State of New Hampshire
Board of Medicine
Concord, New Hampshire 03301

In the Matter of:
Concetta R. Oteri-Ahmadpour, D.O.
License No.: 12549
(Misconduct Allegations)

SETTLEMENT AGREEMENT

In order to avoid the delay and expense of further proceedings and to promote the best interests of the public and the practice of medicine, the New Hampshire Board of Medicine ("Board") and Concetta R. Oteri-Ahmadpour, D.O. ("Dr. Oteri-Ahmadpour" or "Respondent"), a physician licensed by the Board, do hereby stipulate and agree to resolve certain allegations of professional misconduct now pending before the Board according to the following terms and conditions:

1. Pursuant to RSA 329:17, I; RSA 329:18; RSA 329:18-a; and Medical Administrative Rule ("Med") 206 and 207, the Board has jurisdiction to investigate and adjudicate allegations of professional misconduct committed by physicians. Pursuant to RSA 329:18-a, III, the Board may, at any time, dispose of such allegations by settlement and without commencing a disciplinary hearing.
2. The Board first granted Respondent a license to practice medicine in the State of New Hampshire on December 1, 2004. Respondent holds license number 12549. Respondent practices family medicine in Amherst, New Hampshire.
3. On or about January 11, 2017, the Board received information raising concerns about Respondents prescribing practices with respect to two patients who were related.

4. In response to this, the Board conducted an investigation and obtained information from various sources pertaining to Respondent's alleged inappropriate prescribing.

5. Respondent stipulates that if a disciplinary hearing were to take place, Hearing Counsel would prove that Respondent engaged in professional misconduct, in violation of RSA 329:17, VI, by the following facts:

   A. Records for twelve patients treated by Respondent for chronic pain were obtained and reviewed. Following a review of these records, the following were noted for each patient:

      a. The electronic medical records ("EMR") contain sections for chief complaint, history of the present illness, past medical history, past surgical history, family history, social history, review of systems, medications and allergies, however these were frequently left blank.

      b. Sometimes Respondent would document that she reviewed medications, past medical history, social history, family history and review of systems, but these particulars were not documented in the records and these documents were not included in the records.

      c. Physical examinations, as recorded, were minimal and frequently nonexistent. There were rarely any comments or exams of the painful areas mentioned by the patient unless the patient was receiving osteopathic manipulation.

      d. Frequently, the record indicated the visit was complete but the note was not signed.

e. The record often indicated that the record was last changed on a date weeks to months later.

f. There is minimal documentation concerning the use of opioids for chronic pain in the electronic medical record.

g. There is no documented of risk assessment.

h. There is minimal or no documentation concerning the rationale for the use of opioids.

i. There is no written informed consent explaining the risk of opioids.

j. There is no evidence of the written treatment agreement.

k. There is no evidence of consideration for consultation when a patient is receiving more than 100 morphine equivalent dose ("MED") per day, or when the patient is at high risk for abuse or addiction.

l. There is no documentation of reevaluating the treatment plan twice a year.

m. For ten of the patients reviewed, there is no evidence any drug screens were ever ordered or obtained. Two patients had one drug screen each.

n. There was no documentation indicating that the New Hampshire prescription drug monitoring program database (PDMP) was queried.

o. Some patients had unexplained gaps in treatment and gaps in prescriptions despite being prescribed high doses of opioids.

p. Prescriptions for opioids and doses were changed with little to no explanation, discussion, or indication.

q. Often prescriptions for opioids were not entered into the EMR and therefore were not included in the list of current medications, making it difficult to determine what medications were actually being prescribed to the patient at any given time.

r. Some patients were also prescribed psychotropic drugs with insufficient clinical indication and documentation.

B. Respondent treated Patient 1 for Chronic Pain, Depressive Disorder, Myalgia myositis, chronic Lyme disease, and hypothyroidism. Between January 2012 and February 2017, Patient 1 was only seen by Respondent seven times, yet she received prescriptions on about 48 occasions, sometimes for multiple controlled substances and other drugs. Most of these prescriptions are not documented anywhere in the patients records. The dose and type of opioid being prescribed changed multiple times without any documented rationale and resulted in large fluctuations in the patient's daily MED.

C. Respondent treated Patient 2 for Anxiety, Headache, Lumbago, Lyme Disease, and Neuralgia/neuritis. Patient 2 is Patient 1's significant other. Between January 2012 and February 2017, Patient 2 was only seen by Respondent seven times, yet received he received prescriptions on about 48 occasions, sometimes for multiple controlled substances and other drugs. Most of these prescriptions are not documented anywhere in the patients records. The dose and type of opioid being prescribed changed multiple times without any

documented rationale and resulted in large fluctuations in the patient's daily MED.

D. Patient 3 was treated for chronic pain syndrome along with other conditions. At the initial visit on December 5, 2013, the patient was complaining of abdominal pain but there is no examination of the abdomen. There was no exam of the extremities and no neurologic exam even though there was reported damage to the nerves of her left arm. She was treated with opioids and benzodiazepines. Often there was little indication as to why dosages of opioids were increased.

E. Respondent prescribed medications to Patient 4 on four different occasions without examining the patient for ailments that she reported over the phone.

F. Patient 5 was being treated for migraines and was initially started on Percocet 5/325 2 tabs daily, which eventually increased to 10/325 taking 2 tabs every 2-3 hours. Acetaminophen is well known to contribute to headaches and was prescribed potentially toxic doses.

G. Patient 6 was prescribed large doses of Oxycodone for multiple years without any drug screens. Many of the prescriptions are not properly documented in Patient 6's record. There was no indication or discussion in the record as to why Patient 6 was prescribed Metformin, Lasix 40 mg, Plaquenil, or ProAir inhaler.

H. Patient 7 admitted to taking 240 mg of Oxycodone daily (MED 360) that he bought off the streets for chronic back pain. Patient 7 lived with Patient 6 at

the time of this disclosure. After learning this, Respondent prescribed Patient 7 Methadone 10 mg 4 PO BID (MED 960). This dosage almost tripled the opioid dose he reported taking and could have resulted in a fatal overdose. Respondent never conducted a drug screen, risk assessment, or pill count for Patient 7 and no treatment plan was documented in the record for Patient 7's chronic pain.

I. Patient 8 was being treated with Vicodin, venlafaxine and tramadol. On June 17, 2016, Patient 8 disclosed to Respondent that she had taken a home pregnancy test and the result was positive. Respondent advised Patient 8 to establish care with an obstetrician or midwife. There is no indication Respondent ordered any tests to verify the pregnancy. There is no discussion documented of the risks of her medication while pregnant and no indication Respondent coordinated any care with any of Patient 8's other providers.

J. Patient 9 was treated for attention deficient disorder without hyperactivity, chronic pain syndrome, depression, posttraumatic stress disorder, as well as other conditions. When the patient presented initially, he disclosed he was on Percocet 15 mg daily for pain despite a strong family history of narcotic addiction. The patient was started on Cymbalta and the next day was started on lithium. Percocet was prescribed two weeks later. In May 2013, the patient complained of shoulder pain unresponsive to prednisone therapy. He had started twitching, and it was then disclosed he had a history of adverse reactions on lithium. By July 2015, the patient was still complaining of

increased shoulder pain despite receiving a MED of 90 mg. There is no documentation in the records indicating when this dosage was increased or the justification for the increase. A description of the pain and associated symptoms does not appear in the records until July 2016, when Respondent provided osteopathic manipulations. A handwritten note in February 20, 2017, states that the patient stopped oxycodone in October and transition to methadone. There is no documentation in the records of this change in record prior to this date. Patient 9 disclosed he was abusing Adderall and Respondent did not refer him to an addiction specialist and there is no documentation indicating she ever queried the PDMP for this patient.

K. Patient 10 was treated by Respondent for a number of conditions including anxiety, posttraumatic stress disorder, attention deficient disorder without hyperactivity, chronic pain syndrome, depression, and epilepsy. In March 2015, the patient fell down the stairs and could not talk and her arms and legs were numb. The emergency room had questioned of a compression fracture and the patient returned for follow-up with Respondent. Respondent did not perform an exam, but sent her for an MRI with a diagnosis of lumbago and wrote prescriptions for oxycodone 10 mg every 4 hours when necessary along with Xanax for muscle relaxation. Patient 10 was started on various medications at various times without any description or indication in the medical records. The patient's opioid doses increased and the type of opioid prescribed changed without any documentation in the record.

L. Patient 11 was treated with a diagnosis of hypothyroidism, pain in the right elbow, along with pelvic and perineal pain. At the initial visit, it is mentioned that the peroneal pelvic pain was worse since insertion of an IUD and the patient was taking maximum doses of Tylenol and Motrin for this. Respondent prescribed Percocet one every 6 hours when necessary. It is documented that there is a concern for sexually transmitted disease. Months later Patient 11 reported increased pain in her pelvis as well as in her head and shoulders and the pain was now near constant. Her oxycodone was increased but there was no documented exam of the painful pelvic area, the head, or the shoulders.

M. On April 22, 2016, Patient 12 complained of severe left-sided pain with hematuria. The patient had a history of renal stones. Vital signs were not taken and physical exam showed that the patient was unable to get comfortable and appeared to be in distress. Treatment consisted of Percocet and Ativan fluids and a urology referral. A May 11, 2016 patient complaining of severe left hip pain. Respondent treated the patient with escalating doses of opioids, but no exam of painful areas was ever documented.

6. The Board finds that Respondent committed the acts as described above and concludes that, by engaging in such conduct, Respondent violated RSA 329:17, VI (c),and/or (d), and/or (k).

7. Respondent acknowledges that this conduct constitutes grounds for the Board to impose disciplinary sanctions against Respondent's license to practice as a physician in the State of New Hampshire.

8. Respondent consents to the Board imposing the following discipline, pursuant to RSA 329:17, VII:

   A. Respondent is reprimanded.

   B. Respondent's license to practice medicine is suspended for 30 days. Fifteen (15) of these days shall be suspended on the condition that the Respondent fully satisfies all the requirements set forth in this *Settlement Agreement*. The period of suspension shall start on April 14, 2018 and continue through April 29, 2018. Respondent may return to practice on April 30, 2018.

   C. Respondent's license to practice medicine in restricted in that she may no longer prescribe any opioids.

   D. Respondent is required to meaningfully participate in additional Category I continuing medical education in the following areas: 15 hours in the area of medical record keeping, 12 hours in the area of ethics and/or practice management, 15 hours in the area of psychopharmacology, 12 hours in the area of treating psychological disorders, 10 hours in the area of treating attention deficit disorder, and 10 hours in pain management. These hours shall be in addition to the hours required by the Board for renewal of licensure and shall be completed by December 31, 2018. Within fifteen (15) days of

completing these hours, Respondent shall notify the Board and provide written proof of completion.

E. Respondent is assessed an administrative fine in the amount of $10,000. Of this, $7,000 shall be suspended, and need not be paid, on the condition that Respondent fully satisfies all other requirements set forth in this *Settlement Agreement.* Respondent shall pay the non-suspended portion of the fine ($3,000) in full within thirty (30) days of the effective date of this *Settlement Agreement*, as defined further below, by delivering a money order or bank check, made payable to "Treasurer, State of New Hampshire," to the Board's office at 121 South Fruit Street, Concord, New Hampshire.

F. Respondent has arranged to undergo a clinical skills assessment with Affiliated Monitors Inc. ("AMI") that will include, but not be limited to, Respondent's practice of family medicine as well as her recordkeeping practices.

1) Respondent shall provide AMI with copies of this *Settlement Agreement* and the confidential Report of Investigation, along with any other documents requested by AMI.

2) The clinical assessment shall include evaluation of Respondent's clinical knowledge, clinical reasoning, patient care decision-making skills, and should address the issues identified in the confidential Report of Investigation. The clinical assessment shall also include a record review, chart-based discussions, case presentations, and topic

based discussions. Following the completion of the clinical assessment, AMI shall provide a detailed report outlining the findings of the assessment and include any recommendations for improving Respondent's practice, including any suggested education.

3) Respondent shall complete the assessment and submit a copy of the AMI's report to the Board within 120 days of the effective date of the *Settlement Agreement.*

4) Respondent shall follow all recommendations made in the clinical assessment report including any additional education recommendations.

G. Respondent shall enter into a monitoring agreement with a Monitor approved by the Board for a period of twenty-four (24) months. The Monitor shall meet in person with Respondent quarterly to review patient records and discuss clinical treatment. The Monitor shall review Respondent's treatment of patients to determine Respondent's compliance with accepted medical practices and all applicable states and federal laws, regulations, and administrative rules, as well as the American Medical Association's Code of Medical Ethics.

1) The Monitor shall provide written reports to the Board and to Respondent every ninety (90) days. The written reports shall:

a. Evaluate Respondent's clinical care in the areas identified as needing further education in Reviewer's Report;

b. Identify any deficiencies in Respondent's care which reasonably warrant corrective action; and

c. Provide an assessment of Respondent's progress in implementing recommendations for her clinical care and recordkeeping practices.

2) Respondent shall take any and all corrective actions that are reasonably necessary to correct any and all deficiencies identified in any review by the Monitor. Not later than thirty (30) days after Respondent's receipt of the monitor's report, Respondent shall submit to the Board a detailed written report identifying the steps that have been taken, or are being taken, to correct the deficiencies cited in the Monitor's report, and the dates by which such corrective actions will be completed.

3) The Board, in its discretion, may request at any time during the period of monitoring that a different monitor be selected. If the monitor becomes unable to serve or fulfill his/her obligations, Respondent may nominate a different monitor who is acceptable to the Board. In the event that the monitor is unable to complete his/her review or report in a timely fashion due to the monitor's own personal and/or professional commitments, Respondent shall notify the Board in writing of the reasons the monitor is unable to complete his/her review or the report by that date, and the Board, for good cause shown, may extend the deadline for completion of the review and report.

4) The terms and provisions of Respondent's monitoring agreement shall be incorporated into this *Settlement Agreement* by reference. Respondent's failure to comply with any monitoring agreement terms shall constitute a violation of the terms of the *Settlement Agreement*. It is the responsibility of Respondent to provide information to the monitor in a timely and complete manner and to assure that all written reports setting forth findings of the monitor are timely transmitted to the Board every ninety (90) days.

H. Respondent shall bear all costs of evaluation, and reporting required by this *Settlement Agreement*, but she shall be permitted to share such costs with third parties.

I. Within ten (10) days of the effective date of this agreement, as defined further below, Respondent shall furnish a copy of the *Settlement Agreement* to any current employer for whom Respondent performs services as a physician or work which requires a medical degree and/or medical license or directly or indirectly involves patient care, and to any agency or authority which licenses, certifies or credentials physicians, with which Respondent is presently affiliated.

J. For a continuing period of one (1) year from the effective date of this agreement, Respondent shall furnish a copy of this *Settlement Agreement* to any employer to which Respondent may apply for work as a physician or for work in any capacity which requires a medical degree and/or medical license

or directly or indirectly involves patient care, and to any agency or authority that licenses, certifies or credentials physicians, to which Respondent may apply for any such professional privileges or recognition.

9. Respondent's breach of any terms or conditions of this *Settlement Agreement* shall constitute unprofessional conduct pursuant to RSA 329:17, VI (d), and a separate and sufficient basis for further disciplinary action by the Board.

10. Except as provided herein, this *Settlement Agreement* shall bar the commencement of further disciplinary action by the Board based upon the misconduct described above. However, the Board may consider the fact that discipline was imposed by this Order as a factor in determining appropriate discipline should any further misconduct be proven against Respondent in the future.

11. This *Settlement Agreement* shall become a permanent part of Respondent's file, which is maintained by the Board as a public document.

12. Respondent voluntarily enters into and signs this *Settlement Agreement* and states that no promises or representations have been made to her other than those terms and conditions expressly stated herein.

13. The Board agrees that in return for Respondent executing this *Settlement Agreement*, the Board will not proceed with the formal adjudicatory process based upon the facts described herein.

14. Respondent understands that her action in entering into this *Settlement Agreement* is a final act and not subject to reconsideration or judicial review or appeal.

15. Respondent has had the opportunity to seek and obtain the advice of an attorney of her choosing in connection with her decision to enter into this agreement.

16. Respondent understands that the Board must review and accept the terms of this *Settlement Agreement*. If the Board rejects any portion, the entire *Settlement Agreement* shall be null and void. Respondent specifically waives any claims that any disclosures made to the Board during its review of this *Settlement Agreement* have prejudiced her right to a fair and impartial hearing in the future if this *Settlement Agreement* is not accepted by the Board.

17. Respondent is not under the influence of any drugs or alcohol at the time she signs this *Settlement Agreement*.

18. Respondent certifies that she has read this document titled *Settlement Agreement*. Respondent understands that she has the right to a formal adjudicatory hearing concerning this matter and that at said hearing she would possess the rights to confront and cross-examine witnesses, to call witnesses, to present evidence, to testify on her own behalf, to contest the allegations, to present oral argument, and to appeal to the courts. Further, Respondent fully understands the nature, qualities and dimensions of these rights. Respondent understands that by signing this *Settlement Agreement*, she waives these rights as they pertain to the misconduct described herein.

19. This *Settlement Agreement* shall take effect as an Order of the Board on the date it is signed by an authorized representative of the Board.

FOR RESPONDENT

Date: 2-22-18

Concetta R. Oteri-Ahmadpour, D.O.
Respondent

FOR THE BOARD/*

This proceeding is hereby terminated in accordance with the binding terms and conditions set forth above.

Date: 3/20/2018

Penny Taylor
(Signature)

PENNY TAYLOR
(Print or Type Name)
Authorized Representative of the
New Hampshire Board of Medicine

/*Board members, recused:
David Conway, MD
Nina Gardner, Public Member