BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

GEORGIA COMPOSITE MEDICAL BOARD, Petitioner,	:	Docket No.: OSAH-CSBME-PHY-1508993-31-Howells
v.	:	
PATRICIA BENTON, M D, Respondent.	:	

INITIAL DECISION

The Georgia Composite Medical Board ("Petitioner" or "Board") initiated this matter for the purpose of sanctioning Respondent's medical license. Specifically, Petitioner seeks the revocation of Respondent's medical license. The hearing was conducted on November 12, 2014 and January 27, 2015.[1] The record was held open until February 23, 2015, to allow the parties to submit written closing arguments.[2] For the reasons stated below, this tribunal finds that Respondent's medical license should be **REVOKED**.

Findings of Fact

1.

Respondent Patricia Benton is licensed to practice medicine in the State of Georgia. She has been licensed in this state since 1977. (Tr. 82).

[1] Although the hearing commenced in November of 2014, the second day of the hearing could not be scheduled until late January 2015, due to the parties' schedules.
[2] The record was initially held open until February 16, 2015; however, because of a delay in receiving the transcript, the deadline to submit closing arguments was extended to February 23, 2015.

2.

Respondent attended four years of undergraduate studies at Spellman College.[3] Thereafter, she attended Hahnemann Medical College in Philadelphia. She graduated from medical school in 1976. (Tr. 56-57). She completed an internship in internal medicine and a residency in radiology at the Drew School MLK Hospital in Los Angeles. She completed her residency in 1980. She has had no further formal medical training since her residency. During her residency, she did not have any courses in or engage in any practice that specialized in pain management. (Tr. 57).

3.

Respondent is not board certified in pain management. The only training she has had in pain management has been through continuing education courses or conferences. (Tr. 59-61, 82).

4.

After completing her residency, she practiced as a radiologist for approximately two years in California and then on a part-time basis in Georgia for another two years. (Tr. 118). Thereafter, it appears that Respondent practiced in the area of occupational medicine in the early 1980s and perhaps the 1990s.[4] (Tr. 63, 84). At some point, Respondent decided to get into the pain management business. (Tr. 63). She has worked at three pain management clinics: Suwanee Pain Management Clinic, Riverdale Medical Center, and Advanced Medical Health Services.[5] (Tr. 85; Exs. P-3, P-4).

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[3] Respondent did not obtain an undergraduate degree from Spellman College because there was a dispute over a course that she took at another college, which Spellman did not accept. She was admitted into medical school after her fourth year at Spellman. (Tr. 56).

[4] Respondent could not give a detailed chronology of all of the places she has worked over the years. (Tr. 84-85).

[5] The application for a license refers to the most recent facility as both "Advanced Medical Services, Inc." and "Advanced Medical Health Services." (Ex. P-11). The sign in front of the facility refers to the facility as "Advanced Medical Health Service, Inc." (Exs. P-1, P-2). The forms used by the clinic use the name "Advanced Medical Health Services, Inc." (*See e.g.*, Exs. P-14 at 1, P-15 at 70). The failure to use a consistent name for the facility raises doubts about the legitimacy of the facility as a serious medical clinic. For the sake of clarity, the undersigned will refer to the facility as Advanced Medical Health Services.

5.

Respondent worked at the Suwanee Pain Management Clinic between 2003 and 2005. (Tr. 88). Thereafter, between 2005 and 2011, she was the medical director and a practicing physician at Accident Injury Clinics of Atlanta ("AICA"). (Tr. 88-89). She left AICA to work at Riverdale Medical Center, where she remained until it was closed in 2013. (Tr. 90-91). She then went to work at Advanced Medical Health Services, around the middle of 2013. (Tr. 90-91, 201-202, 513).

6.

While she was working at the Suwanee Pain Management Clinic in 2003 and 2004, Respondent's treatment of several patients became the subject of an investigation by the Board. Ultimately, on April 1, 2010, a Public Consent Order was docketed in which Respondent admitted that when she practiced pain management medicine at the Suwanee Pain Management Clinic: (a) there was inadequate documentation in her patients' records of any type of physical examination beyond a cursory observation of the patient's general appearance; (b) there was inadequate physician documentation regarding side effects and tolerance [of medications]; (c) there was no documentation in her patient records to support large prescriptions of controlled medications; (d) the documentation in her patients' charts was substandard due to the extreme brevity and incompleteness of the notes; and (e) treatment plans were not documented in her patients' records. (Ex. P-4).

7.

Respondent agreed that her conduct constituted sufficient grounds for the imposition of discipline upon her license to practice as a physician in the State of Georgia pursuant to O.C.G.A. Chs. 1 and 34 [of Title] 43, as amended. (*Id.*)

8.

The Board imposed the following sanctions upon Respondent's license to practice as a physician in the State of Georgia: (a) Respondent was required to maintain a contemporaneous log of all controlled substances prescribed, administered, dispensed, or ordered by Respondent, and make such log available for inspection; (b) prior to prescribing, administering, ordering, or dispensing any controlled substance, Respondent was required to detail fully the examination performed, tests ordered, results of tests, and diagnosis reached in the particular patient's file; (c) Respondent was required to attend and successfully complete the Mini-Residency entitled "Appropriate Prescribing of Controlled Substances: A Program for Physicians and Dentists" sponsored by the Mercer University, Southern School of Pharmacy in Atlanta.; and (d) Respondent was fined in the amount of $3,000.00. (*Id.*)

9.

On February 3, 2012, a Public Board Order Terminating Terms was docketed. The order terminated the April 1, 2010 Public Consent Order after it was determined that Respondent complied with all the required terms and conditions. (*Id.*)

10.

As noted above, around the middle of 2013, Respondent began practicing at Advanced Medical Health Services located at 6525 Professional Place, Suite C, Riverdale, GA. (Tr. 90-91, 201-202, 513; Exs. P-3, P-11). Advanced Medical Health Services was owned by the same person who owned Riverdale Medical Center. (Tr. 511-513). Respondent was essentially the only physician treating patients at Advanced Medical Health Services, except for the rare occasion that Dr. Weston-Hill would cover for Respondent. (Tr. 512-513; Exs. P-3, P-11). Respondent was responsible for managing patient care at Advanced Medical Health Services. (Tr. 94-95).

11.

Advanced Medical Health Services advertised as a pain management clinic. One hundred percent of the patients at the clinic were being treated for chronic pain with opiates or Schedule II medications. (Tr. 95; Exs. P-1, P-2).

12.

Jason O'Toole is an agent with the Board. He is a POST-certified law enforcement officer. His duties include investigating complaints concerning licensees. (Tr. 11-13). He first encountered Respondent, on September 30, 2013, when he was doing a follow-up field investigation of a former pain management clinic in Riverdale, Georgia called Candid. (Tr. 13-18). The purpose of his field investigation was to follow-up on information that the Board had received from the Drug Enforcement Agency ("DEA") and the Georgia Drugs and Narcotics Agency ("GDNA"). (*Id.*) Specifically, the Board had been informed that Candid was a pain management clinic operated by a Florida doctor who was prescribing and dispensing medications at the facility, and that it had been shut down as a result of the DEA and GDNA investigation. (*Id.*)

13.

When Agent O'Toole arrived at the location of the former Candid pain management clinic, he observed that another pain management clinic was operating at the same location. He observed a sign in front of the facility, which read "Advanced Medical Health Service, Inc., Patricia Benton, M.D.," and advertised "Pain Management." (Tr. 14-21; Ex. P-2).

14.

While he was there on September 30, 2013, he observed a loud verbal altercation that started outside the clinic and moved into the clinic. After waiting a few minutes, he went into the clinic. (Tr. 18-19). During that visit, Agent O'Toole interviewed Respondent. Based on the interview and

Respondent's description of the types of patients she treated, he determined that she was practicing pain management. He also informed Respondent about the change in the law requiring pain management clinics to be licensed and that the Board had not received an application for a license from Advanced Medical Health Services. Later that day an application was delivered to the Board via a courier.[6] (Tr. 27, 32).

15.

On November 6, 2013, Agent O'Toole visited Advanced Medical Health Services for a second time. That time a representative from the DEA was also there. After a conversation about Respondent's prescribing practices, the DEA agent asked Respondent to surrender her DEA license, which she did. (Tr. 33). While he was there, Agent O'Toole observed Respondent writing a prescription for pain medicine despite the fact that the clinic was being operated without a license. Agent O'Toole told Respondent what he observed and asked her to sign an agreement not to practice. Respondent refused to sign such an agreement. (Tr. 34). On that second visit, Agent O'Toole brought subpoenas for certain patient records.[7] One of the employees copied the records and provided them to him. Agent O'Toole turned the records over to the Board for peer review. (Tr. 35-37).

16.

Dr. Steven Lobel is a board-certified pain medicine physician. He completed an internship in internal medicine at the University of Virginia, a residency in physical medicine and rehabilitation at Eastern Virginia Medical School, and a fellowship in pain medicine at Emory University. He is board-certified in Physical Medicine and Rehabilitation and the subspecialty of Pain Medicine. (Ex.

[6] The application was tabled during the investigation of this case. (Tr. 32).
[7] He chose which records to obtain based on a conversation he had with the DEA agent about the deaths of two patients and based on patterns he observed in his review of subpoenaed pharmacy records. (Tr. 35-37).

P-5; Tr. 124-125).

17.

Dr. Lobel served as the Board's peer reviewer in this matter. In that capacity he reviewed Respondent's medical records for eight patients: Raymond M., Tim D., Jessie W. Kyra H. Laura D., Kelisha M., Tracy D., and Patricia R. (Exs. P-7, P-8, P-9, P-10, P-12, P-13, P-14, P-15; Tr. 152).

18.

Because Respondent was practicing pain medicine, she was required to adhere to the standard of care for pain medicine physicians. (Tr. 438). For new patients the standard of care for pain medicine requires that the physician obtain, review and document the review of the patient's outside medical records, including prior testing, prior treating physician's notes, and prior imaging. Those prior medical records must be summarized in the physician's history.[8] (Tr. 129, 439-40). The standard of care also requires the pain medicine physician to document the history of the present illness, including the location, onset, duration, intensity, and nature or character of the pain, whether the pain radiates, any numbness or tingling, any aggravating or relieving factors, and prior treatments such as medications, injections, or physical therapy. (Tr. 131-132). If the patient is on pain medication at the time of the first visit, the physician must determine when the prescription was last filled, when the medication was last prescribed, and the physician must obtain the notes from the prescribing physician.[9] (Tr. 443). This is required so the physician can determine whether she can legally prescribe any medications for the patient. (*Id.*)

[8] For patients with chronic pain and who are already on opiates, it is a breach of the standard of care to prescribe opiates on a first visit without adequate records from the patient's prior treating physician. (Tr. 447-48).

[9] Additionally, all new patients who are already on opiates must be screened with an opiate risk tool to determine the patient's risk for substance abuse. (Tr. 146, 448-49).

19.

The standard of care also requires the physician to document the patient's surgical history, social history, and family history, including any family history of substance abuse or psychiatric illness. (Tr. 136-138). The last required component of the history is the review of systems. This is where the physician asks the patient about any other medical conditions. (Tr. 138).

20.

On the first visit, the standard of care requires pain medicine physicians to perform and document a complete neuromuscular exam, assessing the nerves, muscles and joints. (Tr. 139). Additionally, the physician must assess strength, sensation, reflexes, gait, and perform provocative maneuvers, such as a straight leg raise. (Tr. 144, 166). If a new patient is already on pain medication, the standard of care requires the pain medicine physician to obtain a urine drug screen at their initial visit. (Tr. 304-05).

21.

On follow-up visits, the standard of care requires pain medicine physicians to document the location, intensity, quality, and character of the pain, as well as any aggravating or relieving factors as part of the "history of present illness." (Tr. 445). Additionally, the pain medicine physician must perform and document a detailed physical examination of the affected body part.[10] It must include an evaluation of the neurological or musculoskeletal system. For example, if a pain medicine physician is treating a patient for back pain, the physician's failure to perform and document a detailed examination of the spine and neurological system is a breach of the standard of care. (Tr. 140, 153, 443-44).

[10] It is insufficient to simply note "tenderness" or "abnormal" range of motion. Tenderness is based on the patient's subjective report. It is not an objective finding. (Tr. 445-46).

22.

To meet the minimum standard of care, pain medicine physicians who are prescribing narcotics on a chronic basis must document a running narrative of the patient's care, including the reassessment, monitoring, and altering of treatment when appropriate.[11] (Tr. 153, 444). The physician must document the course of the patient's medical evaluation, treatment and response. (*Id.*) Otherwise, the physician will not be able to determine whether the current treatment is effective or whether future care is warranted. (Tr. 444).

23.

Dr. Lobel opined that Respondent breached the standards of care for documentation and narcotic prescribing. (Tr. 152). More specifically, he opined that she breached the standard of care for pain medicine physicians by prescribing narcotics on a chronic basis without adequate documentation of reassessment, monitoring, and alteration of her treatment when appropriate. He further opined that she did not adequately document the course of the patients' medical evaluations, treatments, and response. He found her physical examinations lacking, in that they did not include a neurological or musculoskeletal system evaluation. (Tr. 153.) In most cases, the prior treatment records that she did obtain were insufficient. (Tr. 439). When she did obtain prior records, she did not provide a brief summary of those records in her notes. In Dr. Lobel's opinion, that was a breach of the standard of care. (Tr. 439-440).

[11] For example, it is a breach of the standard of care to recommend exercises to a patient and then fail to document which exercises that the patient is doing and the result or the effectiveness of the exercises. (Tr. 455-57). Similarly, if the physician refers the patient for physical therapy or outside interventional care, the physician must document the name of the physician to whom she referred the patient and the results of the referral. (Tr. 151).

24.

Of the charts Dr. Lobel reviewed, all of the patients except for Tim D. were given narcotics on the first visit, and many were already on narcotics when they came to see her or had previously been prescribed narcotics. (Tr. 448; Exs. P-7, P-8, P-9, P-10, P-12, P-13, P-14). However, Respondent did not assess these patients' risk for substance abuse with an opiate risk tool. (Tr. 449). Although Respondent did not prescribe Tim D. an opiate on his first visit, she did subsequently prescribe Percocet on his second visit despite the fact that he admitted to her on his first visit that he had a history of abusing Percocet. Respondent did not assess Tim D.'s risk for abuse with an opiate risk tool. (Ex. P-15 at 20, 25; Tr. 449). With regard to documentation of the patients' history of present illness, most of Respondent's notes provide very little detail and do not even indicate the severity or intensity of the pain on some type of a scale. (Tr. 445).

Raymond M.

25.

Mr. M's chart contains a document entitled "Advanced Medical Health Services, Inc. New Patient History and Physical." (Ex. P-14 at 5). This document was completed on April 4, 2013, before Respondent ever saw Mr. M. It appears that it was completed by a Dr. Stokes.[12] The New Patient History and Physical indicates that Mr. M. had a previous motor vehicle accident in 2000 and that he had an MRI of the lumbar region on September 23, 2012. (Ex. P-14 at 5). Mr. M's chart also contains some notes from Dr. Stokes dated April 4, 2013 and May 2, 2013. On both occasions, Dr. Stokes prescribed Mobic, Flexeril, and Roxicodone 30mg every 4-6 hours (120 pills). (Ex. P-14 at 15-16, 27).

[12] Respondent testified that there may have been a period of time that the previous Candid pain clinic was operating under the name of Advanced Medical Health Service. Mr. M.'s chart also includes numerous records from the Candid Medical Clinic. (*See* Ex. P-14 at 59-138). Thus, it appears that Mr. M was a former patient of the Candid pain clinic that

26.

Respondent first saw Mr. M. on June 27, 2013.[13] Her note contains no review of Mr. M's previous records, no history of his present illness, no indication of the location, intensity, or character of his pain, and no physical examination. (Ex. P-14 at 34). The note merely describes his chief complaint as "adequate pain control" and "c/o constipation." (*Id.*) Respondent lists the diagnosis as lumbar radiculopathy and her plan is to continue his prescription medications. (*Id.*) On that date, Respondent prescribed Flexeril, Mobic, and oxycodone 30mg every 4-6 hours (120 pills). (Ex. P-14 at 36-38).

27.

Respondent saw Mr. M. again on August 1, 2013. (Ex. P-14 at 39). Again, she did not indicate the location, intensity or character of his pain. (*Id.*) Rather she wrote that the patient was having "ED" (erectile dysfunction) with his medication, but that he had "adequate pain control." (*Id.*) She did not document a physical examination. Instead, she indicated that his back was the "same." (*Id.*) On that day she prescribed Mobic, Flexeril, Viagra, Lyrica, and oxycodone 30mg every 4-6 hours (120 pills). (*Id.* at 41-43). Respondent's note contains no indication of why she prescribed Lyrica. (Ex. P-14 at 39).

28.

Respondent saw Mr. M. on September 5, 2013. Again her note included no description of the location, intensity, or character of Mr. M.'s pain. (Ex. P-14 at 44). She merely noted "adequate pain control" and "no side effects." She did not follow up on the erectile dysfunction mentioned during the previous visit. (*Id.*) Nor did she document a physical examination. (*Id.*) Her plan was to continue prescription medications. (*Id.*) She prescribed the same medications that she prescribed on

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previously operated out of the same location that Respondent subsequently operated Advanced Medical Health Services.

the previous visit, including the Viagra. (*Id.* at 46).

29.

Respondent saw Mr. M. on October 2, 2013. (Ex. P-14 at 47). Beyond indicating that Mr. M had complaints of increased low back pain, she did not indicate the intensity or character of his pain. (*Id.*) The only indication of a physical exam is her notation that Mr. M. has "tenderness over [the] left L4 facet" and "S1 pain with flexion and lateral bend." (*Id.*) No further physical examination is noted. Her plan was to continue his prescription medications. (*Id.*) During that visit, there is no indication that Respondent followed up regarding Mr. M.'s previous complaints of erectile dysfunction. (*Id.*) Nevertheless, she did not continue his prescription for Viagra. (*Id.* at 53). She did continue his prescriptions for Flexeril, Mobic, Lyrica, and oxycodone 30mg four times per day (120 pills). (*Id.*)

30.

Respondent saw Mr. M on October 30, 2013. (Ex. P-14 at 50). Other than noting that Mr. M. had "increased back pain" and complaints of "burning in legs at night," Respondent did not indicate the intensity or the specific location of Mr. M.'s pain. (*Id.*) Her only indication of a physical examination was "back tenderness over paraspinals" and "L2-L5 left facets." (*Id.*) No further physical examination is noted. (*Id.*) Respondent's plan was to continue prescription medications. (*Id.*) She also noted that Mr. M. was "O.K." for chiropractic care. (*Id.*) This was not a referral for chiropractic care. Rather, it was simply to note that she thought it was "O.K." to see a chiropractor. (Tr. 370-71).

[13] Respondent treated Mr. M. from June 27, 2013 through October 30, 2013. (Ex. P-14).

31.

Throughout the entire time that Respondent treated Mr. M., she did not document any referrals or recommendations for interventional care. (*Id.*) She did not require Mr. M. to undergo any urine drug screening during the entire time she treated him, even though his records from Candid indicated at least two negative urine drug screens during the time he was prescribed opiates.[14] (Tr. 357-359, 371-372, 567; Ex. P-14 at 63, 67, 69, 71, 72, 74, 80, 91, 93).

Tim D.

32.

On a Riverdale Medical Center document entitled "History of Present Illness," Mr. D. indicated that he has a history of "torn ACLs," broken wrist, surgery on wrist, and a shattered patella. (Ex. P-15 at 16-18). Additionally, he noted that he had x-rays and an MRI on December 31, 2006, related to the surgery on his wrist. (*Id.* at 16). Respondent did not obtain the films or the reports of the x-rays or the MRI. (Tr. 375-379). Nor did she obtain any medical records related to his wrist surgery or his shattered patella. (*Id.*) The only outside medical records in Mr. D.'s chart are two notes from Prince Avenue Primary Care dated March 13, 2012 and March 21, 2012. (*Id.* at 375; Ex. P-15 at 3, 4). Those notes mention a referral to a John "Dorris" or Norris for a knee evaluation. (Ex. P-15 at 4). Respondent did not obtain any medical records related to this referral. (Tr. 375).

33.

Respondent first saw Mr. D. on August 29, 2012.[15] (Ex. P-15 at 20). During that visit, Mr. D. complained of back, bilateral shoulder, and bilateral knee pain. (*Id.*) He admitted to participation

[14] A negative urine drug screen means that the prescribed drugs are not showing up in the patient's system. (Tr. 146-47). It could be an indication that the patient ran out of the medication, is selling the medication, or is not taking the medication because he is not having pain. (*Id.*)

[15] She treated Mr. D. from August 29, 2012 through October 16, 2013, initially at Riverdale and then subsequently at Advanced Medical Health Services. (Ex. P-15).

in a "12-step" program because he previously abused Percocet, Roxicodone, and Lortab, which he obtained on the "street." (*Id.*; Tr. 379). Respondent's note contains no indication of the intensity, character, or specific location of Mr. D.'s pain. (Ex. P-15 at 20, 78). No examination of his back is documented. (*Id.*) No neurological examination is documented. (*Id.*) Respondent notes "tenderness over joint space" and she circled normal range of motion for both shoulders. No further detail related to a physical examination of Mr. D.'s should is provided. (*Id.*) With regard to the patient's knees, the only documentation is a "surgical scar" on right knee and "supra patella tenderness." (*Id.*) Range of motion for the patient's knees is not documented. (*Id.*) The in-house urine drug screen, and was positive for benzodiazepines, cocaine, marijuana, opiates, and oxycodone.[16] (Ex. P-15 at 21). Because of these results, Respondent refused to prescribe opiates to Mr. D on that first visit. (*Id.* at 78; Tr. 388). Nevertheless, she did prescribe "Klonipin" (sic) on the first visit, and provided no indication in her note as to why this medication was being prescribed.[17] (Ex. P-15 at 20, 23, 78).

34.

Mr. D. returned to the clinic on September 4, 2012, to review the results of the urine sent to the lab for confirmation and for a repeat in-house urine drug screen. (*Id.* at 25; Tr. 387-88). The results of the in-house urine drug screen were negative for all substances, including the Klonopin that Respondent had prescribed on August 29, 2012. (Ex. P-15 at 25; Tr. 388). Respondent did not perform a physical examination on September 4, 2012. (Tr. 387). She did, however, prescribe Percocet 10/325 three times a day (90 pills). (Ex. P-15 at 27).

[16] The urine drug screen indicated that Shelly Moreland performed the test. (Ex. P-15 at 21). Respondent asserts that she subsequently learned that Ms. Moreland was altering the results of patient drug screens. (Tr. 380-82). That same day Respondent did a repeat urine drug screen and sent it to an outside lab for confirmation. (Tr. 382; Ex. P-15 at 26). On the repeat urine drug screen, none of the previously detected substances were detected. (*Id.*)

[17] Respondent misspelled Klonopin on the prescription. (Ex. P-15 at 23).

35.

Mr. D was seen by Dr. Weston-Hill when he returned to the clinic on October 11, 2012. (*Id.* at 28). Dr. Weston-Hill recommended exercise, weight loss, heat, massage, physical therapy, and that he see an addictionologist. (*Id.*) The in-house urine drug screen was only positive for oxycodone. (*Id.* at 29). Dr. Weston-Hill increased Mr. D's opiate prescription from Percocet 10/325 three times per day to oxycodone 15mg every 8 hours.[18] (*Id.* at 31). She also increased his Klonopin from 1mg to 2mg at bedtime. (*Id.*)

36.

Respondent saw Mr. D. on November 8, 2012. (*Id.* at 32). The intensity or specific location of Mr. D's pain is not indicated. (*Id.*) Rather there is a check mark to indicate that his pain is controlled. (*Id.*) Also it appears that he did not have any specific complaints of pain, as there is a check mark indicating that he had no complaints. (*Id.*) Under the heading of "Additional Findings," the note indicates right shoulder crepitus and "Back – paraspinal muscle tender." There is no indication of where along the spine that the patient had paraspinal tenderness, nor is there any indication of any further physical examination. (*Id.*) There is no indication in the note that Respondent followed up on any of the recommendations made by Dr. Weston-Hill during the previous visit. (*Id.*) During this visit, Respondent increased the frequency of Mr. D.'s oxycodone from 15mg every 8 hours to 15mg every 4 to 6 hours (100 pills), despite the fact that she indicated that his pain was controlled. (*Id.* at 31, 32, 35).

[18] Percocet 10/325 contains 10mg of oxycodone and 325mg of acetaminophen (Tylenol). (Tr. 160).

37.

On December 6, 2012, Mr. D. was seen by Dr. Weston-Hill. (Ex. P-15 at 36). Dr. Weston-Hill indicated that Mr. D's pain level was a "4" and that his pain was controlled. (*Id.*) Nevertheless, she increased the number of oxycodone 15mg pill prescribed from 100 pills to 120. (*Id.* at 35, 39).

38.

Respondent saw Mr. D. on January 3, 2013. (*Id.* at 40). The intensity, location, and character of his pain are not noted. (*Id.*) However, there is a check mark indicating that his pain is controlled. (*Id.*) His "complaint" during that visit was congestion. (*Id.*) There is no neuromuscular or musculoskeletal examination indicated. (*Id.*) Respondent continued the increased amount of oxycodone prescribed by Dr. Weston-Hill (i.e. 15mg every 4 to 6 hours – 120 pills). (*Id.* at 42). She also continued the Klonopin 2mg every night at bedtime. (*Id.*)

39.

Respondent saw Mr. D. on January 31, 2013. (*Id.* at 43). There is no indication of the intensity of Mr. D.'s pain or whether it is controlled or not. (Id.) The "Chief Complaint" is blank. Respondent noted that Mr. D. had right shoulder crepitus, left shoulder tenderness, right knee tenderness and laxity of MCL, and supra patella tenderness of the left knee. (*Id.*) Respondent's diagnosis was "DDD" (sic) right knee and right shoulder. (*Id.*) She also noted anxiety and insomnia.[19] (*Id.*) Respondent's recommendation was "definitive" treatment for shoulder and knee. (*Id.*; Tr. 406-07). She also referenced something about "ortho." (*Id.*) However, she did not refer Mr. D. to a particular orthopedist. (Tr. 407).

[19] Although Respondent had been prescribing Klonopin since the first visit, presumably for anxiety and insomnia, January 31, 2013 is the first time Respondent noted any problem with anxiety and insomnia. (Ex. P-14 at 20, 43). There is no indication, however, in the January 31, 2013 note as to the source or cause of the anxiety or insomnia. (*Id.* at 43).

40.

On February 28, 2013 and March 28, 2013, Mr. D. was seen by the nurse practitioner. (Ex. P-15 at 46-47, 49-50); Tr. 408, 413). The notes from both dates do not indicate the level or intensity of Mr. D.'s pain. (Ex. P-15 at 46, 49). Mr. D.'s chief complaint on February 28, 2013 was left knee "popping," "not a lot of pain." (*Id.* at 46). There is very little if any physical examination described on either date. (*Id.* at 46, 49). Nevertheless, Respondent continued the same prescriptions. (*Id.* at 48, 51).

41.

Respondent saw Mr. D. on April 25, 2013. (*Id.* at 52). At that time, he was complaining of severe left shoulder pain. (*Id.*) The only indication of a physical examination in Respondent's note is a reference to "left shoulder – point tenderness over mid trapezius." (*Id.*; Tr. 419). No further physical examination is noted and the "Diagnosis" is blank. (Ex. P-15 at 52). Respondent's plan is to give Mr. D. a Kenalog injection and continue his prescription medications. (*Id.*)

42.

Respondent saw Mr. D. on May 21, 2013. (*Id.* at 55). During that visit, he reported adequate pain control, but also complained of increased pain with pressure on elbow. (*Id.*) There is no documentation of the effect of the Kenalog injection referenced in Respondent's previous note. (*Id.*) Other than a reference to left shoulder tenderness over scapula, there is no indication of any further physical examination. (*Id.*) In the "Diagnosis" section, Respondent wrote 'internal derangement left elbow." (*Id.*) However, on the billing sheet, she wrote "internal derangement left shoulder." (*Id.* at 56). Her plan was to continue prescription medications and consider a cortisone injection in his shoulder. (*Id.* at 55).

43.

Respondent saw Mr. D. on June 20, 2013. (*Id.* at 58). Under chief complaint, Respondent wrote "shoulder pain persists, but controlled on meds." (*Id.*) No physical examination is documented. (*Id.*) Rather, there is a notation of "O = same." (*Id.*) According to Respondent, that means that the physical examination is the same. (Tr. 421-22). Under "Diagnosis" Respondent wrote "Internal Derangement." (Ex. P-15 at 58). Respondent admitted that she should have written "rule out internal derangement," because she cannot prove the diagnosis without an MRI. (Tr. 422). Respondent claims that she did not order an MRI because the patient did not have the money for an MRI. (Tr. 423). However, she did not document the patient's financial situation and the records tend to belie her assertion. (Tr. 423). The patient was paying at least $200.00 at each visit, often in cash.[20] (Ex. P-15 at 22, 30, 34, 38, 41, 44, 47, 50, 53, 56, 59, 62, 70, 72, 76).

44.

Respondent saw Mr. D. on July 18, 2013. (*Id.* at 61). The note for that date reflects a complaint of low back pain due to lifting heavy wire. There is no indication of the intensity or character of the pain. (*Id.*) There is no indication of a physical examination except for a reference to tenderness over right "SI" and that the straight leg raise was negative. (*Id.*) Respondent's plan was to discontinue ibuprofen and add Mobic. (*Id.*) However, there is no indication why she felt this necessary. (*Id.*)

45.

Respondent saw Mr. D. on August 20, 2013. (*Id.* at 66). At that time, he was complaining of increased pain in his lower back. (*Id.*) There is no documentation of what caused the increased back pain. (*Id.*) There is no documentation of the intensity of the pain, and very little documentation of a

[20] Dr. Lobel testified that the cash price for an MRI without contrast can be as low as $350.00 to $450.00. (Tr. 493).

physical examination, except for "Back - ++ tenderness over right SI" and that the straight leg raise was negative. (*Id.*) Respondent's assessment was sciatica. (*Id.*) Respondent gave Mr. D. a Toradol injection and a Kenalog injection and continued his medications. (*Id.* at 66-69). Respondent's note also states "call in 48 hours." (*Id.* at 66). However, there is no indication that the patient called or that someone from the clinic called him to follow up. (Tr. 428).

46.

Respondent saw Mr. D. on September 18, 2013. (Ex. P-15 at 71). She noted that his back pain had improved after the injection. (*Id.*) Other than noting "no spasm or tenderness" in the back, there is no indication of a physical examination. (*Id.*) Nevertheless, Respondent's assessment was "lumbar disc disease." (*Id.*) Her plan was to continue his medications. (*Id.*) However, there was no description of *any* continued pain necessitating the continued prescription of his medications which included 15mg of oxycodone four times per day. (*Id.* at 71, 73). She also continued to prescribe Klonopin (clonazepam), despite the fact that there is no documentation of continued anxiety or insomnia. (*Id.*) Respondent's note indicated that Mr. D. was to continue his exercises. However, she acknowledged that there was never any documentation of what type of exercises he had been instructed to do. (Tr. 424-25).

47.

Respondent's last visit with Mr. D. was on October 16, 2013. (Ex. P-15 at 75). She noted that he had adequate pain control. (*Id.*) She also noted that there was no spasm or point tenderness in his back. (*Id.*) No further physical examination is documented. (*Id.*) Respondent's assessment was lumbar disc disease. (*Id.*) Her plan was to continue his prescription medications. (*Id.*) However, there is no documentation of what pain Mr. D. was purportedly having that would necessitate continued prescription of opiates. (*Id.*)

Jessie W.

48.

Mr. W.'s chart includes a lumbar spine x-ray report dated May 25, 2010, a September 27, 2011 report of a lumbar myelogram and CT of the lumbar spine ordered by Dr. Vincente Galan, Publix pharmacy records from May 2, 2012 through May 2, 2013, and two progress notes from Dr. Betsy Horton dated January 2, 2013 and February 4, 2013. (Ex. P-12 at 19-33). The Publix pharmacy records show multiple prescriptions for oxycodone 30mg (120 pills) from Dr. Vincente Galan, as well as opiate prescriptions from other physicians such as Dr. Amit Patel, Dr. Douglas Freiberger, Dr. Tracy Wimbush, and Dr. Christopher Armour. Additionally, there is a prescription for methadone from Dr. Francis Acquah. (*Id.* at 23-26). Respondent did not obtain medical records from any of Mr. W.'s previous pain medicine physicians. (Ex. P-12; Tr. 304).

49.

One of Dr. Horton's progress notes states that Mr. W. "[g]ot into a verbal altercation with his pain specialist as they wanted to decrease his oxycodone and increase his fentanyl. Patient did not like this and the police were called per Pain specialist note." (Ex. p-12 at 27). Respondent did not address this issue or take it into account in devising a treatment plan for Mr. W.[21] (Tr. 296-298, 304, 452-54).

50.

Mr. W. completed a History of Present Illness form for Riverdale Medical Center on May 2, 2013. (Ex. P-12 at 35). On that form, he described the location of his pain as "all over" and the duration as "all day." (*Id.*) He also listed his current medications as: Zanaflex 4mg, Gabapentin

[21] Dr. Lobel opined that it was a violation of the standard of care for Respondent to prescribe opiates to Mr. W without referring him to an addictionologist or counseling, tapering his opiates, and treating any withdrawal, if necessary. (Tr. 453-54).

300mg, "Celexcia" (sic), Fentanyl 50mg, and oxycodone 30mg. (*Id.* at 35).

51.

Respondent first saw Mr. W. on May 16, 2013. (*Id.* at 40). She noted that he had complaints of back pain radiating down his right leg, neck pain, and bilateral ankle pain. (*Id.*) She noted that he fell 1000 feet off a bridge in New Orleans, broke both lower legs on August 28, 2007, had internal fixation of both lower legs, fractured his tailbone at work (L5 –S1), and purportedly fractured his C4 vertebrae by falling off a bike in 1993. (*Id.*) This information appears to have been given to her by the patient, as it does not appear in the scant outside medical records obtained by Respondent (i.e., the radiology reports and the two progress reports from Dr. Horton).[22] During this initial visit, Respondent did not summarize the outside records in her initial note. (*Id.* at 40-41; Tr. 565). Her initial note references tenderness at the right C6-C7 facet, crepitus over the TMJ, and tenderness of the back at L1-L2, paraspinals at L4-L5, and at the right SI. (Ex P-12 at 40-41). The note did not, however, indicate the intensity or character of Mr. W.'s pain. (*Id.*) Respondent did not require Mr. W to undergo a urine drug screen during the initial visit, despite the fact that he was taking opiates at the time. In fact, during the entire time that she treated Mr. W. she never required him to undergo a urine drug screen. (Ex. P-12 at 34-67; Tr. 323).

52.

On that first visit, without obtaining medical records from his previous pain physicians and without obtaining a urine drug screen, Respondent prescribed oxycodone 30mg four times per day (120 pills), in addition to other medications. (Ex. P-12 at 42-43).

[22] Respondent did not obtain any medical records related to the injury of and subsequent surgery on Mr. W.'s legs. (Ex. P-12).

53.

Respondent saw Mr. W. on June 12, 2013. (*Id.* at 45). His chief complaint at that time was that his left lower leg was "oozing." She noted adequate pain control, but did not describe the intensity, location, or character of his pain. No musculoskeletal or neurological exam is documented. (*Id.*) Respondent's plan was to add a prescription for Bactroban cream, continue his prescription medications, and give him a prescription for a walker with a seat. (*Id.*) Additionally, she wrote that she discussed exercises and wound care with the patient. (*Id.*) However, there is no description of what type of exercises she discussed. (*Id.*) Respondent continued the prescription for oxycodone 30mg four times per day (120 pills), in addition to other medications. (*Id.* at 46-48).

54.

Fourteen days later, Respondent gave Mr. W. an additional prescription of oxycodone 15mg every 4 to 6 hours (90 pills). (*Id.* at 49). There is no documentation in the chart as to why she prescribed this additional amount of oxycodone. (Ex. P-12; Tr. 313). Respondent acknowledged that the standard of care would require her to document the reason for the additional prescription. (Tr. 314).

55.

Respondent saw Mr. W. on July 10, 2013. (Ex. P-12 at 51). At that time, she noted that the left leg wound was healed and had no drainage. (*Id.*) She also noted that Mr. W. had adequate pain control. (*Id.*) Other than noting "neck tenderness over right trapezius" and "paraspinal tenderness [at] L3-L5," no other physical examination is noted. (*Id.*) She noted that she discussed body mechanics and stretching exercises, but she did not note any follow up regarding the exercises she recommended during the previous visit. (*Id.*) For example, there is no indication that Mr. W. was performing the exercises or whether they were effective. (*Id.*; Tr. 316). On this date, Respondent

was given two prescriptions for oxycodone. (Ex. P-12 at 53, 54). One prescription was for oxycodone 15mg four times per day (120 pills) and the other prescription was for oxycodone 30mg four times per day (120 pills). (*Id.*) There is no documentation and apparently no justification for adding the prescription for oxycodone 15mg, particularly in light of the fact that the patient reported adequate pain control since June 12, 2013, when he was only purportedly taking oxycodone 30mg four times per day. (*Id.* at 42, 45). Also on July 10, 2013, Respondent discontinued Mr. W.'s prescription for Gabapentin and added a prescription for Mobic. (*Id.* at 47, 52-55). However, there is no discussion in her note as to why she made this treatment decision. (*Id.* at 51).

56.

Respondent saw Mr. W. on August 7, 2013. (*Id.* at 57). Respondent noted that Mr. W. "still has to take Oxy 30 [four times] a day [and] wants to increase." (*Id.*) Other than noting tenderness over C6-C7 and diffuse paraspinal tenderness, there is no further physical examination. (*Id.*) Again Respondent did not follow-up regarding the exercises she purportedly instructed Mr. W. to perform. (*Id.*) She noted that she discussed tolerance, opiate rotation, and exercise. (*Id.*) At that time, she again prescribed oxycodone 30mg four times per day (120 pills), Mobic, and increased his Fentanyl from 50mcg/hr to 75mcg/hr. (*Id.* at 55, 59).

57.

Respondent saw Mr. W. on September 4, 2013. (*Id.* at 60). At that time, he was complaining of increased swelling and pain in his right knee. (*Id.*) Other than noting a flocculent cyst over medial tibia plateau overlying the surgical scar, there is no further indication of a physical examination. (*Id.*; Tr. 319). There is no documentation of the intensity or character of his pain and no indication that he was continuing to have neck or back pain. (Ex. P-12 at 60; Tr. 319). Nevertheless, Respondent prescribed oxycodone 15mg four times per day. (Ex. P-12 at 61; Tr. 319-

20).

58.

Respondent saw Mr. W. on October 3, 2013. (Ex. P-12 at 63). Respondent noted that the knee swelling was resolving. (*Id.*) Other than noting no swelling of his right knee and neck tenderness with a trigger point in left mid trapezius, there is no further physical examination. (*Id.*) There is no indication that his back was examined. (*Id.*) Respondent did not document the intensity or character of Mr. W.'s pain. (*Id.*) At that time, Respondent scheduled Mr. W. for a trigger point injection.[23] (*Id.*) She also continued to prescribe oxycodone 15mg every four to six hours (120 pills). (*Id.* at 64).

59.

Respondent last saw Mr. W. on October 31, 2013. (*Id.* at 65). At that time he reported adequate pain control, but that he needed an increase in his medications. (*Id.*) Other than noting tenderness over C6-C7, no further physical examination was noted. (*Id.*) Nevertheless, for no apparent reason, Respondent increased Mr. W's prescription for oxycodone from 15mg four times per day to 30 mg four times per day. (*Id.* at 64-66).

60.

At the hearing, Respondent admitted that during the course of her treatment of Mr. W. she never required him to undergo a urine drug screen, she never referred him to any outside medical providers, she never documented the effect of the exercises she allegedly instructed him to do, and she increased his medications without documenting the reasons why. (Tr. 323-24). She further admitted that all of those actions were breaches of the standard of care. (*Id.*)

[23] At the hearing, Respondent acknowledged that Mr. W. did not undergo the trigger point injection. (Tr. 320-321).

Kyra H.

61.

Ms. H.'s chart includes a July 7, 2011 report of an MRI of the lumbar spine ordered by Dr. Isaac Sved and records from Collier's pharmacy from July 8, 2011 through July 7, 2012. (Ex. P-7 at 16-19). The pharmacy records reflect multiple prescriptions for oxycodone from Dr. Isaac Sved, Dr. S. Beebe, and Dr. Michael Katz. (*Id.* at 17-19) Respondent failed to obtain medical records from any of these physicians who had prescribed opiates for Ms. H, one of whom had prescribed oxycodone for Ms. H. nineteen days before she was first seen by Respondent. (Ex. P-7).

62.

Respondent first saw Ms. H. at the Riverdale clinic on July 26, 2012. (*Id.* at 25-26). There is no indication that Respondent reviewed the July 7, 2011 MRI report in her note for July 26, 2012. Other than a reference to an automobile accident two years ago, very little history of Ms. H.'s present illness is documented. (*Id.*) The documentation of the physical examination consists mostly of check marks indicating whether the finding is normal or abnormal. (*Id.*) There is almost no detail describing the extent of any abnormality. (*Id.*) For example, Respondent indicated that Ms. H.'s cervical range of motion was abnormal for flexion, extension, and rotation, but there is no indication of how restricted her range of motion was. (*Id.* at 26). Similarly, beyond indicating paraspinal muscle tenderness and tenderness over the trapezoids, there is no indication of the intensity, location, or character of Ms. H.'s pain. (*Id.* at 25-26). Nevertheless, Respondent prescribed Roxicodone 30mg three times per day (90 pills) and Percocet 10/325 three times per day for "break through pain."[24] (*Id.* at 44). Respondent's assessment was: lumbar disc disease, anxiety, and insomnia. (*Id.* at 25). She did not describe any cause or provide any detail regarding Ms. H.'s alleged anxiety and

[24] Respondent's July 26, 2012 note does not list Ms. H's current pain medications. (*Id.* at 26). Nor is there any

insomnia. (*Id.*) Nor did she refer Ms. H. to any mental health professional for anxiety. (Tr. 254-55). Instead, she prescribed Xanax 2mg two times a day, as needed for anxiety. (Ex. P-7 at 44).

63.

Respondent continued to treat Ms. H until October 31, 2013. (*Id.* at 82). Throughout the time that she treated Ms. H. there was little, if any, documentation as to the intensity, character, or specific location of Ms. H.'s pain. (*Id.* at 27, 28, 30, 32, 34, 38, 39, 40, 74, 77, 81). On some occasions, there is no description of any pain. (*Id.* at 27, 28, 30, 32, 34, 39). On several occasions, Respondent failed to document any physical examination. (*Id.* at 27, 28, 30, 32, 34, 39). On other occasions, the only indication of a physical examination is a reference to some tenderness, the absence of a spasm, or that a straight leg raise was negative. (*Id.* at 38, 40, 74, 77, 81).

64.

Despite the lack of documentation of physical examinations and the extent or presence of Ms. H.'s pain, Respondent continued to prescribe oxycodone or Percocet at every visit. (*Id.* at 25, 44, 46, 48, 50, 52, 57, 61, 66, 68, 73, 75, 78, 83). On several occasions, Respondent prescribed both oxycodone and Percocet, with no documentation as to why two short-acting opiates were required.[25] (*Id.* at 25, 44, 46, 48, 50, 52). On at least one occasion, Respondent increased Ms. H.'s pain medication by increasing the frequency that the medication could be taken without any explanation for the increase.[26] (*Id.* at 27, 28, 46, 48).

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indication that she is, in fact, having break through pain. (*Id.* at 25-26).

[25] Oxycodone and Percocet are both short-acting opiates. (Tr. 158).

[26] For example, on August 23, 2012, Respondent prescribed Roxicodone 30mg three times per day (90 pills), in addition to Percocet 10/325 every six hours (90 pills). (*Id.* at 27, 46). Then, on September 20, 2012, Respondent increased the frequency of the Roxicodone to 30mg every six hours (120 pills) and continued to prescribe the Percocet 10/325 every six hours (90 pills). (*Id.* at 28, 48). There is no explanation or justification for the increase in Respondent's September 20, 2012 note. (*Id.* at 28). In fact, Respondent made check marks indicating that Ms. H.'s pain was controlled and that she had no complaints. (*Id.*)

Laura D.

65.

Ms. D.'s chart contains a September 24, 2013 report of an MRI of the lumbar spine ordered by Dr. Edward Corkran and some records from Walgreens pharmacy from September 27, 2012 through September 27, 2013. (Ex. P-10 at 11-12, 44-48). The pharmacy records show prescriptions for hydrocodone from Drs. R. Price and T. Wells. (*Id.* at 44, 47). Respondent did not obtain any medical records from Drs. Corkran, R. Price, or T. Wells. (Ex. P-10).

66.

Respondent first saw Ms. D on October 1, 2013. (Ex. P-10 at 26-36). Ms. H.'s chief complaint was low back pain, left leg pain with pins and needles, and bilateral knee pain. (*Id.* at 32). Respondent did not document the intensity of Ms. D.'s pain. (*Id.* at 26-36). Other than references to back tenderness at L4-L6, tenderness of the SI joints bilaterally, and a positive straight leg raise bilaterally, there is no further examination of Ms. D.'s back. (*Id.* at 26-28). No neurological examination is documented. (*Id.* at 28, 30, 31).

67.

Respondent did not require Ms. D to undergo a urine drug screen on her first visit, despite the fact that she had been prescribed hydrocodone as recently as September 19, 2013. (*Id.* at 26-36, 44). Nevertheless, Respondent prescribed Mobic, Soma, and Percocet 10/325 every four to six hours (120 pills). (*Id.* at 34). Respondent also noted that she would schedule trigger point injections to SI joints. (*Id.* at 28).

68.

Respondent saw Ms. D. again on October 29, 2013. (*Id.* at 39). At that time, Respondent wrote that Ms. D. was complaining of increased pain and anxiety due to "taking care of elderly

parents." (*Id.* at 39). There is no documentation of the intensity, character, or location of Ms. D.'s pain. Other than a reference to "Back - ++ tenderness" at L4-L5 and bilateral SI joints, there is no further physical examination related to Ms. D.'s complaints of pain. (*Id.*) Again, Respondent wrote "schedule SI injection" and prescribed Mobic, Soma, and Percocet 10/325 every four to six hours.[27] (*Id.* at 39, 42). According to Respondent, the patient did not return after Respondent told her that the pain medication alone was not going to fix her problem, and insisted that Ms. D. have injections. (Tr. 242).

Kelisha M.

69.

Ms. M.'s chart contains a July 11, 2012 report of an MRI of the cervical spine ordered by Dr. Timothy Gibson. (Ex. P-8 at 23). The Impression is that the MRI of the cervical spine is "unremarkable." (*Id.*) Ms. M's chart also contains progress notes from Dr. Gibson dated January 21, 2013, February 22, 2013, June 11, 2013, July 18, 2013, and August 15, 2013. (*Id.* at 26-43).

70.

Dr. Gibson referred Ms. M to Advanced Medical Health Services on September 9, 2013 for complaints of pain in the thoracic spine. (*Id.* at 44). Respondent first saw Ms. M. on September 17, 2013. (*Id.* at 54-61). Ms. M.'s chief complaint was neck and back pain. (*Id.* at 54). Respondent noted that Ms. M.'s paraspinal muscles were "tense" or "tender" at T6-T10, L3-L5, and at the bilateral SI joints.[28] (*Id.* at 56). She also noted that straight leg raises were negative and that the MRI of Ms. M.'s cervical spine was negative. (*Id.* at 54, 56). There is no documentation of the

[27] Respondent's notes indicated that she was going to increase the frequency of Ms. D.'s Percocet from four times per day to every four to six hours. (*Id.* at 28, 33, 37). However, the "Encounter Summary," which appears to be a summary of the prescriptions issued, indicates that Ms. D. had been prescribed Percocet 10/325 every four to six hours on the first visit. (*Id.* at 36). Thus, it appears that Respondent did not actually increase the frequency of Ms. D.'s Percocet on the second visit.

intensity or character of Ms. M.'s pain. (*Id.* at 54-57). Respondent's diagnostic impressions were lumbar strain, thoracic strain, obesity, and insomnia. (*Id.* at 57). Her plan was to obtain x-rays of Ms. M.'s lumbar spine, thoracic spine, and an MRI of her lumbar spine. (*Id.*) Additionally, she prescribed Flexeril, Ibuprofen, and Percocet 10/325 three times per day. (*Id.* at 57, 61, 69).

71.

Respondent saw Ms. M. again on October 15, 2013. (*Id.* at 65). At that time, Ms. M. told Respondent that the Percocet was no relieving her pain, she was sleeping better with the Flexeril, and that she had increased back pain with the weather. (*Id.*) Respondent did not document the intensity or character of Ms. M.'s pain. (*Id.*) Other than noting back tenderness at L4-L5, no further physical examination is documented. (*Id.*) There is no reference or follow up regarding the x-rays that Respondent had planned to obtain in her note from the previous visit. (*Id.*) At that time, her plan was to change Ms. M.'s prescription to oxycodone 15mg four times per day and give her a Toradol injection. (*Id.*) No further visits are noted.

Tracy D.

72.

Mr. D. had been a patient of Candid Medical Center (i.e., the pain clinic that previously operated at the location where Advanced Medical Health Services opened). (Tr. 185). Mr. D.'s chart contains an August 29, 2011 report of an MRI of the lumbar spine ordered by Dr. Carl Ulbrich; pharmacy records from Curl's pharmacy and Turner pharmacy; reports of lab work ordered by Dr. John Sparti; progress notes from Dr. Sparti; and medical records from Coweta Occupational Medicine, Summit Occupational Medicine, and Candid Medical Center. (Ex. P-9 at 1-102).

[28] The word after the reference to "paraspinal muscle[s]" is illegible. (*Id.* at 56). Based on Respondent's documentation in other charts, it is likely that she is referring to paraspinal muscle tenderness.

73.

On June 12, 2013, Mr. D. completed a patient registration form for Advanced Medical Health Services.[29] On an Advanced Medical Health Services questionnaire dated June 12, 2013, Mr. D. denied that he had previously been treated by a pain management clinic. (*Id.* at 130). Respondent saw Mr. D. on five occasions between July 16, 2013 and October 31, 2013. (*Id.* at 148, 150, 152, 157, 161).

74.

During the time that Respondent treated Mr. D., she failed to follow up on complaints from previous visits or recommendations that she made to the patient. For example, on the first visit of July 16, 2013, Mr. D. complained of back pain and bilateral knee pain. (*Id.* at 148). At that time, Respondent prescribed amitriptyline, ibuprofen, Soma, and Percocet 10/325 every six hours (120 pills). (*Id.* at 144-45, 149). Yet, when Mr. D. returned to the clinic on August 13, 2013, there is no reference to his back pain and no examination of his back.[30] (*Id.* at 150). Similarly, on August 13, 2013, Respondent recommended physical therapy. (*Id.*) However, on September 4, 2013, Respondent did not follow up regarding her recommendation for physical therapy.[31] (*Id.* at 152).

75.

Additionally, during the time that Respondent treated Mr. D., she failed to document the reasons why she changed his prescriptions. For example, on October 2, 2013, she added a prescription for Gabapentin. (Ex. P-9 at 159, 160). But her notes for that date do not indicate why

[29] On many of the documents completed by Mr. D., the name of the facility is misspelled as "*Advance* Medical Health Service." (*Id.* at 113) (emphasis added).

[30] When Respondent saw Mr. D. on August 13, 2013, he reported that he had been hit by a go-cart at work. (*Id.* at 150). At that time, he complained of pain in his chest, and pain and swelling in his legs. (*Id.*)

[31] At the hearing, Respondent claimed that Mr. D. did not have insurance or the money to pay for physical therapy. However, according to Respondent's records, Mr. D. was paying $200.00 each visit. (*See id.* at 146, 153, 158). Further, she acknowledged that she did not refer him to an actual facility for physical therapy. (Tr. 220). Instead, he was to come back to her office for "physical therapy" in the form of ultrasound. (Tr. 220).

the Gabapentin was added. (*Id.* at 157-59). Similarly, on October 31, 2013, Respondent changed Mr. D.'s Klonopin to Valium and did not document why she made the change. (*Id.* at 161).

Patricia R.

76.

Ms. R.'s chart contains a January 8, 2013 report of an MRI of the lumbar spine ordered by Dr. Mark Guerdan, a discharge notice from Dr. Guerdan dated May 15, 2013, and pharmacy records from Apex Pharmacy showing prescriptions between December 1, 2012 and May 15, 2013. (Ex. P-13 at 11-19). The pharmacy records show prescriptions for oxycodone, hydrocodone, and diazepam from Dr. Guerdan. (*Id.* at 19). Respondent did not obtain any medical records from Dr. Guerdan, other than the discharge notice that indicated that Ms. R. had been discharged because she was "not following the procedures/guidelines that were given." (*Id.* at 11). Respondent did not contact Dr. Guerdan to find out specifically why Ms. R. was discharged from his care approximately one week before Respondent first saw Ms. R. (Tr. 333-34).

77.

Respondent first saw Ms. R. on May 22, 2013. (Ex. P-13 at 27). At that time, Ms. R. was complaining of back pain radiating down both legs, neck pain radiating to her left elbow, and weakness and twitching in her legs with night cramps. (*Id.*) Ms. R. also reported that she had a history of three lumbar surgeries, a fracture of her left foot with internal fixation, and bilateral knee replacements.[32] (*Id.*) Other than noting that Ms. R. had paraspinal and trapezius muscle tenderness, no further physical examination is noted.[33] (*Id.*) Respondent did not require Ms. R. to undergo a urine drug screen on the first visit, despite the fact that Ms. R. had been discharged by her previous pain physician for failing to follow procedures/guidelines. (Tr. 332). On that first visit, Respondent

[32] Respondent did not obtain any medical records from Ms. R.'s previous surgeries. (Tr. 331).

prescribed Soma, amitriptyline, morphine sulfate ER 30mg twice a day (60 pills), and Roxicodone 15mg four times per day (120 pills). (Ex. P-13 at 28).

78.

Respondent saw Ms. R. again on June 20, 2013. (*Id.* at 29). At that time, Ms. R. reported adequate pain control, continued leg cramps at night, and that she injured her left knee when she tried to get up after a fall. (*Id.*) Respondent did not document the intensity or character of her pain. (*Id.*) Other than tenderness of her back at L4-L5 and the bilateral SI joints, and supra patella tenderness and crepitus of her left knee, no further physical examination is noted. (*Id.*) Respondent did, however, require Ms. R. to undergo a urine drug screen on her second visit. (*Id.* at 31). The screen was positive for benzodiazepines, opiates, methadone, oxycodone, and TCA. (*Id.*) Respondent noted that Ms. R. had violated the contract because she failed the drug screen. (*Id.* at 29). Specifically, Respondent noted that Ms. R. admitted to taking medication from a friend at a funeral. (*Id.*) Respondent noted that she discussed the danger of "methadone and other drugs." (*Id.*) She also noted that she would send Ms. R.'s urine for confirmation. (*Id.*) At the hearing, Respondent asserted that she was going to wait for the confirmation to come back before she prescribed any medication, but the records reflect that she did not wait.[34] (*Id.* at 32-33). In fact, on June 20, 2013, Respondent again prescribed Soma, amitriptyline, morphine sulfate 30mg twice a day (60 pills), and Roxicodone 15mg four times a day (120 pills). (*Id.*)

[33] At the hearing, Respondent asserted that the second page of her note for May 2, 2013 was missing. (Tr. 335-37).
[34] Additionally, there is no indication in the chart that Ms. R.'s urine was sent for an outside confirmation test. (Tr. 342-43).

79.

Respondent last saw Ms. R. on July 17, 2013. (*Id.* at 34). At that time Ms. R. was complaining that she was having increased low back pain and that her pain was not well-controlled. Other than a reference to tenderness at L4-L5 and bilateral SI joints, and negative straight leg raises, no other physical examination is noted. (*Id.*) Respondent's plan was to increase Ms. R.'s MS Contin to 60mg, increase her amitriptyline to 50mg, and to decrease her oxycodone 15mg gradually. (*Id.*) She noted that she gave Ms. R. instructions on starting the increased MS Contin, using the oxycodone for breakthrough pain, and gradually decreasing the oxycodone. (*Id.*; Tr. 349). On that day, Respondent did not require Ms. R. to undergo a urine drug screen, despite the fact that she failed the previous one. (Ex. P-13 at 29, 34). Respondent prescribed Soma, Mobic, amitriptyline, MS Contin 60mg twice a day (60 pills), and oxycodone 15mg four times a day (120 pills). (*Id.* at 37, 39).

80.

Respondent did not see Ms. R. again after July 17, 2013. (Ex. P-13). However, on July 22, 2013, she received a phone call from someone named M. Philip Goodman. (*Id.* at 38). The person on the phone stated that Ms. R. had been found dead by her son. (Id.) Respondent attempted to contact a Mr. Powell, who she believed was Ms. R.'s husband, to confirm whether Ms. R. had actually passed away. (Tr. 347). She left a message, but no one called her back and she never received a call from a coroner or any other official regarding the alleged death of Ms. R. (*Id.*)

Conclusions of Law

1.

Petitioner seeks the revocation of Respondent's medical license. Accordingly, Petitioner bears the burden of proof. Ga. Comp. R. & Regs. 616-1-2-.07. The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. 616-1-2-.21.

2.

Georgia Code section 43-34-8, which is the specific licensing and disciplinary statute for the medical profession, states, in pertinent part, that the Board has the authority to discipline a licensee, upon a finding that the licensee has:

* * *

> (7) Engaged in any unprofessional, unethical . . . , or deleterious conduct or practice harmful to the public, which conduct or practice need not have resulted in actual injury to any person. As used in this paragraph, the term 'unprofessional conduct' shall include any departure from, or failure to conform to, the minimum standards of acceptable and prevailing medical practice and shall also include, but not be limited to, the prescribing or use of drugs, treatment, or diagnostic procedures which are detrimental to the patient as determined by the minimum standards of acceptable and prevailing medical practice or by rule of the board.

O.C.G.A. § 43-34-8(a)(7); *see also* Ga. Comp. R. & Regs. 360-3-.01, 360-3-.03.

3.

Board Rule 360-3-.06, in effect during the time at issue, provided, in pertinent part, as follows:

* * *

> (2) O.C.G.A. § 43-34-8 authorizes the Board to take disciplinary action against licensees for unprofessional conduct, which includes conduct below the minimum standards of practice. With respect to the prescribing of controlled substances for the treatment of pain and chronic pain, the Board has determined that the minimum standards of practice include, but are not limited to the following:
>
> * * *
>
> (c) When initially prescribing a controlled substance for the treatment of pain or chronic pain, a physician shall have a medical history of the patient, a physical examination of the patient shall have been conducted, and informed consent shall have been obtained. In the event of a documented emergency, a physician may prescribe an amount of medication to cover a period of not more than 72 hours without a physical examination.

(d) When a physician is treating a patient with controlled substances for pain or chronic pain for a condition that is not terminal, the physician shall obtain or make a diligent effort to obtain any prior diagnostic records relative to the condition for which the controlled substances are being prescribed and shall obtain or make a diligent effort to obtain any prior pain treatment records. The records obtained from prior treating physicians shall be maintained by the prescribing physician with the physician's medical records for a period of at least ten (10) years. If the physician has made a diligent effort and is unable to obtain prior diagnostic records, then the physician must order appropriate tests to document the condition requiring treatment for pain or chronic pain. If the physician has made a diligent effort and the prior pain treatment records are not available, then the physician must document the efforts made to obtain the records and shall maintain the documentation of the efforts in his/her patient record.

(e) When a physician determines that a patient for whom he is prescribing controlled scheduled substances is abusing the medication, then the physician shall make an appropriate referral for treatment for substance abuse.

(f) When prescribing a Schedule II or III controlled substance for 90 (ninety) days or greater for the treatment of chronic pain arising from conditions that are not terminal, a physician must have a written treatment agreement with the patient and shall require the patient to have a clinical visit at least once every three (3) months *to evaluate the patient's response to treatment*, compliance with the therapeutic regimen through *monitoring* appropriate for that patient, and any new condition that may have developed and be masked by the use of Schedule II or III controlled substances. The physician *shall respond to any abnormal result of any monitoring and such response shall be recorded in the patient's record.* Exceptions to the requirement of a clinical visit once every three (3) months may be made for hardship in certain cases and such hardship must be well documented in the patient record. When a physician determines that a new medical condition exists that is beyond their scope of training, he/she shall make a referral to the appropriate practitioner.

Ga. Comp. R. & Regs. 360-3-.06(2)(c),(d), (e), (f) (2012). With regard to monitoring, Board Rule 360-3-.06(d), in effect during the time at issue, defined "monitoring" as "any method to assure treatment compliance including but not limited to the use of pill counts, pharmacy or prescription program verification." Ga. Comp. R. & Regs. 360-3-.06(d) (2012). The Rule further provided as follows: "Monitoring must include a urine, saliva, sweat, or serum test performed on a random basis. *Id.*

4.

Board Rule 360-3-.02 also defines unprofessional conduct to include:

(1) Prescribing controlled substances for a known or suspected habitual drug abuser or other substance abuser in the absence of substantial justification.

* * *

(7) Failing to maintain appropriate patient records whenever Schedule II, III, IV or V controlled substances are prescribed. Appropriate records, at a minimum, shall contain the following:

(a) The patient's name and address;

(b) The date, drug name, drug quantity, and patient's diagnosis necessitating the Schedule II, III, IV, or V controlled substances prescription; and

(c) Records concerning the patient's history.

Ga. Comp. R. & Regs. 360-3-.02(1), (7) (2012).

Unprofessional Conduct

5.

As more fully set forth in the above Findings of Fact, Respondent engaged in unprofessional conduct by failing to conform to the minimum standards of acceptable and prevailing medical practice for pain medicine physicians. Her failures to meet the minimum standards include the following:

Respondent repeatedly failed to obtain or make a diligent effort to obtain prior pain treatment records or prior diagnostic records related to the underlying conditions of her patients. When she did not obtain the records, she did not order appropriate tests to document her patients' underlying conditions. Her failure to obtain the records, make a diligent effort to obtain the records, or order tests was a violation of Georgia Code section 43-34-8(a)(7) and Board Rule 360-3-.06(2)(d).

Several of the patients reviewed were already on pain medications at the time Respondent first saw them. For most of those patients, Respondent prescribed opiates on the first visit without obtaining the records from the patients' previous pain medicine physicians. This practice is a departure from the minimum standards of acceptable and prevailing medical practice for pain medicine physicians and a violation of Georgia Code section 43-34-8(a)(7).

Most of the patients reviewed were either on opiates when they first saw Respondent or had previously been prescribed opiates. Respondent failed to assess these patients' risk for substance abuse with an opiate risk tool. This failure was a departure from the minimum standards of acceptable and prevailing practice for pain medicine physicians and a violation of Georgia Code section 43-34-8(a)(7).

In many instances, Respondent failed to document the history of her patients' present illness, in violation of Georgia Code section 43-34-8(a)(7) and Board Rule 360-3-.06(2)(c).

In most instances, Respondent failed to evaluate her patients' responses to treatment. On the rare occasions that she recommended exercise or some treatment other than controlled substances, she rarely, if ever, evaluated the patients' responses to the recommended treatment. Similarly, the records are replete with instances when Respondent failed to document or evaluate her patients' responses to the prescribed medication. Her failure to evaluate or document her patients' responses to treatment was a violation of Georgia Code section 43-34-8(a)(7) and Board Rule 360-3-.06(2)(f).

Respondent frequently failed to monitor her patients' compliance with the treatment regimen. On more than one occasion, Respondent failed to obtain a urine drug screen on the initial visit for patients who were already taking pain medication. For two patients, Respondent never obtained a urine drug screen during the entire period of treatment. (*See* Findings of Fact ¶¶31, 51). Her failure to properly monitor her patients' compliance was a violation of Georgia Code section 43-34-8(a)(7)

and Board Rule 360-3-.06(2)(f).

On at least one occasion, Respondent prescribed controlled substances to a patient with a known history of prescription drug abuse without substantial justification. (*See* Findings of Fact ¶33). This is a violation of Georgia Code section 43-34-8(a)(7) and Board Rule 360-3-.02(1).

Respondent repeatedly failed to perform or document adequate physical examinations. She also repeatedly failed to assess or document the intensity, location, and character of her patients' pain. These failures amount to a failure to conform to the minimum standards of acceptable and prevailing medical practice for pain medicine physicians and a violation of Georgia Code section 43-34-8(a)(7).

On at least one occasion, Respondent failed to document the patient's diagnosis necessitating the prescription of a controlled substance. (*See* Findings of Fact ¶41). This is unprofessional conduct in violation of Georgia Code section 43-34-8(a)(7) and Board Rule 360-3-.02(7)(b).

Sanction

6.

Georgia Code section 43-34-8(b) authorizes the Board to discipline a licensee upon a finding that the licensee has engaged in unprofessional conduct or has violated the Boards rules. When the Board finds that a physician should be disciplined, it may suspend (for a definite or indefinite period), revoke, limit, or restrict a license; administer a public or private reprimand; make an adverse finding, but withhold imposition of judgment; or impose the judgment but suspend the enforcement of such judgment and place the physician on probation. Further, the Board may vacate any probation if the physician fails to comply with reasonable terms imposed by the Board. O.C.G.A. § 43-34-8(b); *see also* O.C.G.A. § 43-1-19(d), (e). Finally, the Board may impose a fine of up to $3000.00 for each violation of law, rule or regulation, or in a reasonable amount to reimburse the Board for

administrative costs. O.C.G.A. § 43-34-8(b)(1)(G), (H).

7.

Respondent engaged in unprofessional behavior in violation of Georgia Code section 43-34-8(a)(7) and Board Rules 360-3-.02(1), 360-3-.02(7)(b), 360-3-.06(2)(c), 360-3-.06(2)(d), 360-3-.06(2)(f). Respondent's documentation of the care of her patients was woefully inadequate and did not support the numerous prescriptions for controlled substances. She readily prescribed controlled substances to patients without documenting objective data to justify such prescriptions and frequently failed to monitor her patients' compliance with, or response to, the treatment. This conduct constitutes more than sufficient grounds to sanction Respondent's medical license. Furthermore, Respondent was previously sanctioned by the Board for the exact same conduct. It is clear that she has no intention of changing her behavior. For these reasons, the undersigned concludes that Respondent's license should be revoked.

ORDER

For the above and foregoing reasons, Respondent's medical license is hereby **REVOKED**.

SO ORDERED, this 16th day of March, 2015.

STEPHANIE M. HOWELLS
Administrative Law Judge