IN THE MATTER OF	*	**BEFORE THE**
NICOLA M. TAURASO, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D11324	*	**Case Numbers: 2010-0329 & 2010-0922**

* * * * * * * * * * * *

FINAL DECISION AND ORDER

The Board charged Nicola M. Tauraso, M.D., with unprofessional conduct in the practice of medicine, being professionally, mentally or physically incompetent, and with selling, prescribing, giving away, or administering drugs for illegal or illegitimate medical purposes, under §§ 14-104(a)(3)(ii), (4) and (27) of the Maryland Medical Practice Act, Md. Health Occ. Code Ann. § 14-101 *et seq.*

The Board has given Dr. Tauraso an opportunity to contest the findings set out below and to request an evidentiary hearing at which the State would have the burden of proof. Dr. Tauraso has elected not to avail himself of his hearing rights and thus has not contested the investigative findings, which are now set out as the Board's findings of fact below.

FINDINGS OF FACT

General Findings

1. Ninety-five percent of Dr. Tauraso's practice as of 2009 consisted of "pain management" patients. Dr. Tauraso saw these patients at fifteen-minute intervals throughout the day, and he often saw more than one patient in one fifteen-minute time slot, thus seeing up to 50 patients a day. He often prescribed narcotics and other Controlled Dangerous Substances to these patients for months without ever examining

them, and in all cases set out below he never examined any of them after the first visit. He charged $300 for a first visit and $200 for subsequent visits, as of June of 2010.

2. In almost every case set out below, Dr. Tauraso had the patients list the pain medications that they claimed were already being prescribed for them. These lists usually contained OxyContin[1] and oxycodone[2], two different versions of a dangerous narcotic opoid. A single 80 mg.tablet of OxyContin can cause severe respiratory distress or even death if taken by a person not already tolerant to opoids. In almost all cases examined by the Board, Dr. Tauraso prescribed on the first visit all of those drugs that the patient claimed that they were taking, in the amounts that they claimed they were taking, and he continued prescribing those drugs in the same or in an increased the dosage on subsequent visits.

3. Dr. Tauraso in some cases asked the patients to supply an MRI of the supposedly affected area. At times he continued to prescribe these drugs, whether the MRI was forthcoming or not. In the cases examined by the Board where an MRI was obtained or brought in by the patient, Dr. Tauraso continued to prescribe the same drugs in the same amounts, irrespective of the results shown by the MRIs. Dr. Tauraso was using the existence of an MRI report, not as an aide to inform his medical judgment, but as an excuse to continue to give these patients whatever drugs they claimed that they were already using.

4. a. On one occasion in the records reviewed by the Board, when another person in his office wrote on the chart that there was an indication that a particular patient might

---

[1] OxyContin is a controlled-release form of oxycodone, an addictive Schedule II opoid pain reliever. If taken in amounts greater than 40 mg. by a non-opoid-tolerant person, OxyContin, can cause fatal respitatory depression. *See Physicians' Desk Reference*, 64th ed., 2010, p. 2807.

[2] Oxycodone is the generic active ingredient in OcyContin.

be selling these drugs, Dr. Tuaraso wrote that he would consider terminating the patient from the practice. On another occasion, when others in the office had written in the chart that the patient was apparently lying in order to increase the amount of drugs obtained, Dr. Tauraso ignored the warning and prescribed the increased amounts.

b. On one occasion, Dr. Tauraso was aware that his patient had given some of the patient's OxyContin to a young girl, and that the young girl had almost overdosed as a result. Nevertheless, Dr. Tauraso continued to prescribe OxyContin to this patient.

c. One of the patients in the cases examined by the Board was arrested for selling the OxyContin that Dr. Tauraso prescribed to him. Another made a sale of OxyContin to an undercover agent. It is not certain, however, that Dr. Tauraso knew of these latter two incidents.

5. Dr. Tauraso, or someone under his direction and control, attempted to alter the patient records by whiting out certain entries after the records were subpoenaed by the Board.

Findings Concerning Patient A

6. Patient A, a female born in 1969, initially presented to Dr. Tauraso on October 7, 2009, complaining of pain in her lower right hip and right leg. Dr. Tauraso's entire examination note for Patient A's visit reads: "1998 car accident – lumbar tenderness, esp[ecially] on rt." Dr. Tauraso did not take a history, perform a sufficient physical examination, obtain or consider any past medical records, establish any urine screening or a pain management contract or do anything else other than prescribe Roxicodone 30 mg. (#150)[3], OxyContin 40 mg. (#120) and Xanax 2 Mg. (#60)[4]. With the exception of the

[3] Roxicodone is a brand name for oxycodone. See the U.S. Department of Justice's listing of controlled dangerous substances at www.deadiversion.usdoj.gov. *("Dept. of Justice Website").*

Xanax, which was added, these were the same Schedule II CDS drugs that the patient claimed that she was already taking at the time of that first visit.

7. No examination whatsoever took place on the second visit. No medical record was kept except for the notation of "Ibid. 1 mo." Even this notation was not correct, as he prescribed 180 tablets of oxycodone and 90 tablets of OxyContin on that date. He also wrote a refill of the Xanax prescription a few days later without any indication that an office visit had taken place at all.

8. The patient was then hospitalized for an overdose of Xanax and narcotics, and the hospital diagnosed her with: major depressive disorder, severe, recurrent, with suicidal ideation, opiate dependence, continuous, and sedative hypnotic dependence, continuous. Dr. Tauraso was aware of this diagnosis from the hospital record, and he wrote in the record that he discharged her from his practice for this reason. He did not, however, discharge her from the practice. She continued coming to Dr. Tauraso monthly, and he continued to write prescriptions for OxyContin and oxycodone for her for at least another six months, without any notations in the contemporary medical records as to why he did this. The patient herself filled out medication forms and a form in which she circled a number between 1 and 10 to indicate how helpful she thought the medications were. Other than blood pressure and pulse, however, there were no physical examinations, no medical notations other than "ibid, 1 mos.," no urine screening, no pain management contract, and no reason given for the continued prescriptions for powerful narcotics other than those reasons supplied by the patient.

[4] Xanax (alprazolam) , a benzodiazepine, is a Schedule IV Controlled Dangerous Substance. *Id.*

Findings Concerning Patient B

9. Patient B, a male born in 1970, initially presented to the Dr. Tauraso on January 29, 2009. The patient brought medical records that documented illnesses of clogged ears, congestion and elevated blood pressure only; but these records included documentation that the patient had been prescribed OxyContin 80 mg. (#40) and Roxicodone 15 mg. (#40), and the patient produced a document indicating that he had a pain management appointment elsewhere in February. There were no diagnostic or other studies in the medical records brought to Dr. Tauraso by the patient. Without conducting a physical examination, ordering any diagnostic tests or urine screens, obtaining any previous records, or making any other effort to diagnose the problem, Dr. Tauraso recorded that Patient B had "pain in back pain" and "drug addiction" and prescribed OxyContin and oxycodone.

10. Patient B returned to Dr. Tauraso 2 to 3 times a month through August 2009. Dr. Tauraso's notes state merely, "refill prescription." He performed no physical examination at all, nor did he perform or order any tests, nor did he write anything in the medical records other than "refill prescription." At one point, he increased the OxyContin and oxycodone from 40 to 60 tablets, without documenting any rationale for this increase.

Findings Concerning Patient C

11. Patient C, a male born in 1968, initially presented to Dr. Tauraso on December 29, 2009. He provided Sr. Tauraso a May 2009 radiograph report that revealed anterior listhesis.[5] Dr. Tauraso wrote in the medical record "tender lumbar area,

[5] Listhesis is the forward displacement of 1 of the lower lumbar vertebrae over the lower segment.

sciatica left, numbness and tingling of feet." Dr. Tauraso noted in the record that he ordered an MRI, but either he did not actually order it or he failed to obtain it.

12. Nevertheless, as Patient C reported that his medication regimen as "Roxy" 30 mg and "Oxy" 80 mg., Dr. Tauraso prescribed OxyContin 80 mg (t.i.d. – quantity unspecified) and oxycodone 30 mg (every 4 to 6 hours – quantity unspecified). Patient C returned to Dr. Tauraso for monthly visits through May 2010. Dr. Tauraso failed to examine Patient C, order any diagnostic tests, or document any reason in the record for his action in continuing to prescribe these drugs. On most visits, Dr. Tauraso noted only "ibid, 1 mos" on the bottom of the forms as his entire documentation of the visit.

Findings Concerning Patient D

13. Patient D, a male born in 1981, initially presented to Dr. Tauraso on November 17, 2009 complaining of back pain after moving furniture. He provided a May 27, 2009 radiograph report that was unremarkable except for mild degenerative changes.

14. Dr. Tauraso wrote "tender lumbar area, consistent with MRI results." There were, however, no MRI results in the patient's chart. Dr. Tauraso then prescribed OxyContin 40 mg t.i.d. and oxycodone 30 mg q.i.d., without specifying the quantity. He prescribed 120 tablets of oxycodone in December 2009, and 180 tablets of oxycodone and 90 tablets of OxyContin in April 2010 for this patient.

15. Patient D returned to Dr. Tauraso for monthly visits through June, 2010. At none of these subsequent visits did Dr. Tauraso examine Patient D or order any diagnostic tests or studies. On two occasions Dr. Tauraso noted merely "ibid, 1 mo" on

the bottom of the forms. Dr. Tauraso never documented why he increased the amount of Patient D's oxycodone in April of 2010.

16. When someone else wrote in the record this patient was seen associating with a suspected drug dealer, Dr. Tauraso wrote that he would consider discharging him.

Findings Concerning Patient E

17. Patient E, a male born in 1979, initially presented to Dr. Tauraso on January 25, 2010. Dr. Tauraso noted in the record: "car accident 5 mos ago, [blood pressure/pulse], tender lumbar spine, see MRI's."

18. The results of the October 27, 2009 MRI of Patient E's lumbar spine included: "small right-sided foraminal protrusion and annular fissure abutting the left L5 nerve roots in the neural foramen. There is no extruded fragment or spinal stenosis." The results of the MRI of Patient E's hip MRI include: "findings consistent with right trochanteric bursitis as well as a grade 1 tear [similar to a muscle pull] of the mytendinous junction of the tensor fascia lata. No evidence of avascular necrosis or osteoarthritis of the right hip."

19. Patient E's prior physician, who had seen him two times in October of 2009, had diagnosed Patient E with chronic pain syndrome and had prescribed OxyContin, oxycodone and Xanax. At Patient E's initial visit, Dr. Tauraso continued this medication regimen. He prescribed 210 tablets of oxycodone, 90 tablets of OxyContin 80 mg and 90 tablets of Xanax (with 3 refills).

20. Patient E returned on February 25, 2010 and monthly thereafter. At none of these visits did Dr. Tauraso conduct a physical examination, order any diagnostic testing or complete any urine or any other type of testing for drugs. He increased the dosage of

oxycodone from 210 tablets to 240 on February 25, 2010, without documenting any reason. Dr. Tauraso continued to increase the dosage until it reached 360 tablets by June 21, 2010, all without any examination or rationale, and without the completion of any drug testing. On June 21, 2010, Dr. Tauraso indicated in the records that he would discontinue OxyContin and double the amount of oxycocone.

21. Patient E was in fact selling OxyContin on the street, but there is no proof that Dr. Tauraso had direct knowledge of this.

Findings Concerning Patient F

22. Patient F, a female born in 1963, initially presented to Dr. Tauraso on October 12, 2009 with complaints of neck and back pain. Although she did not list any Controlled Dangerous Substances on her list of medications; Dr. Tauraso noted that she "was taking Vicodin." Dr. Tauraso wrote that Patient F had "pain all over, tenderness all over, believe it's not physical will try meds pending x-rays and MRI's." The MRI reports of Patient F's cervical spine in 2002 and 2004 showed no significant abnormalities; nor did a 2010 MRI of her knee, which showed the existence of a Baker's cyst, a painless lump.

23. At Patient F's initial visit, Dr. Tauraso prescribed MS Contin[6] 60 mg (#90), oxycodone 30 mg (#120) and amoxicillin. He also prescribed OxyContin. Dr. Tauraso never conducted an adequate physical examination on any subsequent visits, though he changed, and then increased, the amount of Controlled Dangerous Substances that were prescribed. On the second visit, Dr. Tauraso changed the OxyContin prescription to

[6] MS Contin is a controlled-release formulation of morphine and a Schedule II Controlled Dangerous Substance. *See Physicians' Desk Reference*, 64th ed., 2010, p. p.2803.

Percocet[7] (#90) without documenting why he was making the change. On January 28, 2010, he increased the amount of oxycodone from 120 tablets per month to 180 tablets based solely on her report of pain but in the absence of any documentation his treatment rationale or physical examination. Without conducting a physical examination, ordering any diagnostic studies or tests, or requiring any urine or other tests for drugs, Dr. Tauraso maintained Patient F's monthly regimen of oxycodone (#180), Percocet (#120) and Xanax (#90) at least through June of 2010.

Findings Concerning Patient G

24. Patient G, a male born in 1978, initially came to Dr. Tauraso on October 22, 2009 with complaints of a back injury. The patient's prior medical records from 2002 to 2007, however, indicated that the patient's primary problem was an ankle injury, and there is only one mention of back pain during those years. Dr. Tauraso recorded in his chart: "tender spine lumbar rt., sciatica L[eft] numbness of foot."

25. Although none of the prior medical records indicated that Patient G had previously been prescribed narcotics, the patient himself listed on an information sheet that he was taking OxyContin 80 mg q.i.d. and "RoxyContin" 30 mg q.i.d. Dr. Tauraso immediately prescribed OxyContin 80 mg (#120) and Roxicodone 30 mg (#120). Dr. Tauraso continued to prescribe these drugs in these amounts through at least May of 2010, all without again examining the patient, ordering diagnostic studies or tests, or requiring a drug urine screen or other drug test.

26. Dr. Tauraso maintained Patient G's monthly regimen through May 2010 (the last available record); Dr. Tauraso failed to document his findings at any of the visits. On

[7] Percocet is oxycodone combined with acetaminaphen and is a Schedule II Controlled Dangerous Substance. Md. Crim. Law Code Ann., § 5-403(b)(1)(xiv). *See also Dept. of Justice Website.*

May 5, 2010, Dr. Tauraso noted that the patient had "reinjured self" and increased the daily amount of oxycodone, but he failed to state in the record the type, severity, or even the location, of Patient G's alleged re-injury.

Findings Concerning Patient H

27. Patient H, a male born in 1982, first came to Dr. Tauraso on September 13, 2009 complaining of a painful left testicle, the result of a varicocele.[8] Dr. Tauraso did not review any prior medical records. In his initial note, the Tauraso wrote that both of Patient H's testicles had been operated on and that his left testicle was "v. painful and shrinking." He noted that he planned to refer the patient to a urologist; however, he failed to do so. Dr. Tauraso did not conduct an adequate physical examination on this initial visit.

28. The patient claimed that his current medication regimen was OxyContin 80 mg (4/day) and oxycodone 30 mg (3/day). Dr. Tauraso prescribed oxycodone 40 mg (#120). He then increased the dosage to 80 mg after the patient's first monthly visit. He failed to conduct a physical examination, refer the patient for any testing, require urine screening or any other drug testing, or document the reason for the dosage increase. His medical records concerning all later visits consisted essentially only of the list of the drugs he prescribed.

29. On October 30, 2009, 10 days after a previous visit, Dr. Tauraso prescribed 20 days worth of OxyContin and oxycodone to the patient because the patient stated that the previous dosage had been stolen. On November 17, Dr. Tauraso added Adderall[9] to

[8] The abnormal enlargement of the vein in the scrotum draining the testicles.
[9] Adderall, an amphetamine product, is a Schedule II CDS. *See Dept. of Justice Website.*

Patient H's regimen; on December 17, 2009, he added Klonopin;[10] Dr. Tauraso failed to document his treatment rationale, if any, for starting either drug.

30. Dr. Tauraso admitted to the Board's investigator that he was aware of numerous telephone calls implicating this patient as a drug dealer, and he claimed that he eventually discharged this patient. It is unclear for how long he saw this patient, however, because the notes that he provided to the Board investigator do not match the medical records kept in the office. In the record of a January, 2010, visit, Dr. Tauraso noted that the patient was sending other patients to the office and threatening them with guns to force them to sell their medications to him. Patient H was in fact arrested in or around February 2010 by Frederick County police for selling OxyContin pills obtained from Dr. Tauraso.

Findings Concerning Patient I

31. Patient I, a male born in 1979, first presented to Dr. Tauraso on November 23, 2009 after having undergone a replacement of his right hip over a year earlier following an accident on an all terrain vehicle. This patient had been discharged on November 20, 2009 from another physician's practice. On Patient I's initial visit Dr. Tauraso did not conduct a physical examination. He simply continued the medications Patient I claimed he was taking: OxyContin 80 mg. (3/day), oxycodone 30 mg. (4 – 6/day), and Xanax (3/day).

32. Although this patient saw Dr. Tauraso on a monthly basis, Dr. Tauraso failed to conduct a physical examination of him, order any diagnostic tests, or require any type of drug screening; his notes of each visit consist of the notation "1 mos" or "ibid." at the bottom of the form filled out by the patient. Despite learning that the patient had been

[10] Klonopin, a benzodiazepine, is a Schedule IV CDS. *See Dept. of Justice website.*

arrested in 2008 for possession of Controlled dangerous Substances, Dr. Tauraso continued to prescribe OxyContin, oxycodone and Xanax without any medical examination, diagnostic tests or drug screening to this patient through at least June of 2010.

Findings Concerning Patient J

33. Patient J, a male born in 1984, initially presented to Dr. Tauraso on October 27, 2009. Prior medical records in Patient J's chart indicate that he had broken his right leg in seven years before while skiing, which injury had been repaired with intramedullary rodding of the tibia. The last orthopedic note, dated April 8, 2002, indicated that overall alignment was satisfactory. An x-ray report of Patient J's thoracic spine dated December 20, 2008 was essentially normal with no degenerative changes seen. Dr. Tauraso merely noted that Patient J's right knee and ankle had "pins," that he complained of lumbar pain with sciatica, and that he had sustained an "accident" 3 months ago in which he "injured hand, knees, ankle & back." He did not examine any of these parts of Patient J's body, nor did he order any x-rays, scans or other tests.

34. Dr. Tauraso never conducted an examination of Patient J. Instead, he merely wrote a prescription for the CDS that the patient claimed he was taking: OxyContin 80 mg, oxycodone 30 mg and Xanax 2 mg. Dr. Tauraso continued prescribing the same drugs at monthly visits thereafter, typically prescribing between 90 – 190 tablets of oxycodone and 60 – 90 tablets of OxyContin.

Findings Concerning Patient K

35. Patient K, a male born in 1983, initially presented to Dr. Tauraso on October 26, 2009 with complaints of neck and back pain. Dr. Tauraso indicated that he was not

convinced of the presence of much pain. Nevertheless, he immediately prescribed OxyContin 80 mg. t.i.d. and Oxycodone 30 mg. q.i.d. (#120). Later, having received an MRI showing that the patient was essentially normal, and noting himself that he believed that patient was faking the pain, Dr. Tauraso nevertheless continued to prescribe the CDS in these amounts for at least another six months, through June of 2010.

Findings Concerning Patient L

36. Patient L, a male born in 1971, initially presented to Dr. Tauraso on December 28, 2009; Dr. Tauraso noted "tender thoracic and lumbar spine" and "left sciatica." Patient L had undergone an MRI of his lumbar spine in March 2008, the results of which indicated some disk space narrowing and desiccation, but with neither disk extrusion nor protrusion.

37. At Patient L's initial visit, Dr. Tauraso continued the regimen Patient L claimed that he was taking: OxyContin 80 mg (3/day); oxycodone 30 mg (6/day), Lyrica (1/day) and a prednisone inhaler. Although Dr. Tauraso prescribed the latter medication presumably based on Patient L's report of "breathing problems;" he failed to examine the patient or document any findings or information regarding this issue.[11]

38. Patient L returned on January 9, 2010, Dr. Tauraso did not perform a medical examination. In his office notes, Dr. Tauraso noted only that he prescribed a proventil inhaler and Soma 350. He failed to document on the office medical records any findings or diagnosis related to the prescription for Soma. On January 21, 2009, Dr. Tauraso whited out Patient L's own assessment of pain as "2" and replaced it with a "6" and continued to prescribe 90 tablets of OxyContin 80 mg and 120 tablets of oxycodone on a

[11] Respiratory depression is the chief danger of taking oxycodone and OxyContin. *See* Physicians' Desk Reference, 64th ed. (2010), p. 2809.

monthly basis through at least June 2010. Although his office staff noted that the patient was coming in for refills much too early and "must be kicked out" of the practice, Dr. Tauraso nevertheless continued to prescribe the same regimen on a monthly basis through at least June of 2010, even after the patient requested additional drugs with the excuse that he had "misplaced" them.

Findings Concerning Patient M

39. Patient M, a female born in 1976, presented to Dr. Tauraso on September 27, 2009, after having been discharged from another physician's practice the previous month. Dr. Tauraso failed to conduct a physical examination of Patient M at her first visit. A July, 2007, procedure note in Patient M's chart from previous treatment sources indicates that she had undergone laparoscopy with cauterization of endometriosis in July of 2007. Dr. Tauraso wrote that Patient M had endometriosis. The patient reported that her current medication regimen was OxyContin 80 mg b.i.d and oxycodone 30 mg q.i.d. Dr. Tauraso prescribed 30 tablets of OxyContin 80 mg and 120 tablets of oxycodone 30 mg. Dr. Tauraso also prescribed 30 tablets of amoxicillin, noting "mod. Bronchitis."

40. Patient M returned to Dr. Tauraso on October 26, 2009. He continued the prescriptions for these substances. He did not examine the patient during this visit, nor did he enter any medical note in her chart except: "ibid." On December 29, 2009, Dr. Tauraso increased Patient M's oxycodone from 120 to 180 tablets in the absence of any examination or any documentation whatsoever. On January 5, 2010, he prescribed furosemide, a diuretic, in the absence of any examination or documentation.

Findings Concerning Patient N

41. Patient N, a male born in 1989, first saw Dr. Tauraso on October 6, 2009, with complaints of knee pain due to arthritis. Patient N claimed that his current medication regimen was OxyContin 80 mg (3 times/day) and oxycodone 30 mg (4 times/day). Dr. Tauraso prescribed these substances in these amounts, without conducting an examination or ordering any diagnostic tests. Later in that month, Dr. Tauraso increased Patient N's oxycodone from 4 tablets a day to 6 tablets a day and increased the number he prescribed to 180 tablets without conducting a medical examination or any diagnostic tests. On January 20, 2010, Dr. Tauraso added Xanax t.i.d. without conducting an examination or documenting his treatment rationale.

42. Dr. Tauraso was aware that the patient had given some of his OxyContin pills to a young girl who had almost overdosed as a result. He was also aware of allegations that Patient N had assaulted someone with a gun. Nevertheless, at Patient N's next visit, Dr. Tauraso prescribed OxyContin and oxycodone as usual.

43. On April 9, 2010, Dr. Tauraso prescribed Patient N OxyContin 80 mg (#90), oxycodone 30 mg (#180) and Xanax (quantity unspecified, 4 refills). In his notes for this appointment, Dr. Tauraso noted that the patient was being put out of the practice. Nevertheless, Dr. Tauraso continued to prescribe the same monthly regimen through at least June of 2010.

Findings Concerning Patient O

44. Patient O, a female born in 1970, first saw Dr. Tauraso on May 27, 2009. Prior medical records in her chart reveal that Patient O had "long-standing issues with depression, anxiety with panic symptoms, idiosyncratic thoughts and attention problems."

Patient O reported that she was in "severe pain," and she listed numerous illnesses, including fibromyalgia, trigeminal neuralgia, myofascial syndrome, endocarditis, hepatitis C, ADHD and chronic fatigue syndrome. She stated that she was taking Klonopin, Ambien[12] and Adderall[13], none of which are opoid substances. Dr. Tauraso did not examine the patient, but he prescribed: Klonopin and Ritalin.[14] He also prescribed Fentanyl, an opoid analygesic, the use of which in non-opoid-tolerant persons can cause fatal respiratory depression.[15]

45. On June 11, 2002, without performing any medical examination, Dr. Tauraso discontinued Fentanyl patches and replaced it with hydrocodone. He noted that Fentanyl patches could lead to "death." In July 2009, however, without performing any medical examination or providing any explanation, Dr. Tauraso resumed prescribing Fentanyl, and he continued to prescribe Patient O Fentanyl patches, Ritalin (#120) and hydromorphone (#100)[16] through October 2009. He never examined her.

Findings Concerning Patient P

46. Patient P, a male born in 1958, initially presented to Dr. Tauraso on October 27, 2009 with a stated history of back pain and diabetes. Dr. Tauraso did not conduct an examination of Patient P, but he did prescribe OxyContin 80 mg. t.i.d. and Roxicodone 30 mg. q.i.d., and albuterol.

47. Dr. Tauraso did ask for the results of a previous MRI, the findings of which were consistent with osteoarthritis of both knees. Patient P returned to Dr. Tauraso on

---

[12] Ambien is a Schedule IV Controlled Dangerous Substance. *See Dept. of Justice Website.*
[13] Adderal is an amphetamine and aSchedule II Controlled Dangerous Substance. *See Dept. of Justice Website.*
[14] Ritalin is a Schedule II Controlled Dangerous Substance. *See Dept. of Justice Website.*
[15] See *Physicians' Desk Reference*, 64th ed. (2010), p. 2604. Fentanyl is an opoid and a Schedule II Controlled Dangerous Substance. *See Dept. of Justice Website.*
[16] Hydromorphone is a Schedule II Controlled Dangerous Substance. *See Dept. of Justice Website.*

December 22, 2009, at which time, without any examination, Dr. Tauraso increased Patient P's Roxicodone from 4 tablets a day to 4 to 6 tablets a day.

48. Patient P saw Dr. Tauraso on a monthly basis through at least June of 2010. Dr. Tauraso failed to examine the patient at any of the visits, conduct any assessment or order any diagnostic studies, or write anything of significance in the chart. On June 16, 2010, Dr. Tauraso noted, without explanation, that he was discontinuing Patient P's OxyContin and replacing it with Dilaudid[17] 8 mg and Roxicodone.

Findings Concerning Patient Q

49. Patient Q, a male born in 1971 and then an inmate at the Frederick County Detention Center, first saw Dr. Tauraso on September 12, 2009 with complaints of low back pain, claiming that he was currently taking OxyContin (#90/month) and Roxicodone 30 mg (#120/month). At Patient Q's first visit, Dr. Tauraso prescribed 120 tablets of OxyContin 40 mg., and oxycodone 30 mg (1 every 6 hours). Dr. Tauraso's medical note stated "pain left lumbar area, sacroiliac joint."

50. Patient Q returned to Dr. Tauraso twice in October and once in November. Dr. Tauraso did not examine him at any of those visits, and he made no medical notes of any significance, but he continued to prescribe OxyContin and oxycodone in the same or larger amounts at these visits. After someone in Dr. Tauraso's office wrote on the chart that Patient Q's identification was fake, Dr. Tauraso discharged him from the practice.

Conclusions of Law

By repeatedly providing his patients with prescriptions for the large amounts of Controlled Dangerous Substances that they requested, in the absence of any illness that would reasonably call for those prescriptions, and in the absence of an adequate medical

[17] Dilaudid is a trade name for hydromorphone hydrochloride.

examination, and by failing to once reexamine these patients before continuing the prescriptions or even increasing the amounts of the substances prescribed, Dr. Tauraso prescribed drugs for illegal or illegitimate medical purposes, in violation of H.O. § 14-404(a)(27).

By that same conduct, and because he continued this prescribing in one case even when he knew that the patient had given the drug to another person who subsequently suffered adverse health consequences, and because he ignored explicit warnings from his staff that another patient should be terminated from the practice for requesting additional drugs, Dr. Tauraso demonstrated that he is professionally incompetent to practice medicine within the meaning of H.O. § 14-404(a)(4).

By the same conduct listed in the two paragraphs above, and because he or someone under his control and direction altered medical documents after they were subpoenaed by the Board, Dr. Tauraso committed unprofessional conduct in the practice of medicine, in violation of H.O. § 14-404(a)(3)(ii).

SANCTION

The Board placed quotation marks around the words "pain management" in this decision for a reason. The Board does not consider Dr. Tauraso's repeated dispensing of prescriptions for Controlled Dangerous Substances, at will, to patients whose conditions he barely took note of, to be a pain management practice at all. His indiscriminate writing of these prescriptions for these highly addictive and dangerous substances with a high street value and potential for diversion was not really the practice of medicine at all. Although he did cover his actions with a very thin veneer of medical terminology, Dr. Tauraso was not really practicing medicine. He was selling prescriptions. In the cases

reviewed by the Board, he was using his medical practice merely as a cover for this activity. In the case of Patient N, he continued prescribing even after he knew that the patient had diverted the drug to a person who suffered adverse health consequences. In the case of Patient L, he continued prescribing in the face of strong indications that the patient was abusing or diverting the drug. In short, Dr. Tauraso was knowingly profiting from endangering the health not only of his patients but even of the public at large. The Board has determined that a strong sanction is appropriate and that it should include a substantial fine in light of the financial gain he derived from these despicable activities.

ORDER

It is therefore **ORDERED** that the medical license of Dr. Nicola M. Tauraso be, and it hereby is, **REVOKED**; and it if further

ORDERED that this revocation is permanent, and the Board will not accept any application for reinstatement from Dr. Tauraso, and it is further

ORDERED that Dr. Tauroso be fined $50,000 according to COMAR 10.32.02.06 C (4)(c); and it is further

ORDERED that this order constitutes a public document pursuant to Md. State Gov't Ann. § 10-617.

6/9/11
Date

C. Irving Pinder, Jr.
Executive Director
Maryland State Board of Physicians

NOTICE OF RIGHT TO APPEAL

Pursuant to section 14-408(b) of the Health Occupations Article, Dr. Tauraso has the right to seek judicial review of this decision. Any petition for judicial review shall be

filed within 30 days from the date this Final Decision and Order is mailed. This Final Decision and Order is mailed on the date it is executed, which is set out above. The petition for judicial review shall be made as provided for in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222, and Maryland Rules 7-201 *et seq.*

If Dr. Tauraso files an appeal, the Board is a party and should be served with the court's process at the following address: **Maryland State Board of Physicians, c/o Christine Farrelly, Chief of Compliance Administration, 4201 Patterson Avenue, Baltimore, Maryland 21215.** The administrative prosecutor is not involved in the circuit court process and need not be served or copied on pleadings filed in the circuit court.