WS WPW (F

Final Order No. BPR-94-03696 Date 6-22-94
FILED
Dept. of Business and Professional Regulation
AGENCY CLERK
Sarah Wachman, Agency Clerk
By: Brandon D. Moore

STATE OF FLORIDA
DEPARTMENT OF BUSINESS AND PROFESSIC
BOARD OF MEDICINE

DEPARTMENT OF BUSINESS AND
PROFESSIONAL REGULATION,

Petitioner,

v.

DBPR CASE NUMBER: 91-03391
LICENSE NUMBER: ME 0050155

JOSEPH N. DE LUCA, M.D.,

Respondent.
_____/

FINAL ORDER

THIS MATTER came before the Board of Medicine (Board) pursuant to Section 120.57(3), Florida Statutes, on June 3, 1994, in Palm Beach, Florida, for consideration of a Consent Agreement (attached hereto as Exhibit A) entered into between the parties in the above-styled case. Upon consideration of the Consent Agreement, the documents submitted in support thereof, the arguments of the parties, and being otherwise advised in the premises, the Board rejected the Consent Agreement proposed and offered an amendment at the hearing, which amendment was accepted without objection by the parties.

IT IS HEREBY ORDERED AND ADJUDGED that the Consent Agreement as submitted be and is hereby approved and adopted in toto and incorporated by reference herein with the amendment that the Letter of Caution set forth in Paragraph 3 of the Stipulated Disposition is amended to reflect a Reprimand. Additionally, the Respondent shall within three (3) months of the filing of the final order in this case, write and present to the Probationer's Committee for approval, an article, suitable for publication, on the indications

for Ritalin in the practice of psychiatry and the legal requirement imposed by the Medical Practice Act and Rules of the Board of Medicine.

Accordingly, the parties shall adhere to and abide by all of the terms and conditions of the Consent Agreement, as amended.

This Final Order takes effect upon filing with the Clerk of the Department.

DONE AND ORDERED this 23rd day June, 1994.

BOARD OF MEDICINE

GARY E. WINCHESTER, M.D.
VICE CHAIRMAN

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been provided by certified U.S. Mail to Joseph N. De Luca, M>D. 505 Wekiva Springs Road, #400, Longwood, Florida 32779, Terry D. Dixon, Esquire, 108 East Central Boulevard, P.O. Box 753, Orlando, Florida 32802-0753, and by interoffice delivery to Larry G. McPherson, Jr., Chief Medical Attorney, Department of Business and Professional Regulation, Northwood Centre, 1940 North Monroe Street, Tallahassee, Florida 32399-0792, at or before 5:00 P.M., this _____ day of _____, 1994.

MARM M. HARRIS, Ed.D.
Executive Director

STATE OF FLORIDA
DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION,

Petitioner,

v. DBPR CASE NO. 91-03391

JOSEPH DE LUCA, M.D.,

Respondent.
_____/

CONSENT AGREEMENT

Joseph De Luca, M.D., referred to as the "Respondent," and the Department of Business and Professional Regulation, referred to as "Department," stipulate and agree to the following Agreement and to the entry of a Final Order of the Board of Medicine, referred to as "Board," incorporating the Stipulated Facts and Stipulated Disposition in this matter.

STIPULATED FACTS

1. At all times material hereto, Respondent was a licensed physician in the State of Florida, having been issued license number ME 0050155.

2. Respondent was charged by an Administrative Complaint filed by the Department and properly served upon Respondent with violations of Chapter 458, Florida Statutes, and the rules enacted pursuant thereto. A true and correct copy of the Administrative Complaint is attached hereto as Exhibit A.

3. Respondent neither admits nor denies the allegations of fact contained in the Administrative Complaint.

STIPULATED CONCLUSIONS OF LAW

1. Respondent admits that, in his capacity as a licensed physician, he is subject to the provisions of Chapters 455 and 458, Florida Statutes, and the jurisdiction of the Department and the Board.

2. Respondent admits that the facts set forth in the attached Administrative Complaint, if proven, would constitute violations of Chapter 458, Florida Statutes, as alleged in the Administrative Complaint.

STIPULATED DISPOSITION

1. **FUTURE CONDUCT**. Respondent shall not in the future violate Chapters 455, 458, and 893, Florida Statutes, or the rules promulgated pursuant thereto. Prior to signing this agreement, the Respondent read Chapters 455, 458, and 893 and the Rules of the Board of Medicine in Section 61 F6, Florida Administrative Code.

2. **FINE**. The Board shall impose an administrative fine in the amount of $4,000.00 against the Respondent. The fine shall be paid by the Respondent to the Board of Medicine within twelve (12) months of its imposition by Final Order of the Board.

3. **LETTER OF CAUTION**. The Respondent shall receive a Letter of Caution from the Board of Medicine.

4. **OBLIGATIONS/REQUIREMENTS**. Under the terms of this Agreement, Respondent shall attend the continuing education course sponsored by the Florida Medical Association Committee on Clinical Excellence entitled "Quality Medical Record Keeping For Health Care Professionals." Respondent shall submit documentation in the form of certified copies of the receipts, vouchers, certificates, or other papers, such as physician's recognition awards, documenting

completion of the medical courses within one (1) year of the entry of the Final Order in this matter. All such documentation shall be sent to the Board of Medicine, regardless of whether some or any of such documentation was previously provided during the course of any audit or discussion with counsel for the Department. These hours shall be in addition to those hours required for renewal of licensure. Unless otherwise approved by the Board, said continuing medical education courses shall consist of a formal, live lecture format.

5. It is expressly understood that this Agreement is subject to the approval of the Board and the Department. In this regard, the foregoing paragraphs (and only the foregoing paragraphs) shall have no force and effect unless a Final Order incorporating the terms of this Agreement is entered by the Board.

6. Respondent shall appear before the Board at the meeting of the Board where this Agreement is considered. Respondent, in conjunction with the consideration of this Agreement by the Board, shall respond to questions under oath from the Board, Board staff or Department staff whereby he demonstrates what actions have been taken in his medical practice to insure that this type of episode does not reoccur.

7. Should this Agreement be rejected, no statement made in furtherance of this Agreement by Respondent may be used as direct evidence against the Respondent in any proceeding; however, such statements may be used by the Petitioner for impeachment purposes.

8. Respondent and the Department fully understand that this joint agreement and subsequent Final Order incorporating same will in no way preclude additional proceedings against Respondent for

acts or omissions not specifically set forth in the Amended Administrative Complaint attached as Exhibit "A" herein.

9. Upon the Board's adoption of this Agreement, Respondent expressly waives all further procedural steps, and expressly waives all rights to seek judicial review of or to otherwise challenge or contest the validity of the Agreement and the Final Order of the Board incorporating said Agreement.

10. Upon the Board's adoption of this Agreement, the parties hereby agree that each party will bear his own attorney's fees and costs resulting from prosecution or defense of this matter. Respondent waives the right to seek any attorney's fees or costs from the Department in connection with this matter.

11. This agreement is executed by the Respondent for the purpose of avoiding further administrative action with respect to this cause. In this regard, Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent prior to or in conjunction with consideration of the Agreement. Furthermore, should this joint Agreement not be accepted by the Board, it is agreed that presentation to and consideration of this Agreement and other documents and matters by the Board shall not unfairly or illegally prejudice the Board or any of its members from further participation, consideration, or resolution of these proceedings.

SIGNED this 29 day of April, 1994.

Joseph De Luca, M.D.

Before me, personally appeared Joseph De Luca, M.D., whose identity is known to me by personally (type of identification) and who, under oath, acknowledges that his signature appears above.

Sworn to and subscribed before me this 29th day of April, 1994.

Marilynn U. Richards
NOTARY PUBLIC

MARILYNN U. RICHARDS
MY COMMISSION # CC 230908
EXPIRES: September 24, 1998
Bonded Thru Notary Public Underwriters

My Commission Expires:

Approved this 5 day of May, 1994.

George Stuart
Secretary

By: Larry G. McPherson, Jr.
Chief Attorney

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL REGULATION,

PETITIONER,

vs. CASE NO. 9103391

JOSEPH N. DE LUCA, M.D.

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Department of Professional Regulation, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against JOSEPH N. DE LUCA, M.D., hereinafter referred to as "Respondent," and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.30, Florida Statutes; Chapter 455, Florida Statutes; and Chapter 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0050155. Respondent's last known address is 505 Wekiva Springs Road #400, Longwood, Florida 32779.

3. On or about February 22, 1990, Patient #1, a 28 year old woman, whose major complaint was depression, first sought medical care from Respondent, a medical doctor with an alleged Ph.D.

4. The patient's therapist, Mr. Steve Peirsol, referred Patient #1 to Respondent for additional treatment.

5. On or about February 22, 1990, medical records reflect Respondent performed a clinical interview and mental status evaluation on Patient #1; Respondent assessed that Patient #1 suffered from Depression Endogenous.

6. On or about February 22, 1990, in his initial evaluation report, Respondent recommended the following plan of treatment: an increase in the dosage of Prozac, previously prescribed by another physician; that the Patient #1 receive a medicine check in four (4) weeks, or as needed; an explanation of the course of action and possible side effects were explained to the patient; and Respondent recommenced Patient #1 continue individual psychotherapy with Mr. Peirsol.

7. From on or about February 22, 1990, to on or about September 13, 1990, Respondent's medical records for Patient #1 document the treatment Patient #1 received at his office.

8. Respondent's appointment ledger and medical records document that Patient #1 visited Respondent's office on seven (7) occasions: February 22, March 19, April 2, April 24, May 24, June 25, and July 20, 1990.

9. Contained in Respondent's medical record for Patient #1 is an American Psych Management Outpatient Treatment Report indemnity form, signed and dated on or about February 13, 1990 by the therapist, and signed and dated on or about February 21, 1990 by Respondent, stating that Respondent provided supervisory

services to Mr. Peirsol, M.S., in the therapist's care of Patient #1, from on or about December 10, 1989 to on or about February 22, 1990.

10. From on or about December 10, 1989, through on or about February 22, 1990, during the time Respondent provided supervision over Mr. Peirsol' care of Patient #1, as documented in the indemnity form signed by Respondent, Respondent's medical records for Patient #1 do not document the care and progress made by the patient in her therapy sessions with Mr. Peirsol.

11. On or about June 3, 1991, in a telephone interview Mr. Peirsol stated he is not a licensed Mental Health Counselor in the State of Florida, but works under the supervision of physicians, including the Respondent.

12. On or about May 24, 1991, in an interview Respondent denied any business, professional or supervisory relationship with Mr. Peirsol.

13. Respondent billed Patient #1's insurance carrier, for services neither performed nor supervised by Respondent on the following dates: December 10, 1989; December 16, 1989; January 6, 1990; January 10, 1990; January 13, 1990; January 20, 1990; January 24, 1990; January 27, 1990; February 7, 1990; February 22, 1990.

14. From on or about December 10, 1989, through on or about December 16, 1989, Respondent billed Patient #1's insurance company for services neither performed nor supervised by Respondent in the amount of two hundred ninety-five dollars ($295.00).

15. From on or about January 6, 1990, through on or about January 27, 1990, Respondent billed Patient #1's insurance company for services neither performed nor supervised by Respondent in the amount of seven hundred and forty-five dollars ($745.00).

16. From on or about February 7, through on or about February 10, 1990, Respondent billed Patient #1's insurance company for services neither performed nor supervised by Respondent in the amount of one hundred and ninety-five dollars ($195.00).

17. On or about February 17, 1990, Respondent billed Patient #1's insurance company for services neither performed nor supervised by Respondent in the amount of ninety-five dollars ($95.00).

18. In the aforementioned interview, Respondent stated he saw Patient #1 as a patient from February 1990 through July 1990.

19. On or about March 19, 1990, Respondent failed to record in the patient's progress notes the treatment Patient #1 received on that date, but reference is made to the treatment provided on that date in a letter to Patient #1 dated September 21, 1990.

20. The September 21, 1990 letter summarizes the overall care and attempts to justify to the patient the types and quantity of medications prescribed to Patient #1 over the course of his treatment.

21. Respondent failed to record in Patient #1's medical records her visits to his office to receive Vitamin B-12 shots on the following dates: June 27, 1990 and July 20, 1990.

22. Respondent received payment from the patient's insurance carrier for the medical services rendered on June 27, 1990 and July 20, 1990.

23. Respondent billed and received payment from Patient #1's insurance carrier, Equitable Life Assurance Society of the United States, for twenty-one (21) billed office visits which are not documented in Respondent's medical records for Patient #1.

24. From on or about February 24, 1990 to on or about August 21, 1990, Respondent billed Patient #1's insurance company for services not supervised or performed by Respondent for the approximate dollar value of three thousand eight hundred eighty-five dollars ($3,885.00).

25. From on or about December 1989, to on or about August 1990, insurance forms indicate in summary format that Respondent received payment for services rendered on the aforementioned dates, when in fact services were not performed by the Respondent or under his supervision, but were billed for the financial benefit of a third party, Mr. Peirsol.

26. On or about June 11, 1991 in an interview, Mr. Peirsol stated that he initially received direct payment from Patient #1, but later received payment from Respondent's secretary after the insurance company paid Respondent.

27. On or about June 3, 1991, in an interview Mr. Peirsol stated he provided Respondent with verbal and written reports concerning Patient #1's progress.

28. Respondent's medical records for Patient #1 do not contain consultation reports or references to conversations between the patient's therapist and Respondent concerning Patient #1's progress.

29. Over the course of treating Patient #1, Respondent prescribed a variety of medications to the patient in order to treat his initial diagnosis of Depression Endogenous.

30. Medical records indicate Respondent prescribed or knew Patient #1 was taking, among other medications, the following: Prozac, Sinequan, Prolixin, Synthroid, Vivactil, Cogentin, Halicon, Norpramin.

31. Respondent provides a summary explanation of his medication program in a letter to the patient dated September 21, 1990.

32. In the aforementioned letter, Respondent acknowledges that Patient #1 complained of nightmares, hallucinations and day-time fatigue.

33. The letter documents Patient #1 frequently called Respondent's office expressing concern as to how she felt after taking medications prescribed by Respondent.

34. On several occasions, Patient #1 called to inform the Respondent that she modified or discontinued taking medications he prescribed.

35. Patient #1 felt over-sedated and medical records indicate Respondent saw the patient on only seven (7) visits.

36. Respondent should have seen Patient #1 more frequently to monitor, by direct observation, the clinical status of her complaints regarding the medications he prescribed.

37. Medical records indicate that Respondent prescribed, among other drugs, Synthroid, a thyroid hormone supplement used to treat hypothyroidism.

38. Respondent's rationale for prescribing Synthroid is based on the theory that 25 mcg. of Synthroid would increase the receptor site available for the antidepressant to attach to, and make it more efficacious.

39. On or about June 5, 13, and 19, 1990, Respondent serially increased the dosage of Synthroid, from 25 mcg. to 75 mcg., in response to Patient #1's fatigue complaints.

40. In the absence of hypothyroidism, the serial increase in Synthroid is a deviation from the standard of care in the appropriate use of thyroid medication.

41. On or about February 22, 1990, Respondent's medical records indicate he initially diagnosed Patient #1 as Depression Endogenous, then noted on April 2, and April 24, 1990, Rule/Out (R/O) schizo-affective, without elaboration.

42. The medical records fail to reflect that Respondent performed psychological testing to clarify his initial diagnosis of depression, or that Respondent considered the possibility that the patient's complaints were attributable to drug sensitivity, resulting in a toxic-organic reaction to the combinations medications Respondent prescribed.

COUNT ONE

43. Petitioner realleges and incorporates paragraphs one (1) through forty-two (42), as if fully set forth herein this Count One.

44. Respondent filed a report which he knew to be false when he filed false claim reports with Patient #1's insurance company for services not personally performed or supervised by Respondent on or about December 10, 1989 through on or about August 21, 1990.

45. Based on the foregoing, Respondent violated Section 458.331(1)(h), Florida Statutes, making or filing a report which the licensee knows to be false, intentionally or negligently failing to file a report or record required by state or federal law.

COUNT TWO

46. Petitioner realleges and incorporates paragraphs one (1) through forty-two (42), and forty-four (44), as if fully set forth herein this Count Two.

47. Respondent made a fraudulent representation in or related to the practice of medicine when he submitted a fraudulent statement on an indemnity claim form stating he supervised the activities of Patient #1's therapist, when Respondent subsequently denied any professional, business or supervisory relationship with that therapist.

48. Based on the foregoing, Respondent violated Section 458.331(1)(k), Florida Statutes, making deceptive, untrue, or

fraudulent representations in or related to the practice of medicine or employing a trick or scheme in the practice of medicine.

COUNT THREE

49. Petitioner realleges and incorporates paragraphs one (1) through forty-two (42), forty-four (44), and forty-seven (47), as if fully set forth herein this Count Three.

50. Respondent failed to keep written medical records justifying the course of treatment of the patient, in that the Respondent's medical records on Patient #1 fail to reflect the following: detailed evaluation to justify the differential diagnose and course of treatment; no progress notes on the treatment Respondent provided from on or about December 10, 1989 through February 21, 1990; no medical record document the treatment received on or about March 19, 1990; medical records do not contain consultation reports or references to conversation with the patient's therapist for psychotherapy sessions recommended by Respondent; and no documentation of the administration of Vitamin B-12 shots to Patient #1.

51. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

COUNT FOUR

52. Petitioner realleges and incorporates paragraphs one (1) through forty-two (42), forty-four (44), forty-seven (47), and fifty (50), as if fully set forth herein this Count Four.

53. Respondent engaged in a split-fee arrangement when Respondent billed and received payment from the patient's insurance company for services neither performed nor supervised by Respondent when distributed the insurance payment to a third party, Mr. Piersol, for the psychotherapy services provided to Patient #1.

54. Based on the foregoing, Respondent violated Section 458.331(1)(i), Florida Statutes, paying or receiving any commission, bonus, kickback, or rebate, or engaging in any split-fee arrangement in any form whatsoever with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services.

COUNT FIVE

55. Petitioner realleges and incorporates paragraphs one (1) through forty-two (42), forty-four (44), forty-seven (47), fifty (50), and fifty-three (53), as if fully set forth herein this Count Five.

56. Respondent failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances, in that Respondent failed to do the following: perform psychological testing to clarify his diagnosis of Depression Endogenous and to rule out schizo-affective; and

observe and treat the patient's symptoms that may have been related to toxic-organic reaction to the drugs he prescribed.

57. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, and/or any other relief that the Board deems appropriate.

SIGNED this 12TH day of December, 1991.

George Stuart, Secretary

for Larry G. McPherson, Jr.
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:

Larry G. McPherson, Jr.
Chief Medical Attorney
Department of Professional Regulation
1940 North Monroe Street
Tallahassee, Florida 32399-0750
Florida Bar #788643
CJR/GP
PCP: December 5, 1991
Ashkar, Skinner and McEwen

FILED
Department of Professional Regulation
AGENCY CLERK

CLERK _____

DATE 12-12-91