State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
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September 10, 2025

Case number: 25-CRF-0146

William Damm, M.D.
2940 Cranage Rd.
Olmsted Falls, OH 44138
dammw@ccf.org

Dear Doctor Damm:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke or suspend your license or certificate, or refuse to grant or register or issue the license or certificate for which you have a pending application in accordance with Section 9.79 of the Ohio Revised Code, or refuse to renew or reinstate your license or certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) In the routine course of your practice, from in or around March 2018, to in or around November 2022, you utilized controlled substances in your treatment of Patients 1 through 5, as listed in the Patient Key. [Patient Key is confidential and not subject to public disclosure.] You inappropriately prescribed dangerous drugs to, treated and/or failed to appropriately treat, and/or failed to appropriately document your treatment of these patients.

Specific examples of such conduct and care to the six patients include, but are not limited to, the following:

(a) You treated Patient 1 from in or around August 2016, to at least in or around March 2020. Patient 1 presented with neck pain, headache, back pain, abdominal pain, nervous behavior, hypertension, and hyperlipidemia. Patient reported taking Zoloft 50 mg daily, Lopressor 50 mg twice daily, Naprosyn 375 mg daily, Xanax I mg twice daily as needed, and Percocet 5/325 ever 8 hours as needed. You increased Patient 1's Percocet prescription to four times a day as needed at this initial visit. No urine drug screen was obtained or documented in the record. The physical exam was substandard for the numerous complaints with which the patient presented and the medications she was prescribed. There was inadequate diagnostic testing for Patient 1's physical complaints. No referral to physical therapy was made.

Between November 30, 2018 and March 5, 2020, you prescribed Patient 1 1,860 Xanax tablets and 2,310 Percocet tablets. On or about September 12, 2019,

Patient 1 was administered a drug screen, which was negative for oxycodone, despite the high daily dose she was supposed to be taking. Your prescribing of Percocet continued. An Ohio Automated Reporting Rx Reporting System [OARRS] indicated Patient 1 was utilizing multiple pharmacies and multiple prescribers. You failed to include any consult with physical therapy or surgery in the entire record and continued prescribing oxycodone despite the possible red flags for abuse.

(b) You treated Patient 2 from in or around November 2018, to at least in or around March 2020. Patient 2 presented to you with hardware in the lower back from a prior fusion. You diagnosed the patient with chronic low back pain without sciatica. You ordered radiology and pain medication. The radiologist recommended consult with a spine specialist. You failed to order or failed to document ordering Patient 2 to a spine specialist. You began the patient on oxycodone ER 20 mg four times a day. You also diagnosed Patient 2 with attention deficit hyperactivity disorder (ADHD) and began her on Strattera. You failed to conduct or failed to document conducting standard psychiatric testing to determine diagnosis.

You treated Patient 2 long term with schedule II opiates without proper diagnostic testing. You ignored specialists including a radiologist who recommended a spine specialist, and an orthopedist who noted that Patient 2's pain was out of proportion to findings. You failed to check the Ohio Automated Rx Reporting System [OARRS] and failed to document conducting urine screens.

(c) You treated Patient 3 from in or around May 2016, to at least in or around January 26, 2020. Patient 3 presented with a complaint of chronic gastrointestinal [GI] pain. You failed to order diagnostic testing. You treated the patient's GI pain with oxycodone. You failed to attempt or failed to document attempting other means of which to treat Patient 3's GI symptoms. An OARRS check showed Patient 3 had seen twenty-two providers in about twelve months' time. This was a red flag for possible drug abuse. Throughout the course of Patient 3's treatment, Patient 3 made calls for early refills, a red flag for drug abuse. Patient 3 developed a complaint of insomnia, and you prescribed lorazepam in addition to oxycodone. Patient 3 asked to be prescribed more tramadol in order to take less oxycodone, and you prescribed tramadol. However, Patient 3 continued asking to refill the oxycodone at the same dosage level. This discrepancy in Patient 3's behavior was not noted in the chart, nor did you document talking to Patient 3 about it. Patient 3 had toxicology screens that were negative for oxycodone, but you continued to prescribe oxycodone. This is another red flag for abuse. On March 3, 2018 you informed Patient 3 by letter that you would no longer prescribe her controlled substance pain medication. On March 19, 2018, you continued prescribing Patient 3 oxycodone. You failed to properly check or evaluate OARRS.

(d) You treated Patient 4 from in or around July 2015 through at least in or around February 2020. The patient presented initially with chief complaints including muscle weakness/pain, diabetes, lower back pain, and nervous behavior. You diagnosed Patient 4 with hypertension, anxiety, and arthralgia in the patient's lower back. You began Patient 4 on medications, including prednisone, alprazolam, and oxycodone. At the next month's visit, you noted "Unable to refill percoset as patient

saw pain mgmt., and they recommend against chronic opiate medication." You checked OARRS on or about September 17, 2015, and refilled the alprazolam. On October 23, 2015, you refilled Patient 4's oxycodone. You failed to document a medical need for this medication. You failed to document how you resolved the pain consult opinion that he did not need this medication. The physical exam that you conducted did not support prescribing oxycodone.

On or about November 23, 2015, your medical assistant noted that the patient was not experiencing pain. However, you authorized another oxycodone fill. On or about July 5, 2016, the medical assistant documented Patient 4 not experiencing pain. The patient's drug screen was negative for oxycodone. You authorized another oxycodone refill on August 2, 2016. On or about December 1, 2016, Patient 4's urine drug screen was negative for alprazolam. You called in a refill of Patient 4's alprazolam on January 11, 2017.

You sent Patient 4 a letter in August 2018, informing him that you would have to discuss the efficacy of using opiates to treat pain long term. At Patient 4's September 2018 appointment, you prescribed another three months of 100 tablets of oxycodone per month and continued thereafter until at least the February 2020.

(e) You treated Patient 5 from in or around September 22, 2014 to on or about September 18, 2019. She presented at initial visit on September 22, 2014 with a wrist problem, which you diagnosed as De Quervain's syndrome (tenosynovitis). You prescribed hydrocodone-ibuprofen 20 tablets, with one refill. You diagnosed Patient 5 with anxiety and prescribed alprazolam. You failed to conduct or failed to document conducting psychiatric assessment to support prescribing benzodiazepines. You denied Patient 5 a refill for this hydrocodone prescription on or about October 10, 2014, as you noted a refill was not appropriate. You started Patient 5 back on hydrocodone at her repeated request in 2016, this time for low back pain/sciatica. You increased at Patient 5's request her alprazolam dosage, as one tablet three times daily became necessary. You diagnosed Patient 5 with a "concentration deficit" and started the patient on Vyvanse, eventually increasing the dosage to 40 mg daily. You failed to conduct or failed to document conducting psychiatric assessment to support prescribing schedule II stimulants to this patient, who you were already being prescribed benzodiazepines and opiates.

On or about May 2, 2016, you started Patient 5 on Soma, in addition to hydrocodone, alprazolam, and Vyvanse. Patient 5 called for early refills and with concerns about running out early, which are red flags for abuse. You increased Patient 5's dosage of Vyvanse on or about her August 2016 visit to 60 mg, due to her reports of "crashing" after her Vyvanse. On or about September 2016, Patient 5 called to say the increase of Vyvanse was working at first, however, she had begun "crashing" during the day. She asked for a dosage increase. You increased dosage to 70 mg. On or about November 29, 2016, Patient 5 was seen by another practitioner and denied narcotics. Patient 5 called on or about December 28, 2016 to ask for more refills on her Vyvanse and alprazolam due to theft. Between April 2017 and September 2018, you ordered refill medications for Patient 5 despite not seeing her in your office during that time. There is no documented reason for this

failure to conduct an office visit with this patient. You failed to properly check and evaluate OARRS.

Your acts, conduct, and or/ omissions in paragraphs (1)(a) through (1)(e) above, individually or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as that clause is used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1)(a) through (e) above, individually and/or collectively, constitute a "departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Additionally, your acts, conduct, and/or omissions that occurred on or after December 31, 2015, as alleged in paragraphs (1)(a), (b), and (c) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02, Ohio Administrative Code, "General provisions." Furthermore, a violation of any provision of this rule, as determined by the Board, shall constitute any or all of the following: "failure to maintain minimal standards applicable to the selection or administration of drugs," as that clause is used in division (B)(2) of section 4731.22 of the Revised Code; and "a departure from, or the failure to conform to, minimal standards of care of similar physicians under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

Additionally, your acts, conduct, and/or omissions as alleged in paragraph (1)(e) that occurred on or after December 31, 2015 to the present, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-03, Ohio Administrative Code, "Utilization of anabolic steroids, schedule II controlled substance cocaine hydrochloride, and schedule II controlled substance stimulants." Furthermore, a violation of any provision of this rule, as determined by the Board, shall constitute any or all of the following: "failure to maintain minimal standards applicable to the selection or administration of drugs," as that clause is used in division (B)(2) of section 4731.22 of the Revised Code; and "a departure from, or the failure to conform to, minimal standards of care of similar physicians under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

Additionally, your acts, conduct, and/or omissions that occurred on or after December 31, 2015, as alleged in paragraphs (1)(a), (b), (c), and (e) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Standards and Procedures for Review of "Ohio Automated Rx Reporting System" (OARRS), Rule 4731-11-11, Ohio Administrative Code, as currently in effect.

Additionally, your acts, conduct, and/or omissions as alleged in paragraphs (1)(a), (c), and (e), which occurred on or after December 31, 2015, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-14, Ohio Administrative Code, "Prescribing for subacute and chronic pain."

Furthermore, for any violations that occurred on or after September 29, 2015, the Board may impose a civil penalty in an amount that shall not exceed twenty thousand dollars, pursuant to Section 4731.225, Ohio Revised Code. The civil penalty may be in addition to any other action the Board may take under section 4731.22, Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of service of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of service of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke or suspend your license or certificate, or refuse to grant or register or issue the license or certificate for which you have a pending application in accordance with Section 9.79 of the Ohio Revised Code, or refuse to renew or reinstate your license or certificate to practice medicine and surgery, or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant or issue a license or certificate to practice to an applicant, revokes an individual's license or certificate to practice, refuses to renew an individual's license or certificate to practice, or refuses to reinstate an individual's license or certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a license or certificate to practice and the board shall not accept an application for reinstatement of the license or certificate or for issuance of a new license or certificate."

Copies of the applicable sections are enclosed for your information.

STATE MEDICAL BOARD OF OHIO

Kim G. Rothermel, M.D.
Secretary

KGR/TCN
Enclosures

Via Email: dammw@ccf.org

IN THE MATTER OF
William Damm, M.D.

25-CRF-0146

September 10, 2025,
NOTICE OF OPPORTUNITY FOR HEARING – PATIENT KEY

SEALED TO PROTECT PATIENT CONFIDENTIALITY