BEFORE THE VIRGINIA BOARD OF MEDICINE

IN RE: TERESA ANNE MOORE, M.D.
License Number: 0101-052933
Case Number: 160207

ORDER

JURISDICTION AND PROCEDURAL HISTORY

Pursuant to Virginia Code §§ 2.2-4019 and 54.1-2400(10), a Special Conference Committee of the Virginia Board of Medicine ("Board") held an informal conference on August 11, 2016, in Henrico County, Virginia, to inquire into evidence that Teresa Anne Moore, M.D., may have violated certain laws and regulations governing the practice of medicine in the Commonwealth of Virginia.

Teresa Anne Moore, M.D., appeared at this proceeding and was represented by Christopher Stevens, Esquire.

NOTICE

By letter dated May 16, 2016, the Board sent a Notice of Informal Conference ("Notice") to Dr. Moore notifying her that an informal conference would be held on July 13, 2016. The Notice was sent by UPS Overnight mail to the legal address of record on file with the Board. By letter dated June 8, 2016, the Board notified Dr. Moore that the informal conference was continued to August 11, 2016. This letter was sent by email and first class mail to the legal address of record on file with the Board.

Upon consideration of the evidence, the Committee adopts the following Findings of Fact and Conclusions of Law and issues the Order contained herein.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Teresa Anne Moore, M.D., was issued License Number 0101-052933 to practice medicine on August 24, 1995, which is scheduled to expire on January 31, 2018.

2. Dr. Moore violated Virginia Code § 54.1-2915.A(3) and (13) with respect to her care and treatment from approximately March 2012 to August 2015 of Patient A, a 31-year-old male with (among other things) schizophrenia and bipolar disorder. Specifically:

a. Starting at Patient A's first visit with Dr. Moore on or about March 23, 2012 and continuing thereafter, Dr. Moore prescribed large quantities of narcotics and other controlled substances with abuse potential notwithstanding information from prior treatment providers and prior medical records indicating that Patient A suffered from substance abuse or that such a medication regimen was otherwise contraindicated. Specifically, Dr. Moore knew or should have known the following information, which is located in her record for Patient A:

i. A psychiatric consultation conducted during a December 1-3, 2010 hospitalization reported Patient A had a significant history of "drug seeking behavior (primarily opiates) and significant paranoid thinking," noting that, since July 2010, Patient A had presented to the emergency room at least 11 times, "most all of which where he is complaining of pain and seeking some type of medication." This physician noted recent escalation in the patient's narcotic-seeking behavior, to include self-injurious actions (e.g., sticking a nail in his ankle and stabbing himself in the thigh), behavior which the patient's mother believed he deliberately engaged in to obtain more pain medication. This consultation report noted that Patient A's grandmother reported the patient would obtain pain medications from other family members and take them in excessive doses and quantities, and the patient's mother confirmed that he had a "severe drug problem." This physician also documented that Patient A had at least 10 prior psychiatric hospitalizations and diagnosed him with

mixed personality disorder (mainly paranoid) and severe opioid dependence, noting that the patient was unlikely to take his prescribed psychotropic medications.

ii. A June 27, 2011 note from Patient A's PCP stated that another physician who was managing the patient's pain refused to prescribe him any more narcotics because of an inconsistent urine drug screen ("UDS") that was negative for the hydrocodone (C-III) this physician had been prescribing Patient A.

iii. An emergency room note from July 24, 2011, when Patient A presented for treatment of the re-opened gunshot wound in his right calf, documented that the patient had recently been hospitalized at another hospital for an overdose of barbiturates and opiates (which required intubation) and also had a long history of narcotic use and dependence. Dr. Moore reported to the Committee that she was not aware of this information.

iv. On or about October 17, 2011, a pain management specialist declined to accept Patient A as a patient based on review of Patient A's "PMP and UDS results, as well as his record including violent behavior and 2 self-inflicted gunshot wounds ....These results and behaviors are highly suggestive of a substance abuse disorder. I would recommend that he be evaluated and treated for addiction.... He [Patient A] also likely has rebound headaches given his multiple daily doses of controlled substances. Weaning of the controlled substances would address the rebound headache issue...[and] would be safer from a potential overdose perspective.... [F]rom my review of the record, I am very concerned that treatment for his pain would be unsuccessful without first addressing the addiction issue." Dr. Moore acknowledged to the Committee that she was aware of this advice, but stated she did not know who else would help Patient A if she did not do so.

v. A discharge summary from a February 9-25, 2012 hospitalization (wherein Patient A was treated for recurrent infection of his right leg gunshot wound) documented the pain management

team's concern that "[u]ltimately, it was felt he [Patient A] had a significant component of pain [medication] seeking behavior….Ultimately, we have recommended that he taper and stop all of his pain meds over time. If he cannot do that, I have recommended to him that he seek treatment for substance abuse." Dr. Moore stated that she did not follow this advice because she believed she needed to establish trust and rapport with Patient A first before cutting back his medications.

vi. On or about January 6, 2012, the surgeon treating Patient A's non-healing gunshot wound was contacted by a pharmacist who reported Patient A was receiving prescriptions for Percocet (C-II) from his PCP at the same time the surgeon was prescribing that medication to him. Further, on or about January 25, 2012, Patient A's PCP refused to see the patient anymore after he caused a scene in the waiting room and broke his crutches when the PCP refused to write him a prescription for Percocet.

vii. Patient A reported to his treating surgeon that his pain medications had been stolen on or about February 1, 2012 and then again on March 21, 2012.

b. Despite the plethora of evidence from prior treatment providers and records discussed above indicating Patient A suffered from a severe substance abuse disorder and mental illness that precluded him from being an appropriate candidate for chronic narcotic or benzodiazepine therapy by a general family practitioner, such as Dr. Moore, from approximately March 2012 to August 2015, Dr. Moore regularly prescribed Patient A fentanyl patches (C-II), OxyContin (C-II), Dilaudid (C-II), Fioricet (C-III), and Xanax (C-IV), for chronic pain due to a slowly healing gunshot wound to the right lower leg (self-inflicted in November 2010), neuropathic pain of the right leg, chronic headaches, chronic left ankle pain, and anxiety. Dr. Moore informed the Committee that the preceding historical information was not known to her initially and was likely later added to the record after she began treatment of Patient A.

c. Notwithstanding Patient A's concerning history of substance abuse and mental illness, Dr. Moore failed to adequately monitor and manage the patient's usage of narcotics and other abuseable controlled substances in that Dr. Moore did not enter into a controlled substance agreement with Patient A until March 29, 2013, approximately a year after she had commenced prescribing the patient narcotics and other controlled substances and, once executed, Dr. Moore failed to enforce the provisions of that agreement (see below); Dr. Moore failed to perform or obtain any UDS' during the 3 ½ year treatment period and obtained only one serum drug test on or about June 12, 2013 (which was inconsistent with her medication regimen, see below); and Dr. Moore performed or documented pill counts only during the first six months of treatment and took no appropriate responsive action when such counts were inconsistent with expected results.

d. Despite Patient A's high-risk status for substance abuse and potential medication overdose or other noncompliance, Dr. Moore failed to appropriately address Patient A's misuse or abuse of prescribed medications or concerns expressed by other physicians regarding her medication regimen and instead continued with her chronic prescription of narcotics and other controlled substances. Evidence of such aberrant patient behavior and physician concerns included the following:

i. Although Dr. Moore documented at Patient A's first office visit on March 23, 2012 that she was willing to work with him as long as he was honest with her, but would discontinue treating him if he lied to her or made mistakes with his medications, Dr. Moore continued to provide narcotic therapy to Patient A after multiple incidents of medication noncompliance and suspicious stories from Patient A with respect thereto, as documented below.

ii. On numerous occasions, Dr. Moore documented that Patient A reported his brother, sister, roommate, friends, or others had stolen his pain medications, e.g., at his first visit on or about March 23, 2012; on or about May 18, 2012 (Patient A's sister allegedly stole his bottle of Dilaudid and

about 1/3 of his Fioricet); on or about June 15, 2012 (bottle of Dilaudid stolen by his roommate); on or about November 30, 2012 (all medications stolen the day before Thanksgiving when the patient left his lock box open, but his mother allegedly would not let him report this theft to the police); and on or about February 28, 2013 (family members were periodically stealing his medications). However, Patient A did not provide and Dr. Moore failed to require a police report substantiating any of these alleged thefts, and Dr. Moore routinely provided replacement prescriptions for these stolen medications.

iii. At his second visit on or about April 11, 2012, Patient A reported that he had run out of his Dilaudid early because he was carrying it with him in the car when the pills fell out of his coat pocket into the back seat. Patient A reported other instances where he lost or inexplicably could not find his medications, e.g., on or about February 5, 2013, Patient A reported his Fioricet had gone missing when he recently went to the ER for suicidal ideation and worsening schizophrenia symptoms; and on or about May 1, 2014, Patient A reported he lost his pain medications when he went for physical therapy, stating they were in his pocket when he went in but were not there afterwards.

iv. At Patient A's June 15, 2012 visit, his bottle of Dilaudid was again missing. This time Patient A asserted that he found his roommate (who allegedly suffered from AIDS) in possession of his pain medications, with blood covering this man's hands as well as several of the medication bottles. Patient A then reported that he could not find the bloody bottle of Dilaudid. When Dr. Moore refused to prescribe him any more Dilaudid, Patient A reported that, even if he could find the bottle of Dilaudid, he would be afraid to take it because of potential HIV exposure due to the bloody pills and bottle. Although Dr. Moore informed him she would prescribe him more Dilaudid if he brought in the bloody bottle of Dilaudid pills, Patient A failed to do so and subsequently called to inform Dr. Moore that he had found the pill bottle.

v. On or about July 5, 2012, Dr. Moore (or her staff) documented a call from a local pharmacist stating that Patient A had consumed #40 Dilaudid in just three days and that the pharmacy frequently had problems with this patient and his medications. Patient A then called complaining that the pharmacist had only given him #40 pills out of the #180 prescribed on June 29, 2012 and requested that Dr. Moore provide him another script for #140 Dilaudid so he could get it filled at another pharmacy before he left town for northern Virginia (to which he stated he was relocating). Dr. Moore's nurse practitioner then provided Patient A with a prescription for #50 Dilaudid.

vi. At his August 21, 2012 office visit, Patient A informed Dr. Moore that recently, while feeling paranoid, he had falsely accused a friend of stealing his bottle of Dilaudid; however, the patient subsequently found this medication bottle under his bed where he had packed it for travel. Further, Patient A reported that his pill count for Dilaudid was off because, out of anger toward the person he believed had stolen his medication, he threw some of his Dilaudid pills at this person outside in the yard, where they got soaked.

vii. On or about October 25, 2012, another physician in Dr. Moore's practice who saw Patient A noted that the patient was being prescribed "unbelievable doses of opiates along with benzos."

viii. A blood serum drug test performed on or about June 12, 2013 was inconsistent with Dr. Moore's medication regimen because it was negative for Dilaudid, a medication Dr. Moore regularly prescribed Patient A. When Dr. Moore questioned Patient A about this at his next visit on or about July 22, 2013, Patient A reported he had been trying to cut back on pain medications and had stopped taking Dilaudid about 1-2 days before the blood test. Patient A stated he failed to inform Dr. Moore of this at his last visit because he thought the medication would still show up in his blood and he did not want Dr. Moore to be mad at him for not taking his Dilaudid exactly as prescribed. Moreover, Patient

A reported that, on or about July 19, 2013, he had run out of the month's supply of Dilaudid and Xanax Dr. Moore had prescribed him on June 12, 2013, with fill dates of June 30, 2013. Despite this evidence of substantial noncompliance, Dr. Moore noted she would "give him the benefit of doubt and am refilling his meds. for 1 month."

ix. At an office visit on or about August 1, 2013, Patient A's mother informed Dr. Moore that Patient A at times overtook his medications and then, due to his schizophrenia, believed others were stealing his medications. Although Patient A's mother agreed to keep the patient's medications locked in a safe and they both agreed to document when she dispensed medications to him, Patient A's significant noncompliance with Dr. Moore's medication regimen continued, as discussed below. Further, on or about January 10, 2014, Patient A reported to Dr. Moore that his mother had given him back his medications to manage himself.

x. On or about August 16, 2013, Dr. Moore authorized an early refill of Patient A's Dilaudid (and increased the dosage thereof) based on the patient's report that he had used more Dilaudid than prescribed due to the fact that the generic fentanyl patches Dr. Moore prescribed him were falling off. Dr. Moore also documented that she would return to the lower dosage of Dilaudid previously prescribed at Patient A's next visit, once his issue with the fentanyl patches was resolved. However, Dr. Moore failed to subsequently reduce Patient A's Dilaudid dosage despite improvement in Patient A's fentanyl patch utilization with the prescription of a more adhesive brand name.

xi. On or about November 14, 2013, Dr. Moore viewed a video Patient A had secretly recorded, which appeared to show his sister stealing a pain patch off of his desk. Although Dr. Moore encouraged Patient A to report this to the police, he declined to do so, stating that his sister had gone into treatment last week.

xii. On or about January 10, 2014, Patient A reported that, while sleeping several nights ago, he removed his fentanyl patch and had to compensate with extra Dilaudid and patches, without realizing that he had done this until the next morning.

xiii. On or about May 1, 2014, Patient A reported that he had recently filled a prescription for Lortab received from a dentist who extracted several of his teeth (a violation of Dr. Moore's pain management contract). Dr. Moore responded by prescribing Patient A more Lortab and giving him early scripts for his Dilaudid and fentanyl patches.

xiv. On or about June 4, 2014, Patient A and his mother reported that he had recently been hospitalized in a psychiatric facility. Further, Patient A's mother admitted that she had returned management of Patient A's medications to him because he kept pestering her for them. Despite Dr. Moore's documented concerns about Patient A's continued access to pain medications "if the potential for an intentional or accidental overdose" existed, Dr. Moore nevertheless continued to prescribe Patient A a multitude of controlled substances at high dosages and quantities. Although Dr. Moore documented Patient A's father would now be managing his medications, Dr. Moore also recorded in that same note that the patient's mother would resume controlling and administering his abuseable medications.

xv. On or about June 30, 2014, Patient A reported that he was hurting more than usual because he could not take extra medication since his mother had taken back control of his pain medications. However, in that same note, Dr. Moore documented that recent travel and activities with his family caused Patient A to take more pain medication than prescribed. Dr. Moore responded by providing Patient A with early renewals of Dilaudid and fentanyl and increased the dosage of the fentanyl patches, despite her notation that the patient's psychiatric issues made it difficult to get his pain under control.

xvi. On or about July 9, 2014, Patient A informed Dr. Moore that his mother had not given him any fentanyl patches since July 2, 2014, which caused him to take extra Dilaudid. Dr. Moore noted that, while she was out of town, Patient A's mother had left a message asking if her son could take an extra Dilaudid pill per day (which Dr. Moore approved) and that Patient A wanted to take back control of his medications. Dr. Moore responded to this information by admonishing Patient A not to take extra Dilaudid and prescribed him more fentanyl patches.

xvii. On or about July 21, 2014, Patient A requested an early refill of Dilaudid since he allegedly had been vomiting them up due to nausea associated with a rash.

xviii. After Dr. Moore provided Patient A three month's worth of prescriptions for Dilaudid (#540), fentanyl patches (#45), and Fioricet (#360) on or about August 25, 2014, Patient A was taken to the emergency room after misusing these medications. Notwithstanding this ongoing pattern of medication abuse, Dr. Moore prescribed Patient A more Dilaudid and fentanyl patches at his September 25, 2014 visit after his mother yet again agreed to manage his medications, noting that "this will be [Patient A's] last chance to show his responsibility." Dr. Moore also documented that, if Patient A started harassing his mother about his medication, she would notify Dr. Moore and Dr. Moore would stop prescribing him pain medication. However, at Patient A's office visit on November 25, 2014, Dr. Moore noted that the patient was frequently asking his mother to dispense his pain medications early, yet Dr. Moore continued to prescribe him such medications.

xix. Although Dr. Moore had documented as recently as September 25, 2014 that Patient A "has not proven that he is able to manage them [his medications] himself," Dr. Moore nevertheless returned control of Patient A's medications to him on or about January 7, 2015, prescribing him Dilaudid 8 mg, qid, #150, with the understanding that his mother would control #30 extra Dilaudid tablets that Dr. Moore would prescribe for her to hold and dispense to Patient A in case he had bad breakthrough pain.

xx. At Patient A's next visit with Dr. Moore on or about January 28, 2015, he reported he had run out of his Dilaudid two days earlier due to the fact that he had increased his daily dosage, allegedly because of increased pain. In response to this self-titration of medication, Dr. Moore increased Patient A's daily dosage of Dilaudid from four to six times per day.

xxi. On or about March 10, 2015, Patient A informed Dr. Moore that he had taken all of the #60 Fioricet that she had previously prescribed him with explicit instructions that the medication was to last until March 28, 2015. Dr. Moore responded to such noncompliance by providing Patient A an early Fioricet script with an increased quantity.

xxii. On or about June 18, 2015, Patient A reported that he had increased his consumption of Dilaudid to two pills every six hours, approximately double the dose Dr. Moore had prescribed him. Patient A justified this self-titration by stating he had to lessen his pain because, if he failed to do so, he would experience increased suicidal ideation and hallucinations. Dr. Moore responded to this noncompliance by conforming the daily dosage of Dilaudid she prescribed Patient A to his self-titrated dose, noting that she did "not believe that he is abusing the meds. I believe that his pain is uncontrolled."

xxiii. On or about July 2, 2015, Patient A reported acute withdrawal symptoms and suicidal thoughts because he had been out of Dilaudid for twelve days due to the fact that the pharmacy refused to fill the early Dilaudid prescription Dr. Moore gave him at his last visit on June 18, 2015.

e. Despite the preceding information indicating that Patient A was abusing or addicted to his pain medications, Dr. Moore failed to refer him for substance abuse evaluation or treatment and continued to prescribe him abuseable controlled substances. Moreover, Dr. Moore failed to alter her treatment plan or to take other appropriate responsive action when it became apparent that Patient A's

mental illness prevented him from responsibly taking the medications she was prescribing him or otherwise adhering to her treatment plan.

f. Dr. Moore explained to the Committee that she became involved in Patient A's treatment when his surgeon called and asked her to take over Patient A's care because pain management specialists would not take him, and the surgeon did not know what to do with him, stating she believed Dr. Moore was the best physician to treat Patient A.

g. Dr. Moore informed the Committee that she decided to prescribe the foregoing medications to Patient A based on her belief that the patient had pain.

h. Dr. Moore stated that Patient A absolutely refused to see mental health providers in the area during most of the treatment period.

i. Dr. Moore reported that the reason she did not threaten to cut Patient A off from his narcotic regimen due to his noncompliance was because she wanted him to buy into the treatment plan and comply voluntarily with her recommendations.

j. In retrospect, Dr. Moore stated she should have implemented a narcotic contract immediately with this patient. She reported that she now uses such contracts with all of her pain management patients.

k. Dr. Moore reported that Patient A is now being treated as an inpatient in Western State Hospital.

3. Dr. Moore violated Virginia Code § 54.1-2915.A(3) and (13) with respect to her care of Patient B (a 41-year-old male at the start of treatment) from approximately 1999 to May 2012 and then from April 2014 to July 2015. Specifically:

a. For over 10 years (from approximately December 1999 to August 2010), Dr. Moore prescribed Patient B a multitude of narcotic medications in extremely large quantities and high dosages to

treat the patient's fibromyalgia, e.g. prescribing up to 360 mg per day of OxyContin IR; up to 72 mg per day of Dilaudid; up to 240 mg per day of methadone; up to 510 mg per day of morphine sulfate immediate release ("MSIR"); and up to 460 mg MS Contin per day (with two or more of such medications often prescribed concurrently). However, Dr. Moore lacked a medical justification for such prescribing in that narcotic therapy is not indicated for treatment of fibromyalgia. Moreover, Dr. Moore failed to perform or document an adequate physical evaluation or work-up to establish that diagnosis for Patient B (and the patient's prior treatment records also failed to document such an evaluation or work-up).

b. Even after Dr. Moore diagnosed Patient A with degenerative lumbar disc disease, central canal stenosis, and facet arthropathy in August 2010 (based on, among other things, lumbar MRI and x-ray findings), the narcotic therapy Dr. Moore employed to treat these conditions was unreasonable in that she prescribed ever increasing quantities and dosages of such medication, escalating up to 600 mg per day of MS Contin and 360 mg per day of MSIR, which Dr. Moore prescribed concurrently.

c. Throughout the treatment period, Dr. Moore treated Patient B's severe and ongoing depression and anxiety with an ever-changing regimen of anti-depressive and other psychiatric medications despite the fact that Patient B, a complicated psychiatric patient who regularly expressed suicidal ideation to Dr. Moore (twice with a plan) and whose mental health conditions did not improve under Dr. Moore's care, needed treatment by a mental health specialist. Although Dr. Moore referred Patient B to a psychiatrist and/or counselor and recommended inpatient hospitalization on several occasions, she took no appropriate responsive action when the patient refused or failed to comply with these referrals/recommendations. Although Patient B reported on or about November 24, 2010, that he had seen a psychiatrist, Dr. Moore failed to consult or confer with said physician regarding Patient B's psychiatric care and continued her ongoing treatment of Patient B's mental health conditions.

d. Dr. Moore's continuous prescription of extremely large quantities of high-dose narcotics and other controlled substances to Patient B was dangerous in light of the ever-present danger of suicide by overdose that such prescribing presented for this patient. Although Dr. Moore discussed with Patient B (on or about June 5, 2015) her concern regarding "the multiple medications that he takes and the fact that the medications could interact and cause an accidental overdose," Dr. Moore nevertheless continued to prescribe such medications to him.

e. On numerous occasions, Dr. Moore prescribed narcotics and other controlled substances to Patient B without first performing and/or documenting any (or an adequate) physical examination, evaluation or assessment, often in response to the patient's telephone requests for more medication or for scripts to be mailed to him. Such periods of prescribing without documentation of any physical examination or assessment of Patient B were extensive at times, as set forth below:

Dates of Consecutive Office Visits	Length of Time Period During Which Narcotics/Other Controlled Substances Were Prescribed Without Any Examination	Approximate # of Dosage Units Prescribed During Period Patient Was Not Seen
2/4/03, 9/24/03	Approximately seven months	Restoril #30 Percocet 5/325, #1,000 Methadone 10 mg, #3,420 Fioricet #210 Lorazepam #60
8/13/08, 6/8/09	Approximately ten months	Valium 10 mg, #1,080 MS Contin 200 mg, #660 OxyContin IR 30 mg, #1,500 Provigil 200 mg, #720 Fioricet, #360
10/8/09, 3/1/10	Approximately five months	Provigil 200 mg, #300 OxyContin IR 30 mg, #740 MS Contin 200 mg, #240 MS Contin 30 mg, #240 Valium, #90
10/13/11, no follow up date because patient (temporarily) left practice in May 2012	Approximately seven months	Tramadol 50 mg, #240 MSIR 30 mg, #2,160 MS Contin 200 mg, #810 Valium #1,800
8/21/14, 2/24/15	Approximately six months	MSIR 30 mg, #1,800 MS Contin 200 mg, #450

f. Dr. Moore failed to adequately monitor and manage Patient B's usage of narcotics and other controlled substances in that she failed to enforce the provisions of her controlled substance agreement with Patient B (see below); Dr. Moore obtained only one UDS during the approximate 15-year- treatment period and it did not test for one of the medications (Dilaudid) she was prescribing the patient; and Dr. Moore seldom performed or documented pill counts or accessing Patient B's PMP during that period. Dr. Moore failed to take appropriate responsive action (such as substance abuse evaluation and treatment or referral for same) and continued to prescribe Patient B narcotics and other controlled substances after he exhibited signs and symptoms that he was misusing or abusing these medications or that these medications were otherwise contraindicated, to include the following information (which Dr. Moore knew or should have known):

i. Dr. Moore constantly documented that Patient B had taken more of his narcotic or benzodiazepine medication than she had prescribed or that Patient B had, without her knowledge or authorization, self-increased his medication dosages, e.g., on or about December 3, 2002; January 14, 2004 (although noting Patient B had doubled the dose of his prescribed Dilaudid, Dr. Moore documented that the patient "has shown no signs of abuse or misuse of the products"); May 3, 2004 (patient more than doubled dose of lorazepam prescribed); September 24, 2004; January 6, 2005 (taking more Dilaudid than usual due to foot pain; patient encouraged not to do this); May 18, 2006 (patient had to take rescue doses of Dilaudid); February 1, 2010 (patient took extra OxyContin IR and MS Contin last month); April 1, 2010 (patient has run out of all of his OxyContin IR even though his pain was adequately controlled this past month); October 21, 2010 (patient reports using more OxyContin IR due to increased pain); October 28, 2010 (patient self-increased MS Contin due to unbearable pain); June 19, 2014 (patient running out of breakthrough pain medications as he is waking up at night to take them); and May 7, 2015 (patient reports overtaking medication). Despite the fact

that this conduct violated Dr. Moore's controlled substance agreement with Patient B, she generally responded to such noncompliance by providing an early refill of the medication in question at the increased dosage that Patient B had self-initiated.

ii. Patient B regularly requested an increase in the quantity or strength of the narcotic medications that Dr. Moore prescribed him or to switch to or add a different, stronger narcotic, generally due to alleged increases in pain, e.g. on or about July 7, 2003; November 11, 2003; December 8, 2003 (patient's request for increased Dilaudid denied by another physician in Dr. Moore's practice while she was out of town); December 24, 2003; June 13, 2005; December 16 and 20, 2005; February 16, 2006; May 22, 2006; November 28, 2006; January 30, 2007; April 23, 2009; June 29, 2009; September 23, 2010; October 20, 2010; November 24, 2010; October 13, 2011; and May 23, 2014. Despite the fact that these constant requests for more pain medication indicated Dr. Moore's narcotic therapy was not working to adequately treat Patient B's pain, Dr. Moore continuously responded to these requests by increasing the medications/dosages prescribed to the patient.

iii. In addition to providing early script renewals or refills as described above, Dr. Moore provided Patient B early refills/renewals of his medications in response to unlikely or suspicious information reported by Patient B or in other unwarranted circumstances, to include the following:

- On or about January 6, 2005, Patient A requested an early refill of Valium, reporting that this medication had been thrown out accidentally by people who came to help him clean up his house after his partner died.
- On or about April 10, 2006, Patient B informed Dr. Moore that he had spilled some of the liquid morphine sulfate she prescribed him.

- On or about April 27, 2009, Dr. Moore provided Patient B with early renewals of MS Contin and OxyContin IR based on his report that the prescriptions her office had mailed him on April 23, 2009 had not arrived yet.
- At an October 8, 2009 office visit, Dr. Moore documented providing Patient B with an early prescription for MS Contin so she could "avoid having to mail this" to him later.
- On or about October 21, 2010, Dr. Moore (or her staff) documented a phone call from a pharmacist who refused to fill a prescription written for #90 MS Contin on October 20, 2010 because it was too early.
- On or about October 28, 2010, Dr. Moore documented that, although Patient B had recently taken more OxyContin IR and MS Contin than prescribed, "this is the first overuse of his medications in the last 10+ years that I have been treating him," a statement that was patently incorrect in light of the information cited above. Based on this inaccurate assessment of Patient B's compliance and after admonishing him not to adjust his medications without calling her first, Dr. Moore provided him with early prescriptions for MS Contin 200 mg, MS Contin 60 mg, and OxyContin IR 30 mg.
- When Dr. Moore refused to provide Patient B with an early MSIR prescription prior to May 15, 2015, as repetitively requested by the patient via text, Patient B became angry and informed Dr. Moore that she was "expecting too much for him to come and get his prescriptions" in response to Dr. Moore's new policy whereby she would no longer mail him narcotic prescriptions.
- On or about June 1, 2015, Patient B again reiterated that he could not see Dr. Moore this month, "it's just too much, too much going on." He further stated that "I don't need to see her. I need my morphine and I'm going to have a royal fit with her if she can't give me

my prescriptions." When he asked if his sister could pick up his medications from her office, Dr. Moore again declined to provide these prescriptions because they were too early. Patient B responded by stating "I am pissed off at her. I will not speak to her at my appointment. I will have to get my meds from someone else.... I am sick of her and you can tell her that."

- After many texts from Patient B and cursing and yelling over the telephone about his medications, Dr. Moore acceded to his demands and provided him with early morphine scripts on June 3, 2015, noting that she was doing this for him "this one time" to facilitate getting the two scripts to come due on the same date. Further, at his next appointment on June 5, 2015, Dr. Moore offered to bring Patient B prescriptions to him at his home from time to time when her schedule permitted, rather than require him to come in and pick them up.

iv. In April 2005 and thereafter, Patient B reported frequent falls, allegedly due to lower extremity weakness and disequilibrium. Dr. Moore noted that the methadone, Phrenilin, Dilaudid, Valium, Prozac, and Flexeril that she was prescribing him could be causing this disequilibrium and that the "potential for drug interactions on as many medications that affect the central nervous systems as he is taking is very high." Although Dr. Moore discussed discontinuing all of Patient B's medications for a period of time and then slowly adding them back to see if this would alleviate or help these symptoms, no such plan was implemented.

v. On or about July 22, 2005, Dr. Moore documented that she had learned, via a complaint filed with the Board of Medicine by a friend of Patient B's, that he was misusing and abusing the medications she prescribed him, including stockpiling them with a plan to harm himself. When confronted with this information, Patient B denied he was stockpiling medication and explained that he frequently

filled his prescriptions a week or two early because he had money at the beginning of the month and was afraid he would not have the money to fill the prescriptions if he waited until later in the month. Dr. Moore noted that the patient's "request for refills over time indicates to me that he does not have medications stock piled." Although Dr. Moore instructed Patient B to submit to a UDS, he allegedly was unable to produce enough urine to do so. Instead, Dr. Moore informed Patient B that she would order another UDS at his next office visit.

vi. Although Dr. Moore noted on or about October 25, 2005 that it was difficult to tell whether or not Patient A's chronic migraine headaches were rebound, medication-related headaches, Dr. Moore nevertheless continued to regularly prescribe him large quantities of narcotics.

vii. On or about April 15, 2011, Patient B informed Dr. Moore that he had misplaced in a pile of papers the prescriptions for MSIR and MS Contin for the months of April and May that she had previously written and given him on or about March 17, 2011 and was too sick to search for them in the stack. Dr. Moore responded by noting "this is unusual" for Patient B and agreed to mail him prescriptions for one month of these medications; however, Dr. Moore informed him he must find the lost scripts or file a police report before she would prescribe him additional medication. Despite re-iterating the requirement for a police report when Patient B again claimed he could not find the lost scripts on May 10, 2011, Dr. Moore agreed to write them the next day when the patient stated he had tried to report the incident to the police, but they refused to take a report since the medications were "lost" and not stolen.

viii. Upon admission to the hospital on or about May 20, 2012 for treatment of diabetic ketoacidosis, the admitting physician noted that Patient B was "quite under the influence of [pain medications]. He has got slurred speech, difficult to communicate with due to his lethargy and drifting asleep during the interview." This physician also noted that a new physician had recently taken over Patient B's care, and this PCP reported he would like to reduce the amount of pain medications the patient

was on and had already discontinued some of his medications, including his extended release morphine, as well as Valium and Flexeril. Dr. Moore reported to the Committee that she never saw these same behaviors when Patient B was seen in her office, and it was possible that the slurred speech and lethargy observed by the ER physician was attributable to the diabetic ketoacidosis.

ix. Upon discharge from the hospital on May 22, 2012, Patient B's treating physician noted that the "patient was on tremendously high doses of narcotics when he came into the hospital and we reduced" or discontinued most of those, with a plan to further decrease his MS Contin over the next several months. Although this documentation from the hospital was in Dr. Moore's file for Patient B, she nevertheless resumed her medication regimen of multiple high-dose narcotics for the patient when he returned to Dr. Moore's practice in April 2014 after an approximate two-year absence.

x. Upon his return to Dr. Moore's practice, Patient B reported that he had left the other physician's care because this physician insisted on performing a rectal examination. However, Dr. Moore obtained this physician's treatment records for Patient B, and noted no documentation therein regarding a request for a rectal exam. Patient B then changed his story and stated he had stopped seeing this physician because he had "sent the cops out for me." Without following up with this physician to ascertain why Patient B was no longer his patient or to obtain more information regarding why he would have directed the police to Patient B, Dr. Moore resumed treating Patient B with narcotic therapy.

g. Dr. Moore reported that she has referred Patient B to a pain management specialist and that specialist determined that the patient was at low risk for abuse.

h. Dr. Moore stated that, over the past year, she has been slowly tapering Patient B down to a lower dose of medications. Additionally, she reported she is working to get all of her patients who are on a high narcotic dose down to under a 100mg morphine equivalent dose per day and/or to refer them to pain management.

4. Dr. Moore violated Virginia Code § 54.1-2915.A(3), (13), and (18) and 18 VAC 85-20-26.C of the Board's Regulations with respect to her care (from approximately 2008 to July 2015) of Patient C, a 65-year-old female at the start of treatment diagnosed with coronary artery disease, peripheral vascular disease, lupus, osteoarthritis in bilateral knees and lumbar spine, and chronic bilateral knee pain, among other things. Specifically:

a. Dr. Moore failed to adequately manage and monitor Patient C's usage of narcotics in that she did not enter into a controlled substance agreement with Patient C until July 30, 2015, over six years after Dr. Moore had commenced regularly prescribing the patient Lortab; Dr. Moore failed to perform or obtain (or document) any UDS' during the treatment period; and Dr. Moore failed to perform or document any pill counts or accessing the patient's PMP to determine if she was compliant with her medication regimen during the treatment period.

b. Dr. Moore constantly authorized early renewals of prescriptions for a 90-day supply of Lortab 5/500 or 10/500 for Patient C in that she routinely wrote a script for #720 Lortab, to be taken 2 qid, with two refills, and then after only two months, when one refill should have still been left on the original prescription, Dr. Moore authorized another prescription for #720 Lortab, 2 qid, with two refills. In this way, Dr. Moore routinely provided Patient C #720 dosage units of Lortab every two months, for an effective dosage of 12 pills per day, rather than the 8 per day that Dr. Moore had prescribed. Such prescribing exceeded the maximum safe daily dosage of 4,000 mg of acetaminophen. On two occasions in 2014, Patient C's insurance company notified Dr. Moore of this dangerous prescribing, yet she continued to prescribe in this manner. Dr. Moore explained to the Committee that there were administrative process issues that led to the insurance company notifications being scanned into a document system, rather than being sent to her for review. Dr.

Moore stated she was very upset when she learned of this issue and has taken steps to correct this process with staff.

c. Dr. Moore explained she did not believe that Patient C was abusing her medications and believed the patient had pain. Since July 30, 2015, Dr. Moore has implemented a pain contract and reviewed the PMP regularly on this patient.

5. Dr. Moore violated Virginia Code § Section 54.1-2915.A(3), (13), and (18) and 18 VAC 85-20-26.C of the Board's Regulations with respect to Patient D, a 58-year-old male at the start of treatment to whom she (or her nurse practitioner) provided care, including chronic pain management, from approximately 2000 to August 2015. Specifically:

a. Dr. Moore failed to adequately manage and monitor Patient D's narcotic therapy in that she did not enter into a controlled substance agreement with the patient despite the fact that Dr. Moore (or her nurse practitioner) regularly prescribed him #180 Percocet per month over the course of many years; Dr. Moore failed to perform or obtain (or document) any UDS' during the treatment period; and Dr. Moore failed to perform or document any pill counts or to access the patient's PMP during the treatment to determine medication compliance.

b. Dr. Moore explained to the Committee that in the past, when she initiated narcotics for a patient, she would typically utilize a pain management contract. However, when patients came to her already on narcotics, as in the case of Patient D, she would not typically utilize a pain management contract. Dr. Moore stated it is now her practice to put all chronic narcotic patients on a pain contract.

6. Dr. Moore reiterated in her closing remarks that she made several efforts to get Patient A treatment from other providers, and noted that he was an extremely difficult patient.

7. Dr. Moore acknowledged that she has a hard time not helping people, but expressed that her goal has always been to help her patients and provide the best care possible. She stated she does

not want to give up on her patients and has taken steps to improve her processes to ensure these issues do not reoccur.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Board hereby ORDERS as follows:

1. Teresa Anne Moore, M.D., is REPRIMANDED.

2. The license of Teresa Anne Moore, M.D., is placed on the following terms and conditions for a period of twelve (12) months from entry of this Order:

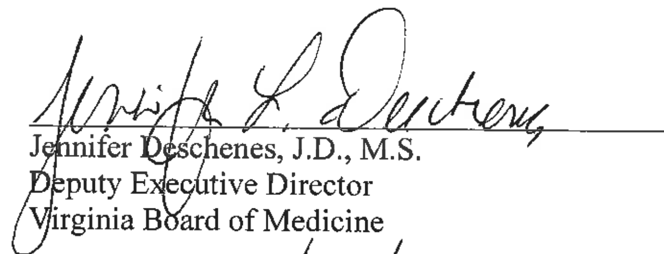
a. Starting (30) days after entry of this Order, Dr. Moore is prohibited from treating or supervising any provider treating patients with chronic pain, i.e., a non-acute injury requiring the prescription of Schedule II or III controlled substances for more than two weeks.

b. Within twelve (12) months from the date of entry of this Order, Dr. Moore shall provide written proof satisfactory to the Board of successful completion of Board-approved courses of at least 15 credit hours in the subject of proper prescribing and pain management and at least 8 credit hours in the subject of recognizing addiction. These courses shall be approved in advance of registration by the Executive Director of the Board. All continuing education hours/courses shall be completed through face-to-face, interactive sessions (i.e., no home study, journal, or Internet courses). Continuing education obtained through compliance with this term shall not be used toward licensure renewal.

3. Upon compliance with the preceding terms, the Committee authorizes the Executive Director to close this matter or refer it to an informal fact-finding conference.

Pursuant to Virginia Code §§ 2.2-4023 and 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD



Jennifer Deschenes, J.D., M.S.
Deputy Executive Director
Virginia Board of Medicine

ENTERED: 9/13/2016

NOTICE OF RIGHT TO APPEAL

Pursuant to Virginia Code § 54.1-2400(10), Dr. Moore may, not later than 5:00 p.m., on **October 18, 2016**, notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that she desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated. This Order shall become final on **October 18, 2016**, unless a request for a formal administrative hearing is received as described above.