COMMONWEALTH OF MASSACHUSETTS
APPEALS COURT

NO. 2018-P-0353

COMMONWEALTH OF MASSACHUSETTS,
Appellant

V.

FRANK STIRLACCI AND ANOTHER,
Defendant-Appellee

BRIEF FOR THE COMMONWEALTH ON APPEAL FROM AN ORDER OF THE HAMPDEN COUNTY SUPERIOR COURT DEPARTMENT ALLOWING THE DEFENDANTS' MOTIONS TO DISMISS

HAMPDEN COUNTY

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June 29, 2018

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STATEMENT OF THE ISSUES

I. Whether grand jury evidence established probable cause that the defendants, a medical doctor and an office manager, issued twenty-six controlled substance prescriptions either without a legitimate medical purpose or outside the usual course of professional practice, where the doctor broadly instructed the manager to issue prescriptions to patients, the manager did so from prescription pads pre-signed by the doctor, and the doctor provided no particularized oversight.

II. Whether grand jury evidence established probable cause that the defendants uttered twenty false prescriptions, where they issued prescriptions bearing the signature of a medical doctor who did not write, oversee, or have particularized knowledge of them.

III. Whether grand jury evidence established probable cause that the defendants filed twenty-two false healthcare claims, where the defendants submitted billing documents to insurance companies for twenty-two patient visits which stated that a medical doctor was the service provider and included the doctor's signature on prescriptions, even though the

doctor was incarcerated at the time of each visit and neither provided service nor issued prescriptions to the patients.

STATEMENT OF THE CASE

The defendants, Frank Stirlacci ("Stirlacci") and Jessica Miller ("Miller"), were indicted by the Hampden County Grand Jury on January 26, 2017, each with twenty-six counts of improperly issuing a prescription, in violation of G.L. c. 94C, §19(a), twenty counts of uttering a false prescription, in violation of G.L. c. 94C, §33(b), and twenty-two counts of filing a false healthcare claim, in violation of G.L. c. 175H, §2. 1779CR00039; 1779CR00040; R. I/41-176.[1] Miller was arraigned in

[1] The Record Appendix is cited as "R. Volume/page," and the October 26, 2017, hearing on the motion to dismiss is cited as "Hearing/page." The grand jury minutes and exhibits are included in volumes II and III of the Record, which are under seal. See G.L. c. 268, §13D(e) (grand jury minutes are to be filed and maintained under seal); Mass. R. App. P. 18(g) ("If the entire case has not been impounded, a separate appendix volume shall be filed containing the impounded material and the cover thereof shall clearly indicate that it contains impounded material."); Mass. R. App. P. 20(a) ("No single volume of the appendix shall be more than one and one-half inches thick."). While grand jury proceedings are secret, a court may describe and summarize facts contained in grand jury minutes. Commonwealth v. Cabral, 443 Mass. 171, 173 n.4 (2005).

Hampden County Superior Court on February 14, 2017, and Stirlacci on March 3, 2017. R. I/14, 34.

On September 14 and 25, 2017, the defendants each filed motions to dismiss all indictments based on a lack of probable cause, pursuant to Commonwealth v. McCarthy, 385 Mass. 160 (1982). R. I/16, 35, 177-80, 184-202. On October 26, 2017, the Commonwealth filed a memorandum in opposition to the motion to dismiss in each case. R. I/203-212. Also on October 26, 2017, a non-evidentiary hearing on the motions to dismiss was held, Mason, J., presiding. R. I/16, 36; Hearing/1. On November 13, 2017, Stirlacci filed an addendum to his motion to dismiss the indictments. R. I/16, 181-83.

On November 28, 2017, the motion judge issued an order allowing each of the defendant's motions to dismiss all indictments except for fourteen indictments each for filing false healthcare claims. R. I/16-19, 36-39, 213-246.[2] On December 15, 2017, the

[2] The motion judge's order was based on reasoning largely independent of the arguments presented by the defendants. Stirlacci argued only for the dismissal of the indictments alleging violations of G.L. c. 94C, §19(a), and presented minimal argument without citation to the record. See R. I/177-83. Miller, meanwhile, argued that she was not a practitioner as required by G.L. c. 94C, §19(a), and that she lacked

Commonwealth filed notices of appeal in both cases. R. I/247-48. On February 1, 2018, the Commonwealth filed amended notices of appeal, correcting a scrivener's error appearing in each of the initial notices. R. I/249-52.

Both cases were docketed in this Court on March 14, 2018. R. I/253-54. On March 28, 2018, the Commonwealth filed a motion to consolidate the appeals. R. I/254. On March 29, 2018, the appeals were consolidated under the docket number 2018-P-0353. R. I/253-54. The case is before this Court pursuant to Mass. R. Crim. P. 15(a)(1) and G.L. c. 278, §28E.

STATEMENT OF THE FACTS

Over a three-week period in 2015, an office manager in a medical office issued narcotics prescriptions from prescription pads previously signed by an incarcerated medical doctor. The medical doctor broadly ordered that the prescriptions be issued to patients who sought them, with no individualized review or oversight.

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the required mens rea on all counts because she simply followed Stirlacci's directives. See R. I/195, 197, 199, 201. The motion judge's order relied on independent reasoning and comprehensively referenced the grand jury record. R. I/213-46.

In April and May, 2015, Stirlacci, a medical doctor, operated a Massachusetts medical practice ("the practice"), with one location in Agawam and one in Springfield. R. II/4, 57. Jennifer Rivers ("Rivers") was a licensed nurse practitioner, who worked for Stirlacci at the Springfield location from January, 2014, until May, 2015. R. II/57. Patients were billed for Rivers's services at 85 percent of Stirlacci's rate. R. II/60. Miller was an office manager at the practice; she was not a licensed medical professional and was not authorized to issue prescriptions. R. II/4, 59. Joe Ciurleo ("Ciurleo") was a childhood friend of Stirlacci and participated in the operation of the practice. R. II/59. It was a common practice for Stirlacci to leave pre-signed prescription pads for Miller to use in issuing prescriptions while Stirlacci was absent. R. II/59. Rivers completed patient notes, prescriptions, and billing information for her own patients. R. II/57, 59.

From April 17, 2015 to May 11, 2015, Stirlacci was incarcerated in the Louisville, Kentucky, jail system. R. II/5, 65; R. III/224. During that time, Stirlacci frequently contacted Ciurleo and Miller

regarding the operation of the practice. See R. II/64-612; R. III/1-239.

On April 21, 2015, Miller told Stirlacci that she did not intend to tell Rivers that Stirlacci was incarcerated because Rivers could not "handle it." R. II/228-29. Stirlacci and Miller agreed that others would be told that Stirlacci was on vacation. R. II/230-32. During this conversation, Stirlacci asked Miller to put in charges for patient appointments which had not yet been billed. R. II/238-39. Stirlacci emphasized the importance of maintaining cash flow, and told Miller to list him as the service provider on the documents. R. II/239. Miller and Stirlacci then had the following exchange:

> JESS: What about people that are picking up scrips? Can I put in charges for them?
> MR. STIRLACCI: Yes.
> JESS: Even though they weren't seen?
> MR. STIRLACCI: Yes, put in the 99212.
> JESS: Okay.
> MR. STIRLACCI: For the day that they pick them up because they didn't see the doctor so it's a down charge. So it's a 92 or a 93.
> JESS: Okay.
> MR. STIRLACCI: Just put 93 and a blue note in a sticky pad on their chart. If they're picking up scrips, we're doing work.
> JESS: Okay.
> MR. STIRLACCI: Okay? Because you gotta have a blue note with a super bill. So just put sticky notes on everything. Anything and everything that you can get in, get in.
> JESS: Okay.

R. II/239-40. Stirlacci then repeated, "I'm on vacation[.]" R. II/240. Stirlacci later stated, "So just get some charges in . . . . Doc's on vacation. Anybody comes in for a scrip, blue note, super bill, sticky pad, and get charges in." R. II/244. Miller responded, "Okay." R. II/244. To put charges in referred to forwarding billing codes to insurance companies to receive payment for patient visits. R. II/13.

On April 22, 2015, Stirlacci spoke with Ciurleo, and said, "[j]ust try to plug in as much as we can[,]" and, "the pipeline's got to flow." R. II/260. Stirlacci also spoke with Miller on April 22, 2015. R. II/262. Miller started that call by explaining that she had missed Stirlacci's earlier call because she was "sitting at work writing a scrip for [patient name] . . . ." R. II/262. Miller expressed additional disappointment that she had missed Stirlacci's telephone call, and Stirlacci responded simply, "[I]t's okay, Jess[,]" without mentioning the prescription. R. II/262.

On April 23, 2015, Stirlacci spoke with Miller again. R. II/295. Miller said, "I was [at work] all morning. I did a bunch of scrips." R. II/296.

Stirlacci responded, "Okay." R. II/296. Stirlacci and Miller then discussed a plan to reschedule Agawam patients to see Rivers, condensing patient visit times so Rivers could see them all within eight-hour workdays. R. II/297-98. Miller and Stirlacci both agreed that Rivers needed to be cooperative. R. II/298. Stirlacci then told Miller, "[a]nd you need to obviously -- you know, with the scrips, you just knock those out and don't even let her." R. II/299. Miller responded that she would. R. II/299. Stirlacci then said, "[a]nd enter charges. I don't know how many you wrote today. I don't know how many scrips you have left." R. II/299. Miller asked Stirlacci, "[a]re they going to take your medical license?" R. II/299. Stirlacci responded that they "would not." R. II/299. Stirlacci also said that Rivers may refuse to cooperate with the plan because he was not in the state, R. II/299, that Ciurleo and Miller should explain the situation to Rivers together, R. II/302, 305-06, and that Rivers may simply say, "I'm out of here." R. II/306.

On April 24, 2015, Stirlacci spoke with a third party and said that he was "going to have [Ciurleo] talk with [Rivers], and she's probably going to say

okay, enough is enough." R. II/316. He noted, "she's very OCD about whatever." R. II/316. During this conversation, Stirlacci repeatedly expressed concern about keeping the practice open because he was not permitted to abandon patients, noting that the Board of Medicine would frown upon him not being able to see patients on the following Monday and had already inquired about his ability to see patients. R. II/311-14, 319-20. Stirlacci acknowledged that there would be serious repercussions for 3,000 patients if he was not released. R. II/322-23.

On April 24, 2015, Stirlacci had two conversations with Ciurleo, with Miller participating in portions of both. R. II/331-58. Ciurleo told Stirlacci that Rivers would see patients in Agawam on Monday, but would not go to that location any other day because she did not want to inconvenience her patients. R. II/332-33. Stirlacci asked Ciurleo and Miller to fit as many appointments into Monday as possible, and to relocate Tuesday-through-Thursday Agawam appointments to Springfield. R. II/348-49.

On April 26, 2015, Ciurleo explained to Stirlacci a revised plan to cover patient appointments; Rivers would meet with patients in Agawam on Monday and on

Tuesday afternoon, while covering Springfield on Tuesday morning. R. II/378-79. He also said, "and anybody with refills and stuff like that, [Miller] is going to take care of it during the morning." R. II/379. Stirlacci apparently agreed with this plan. See R. II/379.

On April 30, 2015, Ciurleo asked Stirlacci where he could find a letter for a particular patient so he could change the date and sign Stirlacci's name to it, stating that the patient needed the letter in order "to get the therapy or something." R. II/457-58. Stirlacci responded, "yeah, ok." R. II/458. In a later conversation with Miller on April 30, 2015, Stirlacci said, "you're going to have to run the practice without me." R. II/476. Stirlacci then acknowledged that Rivers was not permitted to practice without his supervision. R. II/481. Nonetheless, when Miller said that she was taking care of refill authorizations, Stirlacci told her that Rivers could issue narcotic prescriptions and Miller could issue other prescriptions by signing her own name, slash, Stirlacci's name. R. II/483. During a conversation on a later date, Stirlacci said that required oversight by a doctor involves the ability to have

telephone contact at any point that a nurse practitioner is seeing a patient. R. II/582, 593.

On May 2, 2015, Ciurleo told Stirlacci that Rivers was "more of a pain in the ass than help[,]" apparently because she had stated that Miller should not be writing prescriptions. R. II/487, 506. Ciurleo then said, "we gotta do what we gotta do." R. II/506. Stirlacci responded, "[h]ow about we survive, [Rivers]? How about if we survive?" R. II/506.

On May 3, 2015, Miller told Stirlacci that she had used a particular billing code for a patient visit because she wanted to bring in money for patients even though Rivers told her she could not issue the bill because Rivers had not seen the patient. R. II/512-13. Miller did not dispute the impropriety of issuing the bill, but said, "[l]et me do it. I want to get money for these [] patients. Shut up." R. II/512. Stirlacci then told Miller, "do what you know is right[,]" and said he was not sure how long Rivers would last. R. II/512-13. When Miller said that Rivers was not going to last past Monday, Stirlacci said, "she's not very helpful on some things. She's a great clinician, but she doesn't understand just business sense, and you know, you just have to do --

not break any rules, not commit fraud." R. II/513. He then said, "life is not a squeaky clean bubble. We're not St. Francis. We're not Baystate." R. II/516. Stirlacci also asked Miller how many prescriptions she had remaining. R. II/517-18. Miller responded that she was trying to save some. R. II/518. Stirlacci then told Miller to have Rivers sign some, and said, "[a]nything you can save, save." R. II/518.

On May 4, 2015, Rivers gave a notice of resignation. R. II/579. She then ultimately left the practice on May 7, 2015. R. II/58.

On May 5, 2015, Stirlacci told a third party that Rivers resigned because "she's very stringent, she's very OCD about her job and everything like that, and she's not going to break the law." R. III/11-12. Stirlacci then explained that he was legally obligated to be available to patients, and said that he did not blame Rivers for resigning so that she would not jeopardize her license. R. III/11-12.

On May 5 and 6, 2015, Stirlacci several times said that the practice was failing, suggesting at one point that it would implode and that he could restart a practice the following year. R. III/51, 87. On May

6, 2015, Ciurleo discussed Rivers, stating that he did not need her saying, "we can't be doing this and we can't be practicing, we can't bill for this because you're not, you know what I mean? You're going to be investigated." R. III/84. Ciurleo then said, "I don't need that either." R. III/84. Stirlacci responded simply by saying, "No, I know[,]" and, "[w]ell, hold it together." R. III/84. Ciurleo expressed a similar sentiment a short time later. R. III/90. He portrayed Rivers as saying, "[w]e're not supposed to be writing them, we're not supposed to be billing them and all the other stuff. We're going to be investigated." R. III/90. Ciurleo then said, "[y]ou don't need that from that bitch because you know how she is." R. III/90. Stirlacci responded, "I know how she is." R. III/90. Stirlacci then said, "[w]ell, hold down the fort." R. III/91. Ciurleo also told Stirlacci that he had begun looking for a doctor to fill in at the practice. R. III/93.

On May 7, 2015, Ciurleo told Stirlacci, "You got three thousand patients who need to be seen, and we can't see them." R. III/120. Stirlacci responded, "[c]orrect." R. III/120. Stirlacci and Ciurleo also discussed the fact that they either needed to start

seeing patients or advise patients to find another doctor. R. III/128. Stirlacci noted that with Rivers gone, "we're dead in the water from this point forward until I get out." R. III/135. Stirlacci repeated this sentiment several more times. R. III/136, 146.

On May 7, 2015, Stirlacci also spoke with Miller. R. III/147. In discussing her frustration with Rivers trying to give Miller instructions, Miller said, "I know you don't like it, but that doesn't make -- you don't make any decisions. Doc is the one that make [sic] any decisions, and he told me to write scrips, so I'm writing scrips." R. III/151. Stirlacci responded, "[r]ight. And so what didn't she like? The patients were seen. They came into the office." R. III/151. Miller answered, "[s]he doesn't like that we were writing scrips for patients and then expecting her to do the office note." R. III/151. Stirlacci then said, "[o]kay. Well, all right. Well, see all these patients then, [Rivers.]" R. III/151. Stirlacci said that Rivers would not make it in the real world and that she was institutionalized. R. III/158. He said further that when you are self-employed you make your own rules and that some rules

and regulations do not work because they are not good for business. GJ Ex. 4/159.

On May 8, 2015, Stirlacci spoke with Ciurleo again. R. III/199-214. Ciurleo said, "[i]f nobody can see them, nobody can do this, you know, we really can't -- you know, we're not really supposed to be doing what we're doing right now. This is a complication that might affect you in another way." R. III/209-210. Stirlacci responded, "I know, I know." R. III/210.[3]

At least twenty-six prescriptions for hydrocodone, oxycodone, methadone, and fentanyl were issued in Stirlacci's name during the time he was incarcerated. R. II/19-24, 33-55; R. III/240-636, 240, 267, 268, 279, 293, 333, 372, 408, 424, 460, 476-478, 479-81, 535-546, 563, 568, 573,[4] 577, 579, 586,

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[3] The cryptic, vague language here and frequently used by the parties should be considered in light of the fact that they were expressly informed that their conversations were being recorded. See R. II/25-27, 128. At one point, when Miller asked Stirlacci to explain his terse answers, Stirlacci reminded her that the call was being recorded and could be used against him in court. See R. III/38. It is not clear what court proceeding he had in mind. At another point, Stirlacci clarified that one of Miller's comments was a joke, apparently for the exclusive benefit of the recording. See R. II/241.

[4] The date on one indictment for each defendant regarding this prescription does appear to be

588, 590, 598, 600, 605/630.[5] As used in the grand jury proceedings, the term "narcotic" referred to controlled substances. R. II/49. Rivers reviewed these prescriptions and recognized Stirlacci's signature and Miller's handwriting in the bodies of the prescriptions. R. II/59. Also during this time, both Miller and Ciurleo asked Rivers to sign Agawam patient notes for patients that she had not seen. R. II/59.

The practice submitted billing documentation to various insurance companies for twenty-two patients, which included the twenty-six narcotics prescriptions at issue, purportedly issued and signed by Stirlacci. See R. II/17-24, 33-55; R. III/240-636. A witness also testified that the billing documents purported that each patient was seen by Stirlacci, R. II/55, and made the same claim when specifically addressing each

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incorrect. The prescription was issued on May 7, 2015, R. III/573, but the indictments list April 23, 2015. R. I/53, 121.

[5] For some of the handwritten prescriptions, the accompanying documentation is necessary to determine prescription details. For instance, the date and signature on the prescription at R. III/630 are essentially unreadable. But an accompanying document states that the prescription was issued by Stirlacci to the patient at issue for hydrocodone on April 22, 2015. R. III/605. Elsewhere, the accompanying documentation is helpful but not necessary to confirm the contents of prescriptions.

of fourteen of the patients. Tr. II/37-54. The billing documents for the remaining eight patients listed Stirlacci as the service provider and included prescriptions signed by him. R. III/240, 241; 250, 267; 268, 270; 279, 282; 293, 295; 372, 374; 408, 412; 424, 427.

The motion judge dismissed the indictments for issuing invalid prescriptions (G.L. c. 94C, §19(a)), finding that the grand jury would have had to engage in "'conjecture and guesswork'" to find that prescriptions were issued without a "'legitimate medical purpose.'" R. I/237. The motion judge dismissed the indictments for uttering false prescriptions (G.L. c. 94C, §33(b)), finding that "there was no evidence that the prescriptions were 'false.'" R. I/238. The motion judge dismissed eight of the indictments for filing false healthcare claims (G.L. c. 175H, §2), finding that the billing documents did not represent that Stirlacci had face-to-face meetings with these eight patients. R. I/240-41.

SUMMARY OF THE ARGUMENT

I. The crime of issuing an invalid prescription for a controlled substance requires that a medical practitioner issue a prescription either without the

intention to issue it for a legitimate medical purpose or issue a prescription outside the usual course of professional practice. P. 22. There was probable cause that the defendants issued prescriptions without a legitimate medical purpose when Miller completed and issued prescriptions pre-signed by Stirlacci while he was incarcerated outside the Commonwealth. P. 28. Probable cause is based in part on Stirlacci delegating prescriptions to Miller without providing any oversight, P. 28, and from his instructing her to issue prescriptions to anyone who came into the office for one without qualification. P. 31. There also was probable cause of the alternate theory that the defendants acted outside the usual course of professional practice based on the broad delegation of authority to a person without a medical license, P. 32, and from the defendants' own implicit acknowledgements that they were acting improperly. P. 33, 34.

II. The grand jury also could find probable cause that the defendants uttered false prescriptions in that they offered prescriptions as genuine, which they knew to be false, with the intent to defraud. P. 36. Falsity broadly includes forgery, alteration, or

counterfeiting. P. 36. Prescriptions were false where they bore Stirlacci's signature even though he did not issue, oversee, or apparently even have particularized knowledge of them. P. 40. These prescriptions also were issued with the intent to defraud in that they were intended to impose liabilities on others through deceit. P. 42.

III. The evidence before the grand jury also was sufficient to establish probable cause that the defendants filed false healthcare claims. P. 43. Testimony that the defendants represented to insurance companies that patients were seen by Stirlacci when they were not, alone, was sufficient. P. 44. But the defendants' representations to insurance companies that Stirlacci had issued prescriptions and provided services to them when he had not done so independently established probable cause. P. 44.

ARGUMENT

The Motion Judge Erred in Dismissing the Indictments at Issue Because Each was Supported by Probable Cause.

Generally, a "court will not inquire into the competency or sufficiency of the evidence before the grand jury." Commonwealth v. McCarthy, 385 Mass. 160, 161-62 (1982), quoting Commonwealth v. Robinson, 373 Mass. 591, 592 (1977). The McCarthy Court established a limited exception to that rule: a court will review the evidence before the grand jury to determine whether the grand jury heard sufficient evidence to establish the identity of the accused and probable cause to arrest him for the offenses charged. McCarthy, supra at 163. "To survive a motion to dismiss, the grand jury must simply be presented with evidence supporting a finding of probable cause as to 'each of the . . . elements' of the charged crime." Commonwealth v. Walczak, 463 Mass. 808, 817 (2012), quoting Commonwealth v. Moran, 453 Mass. 880, 884 (2009) (alteration in original). "Probable cause requires sufficient facts to warrant a person of reasonable caution in believing that an offense has been committed[.]" Commonwealth v. Levesque, 436 Mass. 443, 447 (2002). "[A] requirement of sufficient

evidence to establish the identity of the accused and probable cause to arrest him is considerably less exacting than a requirement of sufficient evidence to warrant a guilty finding." Commonwealth v. O'Dell, 392 Mass. 445, 451 (1984). The evidence before the grand jury is considered in the light most favorable to the Commonwealth, Walczak, supra at 817, and "an indictment may be based solely on hearsay." McCarthy, supra at 162. Furthermore, "because 'we consider ourselves in as good a position as the motion judge to assess' the evidence before the grand jury, [an appellate court does] not defer to [a motion judge's] factual findings or legal conclusions." Walczak, supra at 817, quoting Commonwealth v. Silva, 455 Mass. 503, 526 (2009) (internal citations omitted).

A defendant may be convicted of a crime if he "knowingly participated in the commission of the crime charged, alone or with others, with the intent required for that offense[.]" Commonwealth v. Zanetti, 454 Mass. 449, 466 (2009). "[O]ne who aids, commands, counsels, or encourages the commission of a crime while sharing with the principal the mental state required for the crime is guilty as a

principal[.]" Id. at 464, quoting Commonwealth v. Soares, 377 Mass. 461, 470 (1979).

I. The Grand Jury Evidence Established Probable Cause that the Defendants Issued Invalid Prescriptions, in Violation of G.L. c. 94C, §19(a).

The motion judge erroneously found that there was insufficient evidence to establish probable cause that the defendants violated G.L. c. 94C, §19(a). R. I/237.

G.L. c. 94C, §19(a) criminalizes the prescription of a controlled substance "for no legitimate medical purpose and not in the usual course of [ ] professional practice[.]" Commonwealth v. Brown, 456 Mass. 708, 724-25 (2010). Courts vaguely have treated "legitimate medical purpose" and "usual course of professional practice" as closely interconnected elements or as subparts of the same element. See Id. at 721 ("a 'valid prescription' is one issued for a legitimate medical purpose in the course of usual professional practice."); Commonwealth v. Comins, 371 Mass. 222, 232 (1976) ("issues a prescription not intending to treat a patient's condition in the usual course of his practice"); Commonwealth v. Brown, 74 Mass. App. Ct. 75, 84 (2009), aff'd, 456 Mass. 708

(2010) ("§19 sets forth the elements of the offense of dispensing in the circumstances of physicians writing prescriptions for other than a legitimate medical purpose."); Commonwealth v. Kobrin, 72 Mass. App. Ct. 589, 607 (2008)("bad faith prescribing absent a legitimate medical purpose"). These indeterminate statements of the elements suggest, without conclusively finding, that the Commonwealth is required only to establish one of two alternate elements. But this could be viewed as an open question. The motion judge in fact found distinct elements, each requiring separate proof. See R.I/224, 232-36.

Use of the conjunction "and" instead of "or" in the statute at first appears to support this view. The language is explained, however, by the fact that the statute serves two purposes: first to exempt medical practitioners from general drug distribution liability for issuing valid prescriptions, and second, to criminalize invalid prescriptions. See Brown, 456 Mass. at 717. The statute does this by stating positively what is required for a prescription to be valid. See G.L. c. 94C, §19(a). The imposition of two requirements for a prescription to be valid

necessitates that a prescription is invalid if it lacks either of those requirements. As a result, the conjunctive "and" in the statute should be read as establishing alternative elements. "There is ample precedent for construing the word 'and' disjunctively in order to further a recognized legislative purpose." Somerset v. Dighton Water Dist., 347 Mass. 738, 742-43 (1964). The Commonwealth, therefore, is required to establish either that a prescription was issued not for a legitimate medical purpose **or** not in the usual course of professional practice.

Consistent with this, the United States Court of Appeals for the Tenth Circuit has interpreted the federal regulation with parallel language as requiring proof of just one of the two elements -- although the federal regulation avoids the use of either conjunction. United States v. Nelson, 383 F.3d 1227, 1231-32 (10th Cir. 2004) ("A practitioner has unlawfully distributed a controlled substance if she prescribes the substance either outside the usual course of medical practice or without a legitimate medical purpose."). See 21 C.F.R. § 1306.04(a). The Massachusetts Supreme Judicial Court ("SJC") previously has noted the parallel language of 21

C.F.R. §1306.04(a) in interpreting the Massachusetts statute. See Brown, 456 Mass. at 717 n.10.

Additional elements are more straightforward. The plain language of the statute requires that a defendant issue a prescription for a controlled substance. G.L. c. 94C, §19(a). It is also required that the prescription be issued by a practitioner. Commonwealth v. Chatfield-Taylor, 399 Mass. 1, 4 (1987).

The elements of the offense, therefore, can be stated as follows:

1) A medical practitioner,
2) Issues a prescription for a controlled substance,
3) Not for a legitimate medical purpose, or
4) Not in the usual course of professional practice.

As for the first element, the applicable definition of practitioner is found in G.L. c. 94C, §1, Chatfield-Taylor, supra at 4, and the definition includes a physician. See G.L. c. 94C, §1. There was considerable evidence before the grand jury that Stirlacci was a practitioner, including direct testimony that he was the doctor in charge of the practice and discussion of his medical license. R. II/4, 57, 299.

There also was abundant evidence of the second element, that the defendant issued prescriptions; the evidence is fully intertwined with the evidence supporting the third and fourth elements. See Argument, infra at 28-35.

The third element, not for a "legitimate medical purpose," raises a question of a practitioner's objective in issuing a prescription. See Comins, supra at 232 ("the physician's purpose, his state of mind, must be shown to have been such that he was not intending to achieve a legitimate medical objective."). "The question whether the defendant acted in bad faith is a question of fact for the jury." Commonwealth v. Pike, 430 Mass. 317, 321 (1999). The element has not been established if "[t]he inference that [a practitioner] exercised independent medical judgment is as compelling as the inference that he issued prescriptions on request without legitimate medical purpose." Commonwealth v. Eramo, 377 Mass. 912, 912 (1979).

As for the fourth element, "'[t]he term 'professional practice' refers to generally accepted medical practice[.]'" United States v. Birbragher, 603 F.3d 478, 485 (8th Cir. 2010), quoting United

States v. Vamos, 797 F.2d 1146, 1151 (2d Cir. 1986) (alteration in original). The same definition has been applied to the Massachusetts statute. See Kobrin, supra at 596 (the Commonwealth must prove that a "physician failed to adhere to accepted medical practice"). Usual course of professional practice "connotes an observance of conduct in accordance with what the physician should reasonably believe to be proper medical practice." Vamos, supra at 1153, quoting United States v. Voorhies, 663 F.2d 30, 33-34 (6th Cir. 1981). "[T]he practitioner must have deliberately acted in this fashion in order for him to be convicted of a crime." United States v. Feingold, 454 F.3d 1001, 1008 (9th Cir. 2006).

> The physician's purpose, state of mind, intent -- all that bears on the bona fides of the physician's conduct -- may not be "susceptible of proof by direct evidence, so resort is frequently made to proof by inference from all the facts and circumstances developed at trial . . . . The question whether the defendant acted in bad faith is a question of fact for the jury."

Kobrin, supra at 597, quoting Pike, supra at 321 (alterations in original). See Comins, supra at 232-33 (doctor took no medical histories and conducted no physical examinations, which supported "an inference

that the defendant did not have medical needs in mind when he issued the prescriptions and that he was not interested in finding physical indications of such needs.").

As for Miller, she may be held liable as an aider and abettor if she provided aid to Stirlacci with the shared intent for prescriptions to issue either not for a legitimate medical purpose or not in the usual course of professional practice. See Zanetti, supra at 466. "While those who assist practitioners in distributing controlled drugs clearly cannot be held to the standard of a reasonable practitioner, they are not free to unreasonably rely on the judgment of their employers." Vamos, supra at 1153-54.

The evidence supported a finding that Stirlacci issued prescriptions through Miller without any intent to achieve a legitimate medical purpose, thereby satisfying the third element. See Comins, supra at 232. The parties, instead, intended to issue prescriptions in order to generate revenue by billing insurance companies for prescriptions, regardless of the medical need for them.

Rivers testified that Stirlacci left pre-signed prescription pads for Miller's use. See R. II/59.

Stirlacci himself repeatedly, implicitly, conceded that he had done this. First, he said at one point, "I don't know how many you wrote today. I don't know how many scrips you have left." R. II/299. At a later point, he asked Miller how many prescriptions she had remaining, R. II/517-18, and Miller responded that she was trying to save some. R. II/518. Stirlacci then told Miller to have "her" sign some, and said, "[a]nything you can save, save." R. II/518. This last statement eliminates the already suspect possibility that Stirlacci simply was discussing blank prescriptions, instead of pre-signed ones. Because Stirlacci elsewhere says that nonnarcotic prescriptions do not require his signature, R. II/483, it is also clear that he specifically has in mind narcotics prescriptions.

The conversations between the defendants made abundantly clear that Stirlacci was providing no oversight of Miller's prescriptions beyond broadly ordering her to issue them. At one point, Miller reported without providing details that she was writing a prescription, and Stirlacci did not discuss the prescription at all. R. II/262-63. At another point, Miller said, "I was [at work] all morning. I

did a bunch of scrips." R. II/296. Stirlacci responded, "Okay." R. II/296. Later, Stirlacci summarized the arrangement quite directly when he said, "you're going to have to run the practice without me." R. II/476. At another point, Miller told Stirlacci that she issued a prescription and used a particular billing code in order to bring in money even though Rivers told her that she was not permitted to do so because Rivers had not seen the patient. R. II/512-13. Stirlacci simply told Miller, "do what you know is right[.]" R. II/513. Miller left no doubt about the agreement between the defendants when she was venting frustration about interference from Rivers. Without disputing that Rivers correctly viewed her conduct as improper, Miller simply said, "let me do it. I want to get money for these [] patients." R. II/512. Reciting another conversation she had with Rivers, Miller said, "I know you don't like it, but that doesn't make -- you don't make any decisions. Doc is the one that make [sic] any decisions, and he told me to write scrips, so I'm writing scrips." R. III/151. Stirlacci provided further confirmation by responding, "[r]ight. And so what didn't she like? The patients were seen. They

came into the office." R. III/151. Miller answered, "[s]he doesn't like that we were writing scrips for patients and then expecting her to do the office note." R. III/151.

Additionally, Stirlacci made no inquiries that might be construed as meaningful oversight of the prescribing; instead, he essentially instructed Miller to issue prescriptions indiscriminately so long as she generated bills. At one point, Stirlacci instructed Miller in detail about how to issue bills, See R. II/238-39, and then said, "you gotta have a blue note with a super bill. So just put sticky notes on everything. Anything and everything that you can get in, get in." R. II/240. He reiterated, "[s]o just get some charges in . . . . Doc's on vacation. Anybody comes in for a scrip, blue note, super bill, sticky pad, and get charges in." R. II/244. Miller agreed to this. R. II/244. In another discussion regarding Rivers, Stirlacci said, "[a]nd you need to obviously -- you know, with the scrips, you just knock those out and don't even let her." R. II/299. Miller responded that she would. R. II/299. Stirlacci then clearly stated that he had no knowledge of the prescriptions Miller was issuing as he instructed her

to generate more revenue: "[a]nd enter charges. I don't know how many you wrote today. I don't know how many scrips you have left." R. II/299. Moreover, in a conversation with Ciurleo, Stirlacci said, "[j]ust try to plug in as much as we can[,]" and, "the pipeline's got to flow." R. II/260. It is a reasonable, necessary object of any medical practice to generate revenue, but this purpose may not override the object of issuing controlled substance prescriptions for legitimate medical purposes. The grand jury properly found probable cause that Miller and Stirlacci did just that.

The evidence supporting the fourth, alternate element also was sufficient. The grand jury easily could have found probable cause that the defendants intentionally acted outside accepted medical practice when Miller prescribed fentanyl and other controlled substances, using pre-signed forms, based on blanket authorization with no meaningful supervision. See argument, supra at 26, 28-32. While the detailed rules regarding narcotics prescriptions may not be within common knowledge, the fact that specialized licensing or qualifications are required to issue them surely is. The very nature and purpose of

prescriptions requires this. The record was clear that Miller was an office manager without a medical license or the authority to issue prescriptions. R. II/4, 59. Nothing more was needed to establish probable cause on this point.

The grand jury, however, was provided substantially more evidence of the defendants' knowledge that they were acting outside accepted practice. Stirlacci did not describe the precise contours of his obligations, but repeatedly noted that he was required to be available to patients and that he was not meeting that obligation. See R. II/311-12, 313, 314, 319-20; R. III/12, 55. In discussing this obligation, Stirlacci said he did not blame Rivers for resigning so she would not jeopardize her medical license. R. III/11-12. He also previously had noted that Rivers may be uncooperative because Stirlacci was out of the state. R. III/299. Stirlacci also told Miller that when you are self-employed you keep some rules but not others because some rules and regulations do not work because they are not good for business. R. III/159. Moreover, during one conversation, Ciurleo told Stirlacci, "[i]f nobody can see them, nobody can do this, you know, we really

can't -- you know, we're not really supposed to be doing what we're doing right now. This is a complication that might affect you in another way." R. III/209-210. Stirlacci responded, "I know, I know." R. III/210.

While the parties frequently criticized Rivers for being uncooperative with the plan to preserve the practice, they did not doubt the legitimacy of her concerns. Stirlacci noted that because she was "very OCD about whatever[,]" "she's probably going to say okay, enough is enough." R. II/316. Ciurleo at one point complained to Stirlacci that Rivers was "a pain in the ass" because she said that Miller should not be writing prescriptions. R. II/506. Stirlacci did not dispute the impropriety of Miller doing so, but simply responded, "[h]ow about we survive, [Rivers]? How about if we survive?" R. II/506. Stirlacci later complained about her failure to see that "life is not a squeaky clean bubble[,]" and apparently her unwillingness to break rules. R. II/513, 516.

Perhaps the most compelling evidence that the defendants knew their conduct was improper was a conversation between the defendants on April 30, 2015. Stirlacci said, "[y]ou can't have a solo practice

without no doctor[,]" R. II/481, even though he was essentially trying to do just that. Stirlacci also acknowledged that Rivers was not permitted to practice without his supervision. R. II/481. He also said that required oversight involved the ability to have telephone contact at any point that a nurse practitioner is seeing a patient. R. II/582, 593. Then, apparently to preserve pre-signed prescriptions, Stirlacci suggested that Rivers should issue narcotics prescriptions and Miller should issue other prescriptions by signing her own name, slash, Stirlacci's name. R. II/483. Stirlacci's comments were an explicit acknowledgement that he was not providing the required oversight to Rivers. They also implicitly acknowledged that Miller was not permitted to be issuing narcotics prescriptions. For Miller's part, Stirlacci's acknowledgements were sufficient to put her on notice of the improprieties, even if she was otherwise unaware. But Miller also explicitly recognized the impropriety when she asked Stirlacci, "[a]re they going to take your medical license?" R. II/299.

II. The Grand Jury Evidence Established Probable Cause that the Defendants Uttered False Prescriptions, in Violation of G.L. c. 94C, §33(b).

G.L. c. 94C, §33(b) prohibits the uttering of "a false prescription for a controlled substance[.]" Id. "In order to support a conviction for uttering, the Commonwealth must show that the defendant: '(1) offer[ed] as genuine; (2) an instrument; (3) known to be forged; (4) with the intent to defraud.'" Commonwealth v. Bonilla, 89 Mass. App. Ct. 263, 265 (2016), quoting Commonwealth v. O'Connell, 438 Mass. 658, 664 n.9 (2003). By its clear terms, G.L. c. 94C, §33(b) narrows the scope of these uttering elements by requiring that the instrument at issue be a "prescription for a controlled substance." G.L. c. 94C, §1 defines "controlled substances" to include any substance appearing in one of the drug schedules of that chapter. Because all prescription drugs are included in a drug schedule, they all are controlled substances. See G.L. c. 94C, §31 (any prescription drug not otherwise included in a drug schedule is categorized as a schedule E drug).

"Forgery consists of falsely making, altering, forging or counterfeiting any instrument described in

the appropriate statute." Commonwealth v. Levin, 11 Mass. App. Ct. 482, 493 (1981). See G.L. c. 267, §5. By its express terms, G.L. c. 94C, §33(b), requires only falsity, and forgery is sufficient to establish falsity, even though falsity includes more than mere forgery. See Commonwealth v. Bond, 188 Mass. 91, 92 (1905); Commonwealth v. Costello, 120 Mass. 358, 358 (1876) ("[a]n instrument falsely made, with intent to defraud, is a forgery[.]"); Gilday v. Garvey, 919 F. Supp. 506, 514 (D. Mass. 1996) ("the gravamen of uttering is the intentional publishing or presentation of a false writing, regardless of whether the false character stems from forged execution or false content."). "It is not necessary to the offense that the whole instrument should be fictitious." Commonwealth v. Segee, 218 Mass. 501, 504 (1914), citing Commonwealth v. Boutwell, 129 Mass. 124 (1880).

A defendant also must act with the intent to defraud. Bonilla, supra at 265. To defraud is "[t]o cause injury or loss to (a person or organization) by deceit; to trick (a person or organization) in order to get money." Black's Law Dictionary, 434 (7th ed. 2014). See Commonwealth v. Analetto, 326 Mass. 115, 118-19 (1950) (forged check could have resulted in

loss either to an individual or a bank, among other possibilities). "[T]here need not be an intent to injure or defraud a particular person. An intent to defraud anyone is sufficient. Nor is it necessary to show that any person actually was defrauded." Analetto, supra at 118, citing Bond, 188 Mass. 91. "[P]roof of intent to injure or defraud may be inferred from the circumstances." O'Connell, supra at 664.

Use of a forged document to obtain a benefit is fraudulent even if a defendant otherwise is entitled to that benefit. See Commonwealth v. Peakes, 231 Mass. 449, 456 (1919) (defendant acted with the intent to defraud even though he had the "'belief' that he had a right to resort to forgery and other illegal acts in collecting a debt . . . ."); Commonwealth v. Burton, 183 Mass. 461, 469 (1903) (false representations in an attempt to obtain compensation to which the defendant believed he was entitled, nonetheless, were fraudulent); Commonwealth v. Zaleski, 3 Mass. App. Ct. 538, 544 (1975), quoting Perkins, Criminal Law, 354 (2d ed. 1969) ("an intent to use an instrument to which the signature of another is wrongfully attached is fraudulent even if that

other actually owes the forger the amount of money represented and this is merely a device used to collect the debt.").

The motion judge dismissed all indictments for uttering a false prescription because he found that "there was no evidence that the prescriptions were 'false.'" R. I/238. The motion judge stated that a "[p]rescription renewal, authorized by a practitioner, simply cannot be a 'false prescription.'" R. I/238. He then declined to consider evidence of fraud and forgery, finding that these issues are not relevant to whether a defendant uttered a false prescription. R. I/239. The motion judge's vague conception of an element of falsity wholly independent of fraud and forgery ignores the expressly stated elements of uttering. See Bonilla, supra at 265.

The first and second element may be easily dispensed with: twenty-six controlled substance prescriptions were offered as genuine. See id. The evidence was clear that the prescriptions for controlled substances were issued to patients and were submitted to insurance companies in billing documentation. See R. II/19-24, 33-55; R. III/240-636, 240, 267, 268, 279, 293, 333, 372, 408, 424, 460,

476-478, 479-81, 535-546, 563, 568, 573, 577, 579, 586, 588, 590, 598, 600, 605/630.

As for whether the prescriptions were forged or otherwise were false, the motion judge erred in finding that a "[p]rescription renewal, authorized by a practitioner, simply cannot be a 'false prescription.'" See R. I/238.

Miller was an office manager who was not authorized to issue prescriptions, but Stirlacci nonetheless left pre-signed prescription pads for her use when Stirlacci was not present. R. II/4, 59. The evidence further established that Miller filled and issued these pre-signed prescriptions to patients and that Stirlacci told her to do so. See Argument, supra at 28-32. The grand jury had before it twenty-six controlled substance prescriptions dated during the time Stirlacci was incarcerated, but signed by him. R. II/19-24, 33-55; R. III/240-636, 240, 267, 268, 279, 293, 333, 372, 408, 424, 460, 476-478, 479-81, 535-546, 563, 568, 573, 577, 579, 586, 588, 590, 598, 600, 605/630. Rivers identified the signatures as belonging to Stirlacci, and the other writing as belonging to Miller. R. II/59.

Whether the prescriptions are best categorized as forged, altered, or counterfeit, there clearly was probable cause that each was false. See Levin, supra at 493. The grand jury could find that Stirlacci's signature on each prescription was a representation to the pharmacists filling the prescriptions and insurance companies billed for them, alike, that Stirlacci had written, or otherwise authorized the prescriptions in some meaningful way.

This assertion was false. The realities were that Stirlacci left pre-signed prescriptions for Miller to fill (R. II/59), broadly authorized her to run the practice without him (R. II/476), told her to issue prescriptions to anyone who came in for one (R. II/244), and said to "knock out" the prescriptions (R. II/299). Stirlacci's supervision was so minimal that he had no idea how many pre-signed prescriptions Miller had remaining. R. II/299, 517. The motion judge appears to place great weight on the fact that the prescriptions were issued to returning patients, characterizing the prescriptions as "renewals." See R. I/238. But whether Stirlacci hypothetically would have issued similar or identical prescriptions had he been present and able to do so has no apparent

relevance. Moreover, the defendants acted with the intent to defraud even if the practice was entitled to payment, or would have been under slightly different circumstances. See Zaleski, supra at 544.

To return an indictment, the grand jury also was required to find probable cause that the defendants acted with "the intent to defraud." Bonilla, supra at 265. The evidence was sufficient in that it established that the defendants intended deceitfully to impose liabilities on insurance companies by using Stirlacci's signature on Miller's prescriptions. See Analetto, supra at 118-19. The grand jurors certainly could have drawn this inference without direct evidence of intent, but there also was clear evidence that the defendants' purpose was to obtain payment from insurance companies, and that doing so required Stirlacci's signature. See R. II/244 ("[a]nybody comes in for a scrip, blue note, super bill, sticky pad, and get charges in."). Miller was not authorized to issue controlled substance prescriptions herself, so her signature would accomplish nothing. See R. II/159. The necessity of Stirlacci's signature is underscored by his twice expressing concern about the number of pre-signed prescriptions that remained, R.

II/299, 517, and twice stressing the importance of Rivers signing prescriptions to conserve the pre-signed forms. See R. II/483, 518.

III. The Grand Jury Evidence Established Probable Cause that the Defendants Filed False Healthcare Claims, in violation of G.L. c. 175H, §2.

In addition to criminalizing other conduct, G.L. c. 175H, §2, makes it a crime for any person to:

> 1) knowingly and willfully make[] or cause[] to be made any false statement or representation of a material fact in any application for a payment of a health care benefit; or (2) knowingly and willfully present[] or cause[] to be presented an application for a health care benefit containing any false statement or representation of a material fact[.]

Id.

The motion judge found the evidence before the grand jury was sufficient to establish probable cause for fourteen counts of filing false insurance claims. R. I/240. This finding was based on express testimony before the grand jury that the billing documents alleged that fourteen patients had been seen by Stirlacci on dates when he was jailed. R. I/240; R. II/33, 37-55. The motion judge allowed the motion to dismiss as to the other eight counts of filing a false healthcare claim -- he identified the counts as being

based on exhibits five to nine, and eleven to thirteen. R. I/240. On these counts, the motion judge reasoned that the billing paperwork alleged that Stirlacci was the service provider, but did not suggest that he had face-to-face visits with patients, and there was no express testimony that the paperwork alleged that he had done so. R. I/240-41.

The evidence was more than sufficient on these eight counts. The grand jury exhibits included billing documentation relevant to the twenty-two patients corresponding to the twenty-two counts at issue. R. III/240-636. There also was testimony that the billing documents purported that each of these patients was seen by Stirlacci. Tr. II/55. This alone was sufficient to establish probable cause, but the documentation itself provided additional evidence. For each of the eight counts dismissed by the motion judge, the billing documents expressly represent that Stirlacci signed a prescription, and that he was the service provider on the date in question.

1) R. III/240-41

2) R. III/250, 267

3) R. III/268, 270.

4) R. III/279, 282

5) R. III/293, 295

6) R. III/372, 374

7) R. III/408, 412

8) R. III/424, 427

The assertions that Stirlacci was the service provider alone were sufficient to establish probable cause because he in fact provided no service. But the inclusion of prescriptions bearing Stirlacci's signature in each of the billing documents provided a wholly independent and sufficient basis for probable cause. As discussed, the grand jury could find that the inclusion of these prescriptions with Stirlacci's signature falsely represented that Stirlacci had issued them. See Argument, supra at 41-43. The truth was that he had delegated the medical task to an unqualified office manager. Moreover, the grand jury was not required to isolate the individual representations to insurance companies. The combination in each billing document of a prescription signed by Stirlacci and the statement that he was the service provider established probable cause even if these facts on their own were insufficient.

The motion judge considered only the fact that Stirlacci was listed as the service provider. R.

I/241. He found this assertion in each document insufficient to establish probable cause because the billing codes appearing in many of the documents suggested that Stirlacci did not actually meet with the patients. R. I/241. While instructing Miller about how to enter charges, Stirlacci said to put in the code 99212 for patients picking up prescriptions because "they didn't see the doctor[.]" R. II/240. But the exchange between the parties on the whole strengthened the evidence supporting probable cause. The defendant expressly told Miller to list him as the service provider, R. II/239, meaning that the defendants took an affirmative action to represent that Stirlacci had provided service -- this was not an unintended, automated input in the billing system. Then, immediately after telling Miller to use a different code when billing patients who get a prescription renewal, Stirlacci said:

> Just put 93 and a blue note in a sticky pad on their chart. If they're picking up scrips, we're doing work . . . . Okay? Because you gotta have a blue note with a super bill. So just put sticky notes on everything. Anything and everything that you can get in, get in.

R. II/239-40. These statements support the claim that the plan was for Miller to do whatever was necessary

to bill for prescriptions that were issued. Probable cause of a false representation does not require evidence that all representations are false. Presumably many of the defendants' representations were correct. The relevant issue is whether each of the eight patient records at issue included a knowing and willful false statement. The motion judge's reliance on an apparently correct statement to determine that all statements were correct is perplexing and baseless.

Moreover, the defendants implicitly acknowledged that even the billing codes were improper. Miller told Stirlacci at one point that she used a particular billing code for a patient visit in order to bring in money even though Rivers told her she was not permitted to do so because Rivers had not seen the patient. R. II/512-13. Stirlacci did not question the impropriety, but simply told Miller, "do what you know is right[,]" even as Miller apparently accepted that the billing code was improper. See R. II/512-13.

CONCLUSION

For the foregoing reasons, the Commonwealth respectfully requests this Honorable Court reverse all of the Superior Court's dismissals of indictments in Hampden County Superior Court Criminal Numbers 1779CR00039 and 1779CR00040.

Respectfully submitted,

THE COMMONWEALTH,

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ADDENDUM

Massachusetts General Laws
Chapter 94C, Section 1

As used in this chapter, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Administer'', the direct application of a controlled substance whether by injection, inhalation, ingestion, or any other means to the body of a patient or research subject by--

(a) a practitioner, or

(b) a nurse at the direction of a practitioner in the course of his professional practice, or

[Clause (c) of the definition of "Administer'' effective until October 6, 2016. For text effective October 6, 2016, see below.]

(c) an ultimate user or research subject at the direction of a practitioner in the course of his professional practice.

[Clause (c) of the definition of "Administer'' as amended by 2016, 283, Sec. 10 effective October 6, 2016. For text effective until October 6, 2016, see above.]

(c) a registered pharmacist acting in accordance with regulations promulgated by the department, in consultation with the board of registration in pharmacy and the department of mental health, governing pharmacist administration of medications for treatment of mental health and substance use disorder and at the direction of a prescribing practitioner in the course of the practitioner's professional practice; or

[Clause (d) of the definition of "Administer'' added by 2016, 283, Sec. 10 effective October 6, 2016.]

(d) an ultimate user or research subject at the direction of a practitioner in the course of the practitioner's professional practice.

"Agent'', an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser; except that such term does not include a common or contract carrier, public warehouseman, or employee of the carrier or warehouseman, when acting in the usual and lawful course of the carrier's or warehouseman's business.

"Bureau'', the Bureau of Narcotics and Dangerous Drugs, United States Department of Justice, or its successor agency.

"Class'', the lists of controlled substances for the purpose of determining the severity of criminal offenses under this chapter.

"Commissioner'', the commissioner of public health.

"Controlled substance'', a drug, substance, controlled substance analogue or immediate precursor in any schedule or class referred to in this chapter.

"Controlled substance analogue'', (i) a drug or substance with a chemical structure substantially similar to the chemical structure of a controlled substance in Class A, B, C, D or E, listed in section 31 and which has a stimulant, depressant or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant or hallucinogenic effect on the central nervous system of a controlled substance in Class A, B, C, D or E, listed in said section 31; or (ii) a drug or substance with a chemical structure substantially similar to the chemical structure of a controlled substance in Class A, B, C, D or E, listed in said section 31 and with respect to a particular person, which such person represents or intends to have a stimulant, depressant or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant or hallucinogenic effect on the central nervous system of a controlled substance in Class A, B, C, D or E, listed in said section 31; provided, however, that

"controlled substance analogue'' shall not include: (1) a controlled substance; (2) any substance for which there is an approved new drug application; (3) with respect to a particular person, any substance for which there is an exception in effect for investigational use for that person, under section 8, to the extent conduct with respect to the substance is pursuant to such exemption; or (4) any substance not intended for human consumption before such an exemption takes effect with respect to that substance; provided, however, that for the purposes of this chapter, a "controlled substance analogue'' shall be treated as the Class A, B, C, D or E substance of which it is a controlled substance analogue.

"Counterfeit substance'', a substance which is represented to be a particular controlled drug or substance, but which is in fact not that drug or substance.

"Deliver'', to transfer, whether by actual or constructive transfer, a controlled substance from one person to another, whether or not there is an agency relationship.

"Department'', the department of public health.

"Depressant or stimulant substance'',

(a) a drug which contains any quantity of barbituric acid or any of the salts of barbituric acid; or any derivative of barbituric acid which the United States Secretary of Health, Education, and Welfare has by regulation designated as habit forming; or

(b) a drug which contains any quantity of amphetamine or any of its optical isomers; any salt of amphetamine or any salt of an optical isomer of amphetamine; or any substance which the United States Attorney General has by regulation designated as habit forming because of its stimulant effect on the central nervous system; or

(c) lysergic acid diethylamide; or

(d) any drug except marihuana which contains any quantity of a substance which the United States

Attorney General has by regulation designated as having a potential for abuse because of its depressant or stimulant effect on the central nervous system or its hallucinogenic effect.

"Dispense'', to deliver a controlled substance to an ultimate user or research subject or to the agent of an ultimate user or research subject by a practitioner or pursuant to the order of a practitioner, including the prescribing and administering of a controlled substance and the packaging, labeling, or compounding necessary for such delivery.

"Distribute'', to deliver other than by administering or dispensing a controlled substance.

"Drug'',

(a) substances recognized as drugs in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them;

(b) substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or animals;

(c) substances, other than food, intended to affect the structure, or any function of the body of man and animals; or

(d) substances intended for use as a component of any article specified in clauses (a), (b) or (c), exclusive of devices or their components, parts or accessories.

"Drug paraphernalia'', all equipment, products, devices and materials of any kind which are primarily intended or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, ingesting, inhaling or otherwise introducing into the human body a controlled substance in violation of this chapter. It includes, but is not limited to:

(1) kits used, primarily intended for use or designed for use in planting, propagating, cultivating, growing or harvesting of any species of plant which is a controlled substance or from which a controlled substance can be derived;

(2) kits used, primarily intended for use or designed for use in manufacturing, compounding, converting, producing, processing or preparing controlled substances;

(3) isomerization devices used, primarily intended for use or designed for use in increasing the potency of any species of plant which is a controlled substance;

(4) testing equipment used, primarily intended for use or designed for use in identifying or in analyzing the strength, effectiveness or purity of controlled substances;

(5) scales and balances used, primarily intended for use or designed for use in weighing or measuring controlled substances;

(6) diluents and adulterants, such as quinine hydrochloride, mannitol, mannite, dextrose and lactose, used, primarily intended for use or designed for use in cutting controlled substances;

(7) separation gins and sifters used, primarily intended for use or designed for use in removing twigs and seeds from or in otherwise cleaning or refining marihuana;

(8) blenders, bowls, containers, spoons and mixing devices used, primarily intended for use or designed for use in compounding controlled substances;

(9) capsules, balloons, envelopes and other containers used, primarily intended for use or designed for use in packaging small quantities of controlled substances;

(10) containers and other objects used, primarily intended for use or designed for use in storing or concealing controlled substances;

(12) objects used, primarily intended for use or designed for use in ingesting, inhaling, or otherwise introducing marihuana, cocaine, hashish or hashish oil into the human body, such as:

(a) metal, wooden, acrylic, glass, stone, plastic or ceramic pipes, which pipes may or may not have screens, permanent screens, hashish heads or punctured metal bowls;

(b) water pipes;

(c) carburetion tubes and devices;

(d) smoking and carburetion masks;

(e) roach clips; meaning objects used to hold burning material, such as a marihuana cigarette that has become too small or too short to be held in the hand;

(f) miniature cocaine spoons and cocaine vials;

(g) chamber pipes;

(h) carburetor pipes;

(i) electric pipes;

(j) air-driven pipes;

(k) chillums;

(*l*) bongs;

(m) ice pipes or chillers;

(n) wired cigarette papers;

(*o*) cocaine freebase kits.

In determining whether an object is drug paraphernalia, a court or other authority should consider, in addition to all other logically relevant factors, the following:

(a) the proximity of the object, in time and space, to a direct violation of this chapter;

(b) the proximity of the object to controlled substances;

(c) the existence of any residue of controlled substances on the object;

(d) instructions, oral or written, provided with the object concerning its use;

(e) descriptive materials accompanying the object which explain or depict its use;

(f) national and local advertising concerning its use;

(g) the manner in which the object is displayed for sale;

(h) whether the owner, or anyone in control of the object, is a supplier of like or related items to the community, such as a licensed distributor or dealer of tobacco products;

(i) direct or circumstantial evidence of the ratio of sales of the object to the total sales of the business enterprise;

(j) the existence and scope of legitimate uses for the object in the community;

(k) expert testimony concerning its use.

For purposes of this definition, the phrase "primarily intended for use'' shall mean the likely use which may be ascribed to an item by a reasonable person. For purposes of this definition, the phrase "designed for use'' shall mean the use a reasonable person would ascribe to an item based on the design and features of said item.

[Definition of "Extended-release long-acting opioid in a non-abuse deterrent form'' inserted following the definition of "Drug paraphernalia'' by 2016, 52, Sec. 19 effective March 14, 2016.]

"Extended-release long-acting opioid in a non-abuse deterrent form'', a drug that is: (i) subject to the United States Food and Drug Administration's extended release and long-acting opioid analgesics risk evaluation and mitigation strategy; (ii) an opioid approved for medical use that does not meet the requirements for listing as a drug with abuse deterrent properties pursuant to section 13 of chapter 17; and (iii) identified by the drug formulary commission pursuant to said section 13 of said chapter 17 as posing a heightened level of public health risk.

"Immediate precursor'', a substance which the commissioner has found to be and by rule designates as being a principal compound commonly used or produced primarily for use, and which is an immediate chemical intermediary used or likely to be used in the manufacture of a controlled substance, the control of which is necessary to prevent, curtail, or limit manufacture.

"Isomer'', the optical isomer, except that wherever appropriate it shall mean the optical, position or geometric isomer.

"Manufacture'', the production, preparation, propagation, compounding, conversion or processing of a controlled substance, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, including any packaging or repackaging of the substance or labeling or relabeling of its container except that this term does not include the preparation or compounding of a controlled substance by an individual for his own use or the preparation, compounding, packaging, or labeling of a controlled substance:

(a) by a practitioner as an incident to his administering a controlled substance in the course of his professional practice, or

(b) by a practitioner, or by his authorized agent under his supervision, for the purpose of, or as an incident to, research, teaching or chemical analysis and not for sale, or

(c) by a pharmacist in the course of his professional practice.

"Marihuana'', all parts of the plant Cannabis sativa L., whether growing or not; the seeds thereof; and resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds or resin. It does not include the mature stalks of the plant, fiber produced from the stalks, oil, or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks, except the resin extracted therefrom, fiber, oil, or cake or the sterilized seed of the plant which is incapable of germination.

"Narcotic drug'', any of the following, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(a) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate;

(b) Any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in clause (a), but not including the isoquinoline alkaloids of opium;

(c) Opium poppy and poppy straw;

(d) Coca leaves and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, but not including decocainized coca leaves or extractions of coca leaves which do not contain cocaine or ecgonine.

"Nuclear pharmacy'', a facility under the direction or supervision of a registered pharmacist which is authorized by the board of registration in pharmacy to dispense radiopharmaceutical drugs.

"Nurse'', a nurse registered or licensed pursuant to the provisions of section seventy-four or seventy-four A of chapter one hundred and twelve, a graduate nurse as specified in section eighty-one of said chapter one hundred and twelve or a student nurse enrolled in a school approved by the board of registration in nursing.

"Nurse anesthetist'', a nurse with advanced training authorized to practice by the board of registration in nursing as a nurse anesthetist in an advanced practice nursing role as provided in section 80B of chapter 112.

"Nurse practitioner'', a nurse with advanced training who is authorized to practice by the board of registration in nursing as a nurse practitioner, as provided for in section eighty B of chapter one hundred and twelve.

"Opiate'', any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. It does not include, unless specifically designated as controlled under section two, the dextrorotatory isomer of 3-methoxy-n-methyl-morphinan and its salts, dextromethorphan. It does include its racemic and levorotatory forms.

"Opium poppy'', the plant of the species Papaver somniferum L., except its seeds.

"Oral prescription'', an oral order for medication which is dispensed to or for an ultimate user, but not including an order for medication which is dispensed for immediate administration to the ultimate user by a practitioner, registered nurse, or practical nurse.

"Outsourcing facility,'' an entity at 1 geographic location or address that: (i) is engaged in the compounding of sterile drug preparations; (ii) has registered with the federal Food and Drug Administration as an outsourcing facility pursuant to 21 U.S.C. section 353b; and (iii) has registered with the board of registration in pharmacy pursuant to section 36E of chapter 112.

"Person'', individual, corporation, government, or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

"Pharmacist'', any pharmacist registered in the commonwealth to dispense controlled substances, and including any other person authorized to dispense controlled substances under the supervision of a pharmacist registered in the commonwealth.

"Pharmacy'', a facility under the direction or supervision of a registered pharmacist which is authorized to dispense controlled substances, including but not limited to "retail drug business'' as defined below.

"Physician assistant'', a person who is a graduate of an approved program for the training of physician assistants who is supervised by a registered physician in accordance with sections nine C to nine H, inclusive, of chapter one hundred and twelve.

"Poppy straw'', all parts, except the seeds of the opium poppy, after mowing.

"Practitioner'',

(a) A physician, dentist, veterinarian, podiatrist, scientific investigator, or other person registered to distribute, dispense, conduct research with respect to, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research in the commonwealth;

(b) A pharmacy, hospital, or other institution registered to distribute, dispense, conduct research with respect to or to administer a controlled substance in the course of professional practice or research in the commonwealth.

(c) An optometrist authorized by sections 66 and 66B of chapter 112 and registered pursuant to paragraph (h) of section 7 to utilize and prescribe therapeutic pharmaceutical agents in the course of professional practice in the commonwealth.

"Prescription drug'', any and all drugs upon which the manufacturer or distributor has, in compliance with federal law and regulations, placed the following: "Caution, Federal law prohibits dispensing without prescription''.

"Production'', includes the manufacture, planting, cultivation, growing, or harvesting of a controlled substance.

"Radiopharmaceutical drug'', any drug which is radioactive as defined in the Federal Food, Drug and Cosmetic Act.

"Registrant'', a person who is registered pursuant to any provision of this chapter.

"Registration'', unless the context specifically indicates otherwise, such registration as is required and permitted only pursuant to the provisions of this chapter.

"Registration number'', such registration number or numbers, either federal or state, that are required with respect to practitioners by appropriate administrative agencies.

"Retail drug business'', a store for the transaction of "drug business'' as defined in section thirty-seven of chapter one hundred and twelve.

"Schedule'', the list of controlled substances established by the commissioner pursuant to the provisions of section two for purposes of administration and regulation.

"State'', when applied to a part of the United States other than Massachusetts includes any state, district, commonwealth, territory, insular possession thereof, and any area subject to the legal authority of the United States of America.

"Tetrahydrocannabinol'', tetrahydrocannabinol or preparations containing tetrahydrocannabinol excluding marihuana except when it has been established that the concentration of delta-9 tetrahydrocannabinol in said marihuana exceeds two and one-half per cent.

"Ultimate user'', a person who lawfully possesses a controlled substance for his own use or for the use of a member of his household or for the use of a patient in a facility licensed by the department or for administering to an animal owned by him or by a member of his household.

"Written prescription'', a lawful order from a practitioner for a drug or device for a specific patient that is communicated directly to a pharmacist in a licensed pharmacy; provided, however, that "written prescription'' shall not include an order for medication which is dispensed for immediate administration to the ultimate user by a practitioner, registered nurse or licensed practical nurse.

Massachusetts General Laws
Chapter 94C, Section 19(a)

A prescription for a controlled substance to be valid shall be issued for a legitimate medical purpose by a practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances shall be upon the prescribing practitioner, but a corresponding responsibility shall rest with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section one and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided by sections thirty-two, thirty-two A, thirty-two B, thirty-two C, thirty-two D, thirty-two E, thirty-two F, thirty-two G, and thirty-two H, as applicable.

Massachusetts General Laws
Chapter 94C, Section 31

For the purposes of establishing criminal penalties for violation of a provision of this chapter, there are established the following five classes of controlled substances:

CLASS A

(a) Unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters and ethers, whenever the existence of such isomers, esters, ethers and salts is possible within the specific chemical designation:

(1) Acetylmethadol

(2) Allylprodine

(3) Alphacetylmethadol

(4) Alphameprodine

(5) Alphamethadol

(6) Benzethidine

(7) Betacetylmethadol

(8) Betameprodine

(9) Betamethadol

(10) Betaprodine

(11) Clonitazene

(12) Dextromoramide

(13) Dextrorphan

(14) Diampromide

(15) Diethylthiambutene

(16) Dimenoxadol

(17) Dimepheptanol

(18) Dimethylthiambutene

(19) Dioxaphetylbutyrate

(20) Dipipanone

(21) Ethylmethylthiambutene

(22) Etonitazene

(23) Etoxeridine

(24) Furethidine

(25) Hydroxypethidine

(26) Ketobemidone

(27) Levomoramide

(28) Levophenacylmorphan

(29) Morpheridine

(30) Noracymethadol

(31) Norlevorphanol

(32) Normethadone

(33) Norpipanone

(34) Phenadoxone

(35) Phenampromide

(36) Phenomorphan

(37) Phenoperidine

(38) Piritramide

(39) Proheptazine

(40) Properidine

(41) Racemoramide

(42) Trimeperidine

(b) Unless specifically excepted or unless listed in another schedule, any of the following opium derivatives, their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Acetorphine

(2) Acetyldihydrocodeine

(3) Benzylmorphine

(4) Codeine methylbromide

(5) Codeine-N-Oxide

(6) Cyprenorphine

(7) Desomorphine

(8) Dihydromorphine

(9) Etorphine

(10) Heroin

(11) Hydromorphinol

(12) Methyldesorphine

(13) Methylhydromorphine

(14) Morphine methylbromide

(15) Morphine methylsulfonate

(16) Morphine-N-Oxide

(17) Myrophine

(18) Nicocodeine

(19) Nicomorphine

(20) Normorphine

(21) Pholcodine

(22) Thebacon

(c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation that contains any quantity of the following substances including its salts, isomers and salts of isomers whenever the existence of such salts, isomers and salts of isomers is possible within the specific chemical designations:

(1) Flunitrazepam

(2) Gamma Hydroxy Butyric Acid

(3) Ketamine.

CLASS B

(a) Unless specifically excepted or unless listed in another schedule, any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate

(2) Any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in paragraph (1) except that these substances shall not include the isoquinoline alkaloids of opium

(3) Opium poppy and poppy straw

(4) Coca leaves and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecgonine.

(5) Phenyl-2-Propanone (P2P)

(6) Phenylcyclohexylamine (PCH)

(7) Piperidinocyclohexanecarbonitrile (PCC)

(8) 3,4-methylenedioxy methamphetamine (MDMA).

(b) Unless specifically excepted or unless listed in another schedule, any of the following opiates, including isomers, esters, ethers, salts, and salts of isomer, esters, and ethers, whenever the existence of such isomers, esters, ethers and salts is possible within the specific chemical designation:

[Clause (1) of paragraph (b) of CLASS B effective until March 14, 2016. For text effective March 14, 2016, see below.]

(1) Alphaprodine

[Clause (1) of paragraph (b) of CLASS B as amended by 2016, 52, Sec. 30 effective March 14, 2016. For text effective until March 14, 2016, see below.]

(1) Acetyl fentanyl

[Clause (1 1/2) of paragraph (b) of CLASS B inserted by 2016, 52, Sec. 30 effective March 14, 2016.]

(1 1/2) Alphaprodine

(2) Anileridine

(3) Bezitramide

(4) Dihydrocodeine

(5) Diphenoxylate

(6) Fentanyl

(7) Isomethadone

(8) Levomethorphan

(9) Levorphanol

(10) Metazocine

(11) Methadone

(12) Methadone-Intermediate, 4-cyano-2-dimethylamino-4, 4-diphenyl butane

(13) Moramide-Intermediate, 2-methyl-3 morpholine-1, 1-diphenyl-propane carboxylic acid

(14) Pethidine

(15) Pethidine-Intermediate-A, 4-cyano-1-methyl-4-phenylpiperidine

(16) Pethidine-Intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate

(17) Pethidine-Intermediate-C, 1-methyl-4-phenylpiperidine-4-carboxylic acid

(18) Phenazocine

(19) Piminodine

(20) Racemethorphan

(21) Racemorphan

(c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

(1) Amphetamine, its salts, optical isomers and salts of its optical isomers.

(2) Any substance which contains any quantity of methamphetamine, including its salts, isomers and salts of isomers.

(3) Phenmetrazine and its salts.

(4) Methylphenidate.

(d) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the

following substances having a depressant effect on the central nervous system:

(1) Any substance which contains any quantity of a derivative of barbituric acid, or any salt of a derivative of barbituric acid.

(2) Any substance which contains any quantity of methaqualone, or any salt or derivative of methaqualone.

(e) Unless specifically excepted or listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances or which contains any of their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Lysergic acid

(2) Lysergic acid amide

(3) Lysergic acid diethylamide

(4) Phencyclidine.

CLASS C

(a) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system:

(1) Chlordiazepoxide

(2) Chlorhexadol

(3) Clonazepam

(4) Clorazepate

(5) Diazepam

(6) Flurazepam

(7) Glutethimide

(8) Lorazepam

(9) Methyprylon

(10) Oxazepam

(11) Prazepam

(12) Sulfondiethylmethane

(13) Sulfonethylmethane

(14) Sulfonmethane

(15) Temazepam.

(b) Nalorphine

(c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any salts thereof:

(1) Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit with an equal or greater quantity of an isoquinoline alkaloid of opium.

(2) Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

(3) Not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium.

(4) Not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active nonnarcotic ingredients in recognized therapeutic amounts.

(5) Not more than 1.8 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per

dosage unit, with one or more active nonnarcotic ingredients in recognized therapeutic amounts.

(6) Not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit with one or more active nonnarcotic ingredients in recognized therapeutic amounts.

(7) Not more than 500 milligrams of opium per 100 milliliters or per 100 grams, or not more than 25 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

(8) Not more than 50 milligrams of morphine per 100 milliliters or per 100 grams with one or more active nonnarcotic ingredients in recognized therapeutic amounts.

[There is no paragraph (d).]

(e) Unless specifically excepted or listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances, or which contains any of their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) 3, 4-methylenedioxy amphetamine

(2) 5-methoxy-3, 4-methylenedioxy amphetamine

(3) 3, 4, 5-trimethoxy amphetamine

(4) Bufotenine

(5) Diethyltryptamine

(6) Dimethyltryptamine

(7) 4-methyl-2, 5-dimethoxyamphetamine

(8) Ibogaine

(9) Mescaline

(10) Peyote

(11) N-ethyl-3-piperidyl benzilate

(12) N-methyl-3-piperidyl benzilate

(13) Psilocybin

(14) Psilocyn

(15) Tetrahydrocannabinols

(16) 4-Bromo-2, 5-Dimethoxy-amphetamine.

(17) 3, 4--methylenedioxymethcathinone, MDMC

(18) 3, 4--methylenedioxypyrovalerone, MDPV

(19) 4--methylmethcathinone, 4-MMC

(20) 4--methoxymethcathinone, bk-PMMA, PMMC

(21) 3, 4--fluoromethcathinone, FMC

(22) Napthylpyrovalerone, NRG-1

(23) Beta-keto-N-methylbenzodioxolylpropylamine

(24) 2-(methylamino)-propiophenone; OR alpha-(methylamino) propiophenone

(25) 3-methoxymethcathinone

(26) 4-methyl-alpha-pyrrolidinobutyrophenone

(27) 2-(methylamino)-1-phenylpropan-1-one

(28) 4-ethylmethcathinone

(29) 3,4-Dimethylmethcathinone

(30) alpha-Pyrrolidinopentiophenone

(31) beta-Keto-Ethylbenzodioxolylbutanamine

(32) 3,4-methylenedioxy-N-ethylcathinone.

(f) Unless specifically excepted or listed in another schedule, any material, compound, mixture or preparation, which contains any quantity of the following hallucinogenic substances or cannabimimetic agents within the structural classes identified below:

(1) 2-(3-hydroxycyclohexyl) phenol with substitution at the 5-position of the phenolic ring by alkyl or alkenyl, whether or not substituted on the cyclohexyl ring to any extent;

(2) 3-(1-naphthoyl) indole or 3-(1-naphthyl) indole by substitution at the nitrogen atom of the indole ring, whether or not further substituted on the indole ring to any extent, whether or not substituted on the naphthoyl or naphthyl ring to any extent;

(3) 3-(1-naphthoyl) pyrrole by substitution at the nitrogen atom of the pyrrole ring, whether or not further substituted in the indole ring to any extent, whether or not substituted on the naphthoyl ring to any extent;

(4) 1-(1-naphthylmethyl) indene by substitution of the 3-position of the indene ring, whether or not further substituted in the indene ring to any extent, whether or not substituted on the naphthyl ring to any extent;

(5) 3-phenylacetylindole or 3-benzoylindole by substitution at the nitrogen atom of the indole ring, whether or not further substituted in the indole ring to any extent, whether or not substituted on the phenyl ring to any extent;

(6) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP-47,497);

(7) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (cannabicyclohexanol or CP-47,497 C8-homolog);

(8) 1-pentyl-3-(1-naphthoyl) indole (JWH-018 and AM678);

(9) 1-butyl-3-(1-naphthoyl) indole (JWH-073);

(10) 1-hexyl-3-(1-naphthoyl) indole (JWH-019);

(11) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl) indole (JWH-200);

(12) 1-pentyl-3-(2-methoxyphenylacetyl) indole (JWH-250);

(13) 1-pentyl-3-[1-(4-methoxynaphthoyl)] indole (JWH-081);

(14) 1-pentyl-3-(4-methyl-1-naphthoyl) indole (JWH-122);

(15) 1-pentyl-3-(4-chloro-1-naphthoyl) indole (JWH-398);

(16) 1-(5-fluoropentyl)-3-(1-naphthoyl) indole (AM2201);

(17) 1-(5-fluoropentyl)-3-(2-iodobenzoyl) indole (AM694);

(18) 1-pentyl-3-[(4-methoxy)-benzoyl] indole (SR-19 and RCS-4);

(19) 1-cyclohexylethyl-3-(2-methoxyphenylacetyl) indole (SR-18 and RCS-8); and

(20) 1-pentyl-3-(2-chlorophenylacetyl) indole (JWH-203).

CLASS D

(a)

(1) Barbital

(2) Chloral betaine

(3) Chloral hydrate

(4) Ethchlorvynol

(5) Ethinamate

(6) Methohexital

(7) Meprobamate

(8) Methylphenobarbital

(9) Paraldehyde

(10) Petrichloral

(11) Phenobarbital

(b) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following substances, or which contains any of their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Marihuana

(2) Butyl Nitrite

(3) Isobutyl Nitrite

(4) 1-Nitrosoxy-Methyl-Propane.

CLASS E

(a) Any compound, mixture, or preparation containing any of the following limited quantities of narcotic drugs, which shall include one or more nonnarcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by the narcotic drug alone:

(1) Not more than 200 milligrams of codeine per 100 milliliters or per 100 grams

(2) Not more than 100 milligrams of dihydrocodeine per 100 milliliters or per 100 grams

(3) Not more than 100 milligrams of ethylmorphine per 100 milliliters or per 100 grams

(4) Not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit

(5) Not more than 100 milligrams of opium per 100 milliliters or per 100 grams

(b) Prescription drugs other than those included in Classes A, B, C, D, and subsection (a) of this Class.

Massachusetts General Laws
Chapter 94C, Section 33(b)

No person shall utter a false prescription for a controlled substance, nor knowingly or intentionally acquire or obtain possession of a controlled substance by means of forgery, fraud, deception or subterfuge, including but not limited to the forgery or falsification of a prescription or the nondisclosure of a material fact in order to obtain a controlled substance from a practitioner.

Massachusetts General Laws
Chapter 175H, Section 2

Any person who (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for a payment of a health care benefit; or (2) knowingly and willfully presents or causes to be presented an application for a health care benefit containing any false statement or representation of a material fact; or (3) knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to a health care benefit, including whether goods or services were medically necessary in accordance with professionally accepted standards; or (4) having knowledge of the occurrence of any event affecting his initial or continued right to any health care benefit, conceals or fails to disclose such an event with an intent to fraudulently secure such benefit either in a greater amount than is due or when no such benefit is due; or (5) having knowledge of the

occurrence of any event affecting the health care benefit of any other individual in whose behalf he has made or presented an application for such benefit, or in whose behalf he is receiving any health care benefit, conceals or fails to disclose such an event with an intent to fraudulently secure such benefit either in a greater amount than is due or when no such benefit is due, shall be punished by a fine of not more than ten thousand dollars, or by imprisonment in a jail or house of correction for not more than two and one-half years or in the state prison for not more than five years, or by both such fine and imprisonment, and may be held liable in a civil action under section seven. Notwithstanding the foregoing, a person who is not a provider of services for which a health care benefit may be paid shall not be subject to prosecution hereunder for any statement or representation which such person makes without fraudulent intent.

Massachusetts General Laws
Chapter 267, Section 5

Whoever, with intent to injure or defraud, utters and publishes as true a false, forged or altered record, deed, instrument or other writing mentioned in the four preceding sections, knowing the same to be false, forged or altered, shall be punished by imprisonment in the state prison for not more than ten years or in jail for not more than two years.

Massachusetts General Laws
Chapter 268, Section 13D(e)

Any grand jury transcript or document citing or describing grand jury testimony filed with any court shall be filed and maintained under seal, unless the paper is filed in a criminal prosecution for perjury before a grand jury.

Massachusetts General Laws
Chapter 278, Section 28E

An appeal may be taken by and on behalf of the commonwealth by the attorney general or a district

attorney from the district court to the appeals court in all criminal cases and in all delinquency cases from a decision, order or judgment of the court (1) allowing a motion to dismiss an indictment or complaint, (2) allowing a motion to suppress evidence, or (3) denying a motion to transfer pursuant to section sixty-one of chapter one hundred and nineteen.

An appeal may be taken by and on behalf of the commonwealth by the attorney general or a district attorney from the superior court to the supreme judicial court in all criminal cases from a decision, order or judgment of the court (1) allowing a motion to dismiss an indictment or complaint, or (2) allowing a motion for appropriate relief under the Massachusetts Rules of Criminal Procedure.

An application for an appeal from a decision, order or judgment of the superior court determining a motion to suppress evidence prior to trial may be filed in the supreme judicial court by a defendant or by and on behalf of the commonwealth by the attorney general or a district attorney. If such application is denied, or if such application is granted but the interlocutory appeal is heard by a single justice, the determination of the motion to suppress evidence shall be open to review by the full court after trial in the same manner and to the same extent as determinations of such motions not appealed under the interlocutory procedure herein authorized.

Rules of practice and procedure with respect to appeals authorized by this section shall be the same as those applicable to criminal appeals under the Massachusetts Rules of Appellate Procedure.

Massachusetts Rules of Criminal Procedure 15(a)(1)

The Commonwealth shall have the right to appeal to the Appeals Court a decision by a judge granting a motion to dismiss a complaint or indictment or a motion for appropriate relief made pursuant to the provisions of Rule 13(c).

Massachusetts Rules of Appellate Procedure 18(g)

If the entire case has been impounded, the cover of the appendix shall clearly indicate that the appendix is impounded. If the entire case has not been impounded, a separate appendix volume shall be filed containing the impounded material and the cover thereof shall clearly indicate that it contains impounded material.

Massachusetts Rules of Appellate Procedure 20(a)

Except on order of the appellate court or a single justice, or if filed on behalf of a party allowed to proceed in forma pauperis, all briefs and appendices shall be produced by any duplicating or copying process which produces a clear black image on white paper. However produced, the page shall be eight and one-half inches in width and eleven inches in height. Pages shall be firmly bound at the left by saddle-wiring, side-wiring, stapling, or sewing. If side-wired or sewn, a strong paper cover shall be used. A transcript of testimony or a report of evidence may be included as part of the appendix and may be reproduced by Xerography or a similar process. No single volume of the appendix shall be more than one and one-half inches thick. The text of appendices may appear on both sides of the page.

The following rules shall govern the format of text on a page for all briefs:

(1) The top and bottom margins shall be at least one inch. The left and right margins shall be at least one and one-half inches. Thus, the text area should not be more than five and one-half inches in width no more than nine inches in height. Page numbers may appear in the margin.

(2) The typeface shall be a monospaced font (such as pica type produced by a typewriter or a Courier font produced by a computer word processor) of 12 point or larger size and not exceeding 10.5 characters per inch.

(3) Text shall be double-spaced, except that argument headings, footnotes and indented quotations may be

single-spaced. For purposes of this rule, single spacing means not more than six lines of text per vertical inch; double spacing means not more than three lines of text per vertical inch and not more than twenty-seven double-spaced lines on a page.

(4) The text may appear on both sides of the page.

Briefs or appendices not in substantial compliance with these rules shall not be received unless the appellate court or a single justice shall otherwise order. The cover of the brief of the appellant shall be blue; that of the appellee, red; that of an intervenor or amicus curiae, green; that of any reply brief, gray. The cover of the appendix, if separately bound, shall be white. The front covers of the briefs and appendices, if separately produced, shall contain: (1) the name of the court and the number of the case; (2) the title of the case (see Rule 10(a)); (3) the nature of the proceeding in the court (e.g., Appeal; Application for Review) and the name of the court, agency, or board below; (4) the title of the document (e.g., Brief for Appellant, Appendix); and (5) the names, Board of Bar Overseers (BBO) numbers, addresses, telephone numbers, and e-mail addresses if any of counsel representing the party on whose behalf the document is filed, and, if an individual counsel is affiliated with a firm, the firm name.

Title Twenty-One of the Code of Federal Regulations, Section 1306.04(a)

A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the

penalties provided for violations of the provisions of law relating to controlled substances.

COMMONWEALTH OF MASSACHUSETTS

HAMPDEN, ss.

SUPERIOR COURT
CRIMINAL ACTION
NO. 17-0039

HAMPDEN COUNTY
SUPERIOR COURT
FILED

NOV 28 2017

CLERK OF COURTS

COMMONWEALTH

vs.

FRANK STIRLACCI
(and a companion case[1])

MEMORANDUM OF DECISION AND ORDER ON THE DEFENDANTS' MOTIONS TO DISMISS

This case probes the scope of criminal liability when an office administrator for a physician's solo practice continues to renew controlled substances prescriptions at the physician's orders, though the physician is detained in jail. It is well known that opiate addiction is an ongoing crisis both regionally and nationwide; the court, however, is constrained to review only the narrow issue of whether the crimes for which the defendants stand indicted actually criminalize the conduct properly alleged.

On January 26, 2017, a Hampden County Grand Jury indicted Dr. Frank Stirlacci and his office manager Jessica Miller on sixty-eight indictments. Twenty-six of the indictments charge each defendant with prescribing certain Class B controlled substances listed under G. L. c. 94C, § 31, outside the usual course of professional treatment during the period of April 22, 2015 through May 7, 2015, in violation of G. L. c. 94C, § 19 (a) (hereinafter the "unlawful prescriptions").[2] Twenty of the indictments charge each defendant with uttering a false

11/28/17 mailed to all counsel -ls-

[1] Commonwealth vs. Jessica Miller, 1779CR00040.

[2] Counts 1-6 respectively allege five hydrocodone prescriptions and one oxycodone prescription on April 22, 2015; counts 7-16 respectively allege three hydrocodone, four oxycodone, one fentanyl, and two methadone prescriptions on April 23, 2015; Counts 17-19 respectively allege a hydrocodone, oxycodone, and a fentanyl prescription on May

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prescription, in violation of G. L. c. 94C, § 33 (b) (hereinafter the "false prescriptions").[3] The final twenty-two indictments charge each defendant with submitting false health care claims, in violation of G. L. c. 175H, § 2 (hereinafter the "false health care claims").[4]

Dr. Stirlacci was found to be in contempt of a child support order and subsequently held in a Kentucky facility from April 17 through May 11, 2015. The indictments focus on four dates: April 22, 2015 (six unlawful prescriptions, seven false prescriptions, and seven false health care claims); April 23, 2015 (eight unlawful prescriptions, four false prescriptions, and five false health care claims); May 6, 2015 (three unlawful prescriptions, and two counts each of false prescriptions and false health care claims); and May 7, 2015 (six unlawful prescriptions, seven false prescriptions, and eight false health care claims).[5]

The defendants each move to dismiss the indictments on the ground that there was insufficient evidence to indict. See *Commonwealth* v. *McCarthy*, 385 Mass. 160 (1982). During the hearing on the defendants' motions on October 26, 2017, counsel for Dr. Stirlacci also sought dismissal alleging the Commonwealth's witness knowingly gave false, material testimony in response to a grand juror's question. See *Commonwealth* v. *Salman*, 387 Mass. 160 (1982). For the following reasons, the defendants' motions to dismiss are ALLOWED IN PART.

6, 2015; and Counts 20-26 respectively allege six hydrocodone prescriptions and one methadone prescription on May 7, 2015.

[3] Of these, which may only be distinguished by date, seven counts are alleged to have occurred on April 22, 2015 (counts 27, 40, 42, 47, 51, 55, and 67); four, it is alleged, occurred on April 23, 2015 (counts 49, 53, 57, and 61); two are linked to May 6, 2015 transactions (counts 44 and 65); and the remaining seven are alleged to have occurred on May 7, 2015 (counts 30, 32, 34, 36, 38, 59, and 63).

[4] These indictments are also indistinguishable, except by date. Seven are linked to April 22, 2015 (counts 28, 41, 43, 48, 52, 56, and 68); five list a date of April 23, 2015 (counts 37, 50, 54, 58, and 62); two state May 6, 2015 as the date (counts 45 and 66), and the remaining eight are alleged to have happened on May 7, 2015 (counts 29, 31, 33, 35, 39, 46, 60, and 64).

[5] See, supra, notes 2-4.

BACKGROUND

The following, relevant information is based upon State Trooper Michael Martin's testimony to the grand jury and the corresponding exhibits, with evidence concerning billing practices reserved for later exposition.[6] Dr. Stirlacci operated a solo medical practice in Agawam and, in 2014, opened a second facility in Springfield, which was run by a nurse practitioner, Jennifer Rivers ("Nurse Rivers"), under Dr. Stirlacci's oversight. (Volume I, Minutes pp. 4-5; Volume II, Minutes p. 28). Along with a number of medical staff, Dr. Stirlacci and Nurse Rivers were assisted by an office manager for the Agawam location, Ms. Miller, and Joe Ciurleo, who had an administrative role in the enterprise. (Volume II, Minutes pp. 28-30). Neither Miller nor Ciurleo are licensed medical providers. (Volume II, Minutes p. 30). In all, Dr. Stirlacci was responsible for approximately 3,000 patients. (G.J. Exhibit 3, p. 16; G.J. Exhibit 4, p. 120).

During the period of April 17 to May 11, 2015, Dr. Stirlacci was unexpectedly found to have been in contempt of court and, consequently, detained in the Louisville, Kentucky jail system. (Volume I, Minutes pp. 4-5). Trooper Martin requested and received Dr. Stirlacci's phone records from the Louisville facility, which were presented to the grand jury. (Volume I, Minutes pp. 6-7, 13, 15, 17). Trooper Martin read aloud the following telephone exchange from a volume of phone transcripts dated between April 18, 2015 and April 23, 2015:[7]

> Dr. Stirlacci: I'm on vacation. Hold down the fort. The best thing you can do is listen. Here's what I need you to do. Here's what you can do. In my office on the chair, first chair, is a bunch of people that I saw on Friday,[8] okay?
> Ms. Miller: Uh-huh.

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[6] The grand jury received evidence on this matter on January 17, 2017, and again on January 26, 2017, charging the subject indictments on the latter date. The second volume of grand jury minutes is separately paginated, but the exhibits introduced on the second day are cumulative. Accordingly, the court will refer to these documents as: (Volume _, Minutes, p. _), and (G.J. Exhibit _, p._).

[7] According to the telephone transcripts, this conversation occurred on April 21, 2015. (G.J. Exhibit 2, pp. 164, 174).

[8] Presumably Friday, April 17, 2015.

...
Dr. Stirlacci: Okay. So you log on there and then it will have you pick. You can change the date, you can go other services and then you can go to the provider, which is me. Then you can put in those charges for all of those Fridays since we started the NextGen from March 17th. . . . [I]f you click on that Friday and the date, up will come all the unbilled patients, click on their name, up will come their screen, and then you can put it in the CPT code and the diagnosis. And all you've got to do is look at the ones that I highlighted.
Ms. Miller: Okay.
...
Dr. Stirlacci: . . . [G]et charges in because that brings cash flow.
Ms. Miller: I know.
Dr. Stirlacci: Okay. So that's something you can work on.
Ms. Miller: What about people that are picking up scripts, can I put in charges for them?
Dr. Stirlacci: Yes.
Ms. Miller: Even though they weren't seen?
Dr. Stirlacci: Yes. Put in the 99212.
Ms. Miller: Okay.
Dr. Stirlacci: For the date that they picked up, because they didn't see the doctor, so it's down charged. So, it's a 92 or a 93.
Ms. Miller: Okay.
Dr. Stirlacci: Just put 93 and a blue note in the sticky pad on their chart. If they're picking up scripts, we're doing work.
Ms. Miller: Okay.

(Volume I, Minutes pp. 8-11).

Nurse Rivers told investigators that she worked for Dr. Stirlacci until May 7, 2015, when she quit. (Volume II, Minutes p. 28; G.J. Exhibit 4, p. 107). In April, 2015, when Dr. Stirlacci was incarcerated, Nurse Rivers maintained her own "SOAP notes, scripts, and billing through EMR billing system (Electronic Medical Records) mostly at the Springfield Office." (Volume II, Minutes p. 28). When Dr. Stirlacci had not returned after a week, Nurse Rivers worked part-time at his Agawam office for "approximately one week."[9] (*Id.*) The billing company, however, disapproved of her billing out of two locations, and it had also been informed of Dr. Stirlacci's

[9] This would have been from Monday, April 27, to Friday, May 1, 2015.

plight; accordingly, Nurse Rivers decided only to work out of the Springfield office until she left the practice on May 7, 2015.[10] (Volume II, Minutes pp. 28-29).

Thus, as Trooper Martin testified, Dr. Stirlacci told Ms. Miller: "So just get some charges in. If you need to call Christina, do that. [Doc's] on vacation. Anybody comes in for their script, blue note, super bill, sticky pad and get charges in," to which Ms. Miller replied "Okay." (Volume I, Minutes p. 11). Dr. Stirlacci continued: "We got to be able to talk to [Nurse] Rivers. The bottom line is those people need to be paid."[11] (Volume I, Minutes pp. 11-12).

Trooper Martin told the grand jury that, by "putting charges in," Dr. Stirlacci was referring to "charging patients as if they were seen by a doctor, which would then be forwarded to an insurance company to get paid from the insurance company." (Volume I, Minutes p. 13). A grand juror asked if these were electronic prescriptions, and Trooper Martin responded that they were "[p]re-signed." (Volume I, Minutes p. 28). Then, the following exchange occurred:

> Grand Juror: Was this ongoing therapy for these people?
> Trooper Martin: Each patient has a different history, sir, I wouldn't want to comment on a specific patient.
> Grand Juror: They had narcotic prescriptions in the past?
> Trooper Martin: Yes.
> Grand Juror: The same ones?
> Trooper Martin: Yes.
> Grand Juror: Ongoing?
> Trooper Martin: Yes.

(*Id.*)

Trooper Martin read the grand jury further excerpts from the phone transcripts, which, as might be expected, reflect mounting difficulties as Dr. Stirlacci's detention dragged on. Dr. Stirlacci authorized Joe Ciurleo to sign his name so someone, presumably a patient, "can get the therapy or something." (Volume I, Minutes p. 14; see G.J. Exhibit 3 pp. 149, 151 (conversation

[10] This would have been from Monday, May 4, to Thursday, May 7, 2015.
[11] Dr. Stirlacci believed the office would not be able to make payroll. (See G.J. Exhibit 2, p. 171).

occurred on April 30, 2015)). Dr. Stirlacci authorized Ms. Miller to sign his name with her initials for non-narcotic refills and told her the nurse practitioner would refill the narcotic prescriptions. (Volume I, Minutes pp. 14-15; see G.J. Exhibit 3 pp. 168, 176 (conversation occurred on April 30, 2015)). Ms. Miller worried that someone, presumably a co-worker, disagreed with her writing prescriptions on the authority of a physician who had not seen the patients. (Volume I, Minutes p. 16; see G.J. Exhibit 4 pp. 147, 151 (conversation occurred on May 7, 2015; Ms. Miller was discussing a fight with Nurse Rivers precipitating Rivers' resignation)).

Nurse Rivers' police statement described her patient visit notes, which, it seems, usually consisted of vital information (filled in by the office staff) and medical impressions and a signature, both handwritten by the practitioner. (See Volume II, Minutes p. 29). Nurse Rivers explained that, though she filled in the medical section of the notes, she did not sign all of them. (*Id.*) She said some of them were signed by Dr. Stirlacci when he returned to the office. (*Id.*)

Nurse Rivers also discussed the prescription procedure used when Dr. Stirlacci was away. She said she filled out all of her own prescriptions while Dr. Stirlacci was incarcerated. (Volume II, Minutes p. 30). At the troopers' request, Nurse Rivers reviewed some of Dr. Stirlacci's prescriptions generated during this time period, and commented that, while the signature belonged to Dr. Stirlacci, Ms. Miller had filled out the body of the prescription. (*Id.*) Her statement continues:

> I knew that[,] often when Dr. Stirlacci went away on vacation, or this time to jail, that he would leave behind signed script pads for Miller to issue. I don't know exactly how many pads he would leave, but it seemed to be a common practice with him. To the best of my knowledge[,] Miller is not a licensed medical worker and does not have any – and does not have the legal right to issue scripts.

(*Id.*) While Dr. Stirlacci was incarcerated, Nurse Rivers was twice asked to sign case notes for patients whom she had not seen; she declined. (*Id.*)

The grand jury did not hear any expert testimony explaining the extent of Dr. Stirlacci's ability to authorize prescription renewals while detained in jail.[12] There was no evidence that any of Dr. Stirlacci's patients were or appeared to have been abusing narcotics, nor did the Commonwealth's witness make any representation to that effect. Finally, there was no evidence that any of Dr. Stirlacci's patients were harmed as a result of Dr. Stirlacci's detention.[13]

Excerpts from Dr. Stirlacci's telephone transcripts were shared with the grand jury and entered as exhibits. (See G.J. Exhibits 2-4). I have reviewed the full transcripts, which mostly memorialize Dr. Stirlacci's attempts to resolve his legal trouble with the help of family, friends and co-workers.[14] There are, however, several conversations relevant to the charges alleged. Dr. Stirlacci worried about patient abandonment and loss of the practice in his absence. (G.J. Exhibit 3, pp. 5-6; see *id.* at 15 ("[P]eople, you know, they don't get their medicine and somebody has a stroke because their blood pressure isn't there"); *id.* at pp. 174, 176-177; G.J. Exhibit 4, p. 128). He mentioned a discussion initiated by the Board of Registration in Medicine a month prior, in which the Board confirmed his ability to practice medicine during his divorce. (G.J. Exhibit 3, pp.13-14). And, on multiple occasions, he expressed concern about the legal implications of failing to oversee Nurse Rivers. (G.J. Exhibit 3, p. 174 ("You can't have a nurse practitioner without a doctor overseeing her . . . . [t]hose are the rules and the laws"); G.J. Exhibit 4, p. 12 ("[Nurse Rivers is] not going to break the law. . . . I have to be available . . . . And I can go on

[12] Legal instructions were not required unless requested by the grand jury. See *Commonwealth* v. *Walczak*, 463 Mass. 808, 823 (2014), citing *Commonwealth* v. *Noble*, 429 Mass. 44, 48 (1999).
[13] The phone transcripts reveal that patients' appointments were rescheduled when they could not be seen by Nurse Rivers and they arguably may have suffered as a result of the rescheduling. (See G.J. Exhibit 4, p. 160 (twenty appointments rescheduled on May 6th); *id.* at 161 ("entire day" cancelled on May 7th)).
[14] The jail redacted all conversations between Dr. Stirlacci and his attorney.

vacation and be available by phone, but you can't . . . say I'm available by phone when I'm really not"); *id.* at 107).[15]

On May 6th, Dr. Stirlacci acknowledged that he could be investigated for billing for patient visits during his absence.[16] (See G.J. Exhibit 4, pp. 84, 90). And, on May 7th, Dr. Stirlacci agreed that, with Nurse Rivers' departure, "[w]e can't see patients." (*Id.* at 135). Later that day, Dr. Stirlacci and Ms. Miller discussed Nurse Rivers:

> Dr. Stirlacci: Right. And so what didn't [Nurse Rivers] like? The patients were seen. They came into the office.
> Ms. Miller: She doesn't like that we were writing scripts for patients and then expecting her to do the office note.
> Dr. Stirlacci: Okay. Well, all right. Well, [*you*] see all these patients then . . .

(*Id.* at 151). To be sure, Ms. Miller at times expressed a level of angst about working during Dr. Stirlacci's absence. (See G.J. Exhibit 3, p. 170 (on April 30th: ". . . I can't do it anymore without you"); G.J. Exhibit 4, p. 35 (on May 5th: "When you come home, you see patients immediately"). Nowhere in the evidence, however, is there any indication that Ms. Miller or the office staff were incompetent to assist the patients whom they assisted during Dr. Stirlacci's incarceration.

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[15] The Commonwealth has not prosecuted Dr. Stirlacci on the theory that he failed to supervise Nurse Rivers. It appears that Dr. Stirlacci was alluding to private guidelines he developed with Nurse Rivers, pursuant to the regulatory scheme. See G. L. c. 112, § 80E ("A nurse practitioner . . . may issue written prescriptions . . . pursuant to guidelines mutually developed and agreed upon by the nurse and the supervising physician in accordance with regulations promulgated jointly by the board [of nursing] and the board of registration in medicine after consultation with the board of registration in pharmacy"); 244 Code Mass Regs. § 4.02 (d), (e) (defining "supervising physician" as one who "reviews the prescriptive practice of a certified nurse practitioner . . . as described" in the "mutually developed and agreed upon prescriptive practice guidelines"); 244 Code Mass Regs. § 4.07 (2) (b) (5), (7) (written guidelines must "describe circumstances in which physician consultation or referral is required for the pharmacologic treatment of medical conditions" and must "specify that the initial prescription of Schedule II drugs must be reviewed within 96 hours"). Failure to follow the guidelines is not necessarily illegal, but "is a basis for and may result in disciplinary action." 244 Code Mass. Regs. § 4.07 (2).

[16] The reference appears to be to an administrative, rather than civil, investigation.

In all, the Commonwealth alleges that the defendants improperly billed for office visits with twenty-two patients and unlawfully issued twenty-six narcotics prescriptions to twenty patients.[17] (See Volume I, Minutes pp. 17-24; Volume II, Minutes pp. 3-26; G.J. Exhibits 5-26).

STANDARD OF REVIEW

Ordinarily, courts do not "inquire into the competency or sufficiency of the evidence before the grand jury," *Commonwealth* v. *Robinson*, 373 Mass. 591, 592 (1977), quoting *Commonwealth* v. *Galvin*, 323 Mass. 205, 211-212 (1948). Nonetheless, in *Commonwealth* v. *McCarthy*, 385 Mass. 160, 163 (1982), the Supreme Judicial Court acknowledged the trial court's authority to dismiss an indictment if the grand jury receives "*no* evidence of criminality" on the part of the accused. *Commonwealth* v. *Caracciola*, 409 Mass. 648, 650 (1991). "[A] requirement of sufficient evidence to [indict] is considerably less exacting than a requirement of sufficient evidence to warrant a guilty finding." *Commonwealth* v. *O'Dell*, 392 Mass. 445, 451 (1984). At the very least, however, "the grand jury must hear sufficient evidence to establish the identity of the accused . . . and probable cause to arrest him." *Commonwealth* v. *Gonzalez*, 462 Mass. 459, 463 (2012), quoting *McCarthy*, 385 Mass. at 163.

Probable cause to arrest is "more than mere suspicion," but "something less than evidence sufficient to warrant a conviction." *Commonwealth* v. *Roman*, 414 Mass. 642, 643 (1993) (internal quotations omitted). It exists at the moment "the facts and circumstances within [the investigators'] knowledge and of which they had reasonably trustworthy information were sufficient to warrant a prudent [person] in believing that the [defendant] had committed or was committing an offense." *Commonwealth* v. *Stevens*, 362 Mass. 24, 26 (1972), quoting *Beck* v.

[17] The evidence before the grand jury supported probable cause to believe that, during Dr. Stirlacci's absence, the office staff wrote twenty-six narcotics prescriptions, saw twenty patients who were prescribed narcotics, and saw and billed twenty-two patients for office visits, according to the record. (See Volume I, Minutes pp. 17-24; Volume II, Minutes pp. 3-26; G.J. Exhibits 5-26). More specific testimony concerning the bills is related infra.

Ohio, 379 U.S. 89, 91 (1964). An indictment should be dismissed if the grand jury was not "presented with evidence supporting a finding of probable cause as to each of the . . . elements of the charged crime." *Commonwealth* v. *Walczak*, 463 Mass. 808, 817 (2012), quoting *Commonwealth* v. *Moran*, 453 Mass. 880, 884 (2009). "Conversely, where the Commonwealth satisfies the probable cause standard, the determination [whether the prescriptions were medically illegitimate under G. L. c. 94C, § 19 (a), and whether they or the medical bills were false under G. L. c. 94C, § 33 (b), and G. L. c. 175H, § 2, respectively] is one for a fact finder. See *Commonwealth* v. *Robinson*, 373 Mass. at 592-594 . . . (sufficiency of evidence reserved for trial on merits)." *Commonwealth* v. *Rex*, 469 Mass. 36, 40-41 (2014).

Probable cause should be based upon "reasonably trustworthy information . . . sufficient to warrant a prudent man in believing that the defendant had committed . . . an offense." *O'Dell*, 392 Mass. at 450, quoting *Stevens*, 362 Mass. at 26. This calls for "something definite and substantial, but not a prima facie case of the commission of a crime, let alone a case beyond a reasonable doubt." *Commonwealth* v. *Bond*, 375 Mass. 201, 210 (1978). An indictment is not to be dismissed merely because "the evidence probably would not have been sufficient to overcome a motion for a required finding of not guilty at a trial." *O'Dell*, 392 Mass. at 450.

When an indictment is challenged, the presentment is viewed "in the light most favorable to the grand jury's decision to indict." *Commonwealth* v. *Riley*, 73 Mass. App. Ct. 721, 729 (2009). A reviewing court does not scrutinize the thought processes of grand jurors, but reviews the sufficiency of the evidence according to the objective standard of probable cause to arrest. *Commonwealth* v. *DePace*, 442 Mass. 739, 744 (2004), cert. denied, 544 U.S. 980 (2005). Still, an indictment may not be based solely upon the grand jury's "conjecture or guesswork" employed "to choose between alternative inferences." *Commonwealth* v. *Jansen*, 459 Mass. 21,

28 (2011). If the evidence presented would necessitate such conjecture, dismissal is appropriate. *Id.*

A court must also dismiss indictments that taint the integrity of the grand jury. *O'Dell*, 392 Mass. at 446-447; *Commonwealth* v. *Salman*, 387 Mass. 160, 166 (1982). When grand jurors hear false or deceptive evidence, any indictments handed up should be dismissed when (1) the Commonwealth knowingly, or with a "reckless disregard of the truth" submitted the evidence with intent to procure the indictment; and (2) the evidence "probably influenced" the decision to indict. *Commonwealth* v. *Mayfield*, 398 Mass. 615, 621 (1986). The Commonwealth recklessly disregards the truth when its affiant testifies "without reasonable grounds for believing the false statement to be true." *Commonwealth* v. *Hunt*, 84 Mass. App. Ct. 643, 653 (2013), quoting *Commonwealth* v. *Nine Hundred & Ninety-Two Dollars*, 383 Mass. 764, 769 (1981).

DISCUSSION

1. Improper Prescriptions – G. L. c. 94C, § 19 (a)

The defendants argue that they never authorized any improper prescriptions for controlled substances. The Commonwealth disagrees, maintaining that the license to dispense prescriptions is an affirmative defense and, as such, is irrelevant at this stage. As a threshold matter, the Commonwealth's "defense" argument correctly interprets the letter of the statute—but the Supreme Judicial Court has specifically foreclosed this interpretation. See *Commonwealth* v. *Brown*, 456 Mass. 708, 716 (2010) (interpreting statute to provide that controlled substance prescriptions are presumptively lawful, thereby converting elements of defense into their negative and rendering them elements of crime); *Commonwealth* v. *Chatfield-Taylor*, 399 Mass. 1, 4 (1987) (treating elements of defense as "essential elements" of crime). See also G. L. c. 277, § 38 ("In a prosecution under any provision of chapter ninety-four C, for

unlawfully . . . dispensing . . . a controlled substance . . . , it shall be sufficient to allege that the defendant did *unlawfully . . . dispense* . . . such alleged substance . . . .") (emphasis added). See generally *Commonwealth* v. *Grouse*, 461 Mass. 787, 804 (2012) (primary characteristic of affirmative defense is that it "involves a matter of justification peculiarly within the knowledge of the defendant") (quotation and alteration omitted).

The statute at issue, G. L. c. 94C, § 19 (a), as interpreted by *Brown*, provides that prescriptions for controlled substances are unlawful if they are not issued (1) for a legitimate medical purpose; (2) by a practitioner; or (3) in the usual course of the practitioner's professional practice. If any of these three elements are lacking, a defendant may be penalized under G. L. c. 94C, § 32 and §§ 32A-32H, as applicable. See G. L. c. 94C, § 19 (a); *Commonwealth* v. *Kobrin*, 72 Mass. App. Ct. 589, 596 (2008). The term "practitioner" means "[a] physician . . . or other person registered to distribute [or] dispense . . . a controlled substance in the course of professional practice . . . ." G. L. c. 94C, § 1. Dr. Stirlacci was a practitioner under the statute, and Ms. Miller his agent, thus the second element is easily met.

Ms. Miller, however, argues that she is not a practitioner and so the statute does not apply to her. It is not immediately obvious whether additional language in the statute, resting responsibility for prescribing and dispensing controlled substances on the prescribing practitioner and the pharmacist, would preclude indictment on an accessory theory. See, e.g., *Commonwealth* v. *Lauria*, 359 Mass. 168, 172 (1971) ("[W]e see nothing in Lauria's contention that only a bank employee can aid or abet a bank officer in making a false entry [in a bank report]"). I assume, without deciding, that Ms. Miller may be prosecuted under an accessory theory.

The first and third prongs of the statute, "for a legitimate medical purpose," and "in the usual course . . . of practice," are not as easily interpreted. Generally, a court must attempt to interpret a statute by its terms. See *International Fid. Ins. Co.* v. *Wilson*, 387 Mass. 841, 853 (1983). "[A] statute must be interpreted according to the intent of the Legislature ascertained from all its words construed by the ordinary and approved usage of the language, considered in connection with the cause of its enactment, the mischief or imperfection to be remedied and the main object to be accomplished, to the end that the purpose of its framers may be effectuated" (quotation omitted). *Board of Educ.* v. *Assessors of Worcester*, 368 Mass. 511, 513 (1975). In doing so, the court must consider the entire statute, "not just a single sentence," and it must "attempt to interpret all of [the statute's] terms 'harmoniously to effectuate the intent of the Legislature.'" *Commonwealth* v. *Hanson H.*, 464 Mass. 807, 810 (2013), quoting *Commonwealth* v. *Raposo*, 453 Mass. 739, 745 (2009).

General Laws chapter 94C, the controlled substances act ("the Act"), does not define "legitimate medical purpose," nor does it set forth the meaning of "usual course" of "professional practice." G. L. c. 94C, § 19 (a). Since physicians, even solo practitioners, must at times be unavailable to their patients, whether the cause be an infectious illness, bereavement, vacation, jury duty, or other personal matters, it is unclear to what extent such absences could ever run afoul of the "usual course" of "professional practice," let alone "legitimate medical purposes." And, assuming that a solo practitioner need not close up shop during an absence, it is unclear whether a temporary detention in a jail should be interpreted any differently from, say, selection for an undefined period of jury duty.[18]

[18] See Reasons for Disqualification, Massachusetts Court System, www.mass.gov/courts/jury-info/trial-and-grand-jurors/trial-jurors/reasons-for disqualification/ ("There are no exemptions or occupational disqualifications in Massachusetts, in order to ensure that juries are drawn from as broad and diverse a group of citizens as possible.").

There is voluminous case law discussing the liability of physicians under Section 19 of the Act. The cases, however, appear to be less than illustrative with respect to Dr. Stirlacci's actions because they concern allegations of more egregious conduct, generally overprescribing or profiteering; and because the court was usually called upon to assess the sufficiency of evidence after trial, as opposed to the probable cause inquiry before this court. See *Brown*, 456 Mass. 708, 710, 718 (evidence supported allegation that physician should have known patients were illegal drug users); *Commonwealth* v. *Pike*, 430 Mass. 317, 318, 322 (1999) (evidence supported convictions where psychiatrist was engaged in drug dealing scheme); *Commonwealth* v. *Eramo*, 377 Mass. 912, 912-913 (1979) (holding evidence insufficient for judge to conclude that physician prescribed particular controlled substances at request of undercover officers); *Commonwealth* v. *Comins*, 371 Mass. 222, 230, (1976) (conviction affirmed where physician prescribed controlled substances to drug users on request without taking any medical history); *Commonwealth* v. *Miller*, 361 Mass. 644, 647-650, 661 (1972) (evidence sufficient to support conviction where physician dispensed controlled substances in exchange for favors without taking medical history); *Commonwealth* v. *Noble*, 230 Mass. 83, 84 (1918) (conviction affirmed where physician dispensed controlled substances to habitual users in bad faith under previous, "[unless] obviously needed for therapeutic purposes," version of statute); *Kobrin*, 72 Mass. App. Ct. at 590 (insufficient evidence to support conviction under theory that psychiatrist prescribed benzodiazepines to get patients addicted in furtherance of alleged kickback scheme); *Commonwealth* v. *Wood*, 17 Mass. App. Ct. 304, 305-306 (1983) (evidence sufficient to convict where dentist overprescribed narcotics); *Commonwealth* v. *De La Cruz*, 15 Mass. App. Ct. 52, (1982) (convictions affirmed where physician customarily prescribed Valium after his indecent assaults on patients); *Commonwealth* v. *Lozano*, 5 Mass. App. Ct. 872, 872-873 (1977) (evidence

held sufficient to support conviction where physician prescribed requested controlled substances to undercover officers, agreeing that government should not control right to do drugs). See also *Commonwealth* v. *Perry*, 391 Mass. 808, 808-809 (1984) (noting that physician stipulated to self-prescribing controlled substances, placing himself outside of § 19, purview); *Chatfield-Taylor*, 399 Mass. at 5 (finding sufficient evidence to conclude psychiatrist, accused of medically unacceptable prescribing to curb drug use, was practitioner).

The typical cases in this area of law give the court pause for two interrelated reasons. First, the defendants' alleged wrongdoing is without question less egregious than the misconduct historically prosecuted under § 19 (a), and its predecessors, and, inferentially, prosecution in this case may reach beyond the scope of the statute. Second, the case law tending to shed light on the meaning of "legitimate medical purposes" and "usual course" of practice, having been developed under circumstances more flagrant than those alleged in this case and, perforce, at a post-trial posture, might improvidently steer the court away from recognizing the impropriety of prosecution for milder conduct at the pre-trial stage. See, e.g., *Kobrin*, 72 Mass. App. Ct. at 605 n.18 (noting that the *Comins* court, 371 Mass. at 232-233, had looked to Federal cases regarding "the nature and quantum of evidence sufficient to prove illegal prescribing," listing those cited cases, and explaining that those cases "all reflect facts and circumstances similar to those encountered in *Comins*").

"In interpreting the Controlled Substances Act, the Supreme Judicial Court has . . . looked to the evolving case law under the closely analogous Comprehensive Drug Abuse Prevention and Control Act of 1970 . . . , on which G. L. c. 94C is modeled." *Commonwealth* v. *Doty*, 88 Mass. App. Ct. 195, 199 (2015), citing *Commonwealth* v. *Cantres*, 405 Mass. 238, 240 (1989), and *Brown*, 456 Mass. at 716. See *Kobrin*, 72 Mass. App. Ct. at 605 n.18 (accord).

Accordingly, the court considers the Federal case law under its cognate provision, 21 C.F.R. § 1306.04 (a), which is nearly identical to § 19 (a). See *Brown*, 456 Mass. at 717 n.10 (comparing § 19, with 21 C.F.R. § 1306.04). The comparison, unfortunately, does not shed much light on the probable cause inquiry because the Federal Controlled Substances Act ("the Federal Act") does not impose the "legitimate medical practices" or "usual course of professional practice" limitations on the face of the applicable criminal statute and those limitations are therefore irrelevant at the pleading stage. See *United States* v. *Steele*, 147 F.3d 1316, 1317 (11th Cir. 1998) (en banc), cert. denied, 528 U.S. 933 (1999), citing 21 U.S.C. § 885 (a) (1); *United States* v. *Rodriguez*, 532 F. Supp. 2d 332, 336 n.3 (D.P.R. 2007) ("The issue of whether a physician's conduct exceeds the bounds of professional medical practice . . . . is an element of the offense which the Government must prove to the jury, and is not properly the subject of a motion to dismiss"); *Brown*, 456 Mass. at 717 n.10 ("The difference between the Federal regulation and the Massachusetts statute is significant. Where the Federal regulation cannot establish a criminal prohibition, § 19 clearly does."). Compare *Steele*, 147 F.3d at 1319 (explaining that, though prosecution could pursue any prescribing physician, prosecutors do not have time to bring cases they cannot win), with *Brown*, 456 Mass. at 716 (interpreting statute to require proof of illegitimate medical conduct because "it is apparent that the Legislature did not intend to criminalize all medical care . . . .").

Before departing from the Federal landscape, a recent Supreme Court case may have some bearing on the matter. Justice Kennedy crystalized the "central" issue in that case as, "Who decides whether a particular activity is in 'the course of professional practice' or done for a 'legitimate medical purpose'?" *Gonzales* v. *Oregon*, 546 U.S. 243, 257 (2006). In *Gonzales*, the plaintiffs had challenged the United States Attorney General's interpretive rule declaring

physician-assisted suicide to be neither a professional practice nor a legitimate medical purpose. *Id.* at 249. Since the Attorney General's original regulation, 21 C.F.R. § 1306.04 (a), merely summarized some aspects of the Federal Act and, as such, did not bring the decision as to what is medically illegitimate into the Attorney General's purview, the Court held the Attorney General exceeded his statutory authority by reinterpreting § 1306.04 (a) to deem illegitimate "a controversial practice permitted by state law." *Id.* at 257, 264, 268. Particularly relevant to Dr. Stirlacci's case, the Court, in analyzing whether the Attorney General could have promulgated the rule merely as prosecutorial guidance, revisited the purpose of the Federal Act:

> The statute and our case law amply support the conclusion that Congress regulates medical practice insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood. Beyond this, however, the statute manifests no intent to regulate the practice of medicine generally.

Id. at 269-270. Rather, the Federal Act relies upon "a functioning medical profession regulated under the States' police powers" and by the Secretary of Health and Human Services. *Id.* at 270-271. In sum, the *Gonzales* Court held that Federal attorneys could not prosecute Oregon physicians for prescribing euthanizing narcotics, leaving interpretation of the legitimacy of that procedure to the state and to the Secretary under the Federal Act. *Id.* at 269-271.

Analogously, the Massachusetts Act also does not purport to delegate regulation of the medical profession to state prosecutors. See *Brown*, 456 Mass. at 722-723 ("The first part of the Act, G. L. c. 94C, §§ 2-30, establishes the statutory framework that undergirds an administrative scheme, overseen by the Commissioner of Public Health, that regulates the authorized delivery of controlled substances"); *Perry*, 391 Mass. at 812 n.3 ("When read together, [G. L. c. 94C, §§ 7, 9, 18, 19, 24, 25, and 26] provide that a registered physician is authorized to prescribe medically necessary controlled substances if required procedures are followed, but not

otherwise"). Drawing from those cases, the court looks to the Commissioner of Public Health for guidance as to the "required procedures" for absent physicians. *Perry*, 391 Mass. at 812; *Brown*, 456 Mass. at 722-723. See also G. L. c. 94C, § 6 (providing that, except with respect to retail and wholesale drug businesses, Commissioner of Public Health "may promulgate rules and regulations relative to . . . dispensing . . . controlled substances within the commonwealth").

The Commissioner's regulations, titled "Implementation of M.G.L. c. 94C," are found at 105 Code Mass. Regs. § 700.000 *et seq.* The regulations do not provide a definition for the phrases "course of professional practice" or "legitimate medical purpose." But, with respect to a given practitioner, the regulations parrot the statutory requirement that prescriptions be made "in the course of his or her professional practice." 105 Code Mass. Regs. § 700.001 (defining 'practitioner'); see G. L. c. 94C, § 1 (accord).

The Board of Registration in Medicine ("the Board") on the other hand, charged with adopting "rules and regulations governing the practice of medicine in order to promote the public health, welfare and safety," G. L. c. 112, § 5, has promulgated definitions to the terms left undefined by both the Legislature and the Commissioner of Public Health. To determine whether the Act criminalizes Dr. Stirlacci's prescription practices, other statutory treatment of the scope of appropriate medical conduct is "instructive." See *Commonwealth* v. *J.A., a juvenile*, 2017 Mass. LEXIS 840, *4 (Mass. 2017) (discussing "canon of in pari materia, i.e., looking to statutes of similar subject matter"), citing *Commonwealth* v. *Smith*, 431 Mass. 417, 420 (2000). The Board, pursuant to its statutory directive, defines "Legitimate Medical Purpose" as "whether the physician was acting in good faith in issuing the prescription," and provides factors to consider. Board of Registration in Medicine: Prescribing Practices Policy and Guidelines, Policy 15-05 p.1 (Adopted Oct. 8, 2015) ("Prescribing Policy"),

http://www.mass.gov/eohhs/docs/borim/ policies-guidelines/policy-15-05.pdf, citing *Pike*, 430 Mass. 317; *Miller*, 361 Mass. 644; and *Noble*, 230 Mass. 83.[19] The Prescribing Policy defines "In the Usual Course of a Practitioner's Practice" as requiring a "physician-patient relationship that is for the purpose of maintaining the patient's well-being" with respect to which the physician conforms "to certain minimum norms and standards," which are then described. Prescribing Policy, p.2.

Having reviewed the pertinent case law and statutes, I conclude that the Board's Prescribing Policy sets forth the baseline standard delineating the scope of lawful prescription of controlled substances under the Act. This conclusion is supported by the general similarity the Prescribing Policy bears to the standard of care applied in past prosecutions of Massachusetts physicians under the Act. See, e.g., *Chatfield-Taylor*, 399 Mass. at 7 n.16 (noting that jury likely acquitted because evidence showed defendant was trying to stop drug use and Commonwealth's own expert said defendant's methods were not "accepted medical practice," but "his objective was legitimate"); *Eramo*, 377 Mass. at 912 ("The inference that Eramo exercised independent medical judgment is as compelling as the inference that he issued prescriptions on request without legitimate medical purpose"); *Kobrin*, 72 Mass. App. Ct. at 605 (convictions vacated where there was no evidence that psychiatrist overlapped prior prescriptions, improperly replaced old prescriptions claimed to be lost, or prescribed dosages beyond recommended range). Further, using the Prescribing Policy as the rule in this case aligns with the United States Supreme Court's conclusion that physicians working with the Secretary of Health and Human Services, as opposed to the prosecuting officer alone, set the standard of care under the Federal

[19] I take judicial notice of the Board's Prescribing Practices policy. See *Commonwealth* v. *Greco*, 76 Mass. App. Ct. 296, 301 n.9, rev denied, 457 Mass. 1106, and 458 Mass. 1105 (2010) (permitting judicial notice of facts "capable of accurate and ready determination by resort to resources whose accuracy cannot reasonably be questioned"), quoting Mass. Guide Evid. § 201 (b).

Act. *Gonzales* v. *Oregon*, 546 U.S. at 268-271. To that end, the Prescribing Policy in fact sets forth the "required procedures" that physicians must follow such that their "delivery of controlled substances" remains "authorized" as interpreted by the Board charged with regulating their profession. See *Brown*, 456 Mass. at 722-723; *Perry*, 391 Mass. at 812. The court now turns to the evidence presented to the grand jury to determine whether, in the light most favorable to the Commonwealth, the grand jury could have discerned probable cause to believe that Dr. Stirlacci's conduct fell below the standard of conduct set forth by the Board's Prescribing Policy.

A. Legitimate Medical Practice

The Prescribing Policy lists the following negative factors to consider when scrutinizing a medical transaction for the good faith required in legitimate medical practice: (1) failure to follow at least minimum professional procedure; (2) permitting patient to name the desired drug; (3) expressing concern about filling prescription indicative of belief that prescription is unwarranted; (4) repeated refills over relatively short periods; (5) remarks regarding off-label uses of drugs; (6) actions indicating lack of interest in follow-up care; and (7) circumstances demonstrating that physician knew that drugs were not intended for purported use. Prescribing Policy, p. 1. Somewhat in contrast, the grand jury testimony, combined with the phone transcripts, depicts a professional in crisis, struggling to meet payroll, keep his business afloat, and extricate himself from a civil contempt incarceration due to nonpayment of child support.

The Commonwealth presented excerpts from Dr. Stirlacci's jailhouse phone calls to persuade the grand jury that his focus on generating bills to increase accounts receivable gave his medical practice a criminal veneer. Yet, allowing that this profit motive existed, as the court must, it hardly serves to undermine the legitimacy of Dr. Stirlacci's enterprise; indeed, a profit

motive is one of several motives shared by most physicians. Most of the Prescribing Policy factors, particularly items (2)-(5) and (7), go much further, tending to describe a physician that seeks a profit by 'pushing' or supporting illicit drug use. See, e.g., Prescribing Policy, p. 1 (providing in final, catch-all, factor that lack of good faith is supported by "other circumstances that demonstrate that the physician knew that the drugs were not intended to be used for a therapeutic or medical purpose"). Unless one is to speculate that an inability to see patients, combined with a circumstantial interest in billing them for non-medical treatment, is indicative of a disinterest in treating patients, none of these factors are supported by the evidence presented to the grand jury. See *Jansen*, 459 Mass. at 28 (indictment should not be product of "conjecture or guesswork").

The remaining "Legitimate Medical Practice" factors are (1) a "failure to follow at least minimum professional procedure," or factor (6) "actions indicating lack of interest in follow-up care." The question is whether the evidence could have supported a belief that either factor was met, in turn warranting belief that Dr. Stirlacci acted in bad faith. See *DePace*, 442 Mass. at 744.

As might be expected, "minimum professional procedure" is not defined by the Prescribing Policy. Nor has the Board set forth a definition in any of its other publicly available policies. That is to say, the Board could have required physicians to see and examine patients in order to renew controlled substances prescriptions, but it has not done so. The Board's regulations, however, indicate that a "non-professional assistant" may perform certain services "appropriate to the assistant's skill," so long as the assistant does not practice medicine. 243 Code Mass. Regs. § 2.07 (4). The grand jury heard no testimony that Ms. Miller actually treated the patients, nor is there any indication that she did so in the phone transcripts or the billing

information.[20] Quite to the contrary, even Nurse Rivers represented in her police statement that, as a matter of office policy, patient progress notes were accompanied by Dr. Stirlacci's signature if they did not bear her own. Further, the phone transcripts document Dr. Stirlacci fretting about patient abandonment and Ms. Miller cancelling days' worth of appointments when Nurse Rivers would no longer come into the Agawam office. The only reasonable inference is that Ms. Miller only handled renewals, and only at the request of Dr. Stirlacci as his agent. Given that there was no evidence to the contrary, and that a physician can be expected to be away every now and then while patients must renew their prescriptions, the evidence was insufficient to warrant the grand jury's belief that Dr. Stirlacci's conduct fell below "minimum professional procedure." See *Bond*, 375 Mass. at 210 (probable cause requires "something definite and substantial").

The evidence similarly failed to show Dr. Stirlacci displayed a lack of interest in follow-up care. The Prescribing Policy provides that this factor looks to "[f]ailure to schedule appropriate additional appointments for return visits and other factors indicating a lack of interest in follow-up care." Prescribing Practices, p.1. While this may be a closer issue than the other factors, especially where the Commonwealth focused its grand jury presentation on Dr. Stirlacci's billing motive, a finding of probable cause still required an unfounded assumption by the grand jury. That is, any conclusion that Dr. Stirlacci was disinterested in his patients that could be founded in his attempts to process insurance payments during his detention requires still further proof that the patients his office saw during his absence required his medical care. There

[20] Of the several hundred pages of medical documents presented to the grand jury, one page in Exhibit 17 is suggestive of someone having diagnosed a patient during Dr. Stirlacci's absence. The document, which appears to have been created by an insurer to summarize billing information provided to a claims investigator, reports "Diagnosis's [sic] made by Stirlacci," including one for Chronic Pain Syndrome on April 23, 2015. The prescription received by the patient in question, however, was for "LBP," or low back pain, rather than simply "pain." See, e.g., *Arruda* v. *Barnhart*, 314 F. Supp. 2d 52, 63 (D. Mass. 2004) (altering DDS examiner's "LBP" notation by inserting "[low back pain]"). Thus, even if the grand jury had reviewed this document and inferred that Ms. Miller improperly diagnosed a patient, that conclusion does not bear upon the office's prescription-writing practices.

was, however, no information as to whether the patients seen and billed by office staff needed specific medical care, as opposed to a cursory renewal authorization. Indeed, the Commonwealth's own witness testified: "Each patient has a different history, sir, I wouldn't want to comment on a specific patient." (Volume I, Minutes p. 28). The grand jury would have needed to have speculated about patient needs not evident on the record to believe that Dr. Stirlacci fell short of this factor. Accordingly, the Commonwealth failed to present sufficient evidence to support the "Legitimate Medical Practice" element of its unlawful prescriptions indictments. See *Janson*, 459 Mass. at 28.

B. Usual Course of Practice

The Prescribing Policy defines "In the Usual Course of a Practitioner's Practice" as requiring a "physician-patient relationship that is for the purpose of maintaining the patient's well-being" with respect to which the physician conforms "to certain minimum norms and standards for the care of patients." Prescribing Policy, p.2. This, in turn, requires: proper diagnosis and regimen of treatment; an appropriate exam and history on first visit; prescribing controlled substances with proper regard for their potential danger; and maintaining appropriate records. The Board notes: "Physicians who have been disciplined by the Board for prescription practice violations have written prescriptions for potentially dangerous substances without conducting any physical examinations or after conducting only cursory examinations." *Id.* Still, the Prescribing Policy nowhere indicates that, to comport with the usual course of practice, a physician must see and examine each patient who comes in to renew a prescription for controlled substances.

There was no evidence before the grand jury that any of the patients seen during Dr. Stirlacci's absence, or any of the patients seen at any time in the Agawam office, fell outside the

auspices of a physician-patient relationship. In fact, the grand jury only heard testimony involving renewals of medication, which implies a previously-existing physician-patient relationship. Looking to the norms identified by the Board, there was little evidence before the grand jury regarding whether the patients in question received proper diagnosis and treatment, underwent an appropriate exam and history on their first visit, acquired undue controlled substances, or lacked a thorough medical record. As noted, Trooper Martin refused to present evidence on the circumstances of individual patients. (Volume I, Minutes p. 28). I note that, amid the medical records offered to the grand jury, which are largely confined to April and May, 2015, there is evidence of first-time visit workups, drug addiction prevention, and treatment notes—some of which occurred months and years before the period during which Dr. Stirlacci was incarcerated. (See G.J. Exhibit 6; G.J. Exhibit 26). Since there was no evidence at all showing that Dr. Stirlacci acted outside the usual course of the physician-client relationship when authorizing the renewals in question, the grand jury did not have probable cause on that element of the offense, and the indictments accordingly must fail. See *Bond*, 375 Mass. at 210.

C. Conclusion – Improper Prescription Counts

Dr. Stirlacci's decision to instruct Ms. Miller to renew controlled substances prescriptions when he was unavailable to consult with the patients suffices to raise eyebrows. This was not, however, conduct sufficient to support an indictment under § 19 (a), of the Act. Compare *Kobrin*, 72 Mass. App. Ct. at 605-606 (insufficient evidence to support unlawful prescription convictions: defendant did not prescribe "at intervals overlapping prior prescriptions or between office visits;" he did not write new prescriptions to replace those lost or stolen; he did not exceed the recommended dosage range; defendant did not suggest "different or distant pharmacies to avoid detection by the authorities;" his patients did not abuse, sell, or lie about the prescribed

medication; the defendant did not make "incriminating statements regarding his prescribing practices;" and he did not supply patients with "unmarked or illicit drugs or other controlled substances"), citing *Miller*, 361 Mass. at 648-649; *Comins*, 371 Mass. at 233; *Arthurs* v. *Board of Registration in Med.*, 383 Mass. 299, 305-309 (1981); *Pike*, 430 Mass. at 319; *Lozano*, 5 Mass. App. Ct. at 872-873; and *De La Cruz*, 15 Mass. App. Ct. at 305-306 & n.1. Contrast *Comins*, 371 Mass. at 233 (defendant's conduct "was not in accord with accepted medical practice" where he "took no medical histories and conducted no physical examinations"). See also *State* v. *Naramore*, 965 P.2d 211, 222-224 (Kan. Ct. App. 1998) (reversing criminal conviction and quoting American Osteopathic Association's amicus position that "[c]riminal responsibility should attach only to those physicians whose mistakes are egregious or who demonstrate a gross level of incompetence or indifference in their treatment").

In sum, "[t]he inference that [Dr. Stirlacci] exercised independent medical judgment is [far more] compelling [than] the inference that he issued prescriptions on request without legitimate medical purpose." See *Eramo*, 377 Mass. at 912. Since the evidence presented to the grand jury necessitated "conjecture or guesswork" in order to "choose between alternative inferences," dismissal of the unlawful prescription counts is appropriate. *Jansen*, 459 Mass. at 28. The corresponding indictments against Ms. Miller fail for the same reasons.

2. False Prescriptions – G. L. c. 94C, § 33 (b)

General Laws c. 94C, § 33 (b), provides, "[n]o person shall utter a false prescription for a controlled substance, nor knowingly or intentionally acquire or obtain possession of a controlled substance by means of . . . fraud, deception or subterfuge, including but not limited to the forgery or falsification of a prescription or the nondisclosure of a material fact in order to obtain a controlled substance from a practitioner." See *Commonwealth* v. *Carillo*, 2015 Mass. App.

Unpub. LEXIS 497 *4-5 (Mass. App. Ct. 2015) (Rule 1:28 decision) ("The elements of the crime of uttering a false prescription for a controlled substance are (1) offering as genuine; (2) a prescription for a controlled substance; (3) known to be false. Cf. *Commonwealth* v. *O'Connell*, 438 Mass. 658, 663 . . . (2003)").

The parties focus their arguments on whether the evidence before the grand jury supported the requisite intent to defraud. While the evidence of intent to defraud, both direct and circumstantial, is slight enough that the court could dismiss the indictments for that reason alone, the indictments are more properly dismissed because there was no evidence that the prescriptions were "false." G. L. c. 94C, § 33 (b). As discussed, the evidence before the grand jury only described the prescriptions issued by Dr. Stirlacci's office as renewals. A prescription renewal, authorized by the practitioner, simply cannot be a "false prescription."

There are no published cases enforcing this statute against physicians in Massachusetts, and recourse to the Commissioner of Public Health's regulations on prescriptions yields no requirement that a practitioner be present and actually sign the prescription. See 105 Code Mass. Regs. § 721.000, *et seq* (establishing "the standards for format and security in the Commonwealth that all prescriptions issued by practitioners or reduced to writing by pharmacists must meet in order to comply with M.G.L. c. 112, § 12D and c. 94C"). The renewals, therefore, were not "false prescriptions." Cf. *Brown*, 456 Mass. at 725 ("If the physician issued the prescription for a legitimate medical purpose, or believed that he did so because his patient deceived him, G. L. c. 94C, § 33 (b), the physician has not 'distributed' under the drug statutes"). Compare, e.g., *Marshall* v. *Inspector General*, DAB No. CR2274 (2010) (H.H.S.), 2010 WL 5677028, *1 (Oct. 22, 2010) (Health and Human Services decision excluding registered nurse from participating in Medicare where she pleaded guilty to G. L. c. 94C, § 33 (b), having "forged

the name of a physician on the prescriptions," and "used the forged prescriptions to purchase controlled substances" for her own consumption).

The Commonwealth argues that "ample evidence of forgery and fraud exists," including "evidence of falsification," and points to the fact that prescriptions were issued by Dr. Stirlacci when he was not in the office. But close scrutiny of the statute reveals that forgery, fraud and falsification are only relevant if the target "knowingly or intentionally acquire[d] or obtain[ed] possession" of controlled substances. G. L. c. 94C, § 33 (b). Otherwise, the statute only criminalizes "utter[ing] a false prescription for a controlled substance." Since there is no suggestion that Dr. Stirlacci or Ms. Miller actually acquired or obtained possession of controlled substances, and since there is no evidence that either of them uttered a "false prescription," the false prescription indictments must be dismissed. *McCarthy*, 385 Mass. at 163.

3. False Health Care Claims – G. L. c. 175H, § 2

General Laws c. 175H, § 2, in pertinent part, penalizes knowingly and willfully making or causing to be made a false statement of a material fact in a health bill. See G. L. c. 175H, § 2 (1), (2).[21] "False" is defined to mean "wholly or partially false, fictitious, fraudulent, untrue or deceptive." G. L. c. 175H, § 1. The Commonwealth posits that the defendants falsely

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[21] The full text of the statute provides:

> Any person who (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for a payment of a health care benefit; or (2) knowingly and willfully presents or causes to be presented an application for a health care benefit containing any false statement or representation of a material fact; or (3) knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to a health care benefit, including whether goods or services were medically necessary in accordance with professionally accepted standards; or (4) having knowledge of the occurrence of any event affecting his initial or continued right to any health care benefit, conceals or fails to disclose such an event with an intent to fraudulently secure such benefit either in a greater amount than is due or when no such benefit is due; or (5) having knowledge of the occurrence of any event affecting the health care benefit of any other individual in whose behalf he has made or presented an application for such benefit, or in whose behalf he is receiving any health care benefit, conceals or fails to disclose such an event with an intent to fraudulently secure such benefit either in a greater amount than is due or when no such benefit is due, shall be punished . . . .

G. L. c. 175H, § 2.

misrepresented the material fact "that patients receiving prescriptions had seen Stirlacci when in fact they did not" resulting in "billing health care providers for these 'visits.'" Commonwealth's Memorandum of Law in Opposition to Defendant [Miller's] Motion to Dismiss, p. 5.

Trooper Martin presented evidence relating to twenty-two patients who visited Dr. Stirlacci's office during the time he was incarcerated. (Volume I, Minutes, pp. 17-24; Volume II, Minutes, pp. 3-26; G.J. Exhibits 5-26). Of these patients, all were billed for an office visit. (*Id.*) Although Trooper Martin explained that "putting charges in" meant to charge patients "as if they were seen by a doctor," (Volume I, Minutes p. 13), it was not clear if he meant that a billed "office visit" necessarily connotes a visit with the doctor. In fact, of the five patients discussed on the first day of grand jury testimony, Trooper Martin said they each had simply been billed for an "office visit." (Volume I, Minutes pp. 14-24). On the second day of testimony, the first patient mentioned, K.B., was seen on April 23, 2015, and Trooper Martin testified that Patient 10 was billed as having been "seen by the Doctor." (Volume II, Minutes pp. 3-4). The next three patients were billed only for an "office visit," according to Trooper Martin. (Volume II, Minutes pp. 4-8). Trooper Martin told the grand jury that the remaining thirteen patients were billed either for an "office visit with/from Dr. Stirlacci," or, more usually, as having been "seen by Dr. Stirlacci." (Volume II, Minutes pp. 8-26). Since the grand jury was only told that fourteen of the twenty-two patients were billed for having seen Dr. Stirlacci, as opposed to merely an office visit, the indictments based on billing the insurers for visits by the remaining eight patients lack evidentiary support. *McCarthy*, 385 Mass. at 163. This conclusion is buttressed by a portion of the phone transcripts Trooper Martin read aloud to the grand jury in which Dr. Stirlacci told Ms. Miller to bill differently for renewals "because they didn't see the doctor, so it's down charged." (Volume I, Minutes p. 11).

Still, the court must consider whether these eight false health claim indictments could have been supported by facts and reasonable inferences drawn from anywhere in the evidence. *DePace*, 442 Mass. at 744. The insurance documentation in Grand Jury Exhibits 5-26, corresponding to each patient, does not include any affirmative representation from either defendant that Dr. Stirlacci was present for a face-to-face meeting. Rather, the billing paperwork represents Dr. Stirlacci as "Service Provider," and lists a procedure code next to his name. Of the twenty-two patients for whose billing Dr. Stirlacci and Ms. Miller stand indicted, at least eighteen were billed under either code number 99212 or 99213.[22] (See G.J. Exhibits 5-11, 13, 16-18, 20-26). The Commonwealth's witness did not explain what these codes mean, but the grand jury could have noted that the codes correspond with Dr. Stirlacci's instructions to Ms. Miller, which Trooper Martin read to the grand jury (See Volume I, Minutes p. 11 (instructing her to bill under the "99212" code "because [patients picking up renewal prescriptions] didn't see the doctor, so it's down charged;" "So, it's a 92 or a 93")). Faced with this testimony directly bearing upon the meaning of the service codes, the grand jury could not have believed that this billing paperwork, alone, constituted an expression to the insurer that Dr. Stirlacci was present for each patient's examination. The fact that Trooper Martin represented these bills as only seeking remuneration for an "office visit," as opposed to a visit with Dr. Stirlacci, would have further undermined any inference to the contrary. See *DePace*, 442 Mass. at 744.

As far as the remaining medical and insurance documentation, the grand jury may have gleaned that Dr. Stirlacci's office forwarded progress notes when billing for services to his Health New England patients, a practice that continued during his absence. The progress notes attached in Exhibit 26, for a Medicare patient, include several examples of notes presumably

[22] The service codes for two patients are not reflected in the exhibits (see G.J. Exhibits 12, 14), one patient's billing information could not reviewed by the court (G.J. Exhibit 19 appears to be missing), and one patient was billed under several other codes. (See G.J. Exhibit 13 (patient billed under code numbers 90471, 90715, 99214)).

composed and written by Dr. Stirlacci. (See, e.g., G.J. Exhibit 26, progress notes from January 12, 2016). The format and handwriting style of these notes correspond with the progress notes submitted to Health New England, for dates on which Dr. Stirlacci was in jail in Kentucky. (See G.J. Exhibit 9 (progress note for Patient 9, dated May 7, 2015); G.J. Exhibit 10 (progress note for Patient 10, dated April 23, 2015); G.J. Exhibit 11 (progress note for Patient 11, dated May 7, 2015). See also G.J. Exhibit 26 (handwritten note dated May 10, 2015, ostensibly by Dr. Stirlacci, with respect to April 22, 2015 prescription: "Reviewed chart," "agree w standing order," and "low risk").[23] The grand jury could therefore have inferred that Health New England considered the facts of the physician's examination to be material to the medical claim, and that Dr. Stirlacci supplemented notes at some later date, impliedly misrepresenting to Health New England that he saw the patients in question. Accordingly, the grand jury had an independent ground for probable cause to believe that Ms. Miller at Dr. Stirlacci's request misrepresented that he was present for office visits with Patient 10 on April 23, 2015, and Patients 9 and 11 on May 7, 2015.[24] As a result, the total false health care indictments supported by probable cause now numbers sixteen: the fourteen counts based on patient bills that, according to Trooper Martin's testimony, represented the patient had seen Dr. Stirlacci, which include one count based on Patient 10's bills; and two additional counts based on invoices for Patients 9 and 11, as independently supported by analysis of the medical and insurance paperwork.

[23] Grand Jury Exhibit 26 does not contain a progress note for the visit during Dr. Stirlacci's absence; the handwritten notes dated May 10, 2015, can only be read to imply that he did not actually examine the patient.

[24] It would, however, be speculative to conclude that, because progress notes were material to Health New England, a physician's presence is material to the remaining insurance companies. The fact is that the exhibits unsupported by progress notes far outnumbered those with notes attached; thus, apart from some of Trooper Martin's testimony, there is no reason to believe the other insurance companies viewed progress notes or physician presence as material. Accordingly, the court cannot conclude that the grand jury's potential recourse to the Health New England progress notes to find probable cause that Dr. Stirlacci deceived Health New England could have yielded probable cause to believe he defrauded the other insurance companies.

Of the sixteen false health claim indictments predicated on billing for certain patients, four, Patients 16, 18, 20, and 26, were seen on April 22, 2015; five, Patients 10, 17, 19, 21, and 23, were seen on April 23, 2015; two, Patients 14 and 25, were seen on May 6, 2015, and five, Patients 9, 11, 15, 22, and 24, were seen on May 7, 2015. Of course, the grand jury indictments only list the dates, without any patient identification; thus: seven counts are linked with April 22, 2015, five list April 23, 2015, two occurring on May 6, 2015, and eight on the date of May 7, 2015. Based on this review, the court has no means to determine which of the April 22, 2015, and May 7, 2015, indictments should remain, and which should be stricken for lacking evidence supporting a false material fact by the defendants.

While there is no doubt that three of the seven April 22, 2015, counts and three of the eight May 7, 2015, counts should be dismissed as lacking any support in the evidence, see *McCarthy*, 385 Mass. at 163, the question is whether the indictments are so ill-defined as to be fungible, permitting the court to dismiss some while retaining others, without violating the defendants' constitutional rights. See *Commonwealth* v. *Barbosa*, 421 Mass. 547, 551 (1995) ("It is a rule of the common law, as well as a provision of the Constitution of this Commonwealth, that no one shall be held to answer, unless the crime with which [the Commonwealth intends] to charge him is set forth in the indictment with precision and fulness; and this rule is not to be defeated by allowing the defendant to be convicted upon evidence of another offence of the same kind, committed on the same day, but not identical with it"), quoting *Commonwealth* v. *Dean*, 109, Mass. 349, 352 (1872). It may well be the case that the court could simply dismiss a number of the April 22, 2015, and May 7, 2015, false health care counts and designate the remaining counts as pertaining to those patients' bills whose falsity was supportable by Trooper Martin's testimony or the Health New England notes, as the case might

be. However, in an abundance of caution, the court will, sua sponte, order the Commonwealth to file a bill of particulars with respect to all of the false health care claims counts. See Mass. R. Crim. P. 13 (b) (1). The counts in question are: the April 22, 2015, counts 28, 41, 43, 48, 52, 56, and 68; the April 23, 2015, counts 37, 50, 54, 58, and 62; the May 6, 2015, counts 45 and 66; and the May 7, 2015, counts 29, 31, 33, 35, 39, 46, 60, and 64.[25] In its bill, the Commonwealth shall indicate the "manner, or means" of the crime charged by denoting the subject patients (by reference to their corresponding grand jury exhibit to preserve their anonymity). On receipt of the Commonwealth's filing, the court will dismiss those counts for which the patient's bills bore no suggestion of material falsity on the evidence presented to the grand jury.

Before concluding, the court turns to Ms. Miller's argument that she cannot be held criminally liable for the false health care claims because she lacked the requisite intent. She argues that, rather than "knowingly and willfully" making a false statement of fact on the bill, she merely "follow[ed] [the] Doctor's orders." Memorandum of Law in Support of Defendant [Miller's] Motion to Dismiss, p. 14. She suggests that, under *Kobrin*, 72 Mass. App. Ct. 589 (2008), even if she acted unreasonably, evidence of her poor decision is insufficient to support her indictments. The Commonwealth essentially responds that, regardless of Ms. Miller's quality of decision-making, she still knowingly and willfully made a false statement, which suffices to support an indictment under the plain language of the statute. See G. L. c. 175H, § 2.

The Commonwealth has the better argument. The evidence before the grand jury tended to show that Ms. Miller, at Dr. Stirlacci's request, represented to insurance companies that he was present when he was not present. That evidence sufficed to support certain indictments charging Ms. Miller with submitting false health care claims. See *id.* Ms. Miller's concerns are

[25] To be clear, all of the indictments alleging false health care claims occurring on April 23, 2015, and May 6, 2015, appear to be supported by probable cause. Further particularity on these counts is ordered only for purposes of clarity at trial.

well taken, but they do not add up to a flaw in the indictments; rather, they suggest an affirmative defense, that is, "one that may negative guilt by cancelling out the existence of some required element of the crime." *Grouse*, 461 Mass. at 805, quoting 1 W.R. LaFave, Substantive Criminal Law § 1. 8(c) (1986). Accordingly, Ms. Miller's theory or theories in support of her innocence belong before the factfinder at trial and cannot be resolved at this stage, which merely tests whether the Commonwealth presented "sufficient evidence to establish he identity of the accused . . . and probable cause to arrest [her]." *Gonzalez*, 462 Mass. at 463, quoting *McCarthy*, 385 Mass. at 163.

4. Grand Jury Integrity

Dr. Stirlacci alternatively argues that the Commonwealth procured its indictments by presenting false or deceptive evidence to the grand jury. See *Salman*, 387 Mass. at 166. Specifically, Dr. Stirlacci contends that the prosecutor was duty-bound to elicit a fuller response from Trooper Martin when a grand juror asked about whether the prescriptions were for "ongoing therapy." (Volume I, Minutes p.28) Trooper Martin had responded that he did not want to get into each patient's particular history. (*Id.*) He later conceded that the prescriptions were for ongoing therapy. (*Id.*)

For such evidence to warrant a dismissal, the Commonwealth must have known it was false or submitted it with a "reckless disregard for the truth." *Mayfield*, 398 Mass. at 621. Dismissal is unwarranted on this ground because Trooper Martin's response to the grand juror's inquiry was accurate. At any rate, the claims that survive the defendants' *McCarthy* motions are rooted in Trooper Martin's representation that the defendants billed for certain examinations by Dr. Stirlacci when he was not in fact present. Dr. Stirlacci has not presented any evidence tending to show that this representation by Trooper Martin was untrue. Accordingly, he has not

met his burden to show that the integrity of the grand jury was impaired. See *Salman*, 387 Mass. at 166.

ORDER

For the reasons set forth above, the defendants, Frank Stirlacci and Jessica Miller's, Motions to Dismiss are **ALLOWED** with respect to the G. L. c. 94C, § 19 (a), indictments (counts 1-26), the G. L. c. 94C, § 33 (b), indictments (counts 27, 30, 32, 34, 36, 38, 40, 42, 44, 47, 49, 51, 53, 55, 57, 59, 61, 63, 65, and 67), and with respect to certain of the G. L. c. 175H, § 2, indictments, to be resolved by this court on receipt of the Commonwealth's bill of particulars. In all other respects, the defendants' motions are **DENIED**.

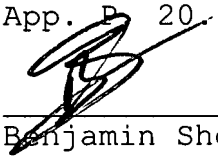
No later than December 4, 2017, the Commonwealth shall file a bill of particulars with respect to the false insurance claims indictments: the April 22, 2015, counts 28, 41, 43, 48, 52, 56, and 68; the April 23, 2015, counts 37, 50, 54, 58, and 62; the May 6, 2015, counts 45 and 66; and the May 7, 2015, counts 29, 31, 33, 35, 39, 46, 60, and 64. See Mass. R. Crim. P. 13 (b) (1). In its bill, the Commonwealth shall indicate the "manner, or means" of the crime charged by denoting the subject patients, identified as Patient #, where the number shall match the grand jury exhibit corresponding with that patient's medical information.

Mark D Mason
Justice of the Superior Court

DATE: November 28, 2017

MASS. R. APP. P. 16(k) CERTIFICATE OF COMPLIANCE WITH THE RULES PERTAINING TO THE FILING OF BRIEFS

I hereby certify, as required by Mass. R. App. P. 16(k), that this brief complies with the rules of court that pertain to the filing of briefs, including, but not limited to, the following: Mass. R. App. P. 16(a)(1-8); Mass. R. App. P.16(d)-(h); Mass. R. App. P. 18; and Mass. R. App. P. 20.



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CERTIFICATE OF SERVICE

I hereby certify, under the pains and penalties of perjury, that today I served copies of the Commonwealth's Brief upon the following attorneys for the defendants by first-class mail:

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COMMONWEALTH OF MASSACHUSETTS
APPEALS COURT

NO. 2018-P-0353

COMMONWEALTH OF MASSACHUSETTS,
Appellant

V.

FRANK STIRLACCI AND ANOTHER,
Defendant-Appellee

BRIEF FOR THE COMMONWEALTH ON APPEAL FROM AN ORDER OF THE HAMPDEN COUNTY SUPERIOR COURT DEPARTMENT ALLOWING THE DEFENDANTS' MOTIONS TO DISMISS

HAMPDEN COUNTY
