patient was also receiving "up to 5,000 milligrams of Tylenol a day" as he believes "Four thousand is a toxic dose . . . ." (Tr. 3-8-05, p. 62.) Several other examples of over-prescribing were provided by Dr. Kessler, as well as his opinion that there were several examples of "rapid escalations" in the dosages being prescribed. (Tr. 3-8-05, p. 64.) The medical records for this patient also indicated that he

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stated that he felt like "committing suicide because of the pain." (Tr. 3-8-05, p. 66.) Dr. Lutz, however, apparently did not refer this patient to either a medical institution or another physician for this suicidal ideation. In summary, Dr. Kessler testified that Dr. Lutz's care of this patient fell below the standard of care required and that Dr. Lutz over-prescribed medication for this patient. (Tr. 3-8-05, p. 66-7.)

John Hambrick testified concerning his investigation into the allegations raised regarding Dr. Lutz, his obtaining documentation from the State of Ohio (Exhibits F and G), and his dealings with the federal Drug Enforcement Administration ("DEA"). As a matter of fact, Mr. Hambrick obtained the medical records on Patients A, B, C, and D from the DEA who had received them directly from Dr. Lutz. Mr. Hambrick testified further that the DEA provided him with photocopies of prescriptions written by Dr. Lutz while suspended (Tr. 3-9-05, p. 156), and photocopies of the same were offered as evidence. Dr. Lutz was suspended by the Board of February 13, 2004. The prescriptions were dated between February 28 or February 26 and March 1st. Mr. Hambrick also testified that he did not believe that Dr. Lutz informed the Board of the agreement made with the State of Ohio licensing board (Tr. 3-9-05, p. 177).

Dr. Lutz presented correspondence from Dr. Steven Lampinen as evidence that Dr. Lutz should not have his license revoked (Defendant's Exhibit 1). All exhibits offered to the Board were admitted into evidence (Tr. 3-9-05, p. 186).

Closing arguments were allowed, rather than post-hearing briefs from the parties.

FINDINGS OF FACT

Based upon the record of the proceedings, including but not limited to the testimony and exhibits offered, the Board finds:

1. The medical records obtained from the DEA pertaining to Patients A, B, C, and D do contain proof of over-prescribing of medications to those patients. Records pertaining to other patients of Dr. Lutz are not before this Board and were not considered.

2. Dr. Robert Kessler testified that Dr. Lutz over-prescribed for Patients A, B, C, and D; and Dr. Kessler is knowledgeable as an expert as to the standard of care in the practice of Osteopathic medicine.

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3. The Board is mandated to license and monitor Osteopathic physicians in this State to protect the public health and safety, and to protect the general welfare of the people of this state. NRS 633.151.

4. Malpractice is defined in NRS 633.071 as the failure of an Osteopathic physician to exercise the degree of care, diligence, and skill ordinarily exercised by Osteopathic physicians in good standing in the community in which he practices.

5. Gross malpractice is defined in NRS 633.041, as where the failure of an Osteopathic physician to exercise the requisite degree of care, diligence, or skill (1) is in willful disregard of established medical procedures; (2) is gross negligence; and (3) is the willful and consistent use of procedures, services, or treatment that the osteopathic physician community deems inappropriate and/or unnecessary.

6. Over-prescribing medications for Patients A, B, C, and D is malpractice as well as gross malpractice, and are grounds for disciplinary action by this Board.

7. The care and treatment rendered to Patients A, B, C, and D fell below the standard of care for Osteopathic physicians in this community, and are grounds for disciplinary action by this Board.

8. The care and treatment rendered to Patients A, B, C, and D included medical procedures, services, and/or treatment which were inappropriate, inadequate, and/or unnecessary, and are grounds for disciplinary action by this Board.

9. By Dr. Lutz's acknowledgment, through counsel, the allegations contained in the Amended Complaint pertaining to Patients B, C, and D were admitted, and are grounds for discipline.

10. Dr. Lutz continued to prescribe medication for patients while his medical license was suspended.

11. Pursuant to NRS 633.651, this Board has the authority to: place a physician on probation, administer a public reprimand, limit a physician's practice, suspend a physician's license, or revoke the medical license of a physician practicing osteopathic medicine.

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3. The lack of due diligence by Dr. Lutz in following up with Patients and their Contracts concerning controlled substance was inadequate. The lack of follow-up includes, but is not limited to, little history taking (if any), lack of following charts, not determining if prescriptions are being filled too frequently, lack of referral of patients to specialists when suicidal ideology is expressed, too rapid of an increase in medication, and no urine tests for drug abuse.

4. The lack of due diligence and follow-up with patients as expressed immediately above is gross malpractice, and the number of patients seen by Dr. Lutz as compared to only these four cases being presented is irrelevant as to whether gross malpractice was committed on these four patients.

5. Dr. Lutz, through counsel, admitted the allegations contained in Counts II through VII, inclusive, of the Amended Complaint pertaining to Patients B, C, and D.

6. Dr. Lutz's care and treatment of Patients A, B, C, and D consistently fell below the standard of care for Osteopathic physicians, in this community, and such care and treatment was in disregard of established medical procedures for patients.

7. Dr. Lutz used medical procedures, services and/or treatment which were inappropriate and unnecessary.

8. Because of the few number of patients whose treatment are at issue, this Board cannot make a determination that a pattern of malpractice existed.

9. Dr. Lutz did issue prescriptions during a period of time when his license was suspended.

10. Should any finding of fact be more properly construed as a conclusion of law, may it be so deemed.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over the parties and the subject matters of the Amended Complaint on file herein pursuant to the provisions of NRS and NAC Chapters 633.

2. Dr. Lutz is a licensed Osteopathic physician subject to the provisions of NRS and NAC Chapters 633.

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12. Based upon the credible testimony and exhibits offered in this matter, disciplinary action in this matter is appropriate pursuant to NRS 633.511.

13. Although NRS 633.651 presents a number of different disciplinary actions, due to Dr. Lutz's disregard of his suspension, the medical license of Dr. Gary Lutz should be revoked pursuant to NRS 633.651.

14. Should any conclusion be more properly construed as a finding of fact, may it be so deemed.

DECISION AND ORDER

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED:

1. The medical license of Dr. Gary Lutz is hereby revoked.
2. Attorneys' fees and costs are awarded to the Board for bringing this disciplinary action. The Investigating Board Member and his counsel are hereby ordered to serve and file an application with this Board setting forth the amounts claimed, allowing Dr. Lutz to either agree or oppose the amount claimed, within 10 days of receipt of the application, and this Board retains jurisdiction to rule on such issue.

DATED THIS 6 day of April, 2005.

NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE

By: Susan L. McCarthy for
Rudy Manthei, Chairman

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