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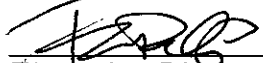
**BEFORE THE NEVADA STATE
BOARD OF OSTEOPATHIC MEDICINE**

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IN THE MATTER OF THE COMPLAINT)
AGAINST)
GARY LUTZ, D.O.)
RESPONDENT.)

Case No.: AD-04-327

Filed: 4-11-05


Executive Director

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

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

Statement of the Case

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

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

1 Discussion of Testimony and Evidence

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

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

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

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

1 prescribing and/or too frequent of filling prescriptions. (Tr. 3-8-05, p. 38-9.) According to Dr.
2 Kessler, the maximum dosage of Tylenol is 4,000 milligrams; and that the most common
3 cause of drug overdose is due to Tylenol as it causes liver damage. (Tr. 3-8-05, p. 39.)
4 Although most physicians try to keep the Tylenol dosage to less than 3,000 milligrams per
5 day, this patient was receiving approximately 3,600 milligrams per day. (Tr. 3-8-05, p. 40.)
6 Inadequate workup and/or examination of this patient were also noted by Dr. Kessler (Tr. 3-8-
7 05, p. 41); and in his opinion, the care and treatment of this patient fell below the appropriate
8 standard (Tr. 3-8-05, p. 45-6).

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

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

18 Concerning Patient D, Dr. Kessler noted the following prescribed medications: Lortab,
19 Klonopin, Desyrel, Dyazide, Soma, Percocet, Methadone, Bextra, Arthrotec, Lexapro, Benicar,
20 Viagra, AndroGel, Ritalin, Neurontin, Actiq, Wellbutrin, Dexedrine, and Vicodin (Tr. 3-8-05, p.
21 57-9). Dr. Kessler expressed concern that this patient was a forklift driver while under such
22 heavy medication (Tr. 3-8-05, p. 60). Dr. Kessler was also critical of Dr. Lutz in his failure to
23 do a physical examination and the inadequacy of the history from this patient (Tr. 3-8-05, p.
24 61). Dr. Kessler expressed his concern that this patient was also receiving "up to 5,000
25 milligrams of Tylenol a day" as he believes "Four thousand is a toxic dose" (Tr. 3-8-05,
26 p. 62.) Several other examples of over-prescribing were provided by Dr. Kessler, as well as
27 his opinion that there were several examples of "rapid escalations" in the dosages being
28 prescribed. (Tr. 3-8-05, p. 64.) The medical records for this patient also indicated that he

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

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

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

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

20 FINDINGS OF FACT

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

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

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

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

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

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

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

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

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

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

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

25 11. Pursuant to NRS 633.651, this Board has the authority to: place a physician on
26 probation, administer a public reprimand, limit a physician's practice, suspend a physician's
27 license, or revoke the medical license of a physician practicing osteopathic medicine.
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1 12. Based upon the credible testimony and exhibits offered in this matter, disciplinary
2 action in this matter is appropriate pursuant to NRS 633.511.

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

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

8 **DECISION AND ORDER**

9 IT IS HEREBY ORDERED, ADJUDGED, AND DECREED:

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

16 DATED THIS 6 day of April, 2005.

17 NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE

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20 By:  for
Rudy Manthei, Chairman

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