Final Order No. DOH-07-2173-S-MQA
FILED DATE OCT 17 2007
Department of Health
By: Rachel R
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NOS.: 1999-55618
2001-05263
2005-01205
LICENSE NO.: ME0017474

PHILIP K. SPRINGER, M.D.,

Respondent.
_____/

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) pursuant to Sections 120.569 and 120.57(4), Florida Statutes, on October 5, 2007, in Orlando, Florida, for the purpose of considering a Settlement Agreement (attached hereto as Exhibit A) entered into between the parties in this cause. Upon consideration of the Settlement Agreement, the documents submitted in support thereof, the arguments of the parties, and being otherwise fully advised in the premises, the Board rejected the Settlement Agreement and offered a Counter Settlement Agreement which was accepted on the record by the parties. The Counter Settlement Agreement incorporates the original Settlement Agreement with the following amendments:

1. The costs set forth in Paragraph 6 of the Stipulated Disposition as agreed upon at the hearing and on the record shall be set at $28,147.38.

2. The restriction on practice regarding the prescribing of legend drugs as set forth in Paragraph 4.(C) of the Stipulated shall be deleted.

3. The direct supervision set forth in Paragraph 10.(A)i., of the Stipulated Disposition shall be amended to grant temporary approval of Respondent's proposed monitor, Elio Madan, M.D. In addition, Respondent shall submit the name of an alternate supervising physician who can directly supervise him in the event that his supervising physician is unavailable for any reason.

4. The responsibilities of the supervising physician set forth in Paragraph 10.(A) v. a) of the Stipulated Disposition shall be amended to require the supervising physician to review 100% review of Respondent's patient records.

IT IS HEREBY ORDERED AND ADJUDGED that the Settlement Agreement as submitted be and is hereby approved and adopted in toto and incorporated herein by reference with the amendments set forth above. Accordingly, the parties shall adhere to and abide by all the terms and conditions of the Settlement Agreement as amended.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 16 day of OCTOBER, 2007.

BOARD OF MEDICINE

Larry McPherson, Jr., Executive Director
for H. FRANK FARMER, JR., M.D., Chair

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to PHILIP K. SPRINGER, M.D., 701 SW 80th Drive, Gainesville, Florida 32607; and Florida State Prison, 7819 NW 228th Street, Raiford, Florida 32026-1000; to William Furlow, Esquire, 106 East College Avenue, Suite 1200, P.O. Box 1877, Tallahassee, Florida 32301; and by interoffice delivery to Ephraim Livingston, Department of Health, 4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-3253 this 17th day of October, 2007.

Jackie Ryles

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Deputy Agency Clerk

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

Petitioner,

v.

DOH Case Nos. 1999-55618
2001-05263
2005-01205

PHILIP SPRINGER, M.D.

Respondent.
_____/

SETTLEMENT AGREEMENT

Philip Springer, M.D., referred to as the "Respondent," and the Department of Health, referred to as "Department" stipulate and agree to the following Agreement and to the entry of a Final Order of the Board of Medicine, referred to as "Board," incorporating the Stipulated Facts and Stipulated Disposition in this matter.

Petitioner is a state agency charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes, and Chapter 456, Florida Statutes, and Chapter 458, Florida Statutes.

STIPULATED FACTS

1. At all times material hereto, Respondent was a licensed physician in the State of Florida having been issued license number ME 0017474.

2. The Department charged Respondent with two Administrative Complaints that were filed and properly served upon Respondent alleging violations of Chapter 458, Florida Statutes, and the rules adopted pursuant thereto. A true and correct copy of the Administrative Complaints is attached hereto as Exhibit A.

3. Respondent neither admits nor denies the allegations of fact contained in the Administrative Complaints for purposes of these proceedings only.

STIPULATED CONCLUSIONS OF LAW

1. Respondent admits that, in his capacity as a licensed physician, he is subject to the provisions of Chapters 456 and 458, Florida Statutes, and the jurisdiction of the Department and the Board.

2. Respondent admits that the facts alleged in the Administrative Complaint, if proven, would constitute violations of Chapter 458, Florida Statutes, as alleged in the Administrative Complaint.

3. Respondent agrees that the Stipulated Disposition in this case is fair, appropriate and acceptable to Respondent.

STIPULATED DISPOSITION

1. **Reprimand** - The Board shall reprimand the license of Respondent.

2. **Fine** - The Board of Medicine shall impose an administrative fine of twenty-five thousand ($25,000) dollars against the license of Respondent, to be paid by Respondent to the Department of Health, HMQAMS/Client Services, Post

Office Box 6320, Tallahassee, Florida 32314-6320, Attention: Board of Medicine Compliance Officer, within thirty-days (30) from the date of filing of the Final Order accepting this Agreement. All fines shall be paid by check or money order. The Board office does not have the authority to change the terms of payment of any fine imposed by the Board.

RESPONDENT ACKNOWLEDGES THAT THE TIMELY PAYMENT OF THE FINE IS HIS/HER LEGAL OBLIGATION AND RESPONSIBILITY AND RESPONDENT AGREES TO CEASE PRACTICING IF THE FINE IS NOT PAID AS AGREED TO IN THIS SETTLEMENT AGREEMENT, SPECIFICALLY: IF WITHIN 45 DAYS OF THE DATE OF FILING OF THE FINAL ORDER, RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION THAT THE FULL AMOUNT OF THE FINE HAS BEEN RECEIVED BY THE BOARD OFFICE, RESPONDENT AGREES TO CEASE PRACTICE UNTIL SUCH WRITTEN CONFIRMATION IS RECEIVED BY RESPONDENT FROM THE BOARD.

3. **Suspension of License** - Respondent's license shall be suspended for a period of one (1) year; however, the Board will stay this suspension and Respondent shall be placed on probation for a period of five (5) years.

4. **Permanent Restriction of License**:

(A) **Restriction on Practice** - Respondent's practice is permanently restricted in that Respondent may not practice medicine except within the confines of the duties and responsibilities of his current employment within the Florida Prison system.

(B) **Restriction on Practice (Controlled Substances)** - Respondent's practice is permanently restricted in that Respondent may not prescribe, administer, or dispense any controlled substance.

(C) **Restriction of Practice (Legend Drugs)** - Respondent's practice is permanently restricted in that Respondent may not prescribe any legend drugs unless approved by his supervising physician.

5. **DEA Licensure** – Respondent shall be permanently restricted from applying for or possessing a DEA license for any controlled substance.

6. **Reimbursement Of Costs** - Pursuant to Section 456.072, Florida Statutes, Respondent agrees to pay the Department for any administrative costs incurred in the investigation and preparation of this case. Such costs exclude the costs of obtaining supervision or monitoring of the practice, the cost of quality assurance reviews, and the Board's administrative cost directly associated with Respondent's probation, if any. The agreed upon amount of Department costs to be paid in this case includes but shall not exceed sixteen thousand ($16,000). Respondent will pay costs to the Department of Health, HMQAMS/Client Services, P.O. Box 6320, Tallahassee, Florida 32314-6320, Attention: Board of Medicine Compliance Officer within thirty-days (30) from the date of filing of the Final Order in this cause. Any post-Board costs, such as the costs associated with probation, are not included in this agreement.

7. **Laws And Rules Course** - Respondent shall complete the Laws and Rules Course, administered by the Florida Medical Association, within one (1) year of the date of filing of the Final Order of the Board. In addition, Respondent shall submit documentation in the form of certified copies of the receipts, vouchers, certificates, or other papers, such as physician's recognition awards, documenting completion of this medical education course within one (1) year of the date of filing of the Final Order incorporating this Agreement. **All such documentation shall be sent to the Board of Medicine, regardless of whether some or any of such documentation was previously provided during the course of any audit or discussion with counsel for the Department. These hours shall be in addition to those required for renewal of licensure. Unless otherwise approved by the Board, said continuing medical education courses shall consist of a live, lecture format.**

8. **Records Course** - Respondent shall complete the course, "Quality Medical Record Keeping for Health Care Professionals," sponsored by the Florida Medical Association, or a Board-approved equivalent, within one year of the date of filing of the Final Order.

9. **Continuing Medical Education** - Within one year of the date of the filing of a Final Order in this cause, Respondent shall attend TEN (10) hours of Continuing Medical Education (CME) in Psychiatric Treatment applicable to Respondent's current scope of employment within the prison system. Respondent shall first submit a written request to the Probation Committee for approval prior to

performance of said continuing medical education course(s). Respondent shall submit documentation in the form of certified copies of the receipts, vouchers, certificates, or other papers, such as physician's recognition awards, documenting completion of this medical course within one (1) year of the date of filing of the Final Order in this matter. All such documentation shall be sent to the Board of Medicine, regardless of whether some or any of such documentation was provided previously during the course of any audit or discussion with counsel for the Department. These hours shall be in addition to those hours required for renewal of licensure. Unless otherwise approved by the Board, said continuing medical education course(s) shall consist of a formal, live lecture format.

10. **Probation of License** - Effective on the date of the filing of the Final Order incorporating the terms of this Agreement, Respondent's license to practice medicine shall be placed on probation for a period of FIVE (5) years. The purpose of probation is not to prevent Respondent from practicing medicine. Rather, probation is a supervised educational experience designed by the Board to make Respondent aware of certain obligations to Respondent's patients and the profession and to ensure Respondent's continued compliance with the high standards of the profession through interaction with another physician in the appropriate field of expertise. To this end, during the period of probation, Respondent shall comply with the following obligations and requirements:

(A) **Restrictions During Probation** - During the period of probation, Respondent's license shall be restricted as follows:

i. **Direct Supervision** - Respondent shall practice only under the direct supervision of Elio Madan, MD, Chief Health Officer of the Florida State Prison in Raiford, Florida, hereinafter referred to as the "supervisor", whose responsibilities are set by the Board. The supervising physician shall be board certified in Respondent's specialty area unless otherwise provided by the Board.

ii. **Required Supervision:**

a) Respondent shall not practice medicine without an approved monitor/supervisor, as specified by the Agreement, unless otherwise ordered by the Board.

b) The monitor/supervisor must be a licensee under Chapter 458, Florida Statutes, in good standing and without restriction or limitation on his license. In addition, the Board may reject any proposed monitor/supervisor on the basis that he has previously been subject to any disciplinary action against his medical license in this or any other jurisdiction, is currently under investigation, or is the subject of a pending disciplinary action. The Board may also reject any proposed monitor/supervisor for good cause shown.

iii. **Mechanism For Approval Of Monitor/Supervisor:**

a) **Temporary Approval** - The Board confers authority on the Chairman of the Probation Committee to

temporarily approve Respondent's monitor/supervisor. To obtain this temporary approval, Respondent shall submit to the Chairman of the Probation Committee the name and curriculum vitae of the proposed monitor/supervisor at the time this agreement is considered by the Board. **Once a Final Order adopting the Agreement is filed, Respondent shall not practice medicine without an approved monitor/supervisor. Temporary approval shall only remain in effect until the next meeting of the Probation Committee.**

b) **Formal Approval** - Respondent shall have the monitor/supervisor with Respondent at Respondent's first probation appearance before the Probation Committee. Prior to the consideration of the monitor/supervisor by the Probation Committee, Respondent shall provide to the monitor/supervisor a copy of the Administrative Complaint and Final Order in this case. Respondent shall submit a current curriculum vita and a description of current practice from the proposed monitor/supervisor to the Board office no later than fourteen (14) days before Respondent's first scheduled probation appearance. Respondent's monitor/supervisor shall also appear before the Probation Committee at such other times as directed

by the Probation Committee. It shall be Respondent's responsibility to ensure the appearance of the monitor/supervisor as directed. Failure of the monitor/supervisor to appear as directed shall constitute a violation of the terms of this Settlement Agreement and shall subject Respondent to disciplinary action.

iv. **Change In Monitor/Supervisor** - In the event that Respondent's monitor/supervisor is unable or unwilling to fulfill the responsibilities of a monitor/supervisor as described above, Respondent shall immediately advise the Probation Committee of this fact. Respondent shall immediately submit to the Chairman of the Probation Committee the name of a temporary monitor/supervisor for consideration. Respondent shall not practice pending approval of this temporary monitor/supervisor by the Chairman of the Probation Committee. Furthermore, Respondent shall make arrangements with his temporary monitor/supervisor to appear before the Probation Committee at its next regularly scheduled meeting for consideration of the monitor/supervisor by the Probation Committee. Respondent shall only practice under the auspices of the temporary monitor/supervisor (approved by the Chairman) until the next regularly scheduled meeting of the Probation Committee at

which the issue of the Probation Committee's approval of Respondent's new monitor/supervisor shall be addressed.

v. **Responsibilities Of The Monitor/Supervisor** - The Monitor shall:

a) Review 25% percent of Respondent's active patient records at least once every quarter for the purpose of ascertaining quality of care. The monitor shall go to Respondent's office once every quarter and shall review Respondent's calendar or patient log and shall select the records to be reviewed.

b) Submit reports on a quarterly basis, in affidavit form, which shall include:

1) A brief statement of why Respondent is on probation;

2) A description of Respondent's practice (type and composition);

3) A statement addressing Respondent's compliance with the terms of probation;

4) A brief description of the monitor's relationship with Respondent;

5) A statement advising the Probation Committee of any problems which have arisen; and

6) The number of records reviewed, and the overall quality of the records reviewed, and the dates Respondent contacted the monitor pursuant to subsection b), 3), above.

c) Report immediately to the Board any violations by Respondent of Chapters 456 or 458, Florida Statutes, and the rules promulgated thereto.

f) Respondent's monitor shall appear before the Probation Committee at the first meeting of said committee following commencement of the probation, and at such other times as directed by the Committee. It shall be Respondent's responsibility to ensure the appearance of Respondent's monitor to appear as requested or directed. If the approved monitor fails to appear as requested or directed by the Probation Committee, **Respondent shall immediately cease practicing medicine until such time as the approved monitor or alternate monitor appears before the Probation Committee.**

vii. **Reports From Respondent** - Respondent shall submit quarterly reports, in affidavit form, the contents of which may be further specified by the Board, but which shall include:

a) A brief statement of why Respondent is on probation;

b) A description of practice location;

c) A description of current practice (type and composition);

d) A brief statement of compliance with probationary terms;

e) A description of the relationship with monitoring physician;

f) A statement advising the Board of any problems which have arisen; and

g) A statement addressing compliance with any restrictions or requirements imposed.

RESPONDENT ACKNOWLEDGES THAT THE TIMELY PAYMENT OF THE COSTS IS HIS/HER LEGAL OBLIGATION AND RESPONSIBILITY AND RESPONDENT AGREES TO CEASE PRACTICING IF THE COSTS ARE NOT PAID AS AGREED TO IN THIS SETTLEMENT AGREEMENT, SPECIFICALLY: IF WITHIN 45 DAYS OF THE DATE OF FILING OF THE FINAL ORDER, RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION THAT THE

FULL AMOUNT OF THE COSTS NOTED ABOVE HAS BEEN RECEIVED BY THE BOARD OFFICE, RESPONDENT AGREES TO CEASE PRACTICE UNTIL SUCH WRITTEN CONFIRMATION IS RECEIVED BY RESPONDENT FROM THE BOARD.

STANDARD PROVISIONS

11. **Appearance**: Respondent is required to appear before the Board at the meeting of the Board where this Agreement is considered.

12. **No force or effect until final order** - It is expressly understood that this Agreement is subject to the approval of the Board and the Department. In this regard, the foregoing paragraphs (and only the foregoing paragraphs) shall have no force and effect unless the Board enters a Final Order incorporating the terms of this Agreement.

13. **Addresses** - Respondent must keep current residence and practice addresses on file with the Board. Respondent shall notify the Board within ten (10) days of any changes of said addresses.

14. **Future Conduct** - In the future, Respondent shall not violate Chapter 456, 458 or 893, Florida Statutes, or the rules promulgated pursuant thereto, or any other state or federal law, rule, or regulation relating to the practice or the ability to practice medicine. Prior to signing this agreement, the Respondent shall read Chapters 456, 458 and 893 and the Rules of the Board of Medicine, at Chapter 64B8, Florida Administrative Code.

15. **Violation of terms considered** - It is expressly understood that a violation of the terms of this Agreement shall be considered a violation of a Final Order of the Board, for which disciplinary action may be initiated pursuant to Chapters 456 and 458, Florida Statutes.

16. **Purpose of Agreement** - Respondent, for the purpose of avoiding further administrative action with respect to this cause, executes this Agreement. In this regard, Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent prior to or in conjunction with consideration of the Agreement. Respondent agrees to support this Agreement at the time it is presented to the Board and shall offer no evidence, testimony or argument that disputes or contravenes any stipulated fact or conclusion of law. Furthermore, should this Agreement not be accepted by the Board, it is agreed that presentation to and consideration of this Agreement and other documents and matters by the Board shall not unfairly or illegally prejudice the Board or any of its members from further participation, consideration or resolution of these proceedings.

17. **No preclusion of additional proceedings** - Respondent and the Department fully understand that this Agreement and subsequent Final Order incorporating same will in no way preclude additional proceedings by the Board and/or the Department against Respondent for acts or omissions not specifically set forth in the Administrative Complaint attached as Exhibit A.

18. **Waiver of attorney's fees and costs** - Upon the Board's adoption of this Agreement, the parties hereby agree that with the exception of costs noted above, the parties will bear their own attorney's fees and costs resulting from prosecution or defense of this matter. Respondent waives the right to seek any attorney's fees or costs from the Department and the Board in connection with this matter.

19. **Waiver of further procedural steps** - Upon the Board's adoption of this Agreement, Respondent expressly waives all further procedural steps and expressly waives all rights to seek judicial review of or to otherwise challenge or contest the validity of the Agreement and the Final Order of the Board incorporating said Agreement.

SIGNED this 5 day of June, 2007.

Philip Springer, M.D.

Before me, personally appeared PHILIP SPRINGER, whose identity is known to me by DRIVERS LICENSE (type of identification) and who, under oath, acknowledges that his/her signature appears above.

Sworn to and subscribed before me this 5th day of JUNE, 2007.

NOTARY PUBLIC

My Commission Expires:

Karen J. Redding
Commission #DD370129
Expires: Nov 12, 2008
Bonded Thru
Atlantic Bonding Co., Inc.

APPROVED this 19 day of June, 2007.

Ana M. Viamonte, M.D., M.P.H.
Secretary, Department of Health

Carol L. Gregg

By: Carol L. Gregg
Elana J. Jones
Assistant General Counsel
Department of Health

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NOS. 1999-55618**
2001-05263

PHILIP K. SPRINGER, M.D.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

Petitioner, Department of Health, by and through undersigned counsel, and files this Administrative Complaint before the Board of Medicine against Respondent, Philip K. Springer, M.D., and in support thereof alleges:

FACTS RELEVANT TO ALL CASE NUMBERS AND COUNTS

1. Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed physician within the State of Florida, having been issued license number ME17474.

3. Respondent's mailing address of record is 701 SW 80th Drive, Gainesville, Florida 32607.

4. Respondent is not board certified, but his area of practice at all times material to this Administrative Complaint was psychiatry.

5. In order to receive payment for services rendered to a Medicaid/Medicare eligible patient, qualifying medical providers in the State of Florida submit fee-for-service claims to Medicaid, Florida Medicare, and/or private insurance carriers. Claims submitted to both Medicaid and Medicare utilize current procedural terminology codes, known as CPT, which correspond to a description of the specific treatment provided to the patient. Both Medicaid and Medicare share the same procedural codes.

6. It is improper to bill both Medicare and Medicaid for single services rendered to one particular patient.

7. It is an unlawful billing procedure for an eligible medical provider to bill Medicare, Medicaid, or a private insurer for medical services that were not necessary or were never performed.

8. It is an unlawful billing procedure for a provider to bill Medicare, Medicaid, or a private insurer at the highest CPT Code level for a service rendered unless that level of service was actually performed.

9. It is an unlawful billing procedure for a provider to bill Medicare, Medicaid, or a private insurer for services rendered by the license provider

when it was actually performed by a person other than the licensed provider or performed without the proper supervision of the licensed provider.

10. Medicaid permits certain billed procedures to be performed by a licensed clinic staff member under Respondent's supervision. However, the State of Florida, Agency for Health Care Administration licensing records reveal that the Springer Group did not retain any licensed staff members other than Respondent.

11. Section 409.920, Florida Statutes (1999), establishes what practices constitute Medicaid provider fraud. The statute states, in pertinent parts:

> (2) It is unlawful to:
>
> > (a) Knowingly make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the agency or its fiscal agent for payment...
> >
> > (c) Knowingly charge, solicit, accept, or receive anything of value, other than an authorized copayment from a Medicaid recipient, from any source in addition to the amount legally payable for an item or service provided to a Medicaid recipient under the Medicaid program or knowingly fail to credit the agency or its fiscal agent for any payment received from a third-party source.

12. Rule 64B8-9.013, Florida Administrative Code (1999), outlines the guidelines for a pain management physician when evaluating a patient for the

use of controlled substances for pain control. The rule states, in pertinent part:

> (3) The Board has adopted the following guidelines when evaluating the use of controlled substances for pain control:
>
> > (a) Evaluation of the Patient. A **complete medical history** and **physical examination MUST be conducted** and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and **history of substance abuse**...
> >
> > (d) Periodic Review. At reasonable intervals based on the individual circumstances of the patient the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician's evaluation of progress toward stated treatment objectives. If treatment goals are **NOT** being achieved, ... the physician should reevaluate the **appropriateness of continued treatment**...
> >
> > (f) Medical Records. The physician is required to keep **accurate** and **complete** records to include, but not limited to:
> >
> > 1. the medical history and physical examination;
> > 2. diagnostic, therapeutic, and laboratory results;
> > 3. evaluations and consultation;
> > 4. treatment objectives;
> > 5. discussion of risks and benefits;
> > 6. treatments;
> > 7. medications;
> > 8. instructions and agreements; and
> > 9. periodic reviews. (Emphasis added.)

FACTS AND COUNTS RELEVANT TO CASE NUMBER 1999-55618

13. THE SPRINGER GROUP, P.A. (the Group) is a psychiatry and pain management clinic operating at 9120 N.W. 36th Place in Gainesville, Florida.

14. Respondent, a licensed physician practicing as a psychiatrist in Gainesville, was the principal physician involved with the Group.

15. An "Investigative Taskforce" used a confidential informant (CI), who had prior direct dealings as a patient with Respondent, to make undercover visits to the Group.

16. The undercover visits to the Group took place between April 21, 1999 and September 14, 1999.

17. During each undercover visit to the Group, CI was provided with copies of medical evaluation documents which contained fraudulent subjective information allegedly provided by CI.

18. During several of the undercover visits, CI had no personal contact, dialogue, or evaluation with Respondent.

19. Respondent failed to maintain adequate medical records that justified the course of treatment provided to CI by Respondent.

20. On several occasions, individuals not employed with the Group, or licensed to perform medical services, were allowed to take CI's vital signs.

FACTS RELATING TO APRIL 21, 1999 OFFICE VISIT

21. On or about April 21, 1999, (the first visit) CI, with the assistance of the Drug Enforcement Administration (DEA), made a controlled, undercover visit to the Group.

22. During this first visit, CI attended a group therapy session with approximately twenty (20) other people.

23. During this first visit, CI obtained the following prescriptions, all dated April 21, 1999: one prescription for one-hundred twenty (120) tablets of Lortab 10mg (Schedule III); one prescription for thirty-six (36) tablets of Mepergan Fortis 50mg (Schedule II); one prescription for thirty (30) tablets of Trazadone 150 mg (Schedule II); four (4) boxes (eight (8) total tablets) of Maxalt 10mg (Schedule II); and a medical evaluation report.

24. Lortab contains hydrocodone bitartrate, a Schedule III controlled substance listed in Chapter 893, Florida Statutes, which is indicated for the relief of moderate to moderately severe pain. The abuse of hydrocodone bitartrate can lead to physical and psychological dependence.

25. Mepergan Fortis is a brand name for promethazine with meperidine. Mepergan Fortis contains meperidine, a Schedule II controlled substance listed in Chapter 893, Florida Statutes, which is indicated for the relief of nausea and vomiting, and the treatment of moderate to severe pain.

Abuse of meperidine may lead to limited physical or psychological dependence.

26. Trazadone is a Schedule II controlled substance listed in Chapter 893, Florida Statutes, and is an antidepressant which may act by preventing the reuptake of serotonin into neurons. Abuse of trazadone may lead to limited physical or psychological dependence.

27. Maxalt is a Schedule II controlled substance listed in Chapter 893, Florida Statutes, and is indicated for the acute treatment of migraine attacks with or without aura in adults. Abuse of maxalt may lead to limited physical or psychological dependence.

28. At no time during the first visit did Respondent conduct any type of medical examination on CI or perform any therapy or tests.

29. Respondent electronically submitted an independent claim to Medicaid using CPT Code 90807 for services allegedly rendered to CI on April 21, 1999. This CPT Code corresponds to the profile for a 45-55 minute individual psychotherapy session.

30. Respondent did not provide an individual psychotherapy session to CI during the first visit.

FACTS RELATING TO JUNE 9, 1999 OFFICE VISIT

31. On or about June 9, 1999 (second visit), CI made another controlled undercover visit to the Group and attended another "group therapy" session.

32. The receptionist at the Group gave CI prescriptions, issued by Respondent, without CI having any contact with Respondent concerning the prescriptions. CI exited the premises.

33. Shortly thereafter, CI realized the receptionist had given him another patient's prescriptions and CI returned to the Group.

34. After CI had returned to the Group, he met with Respondent for approximately seven (7) minutes to clarify the mix-up, and the prescriptions were exchanged. No assessment, evaluation, or testing was conducted on CI to validate his claims.

35. CI obtained the following prescriptions during the second visit: all dated June 9, 1999: one prescription for thirty-six (36) tablets of Mepergan Fortis 50mg; one prescription for one-hundred twenty (120) tablets of Lortab 10mg; one prescription for one-hundred twenty (120) tablets of Valium (Schedule II); one prescription for forty-two (42) pills of Phenergan 25mg (Schedule II); one prescription for forty-two (42) tablets of Soma 350mg

(Schedule III); four (4) boxes (eight (8) total tablets) of Maxalt; and a two-page medical evaluation report.

36. Valium is a brand name for the drug diazepam, a Schedule II controlled substance listed in Chapter 893, Florida Statutes, which is used as a muscle relaxant and may relieve pain in people who have muscle spasms. Abuse of diazepam may lead to limited physical or psychological dependence.

37. Phenergan is a brand name for promethazine, a Schedule II controlled substance listed in Chapter 893, Florida Statutes, which is an antihistamine that blocks the effects of naturally occurring chemical histamine in the body. Promethazine is used to treat allergic symptoms and reactions. Abuse of promethazine may lead to limited physical or psychological dependence.

38. Soma is a brand name for carisoprodol, a Schedule III controlled substance listed in Chapter 893, Florida Statutes, which is used as a muscle relaxant. Abuse of carisoprodol can lead to physical or psychological dependence.

39. Respondent electronically submitted an independent Medicaid claim on behalf of CI for the second visit. Respondent used CPT Code 90862, corresponding to an individual psychotherapy session lasting 45-54 minutes, which was never provided to CI during the second visit.

FACTS RELATING TO JUNE 29, 1999 OFFICE VISIT

40. On or about June 29, 1999, the CI made a third undercover controlled visit to the Group. Once again, CI attended a "group therapy" session.

41. During the third visit "group therapy" session, CI obtained the following prescriptions: one prescription for thirty-six (36) pills of Mepergan Fortis 50 mg; one prescription for one-hundred twenty (120) tablets of Lortab 10mg; one prescription for eight (8) tablets of Maxalt 10mg; one prescription for forty-two (42) tablets of Soma, 350mg; and a two-page medical evaluation report.

42. Respondent subsequently billed Medicaid for services allegedly performed by Respondent on CI during the third visit.

43. Respondent also billed Medicare for services allegedly performed by Respondent on CI during the third visit.

44. Respondent did not evaluate or examine CI during the third visit.

FACTS RELATING TO JULY 29, 1999 OFFICE VISIT

45. On July 29, 1999, CI made a fourth undercover controlled visit to the Group. Once again, CI attended a "group therapy" session.

46. During the fourth visit, CI obtained the following prescriptions: one prescription for thirty-six (36) pills of Mepergan Fortis 50 mg; one

prescription for forty-two (42) Phenergan 25 mg; one prescription for eight (8) tablets of Maxalt 10mg; one prescription for forty-two (42) tablets of Soma 350 mg; and a two-page medical evaluation report.

47. During the subsequent debriefing with the DEA, it was discovered that the evaluation sheet, given to CI by Respondent, said that CI should have received five total prescriptions, instead of the four he was given; a prescription for one-hundred twenty (120) tablets Lortab, 10mg, had not been provided to CI.

48. At approximately 12:50pm, CI returned to Respondent's office. CI met with Respondent and asked for the missing Lortab prescription.

49. Respondent did not conduct any investigation as to whether a prior prescription was ever written for CI or conduct any examination or assessment of CI before subsequently writing out and signing a prescription for the Lortab.

50. Respondent electronically submitted a Medicaid claim on behalf of CI using CPT codes 90807 and 90862, which correspond to an individual psychotherapy session lasting 45-50 minutes, and pharmacological management including prescription.

51. Respondent did not conduct an individual psychotherapy session or pharmacological evaluation of CI during the fourth visit.

FACTS RELATING TO AUGUST 18, 1999 OFFICE VISIT

52. On August 18, 1999, CI, with the assistance of the DEA, made a fifth controlled undercover visit to the Group.

53. CI obtained the following prescriptions, all dated August 18, 1999: one prescription for thirty-six (36) pills of Mepergan Fortis 50 mg; one prescription for one-hundred twenty (120) tablets of Lortab 10mg; one prescription for eight (8) tablets of Maxalt 10mg; one prescription for forty-two (42) tablets of Soma, 350mg; and a two-page medical evaluation report.

54. Respondent electronically submitted a Medicaid claim on behalf of CI using CPT code 90862, corresponding to the profile for pharmacological management including prescription.

55. Respondent had no personal contact with CI and did not conduct a pharmacological management consultation during the fifth visit.

FACTS RELATING TO SEPTEMBER 14, 1999 OFFICE VISIT

56. On or about September 14, 1999, CI made a sixth controlled undercover visit to the Group.

57. During the sixth visit, CI again attended a "group therapy" session and obtained the following prescriptions: one prescription for one-hundred twenty tablets of Lortab 10mg; one prescription for thirty-six (36) tablets of Mepergan Fortis 50mg; one forty-two (42) count prescription of Soma 42mg;

one eight (8) count prescription of Maxalt 10mg; and a two-page medical evaluation report.

58. Respondent electronically submitted a Medicaid claim on behalf of CI using the CPT Code 90805, corresponding to the profile of an individual psychotherapy session.

59. Respondent had no personal contact or conversation with CI during the sixth visit.

60. Respondent never provided individual psychotherapy to CI during the sixth visit.

COUNT ONE

61. Petitioner realleges and incorporates paragraphs one (1) through sixty (60) as if fully set forth herein.

62. Section 458.331(1)(h), Florida Statutes (1999), provides that making or filing a report which the licensee knows to be false or intentionally or negligently failing to file a report or record required by state or federal law constitutes grounds for disciplinary action by the Board of Medicine.

63. Respondent willfully filed fraudulent claims with Florida Medicaid and Medicare in one or more of the following ways:

a. Respondent knowingly made or caused to be made false statements and false representations of material fact in claims

submitted to Medicare and Medicaid for payment on behalf of CI on the following dates: April 21, 1999; June 6, 1999; June 29, 1999; July 29, 1999; August 18, 1999, and September 14, 1999; or

b. Respondent knowingly charged, solicited, accepted, or received payments, other than an authorized co-payment from CI, from Medicare in addition to the amount legally payable for an item or service provided to a CI under the Medicaid program by submitting duplicate claims to Medicare for treatments or procedures already billed to Medicaid on behalf of CI.

64. Based on the foregoing, Respondent has violated Section 458.331(1)(h), Florida Statutes (1999), by knowingly filing fraudulent claims with the Florida Medicare and Medicaid programs and filing materially fraudulent reports and records required by state and federal law to substantiate his fraudulent claims.

COUNT TWO

65. Petitioner realleges and incorporates paragraphs one (1) through sixty (60) as if fully set forth herein.

66. Section 458.331(1)(k), Florida Statutes (1999), provides that making deceptive, untrue, or fraudulent representations in or related to the

practice of medicine or employing a trick or scheme in the practice of medicine constitutes grounds for disciplinary action by the Board of Medicine.

67. Respondent submitted fraudulent documentation, made fraudulent billing claims, and employed deceptive methods with CI to defraud the Florida government of Medicaid and Medicare funds.

68. Based on the foregoing, Respondent has violated Section 458.331(1)(k), Florida Statutes (1999), by making deceptive, untrue, or fraudulent representations in or related to the practice of medicine.

COUNT THREE

69. Petitioner realleges and incorporates paragraphs one (1) through sixty (60) as if fully set forth herein.

70. Section 458.331(1)(m), Florida Statutes (1999), provides that failing to keep legible, as defined by department rule, medical records that justify the course of treatment of the patient including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations constitutes grounds for disciplinary action by the Board of Medicine against the licensee.

71. Respondent failed to maintain adequate medical records for CI by failing to include records of CI's physical examination results and

comprehensive medical history during the office visits that occurred on: April 21, 1999; June 6, 1999; June 29, 1999; July 29, 1999; August 18, 1999, and September 14, 1999.

72. Respondent failed to maintain adequate medical records that justified the necessity for the prescriptions of controlled substances issued to CI during his office visits on: April 21, 1999; June 6, 1999; June 29, 1999; July 29, 1999; August 18, 1999, and September 14, 1999.

73. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (1999), by failing to keep adequate medical records that justify the course of treatment of the patient.

COUNT FOUR

74. Petitioner realleges and incorporates paragraphs one (1) through sixty (60) as if fully set forth herein.

75. Section 458.331(1)(q), Florida Statutes (1999), provides that prescribing, dispensing, administering, or otherwise preparing a controlled substance other than in the course of the physician's professional practice constitutes grounds for disciplinary action by the Board of Medicine. For the purpose of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive quantities is not in the

best interest of the patient and is not in the course of the physician's professional practice, without regard to his or her intent.

76. Respondent prescribed controlled substances to CI, on April 21, 1999; June 6, 1999; June 29, 1999; July 29, 1999; August 18, 1999, and September 14, 1999, without first performing a physical examination of CI.

77. Respondent prescribed controlled substances to CI, on April 21, 1999; June 6, 1999; June 29, 1999; July 29, 1999; August 18, 1999, and September 14, 1999, without creating/maintaining adequate medical records for CI.

78. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (1999), by prescribing, dispensing, administering, supplying, selling, or otherwise preparing a controlled substance other than in the course of his professional practice.

COUNT FIVE

79. Petitioner realleges and incorporates paragraphs one (1) through sixty (60) as if fully set forth herein.

80. Section 458.331(1)(t), Florida Statutes (1999), provides that gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar

physician as being acceptable under similar conditions and circumstances constitutes grounds for disciplinary action by the Board of Medicine.

81. Respondent failed to practice medicine with that level of care that is recognized by reasonably prudent similar physician as being acceptable under similar conditions and circumstances in one or more of the following ways:

a. Respondent prescribed Lortab, Mepergan Fortis, Zyprexa, Trazadone, Maxalt, Phenergen, Valium, and Soma, all controlled substances requiring a prescription, to CI without conducting an adequate evaluation, including a history and physical examination, before prescribing said controlled substances to CI;

b. Respondent did not render a proper diagnosis for CI before prescribing said controlled substances; or

c. Respondent did not maintain adequate medical records for CI.

82. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes (1999), by failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as acceptable under similar conditions and circumstances.

COUNT SIX

83. Petitioner realleges and incorporates paragraphs one (1) through sixty (60) as if fully set forth herein.

84. Section 458.331(1)(w), Florida Statutes (1999), provides that delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified by training, experience, or licensure to perform them is grounds for disciplinary action against the licensee by the Board of Medicine.

85. Respondent knowingly allowed unlicensed staff members and patients present at his clinic during "group therapy" sessions to take vital signs and other medical information to be used in Respondent's medical records and documentation for CI.

86. Respondent violated Section 458.331(1)(w), Florida Statutes (1999), by delegating his professional duties to persons the Respondent knew or had reason to know were not qualified by training, experience, or licensure to perform.

FACTS AND COUNTS RELEVANT TO CASE NUMBER 2001-05263

87. On or about March 21, 2000, Respondent initially evaluated Patient S.H., a twenty-three (23) year-old male, for chronic pain and recorded his notes on a "Personal Progress Interactive Note" (hereinafter Note 1).

88. Respondent did not conduct a complete physical examination or make mention of a history of lower back pain during the initial evaluation of Patient S.H. However, Respondent's Note 1 listed a diagnosis of "Pain Disorder; predominantly medical (chronic)."

89. In Note 1, Respondent described Patient S.H.'s course of treatment as: "The patient began treatment on March 21, 2000 and is currently in Treatment Phase I."

90. Phase I was further defined within Note 1 as:

(1) Initially exploratory individual psycholotherapy with attention to personal, developmental and family issues. (2) Further exploration for appropriate medication. (3) Sharing findings with patient as we proceed so as to mobilize patient initiative. (4) Continuing to share the complexities of the Initial Evaluation with special emphasis on how the personality or character may influence anxiety and depression and (5) offering the 12-step process is emphasized as a means of restoring hope and healing damages to character and personality while comparing it with traditional methods. (6) Recommend early entry into Group Psychotherapy which will run parallel to individual work.

91. Although Respondent's Note 1 for Patient S.H. reflected a plan outline to include "Psychological Treatment, Physical Treatment, and

Pharmacological Treatment", there were no written directions beside any of the options for any treatment follow up for or by Patient S.H.

92. Through a Psychiatric Examination Report, dated March 21, 2000, Respondent recommended the following treatment for Patient S.H.: "individual therapy, group therapy, and medication."

93. On or about April 4, 2000, Patient S.H. presented to Respondent. Respondent's Personal Progress Interactive Note (hereinafter Note 2) recorded that Patient S.H. has "spondylolysis and spondylolisthesis," but he was not a surgical candidate.

94. Further, Note 2 reflected that Patient S.H. had been "given Oxycontin for pain relief for a year in Tenn. but has not had pain medication for the last 6 months." Note 2 reflects that Patient S.H. has been taking "a great deal of Tylenol."

95. Respondent's assessment of Patient S.H. in Note 2 stated: "Though he has reached partial control with the help of medication, chronic pain still remains a significant problem for" Patient S.H. Further, Note 2 states: Patient S.H. "has a chronic pain problem with some evidence of obsessional night thinking (about pain.) We will use Oxycontin and a trial of Zyprexa at night only."

96. Respondent's Note 2 for Patient S.H. reflected the following "Plan" outline: "Psychological Treatment: Group and Individual"; "Physical Treatment: Dr. Scott"; "Pharmacological Treatment: see list"; and "Social/Vocational: active and working full time".

97. Respondent initiated pharmacological treatment for Patient S.H. on or about April 4, 2000 with Oxycontin and Topamax.

98. Respondent's Note 2 recorded the prescriptions of Oxycontin and Topamax, however no amount, strength, or directions are recorded in Respondent's Note 2.

99. Oxycontin is a Schedule II controlled substance under Chapter 893, Florida Statutes. A Schedule II substance has a high potential for abuse and has a currently accepted, but severely restricted, medical use. Abuse of a Schedule II substance may lead to severe psychological or physical dependence.

100. Topamax is a legend drug intended for use as an antiepileptic drug, available for oral administration.

101. On or about April 17, 2000, Patient S.H. again presented to Respondent with complaints of pain. On a scale of 1 (less pain) to 10 (more pain), the pain was recorded as an eight (8) on Patient S.H.'s Personal Progress Interactive Note (hereinafter Note 3).

102. Respondent's patient assessment and description of Patient S.H.'s course of treatment as found in Note 3 stated: "Though he has reached partial control with the help of medication, chronic pain still remains a significant problem for "[S.H.]" As there are no suicidal thoughts or dangerous plans,". This statement is not completed in Note 3.

103. Although Respondent's Note 3 for Patient S.H. reflected the following "Plan" outline, "Psychological Treatment: Physical Treatment: Pharmacological Treatment: and Social/Vocational:', there were no written directions for any of these treatment modalities.

104. Respondent again prescribed 100 Oxycontin 40 mg tablets, with instruction for no refills, and directions "one every 8 hours as needed", and 30 Topamax 25 mg tablets to Patient S.H.

105. The recommended starting dose for Oxycontin is 10 mg by mouth, twice per day. Respondent began Patient S.H.'s Oxycontin dosage at 40 mg twice a day, for a total of four times the amount recommended as a starting daily dosage.

106. Respondent recommended that Patient S.H. return to the office in one month.

107. Approximately two weeks later, on or about May 1, 2000, Patient S.H. presented to Respondent with complaints of pain. The pain was recorded

as a 6 on a scale of 1 (less pain) to 10 (more pain) on his Personal Progress Interactive Note (hereinafter Note 4).

108. Respondent's assessment of Patient S.H. in Note 4 stated: "Though he has reached partial control with the help of medication, chronic pain still remains a significant problem for [Patient S.H.] As there are no suicidal thoughts or dangerous plans[.]" Similar to the first three office notes, Note 4 is incomplete.

109. Respondent's Note 4 for Patient S.H. reflected the following "Plan" outline: "Psychological Treatment: Physical Treatment: Pharmacological Treatment: and Social/Vocational [.]" There were no written directions for any of the individual treatment plans.

110. Respondent again prescribed 100 tablets of Oxycontin 40 mg, with instructions for no refills, and directions "one every 8 hours as needed" to Patient S.H.

111. On or about May 15, 2000, Patient S.H. presented to Respondent, however no pain level was recorded in Respondent's Personal Progress Interactive Note (hereinafter Note 5) for Patient S.H.

112. Respondent's assessment of Patient S.H. as found in Note 5 stated: "The chronic pain of [S.H.] remains a significant problem with partial

control from medications. He has no suicidal ideas or dangerous plans, and there is no need for more intense psychiatric intervention."

113. In Respondent's Note 5, Respondent described Patient S.H.'s course in treatment as: "The patient began treatment on March 21, 2000 and is currently in Treatment Phase I." Respondent's view of Patient S.H.'s "mental health is higher than their own view."

114. Respondent's Note 5 for Patient S.H. reflected the following "Plan" outline, "Psychological Treatment: Group"; "Physical Treatment: [BLANK]; "Pharmacological Treatment: [BLANK]; and Social/Vocational: active and working".

115. Respondent's Note 5 records that Respondent again prescribed 100 Oxycontin 40 mg tablets, with instructions for no refills, and directions "one every 8 hours as needed" and 60 Topamax 25 mg tablets to Patient S.H., despite the fact that Respondent had already prescribed the same amount of Oxycontin to Patient S.H. on May 1, 2000, two weeks earlier.

116. Approximately two weeks later, on or about May 29, 2000, Patient S.H. again presented to Respondent with complaints of pain with a rating of 6 on a scale of 1 (less pain) to 10 (more pain) as documented in Respondent's Personal Progress Interactive Note (hereinafter Note 6) for Patient S.H.

117. Respondent's assessment of Patient S.H. as found in Note 6 stated: "Though he has reached partial control with the help of medication, chronic pain still remains a significant problem for [S.H.]. As there are no suicidal thoughts or dangerous plans," This thought is not completed in Note 6.

118. In Respondent's Note 6, Respondent described Patient S.H.'s course in treatment as: "The patient began treatment on March 21, 2000 and is currently in Treatment Phase I. The mental health of [S.H.] appears to be higher than he reports."

119. In Respondent's Note 6, Respondent recorded the following "Plan" outline, "Psycological Treatment: group and individual"; "Physical Treatment: pain management"; "Pharmacological Treatment: [BLANK]; and Social/Vocational: active an working".

120. Respondent's Note 6 records that Respondent again prescribed 100 Oxycontin 40 mg tablets, with instructions for no refills, and directions "one every 8 hours as needed", to Patient S.H.

121. Respondent prescribed a total of 300 40 mg tablets of Oxycontin to Patient S.H. within the month of May 2000.

122. On or about June 12, 2000, Patient S.H. again presented to Respondent with complaints of pain with a rating of 6 on the same scale of 1

to 10 as documented in Respondent's Personal Progress Interactive Note (hereinafter Note 7) for Patient S.H.

123. Respondent's assessment of Patient S.H. as found in Note 7 stated: "Though he has reached partial control with the help of medication, chronic pain still remains a significant problem for [S.H.]. As there are no suicidal thought or dangerous plans," This thought is not completed in Note 7.

124. In Respondent's Note 7, Respondent described Patient S.H.'s course in treatment as: "The patient began treatment on 3/21/2000 and is currently in Treatment Phase I." S.H. "sees himself as mentally less health than I do."

125. In Respondent's Note 7, Respondent recorded the following "Plan" outline, "Psychological Treatment: group and individual"; "Physical Treatment: pain management"; "Pharmacological Treatment: [BLANK]; and Social/Vocational: active an working".

126. Respondent recorded in his Note 7 that he again prescribed 100 Oxycontin 40 mg tablets, with instructions for no refills, and directions "one every 8 hours as needed", and 60 tablets of Topamax 25 mg to Patient S.H.

127. Respondent failed to outline his plan for pharmacological treatment for Patient S.H. in Note 7, however Respondent continued to prescribe 100 Oxycontin 40 mg tablets to Patient S.H.

128. Approximately two weeks later, on or about June 26, 2000, Patient S.H. presented to Respondent, however no pain level was recorded in Respondent's Personal Progress Interactive Note (hereinafter Note 8) for Patient S.H.

129. Respondent's assessment of Patient S.H. as found in Note 8 stated: S.H.'s "chronic pain is still a significant problem, but has reached partial control with the aid of medication. There are no suicidal ideas present, and I see no reason for his more intense psychiatric intervention."

130. In Note 8, Respondent described Patient S.H.'s course in treatment as: "The patient began treatment on 3/21/2000 and is currently in Treatment Phase I." S.H. "sees himself as mentally less health than I do."

131. In Note 8, Respondent recorded the following "Plan" outline, "Psychological Treatment: group and individual"; "Physical Treatment: pain management"; "Pharmacological Treatment: [BLANK]"; and "Social/Vocational: active an working full time".

132. Respondent's Note 8 also records that Respondent again prescribed 100 Oxycontin 40 mg tablets, with instructions for no refills, and

directions "one every 8 hours as needed", and 60 Topamax 25 mg tablets to Patient S.H.

133. On or about July 10, 2000, Patient S.H. presented to Respondent. However, no pain level was recorded in Respondent's Personal Progress Interactive Note (hereinafter Note 9) for Patient S.H.

134. Respondent's assessment of Patient S.H. as found in Note 9 stated: "Though he has reached partial control with the help of medication, chronic pain still remains a significant problem for" S.H. "As there are no suicidal thoughts or dangerous plans," This thought is not completed in Note 9.

135. Respondent's Note 9 records that Respondent prescribed 120 Oxycontin 40 mg tablets, with instructions for no refills, and directions "one every 8 hours as needed" to Patient S.H.

136. On or about July 24, 2000, Patient S.H. again presented to Respondent with no indication of Patient's pain level recorded in Respondent's Personal Progress Interactive Note (hereinafter Note 10).

137. Respondent's assessment of Patient S.H. as found in Note 10 stated: "Though he has reached partial control with the help of medication, chronic pain still remains a significant problem for [S.H.]. As there are no

suicidal thoughts or dangerous plans," This thought is not completed in Note 10.

138. In Respondent's Note 10, he described Patient S.H.'s course in treatment as "The patient began treatment on 3/21/2000 and is currently in Treatment Phase I." The mental health of S.H. "appears to be higher than he reports."

139. Respondent's Note 10 for Patient S.H. recorded the following "Plan" outline, "Psychological Treatment: group and individual"; "Physical Treatment: pain management"; "Pharmacological Treatment: [BLANK]; and "Social/Vocational: active an working full time."

140. Respondent's Note 10 recorded that Respondent prescribed 120 tablets of Oxycontin 40 mg, with instructions for no refills, and directions "one every 8 hours as needed", to Patient S.H.

141. Respondent's Note 10 did not include any reason/justification for the increase in the number of Oxycontin prescribed to Patient S.H.

142. On or about August 7, 2000, Patient S.H. presented to Respondent with complaints of pain with a rating of 10 as recorded in Respondent's Personal Progress Interactive Note (hereinafter Note 11) for Patient S.H.

143. Respondent's assessment of Patient S.H. as found in Note 11 stated: Patient S.H.'s "chronic pain is still a significant problem, but has reached partial control with the aid of medication. There are no suicidal ideas present, and I see no reason for his more intense psychiatric intervention."

144. Respondent's description of Patient S.H.'s course of treatment in Note 11 stated: S.H.'s "chronic pain is still a significant problem, but has reached partial control with the aid of medication. There are no suicidal ideas present, and I see no reason for his more intense psychiatric intervention."

145. Respondent's Note 11 for Patient S.H. reflected the following "Plan" outline, "Psychological Treatment: group and individual"; "Physical Treatment: pain management"; "Pharmacological Treatment: "[BLANK]"; and "Social/Vocational: active and working full time."

146. Note 11 recorded that Respondent provided two (2) prescriptions for 120 tablets of Oxycontin 40 mg with instructions for no refills, and directions "one or two every 8 hours as needed", in addition to a prescription for 60 tablets of Topamax 25 mg to Patient S.H.

147. Respondent's Note 11 reflects that Respondent recommended Patient S.H. return to the office in one month.

148. Approximately two weeks later, on or about August 22, 2000, Patient S.H. presented to Respondent. No pain level was recorded in Respondent's Personal Progress Interactive Note (hereinafter Note 12) for Patient S.H.

149. In Note 12, Respondent describes Patient S.H.'s course in treatment as: "The patient began treatment on 3/21/2000 and is currently in Treatment Phase IV." Respondent also records that Patient S.H.'s mental health "appears to be higher than he reports."

150. Phase IV is defined in Note 12 as:

> This period is a growth in awareness of how personal change actually takes place. It is seen in the "mirror" of others in the Group as they find and use the tools of personal change. The inertia is strong as well as the fear of venturing to a new level of awareness. This phase corresponds to Step 4 (of 12-Step) as there is need to turn character "flaws" into a higher power [sic] rather than continue to act out the flaws repeatedly, as well as to share with one who has successfully dealt with the Phases and Steps.

151. Respondent's Note 12 for Patient S.H. recorded the following "Plan" outline, "Psychological Treatment: group and individual"; "Physical Treatment: pain management"; "Pharmacological Treatment: "[BLANK]"; and "Social/Vocational: active and working full time.

152. Note 12 recorded that Respondent again provided two (2) prescriptions for 120 tablets of Oxycontin 40 mg, with instructions for no

refills and directions to take "one or two every 8 hours as needed" to Patient S.H.

153. On or about September 18, 2000, Patient S.H. presented to Respondent with a pain rating of 8, as recorded in Respondent's Personal Progress Interactive Note (hereinafter Note 13) for Patient S.H.

154. Respondent's Note 13 recorded Patient S.H. as appearing to be very depressed and worried, honest, and wanting to cease further use of prescription medications. Note 13 also dictates that there was an indication of a 'biologic or chemical depression" because of a relative drop in basic functions such as mood and sleep.

155. Note 13 does not record what, if any, recommendations or treatment options were provided to Patient S.H. by Respondent.

156. Although Patient S.H. had a specialized consultation prior to presenting to Respondent's clinic, at no time during Respondent's care and treatment of Patient S.H. did Respondent enroll, recommend, or prescribe that Patient S.H. participate in a multidisciplinary treatment program to consider other pain relieving treatments and or physical rehabilitative modalities to reduce the need for opioid medications.

157. Respondent had available a neurosurgeon's January 4, 2000 recommendation that Patient S.H. undergo a pain relieving injection

procedure to treat his lower back pain. At no time during Respondent's care and treatment of Patient S.H. did Respondent recommend or perform any palliative injection therapies or procedures to relieve Patient S.H.'s lower back pain.

158. Plain radiographs and an MRI of Patient S.H.'s lumbar spine, that were available to Respondent, had findings of bilateral L5 pars defect, a form of spondylolysis (loss of bone), but no evidence of spondylolesthesis (slip of one vertebral bone in relation to another.)

159. A diagnosis of spondylolysis without a subsequent physical examination is not sufficient, in and of itself to be an explanation for the patient's persistent lower back pain and thus not a valid indication for the continued prescribing of chronic opioid medication restricted for individuals who have been determined to have "intractable pain."

160. At no time during Respondent's care and treatment of Patient S.H. did Respondent recommend or prescribe any pain relieving physical modalities or non-narcotic adjuvant medications for Patient S.H.

161. Respondent prescribed Oxycontin to Patient S.H. in an excessive and/or inappropriate manner by failing to initiate the dosage orally at 10 mg, twice a day, and progressively increasing the dosage after a trial period dependent upon Patient S.H.'s analgesic tolerance and response.

162. Respondent prescribed Oxycontin to Patient S.H. in an excessive and/or inappropriate manner by prescribing approximately sixty-five times the recommended initiating dosage (approximately eight-thousand milligrams/month instead of the recommended 120 milligrams) and increasing the dosage to twice his own recommended dosage per month.

163. There are no medically recognized circumstances in which Oxycontin should be dosed "Pro Re Nata " (PRN), or as needed, as Respondent did for Patient S.H.

164. There are no medically recognized circumstances in which Oxycontin should be prescribed twice or three times per day as needed or one or two tablets three times per day, as prescribed by Respondent to Patient S.H.

COUNT SEVEN

165. Petitioner realleges and incorporates paragraphs one (1) through four (4) and eighty-seven (87) through one hundred sixty-four (164) as if fully set forth herein.

166. Section 458.331(1)(q), Florida Statutes (1999, 2000), provides that prescribing, dispensing, administering, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice constitutes grounds for disciplinary action by

the Board of Medicine. For the purposes of this paragraph, it shall be legally presumed that prescribing inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his or her intent.

167. Respondent inappropriately prescribed Oxycontin to Patient S.H. when he did one or all of the following:

a) Failing to conduct a physical examination of Patient S.H.;

b) Failing to initiate the Oxycontin dosage according to DEA guidelines at 10 mg orally, twice a day, and increase the dosage upward after a trial period dependant upon Patient S.H.'s analgesic tolerance and response to the initial dosage; or

c) Providing Patient S.H. with instructions that his prescription of Oxycontin should be taken "twice or three times per day as needed".

168. Based on the foregoing, Respondent has violated Section 458.331(1)(q), Florida Statutes (1999, 2000), by prescribing, dispensing, administering, mixing, or otherwise preparing a Schedule II controlled substance other than in the course of Respondent's professional practice.

COUNT EIGHT

169. Petitioner realleges and incorporates paragraphs one (1) through five (5) and eighty-seven (87) through one hundred sixty-four (164) as if fully set forth herein.

170. Section 458.331(1)(t), Florida Statutes (1999, 2000) provides that gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances constitutes grounds for disciplinary action by the Board of Medicine.

171. Respondent failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar circumstances, in one or more of the following ways:

(a) Failing to perform the requisite physical examination on Patient S.H. prior to prescribing Oxycontin;

(b) Failing to obtain a complete history of Patient S.H. prior to prescribing Oxycontin;

(d) Failing to make a comprehensive diagnosis and/or treatment plan for Patient S.H. prior to prescribing Oxycontin; and/or

(e) Prescribing Oxycontin to Patient S.H. PRN, or as needed.

172. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes, (1999, 2000) by gross or repeated malpractice or the failure to practice medicine with that level of care, skill,

and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

WHEREFORE, Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 13th **day of** December **, 2004.**

John O. Agwunobi, M.D., M.B.A., M.P.H.
Secretary, Department of Health

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
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DATE 12-13-04

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Reviewed and approved by: mc (initials) 9/15/04 (date)

PCP: December 10, 2004
PCP Members: Gustavo Leon, M.D. (Chairperson), Mammen Zachariah, M.D., and John Beebe

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2005-01205**

PHILIP K. SPRINGER, M.D.,

RESPONDENT.
_____/

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ADMINISTRATIVE COMPLAINT

Petitioner, Department of Health, by and through undersigned counsel, files this Administrative Complaint before the Board of Medicine against Respondent, PHILIP K. SPRINGER, M.D., and in support thereof alleges:

1. Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed physician within the state of Florida, having been issued license number ME 17474.

3. Respondent's mailing address of record is 701 SW 80th Drive, Gainesville, Florida 32607.

4. Respondent is not board certified, but his area of practice at all times material to this case was psychiatry and pain management.

5. At all times relevant to these allegations, Respondent practiced as the principal physician at The Springer Group, P.A. (the Group.) The Group was a psychiatry and pain management clinic operating at 9120 N.W. 36th Place in Gainesville.

MEDICATION RELEVANT TO THESE PROCEEDINGS

6. OxyContin contains oxycodone, a Schedule II controlled substance listed in Chapter 893, Florida Statutes, which is indicated for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. Oxycodone has a high potential for abuse and has a currently accepted, but severely restricted, medical use in treatment in the United States. Abuse of oxycodone may lead to severe physical and psychological dependence. Further, there are no medically recognized circumstances in which OxyContin is appropriately dosed on a "Pro Re Nata" (PRN) or "as needed" basis for long term pain management.

7. Percocet, Roxicet, and Tylox contain oxycodone and are used in pain control, similar to OxyContin, and carry the same risk of severe physical and psychological dependence.

8. OxyIR, MS Contin and Roxicodone contain oxycodone a Schedule II controlled substance, listed in Chapter 893, Florida Statutes. OxyIR, MS Contin, and Roxicodone are time released forms of oxycodone used for the management of moderate to severe break through pain when a continuous, around-the-clock analgesic is needed for an extended period of time. OxyIR and Roxicodone have a high potential for abuse and have a currently accepted, but severely restricted, medical use in treatment in the United States. Abuse may lead to severe physical and psychological dependence.

9. Dilaudid contains hydromorphone, a Schedule II controlled substance listed in Chapter 893, Florida Statutes, which is indicated for the relief of moderate to severe pain. Hydromorphone has a high potential for abuse and dependence. Abuse of hydromorphone may lead to severe physical and psychological dependence.

10. Wellbutrin is a legend drug as defined in Section 465.003(8), Florida Statutes, and is used for the treatment of depression.

11. Methadone is a Schedule II controlled substance listed in Chapter 893, Florida Statutes. Methadone is indicated for the relief of severe

pain, for detoxification treatment in cases of narcotic addiction, and for the temporary maintenance treatment of narcotic addiction. Methadone can produce drug dependence of the morphine type. Psychological dependence, physical dependence, and tolerance may develop upon repeated administration of Methadone.

12. Vicodin and Lorcet contain hydrocodone bitartrate, a Schedule III controlled substance listed in Chapter 893, Florida Statutes. Hydrocodone is a narcotic analgesic indicated for the relief of moderate to moderately severe pain. Hydrocodone has a potential for abuse and the abuse can lead to moderate or low physical dependence or high psychological dependence.

13. Valium contains diazepam, a Schedule IV controlled substance listed in Chapter 893, Florida Statutes. Diazepam is a benzodiazepine anxiolytic (anti-anxiety drug) and muscle relaxant. The abuse of diazepam can lead to physical or psychological dependence.

14. Xanax contains alprazolam, a Schedule IV controlled substance listed in Chapter 893, Florida Statutes. Alprazolam is a benzodiazepine anxiolytic (anti-anxiety drug) and muscle relaxant. The abuse of alprazolam can lead to physical and psychological dependence.

15. Demerol contains meperidine, a Schedule II controlled substance listed in Chapter 893, Florida Statutes. Meperidine is a narcotic analgesic with multiple actions qualitatively similar to those of morphine, and is indicated for relief of moderate to moderately severe pain. Meperidine carries a high potential for abuse and abuse may lead to severe physical and psychological dependence.

16. Soma (carisoprodol) is a legend drug as defined by Section 465.003(7), Florida Statutes, and is a muscle relaxant used as an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions. The effects of carisoprodol and other drugs that depress the central nervous system (CNS) may be additive, and Soma should be prescribed with caution to patients taking other CNS depressant medications, such as narcotics, benzodiazepine anxiolytics and tranquilizers, and barbiturates.

17. Klonopin contains Clonazepam and is a Schedule IV controlled substance listed in Chapter 893, Florida Statutes. Clonazepam has a low potential for abuse but abuse of Clonazepam can lead to physical and psychological dependence. Clonazepam is indicated for anxiety and treatment of seizures.

18. A Duragesic patch contains fentanyl which is a Schedule II controlled substance listed in Chapter 893, Florida Statutes. Fentanyl is a potent opioid analgesic. Fentanyl has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment. Abuse of the substance may lead to severe psychological or physical dependence.

19. Paxil, Elavil, Zoloft, Lexapro, Serzone, and Celexa are legend drugs as defined in Section 465.003(8), Florida Statutes. The above-listed drugs are prescribed for depression, obsessive compulsive disorder, and/or anxiety.

20. Remeron is a legend drug as defined in Section 465.003(8), Florida Statutes. Remeron is prescribed for depression and is known to cause weight gain and by contraindicated for patients with Diabetes.

FACTS RELATING TO PATIENT P.C.

21. From 1997 until 2003, Patient P.C. presented to Respondent with migraine headaches, neurosarcoidosis, chronic back pain, and major depressive disorder.

22. During the time that Respondent was treating P.C., Respondent prescribed numerous controlled substances and other legend drugs for her, including, but not limited to OxyContin, Dilaudid, Percocet, Wellbutrin, Methadone, Xanax, and Zoloft.

23. Respondent did not obtain or document a complete medical history or conduct a physical examination during the six (6) years he treated Patient P.C. or prior to using controlled substances for pain control.

24. Respondent repeatedly prescribed OxyContin to P.C. on a PRN basis.

25. Respondent's records for Patient P.C. document that Respondent inappropriately prescribed the above-described pain medications in that the patient's pain was not controlled and Respondent failed to conduct adequate follow-up and analysis of the effectiveness of the prescribed medications.

26. Respondent failed to create a written treatment plan prior to using controlled substances for pain control and failed to periodically review the effectiveness of treatment.

FACTS RELATING TO PATIENT T.D.

27. From 1999 until 2003, Patient T.D. presented to Respondent with chronic pain syndrome, recurrent depression, and tension headaches, all related to multiple automobile accidents. Patient T.D. was completely disabled and unable to work.

28. During the time that Respondent was treating Patient T.D., Respondent prescribed numerous controlled substances and other legend

prescription drugs for her, including, but not limited to, OxyContin, Methadone, Vicodin, and Lorcet.

29. Respondent did not obtain or document a complete medical history or conduct a physical examination during the four (4) years he treated Patient T.D. or prior to using controlled substances for pain control.

30. Respondent repeatedly prescribed OxyContin to Patient T.D. on a PRN basis.

31. Respondent did not adequately assess Patient T.D.'s complaints or symptoms. Patient T.D.'s medical records do not contain any x-ray reports, CAT scans, or MRI results confirming or eliminating any physical explanation for Patient T.D.'s chronic pain. Respondent's records do not document that he referred Patient T.D. for testing, consultation or imaging studies to determine the etiology of TD's pain.

32. Respondent failed to prepare a written treatment plan prior to using controlled substances for pain control and failed to periodically review the effectiveness of treatment.

FACTS RELATING TO PATIENT F.E.

33. From 1997 until 2003, Patient F.E. presented to Respondent complaining of chronic recurrent depression, chronic pain syndrome, and migraine headaches.

34. During the time that Respondent was treating Patient F.E., Respondent prescribed numerous controlled substances and other legend prescription drugs for her, including, but not limited to, OxyContin, Methadone, Valium and Soma.

35. Respondent did not obtain or document a complete medical history or conduct a physical examination prior to or during the six (6) years he prescribed controlled substances for pain control.

36. Patient F.E. presented with major depressive disorder and Respondent's records do not document a written treatment plan for depression other than the intermittent prescribing of an antidepressant and continuous Valium, an anti-anxiety drug.

37. Respondent routinely changed Patient F.E.'s prescriptions but failed to justify the prescription changes in the medical records.

38. Respondent's records for Patient F.E. indicate that Respondent failed to document a written treatment plan prior to using controlled substances for pain control and failed to periodically review the effectiveness of treatment.

39. Respondent's records for Patient F.E. fail to justify his course of treatment and fail to document a written treatment plan to control the

patient's pain prior to the use of controlled substances to control pain with no documentation regarding the effectiveness of treatment.

40. There are periods of time in 1997 and 1998 and from July of 1998 until April of 2000 that Respondent has no documentation regarding treatment and prescriptions for Patient F.E. although prescription records indicate that he was prescribing medication for Patient F.E. during those periods of time.

FACTS RELATING TO PATIENT C.H.

41. From 1999 until 2003, Patient C.H. presented to Respondent with chronic pain related to low back and joint pain due to arthritis, chronic depression, and a history of alcohol and drug abuse.

42. During the time that Respondent treated Patient C.H., Respondent prescribed numerous controlled substances and other legend prescription drugs for her, including, but not limited to, Tylox, Methadone, and Wellbutrin.

43. Respondent did not obtain or document a complete medical history or conduct a physical examination prior to or during the four (4) years that he treated the patient with controlled substances for pain control.

44. Patient C.H. presented to Respondent with a history of alcohol and drug abuse but Respondent failed to monitor Patient C.H. to insure that she was not abusing her prescriptions for controlled substances.

45. Respondent routinely changed Patient C.H.'s prescriptions but failed to justify the prescription changes in the medical records. Respondent's Methadone prescription dose for Patient C.H. was increased by Respondent without documented justification for the dosage adjustment.

46. Respondent did not adequately assess Patient C.H.'s complaints or symptoms. Patient C.H.'s medical records do not contain any x-ray reports, CAT scans, or MRI results confirming or eliminating a physical explanation for CH's chronic pain. Respondent's records do not document that he referred Patient C.H. for testing, consultation, or imaging studies to determine the etiology of CH's pain.

47. Respondent's records for Patient C.H. document that Respondent inappropriately prescribed the above-described medications, that the patient's pain was not controlled, and that Respondent failed to conduct adequate follow-up and analysis of the effectiveness of the prescribed medications.

48. Respondent's records for Patient C.H. fail to justify his course of treatment.

49. Respondent failed to prepare a written treatment plan prior to prescribing controlled substances for pain control and failed to adequately assess the effectiveness of treatment.

FACTS RELATING TO PATIENT S.B. (Also known as S.J. and S.H.)

50. From 2001 until 2002, Patient S.B. presented to Respondent with a diagnosis of chronic pain syndrome, migraine and cluster headaches, major depression and anxiety disorder.

51. Respondent did not perform a medical examination or physical assessment of Patient S.B.

52. Respondent prescribed numerous controlled substances and other legend prescription drugs for Patient S.B., including, but not limited to OxyContin, OxyIR, Methadone, Wellbutrin, Demerol, Klonopin, and Celexa.

53. Respondent did not obtain or document a complete medical history or conduct a physical examination prior to or during the time he prescribed controlled substances for pain control.

54. Respondent routinely changed Patient S.B.'s prescriptions and dosages but failed to justify the prescription changes in the medical records.

55. Respondent's records for Patient S.B. document that Respondent inappropriately prescribed the above described medications, that the patient's

pain was not controlled, and that Respondent failed to conduct adequate follow-up and analysis of the effectiveness of the prescribed medications.

56. Respondent's records for Patient S.B. fail to justify his course of treatment and demonstrate that Respondent failed to prepare a written treatment plan for Patient S.B. and failed to review the effectiveness of treatment.

FACTS RELATING TO PATIENT K.O.

57. From 2000 until 2003, Patient K.O. presented to Respondent with major depressive disorder, chronic pain syndrome secondary to low back and multiple joint areas, and hypertension.

58. During the time that Respondent treated Patient K.O., Respondent prescribed numerous controlled substances and other legend prescription drugs for her, including, but not limited to, OxyContin, Methadone, Lortab, and Soma.

59. Respondent did not obtain or document a complete medical history or conduct a physical examination prior to or during the 3 (three) years he prescribed controlled substances to Patient K.O. for pain control.

60. Patient K.O. presented with major depressive disorder and Respondent's records do not document a written treatment plan for the

treatment of depression other than the intermittent prescribing of an antidepressant and continuous Valium, an anti-anxiety drug.

61. Respondent routinely changed Patient K.O.'s prescriptions and dosages but failed to justify the prescription changes in the medical records.

62. Respondent's records for Patient K.O. fail to justify his course of treatment and fail to document a written treatment plan to control the patient's pain and major depressive disorder other than controlled substances and intermittent psychotherapy and antidepressants with no documentation regarding the effectiveness of either treatment.

FACTS RELATING TO PATIENT G.P.

63. From 1995 until 2003, Patient G.P. presented to Respondent for pain management following a laminectomy and fusion. In addition, Patient G.P. presented with hypertension, coronary heart disease and Type 2 diabetes.

64. During the time that Respondent treated Patient G.P., Respondent prescribed numerous controlled substances and other legend prescription drugs for her, including, but not limited to, OxyContin, Roxicodone, Lortab, Methadone and Valium.

65. During the time that Respondent treated Patient G.P., Respondent did not obtain or document a complete medical history or

conduct a physical examination prior to or during the time he prescribed controlled substances for pain control.

66. During the time that Respondent treated Patient G.P., Respondent failed to adequately treat or control the patient's blood pressure, coronary heart disease or diabetes and failed to refer Patient G.P. for consultation, evaluation or additional testing.

67. Respondent's medical records for Patient G.P. fail to justify his course of treatment.

68. Respondent failed to prepare a written treatment plan to control Patient G.P.'s pain or to review the effectiveness of treatment.

FACTS RELATING TO PATIENT M.S.

69. From 1997 until 2003, Patient M.S. presented to the Respondent for migraine headaches, chronic pain syndrome and recurrent chronic depression.

70. During the time that Respondent treated M.S., Respondent prescribed numerous controlled substances and other legend prescription drugs for her, including, but not limited to, OxyContin, Percocet, Lorcet, Roxicodone, Roxicet and Zoloft. Respondent did not obtain or document a complete medical history or conduct a physical examination during the time he treated the patient or prescribed the above medication.

71. During the time that Respondent treated Patient M.S., Respondent did not obtain or document a complete medical history or conduct a physical examination prior to or during the time he prescribed controlled substances for pain control.

72. During the six (6) years that Respondent treated Patient M.S., Patient M.S.'s pain and depression were not controlled.

73. Respondent's records for Patient M.S. fail to justify his course of treatment.

74. Respondent failed to prepare a written treatment plan prior to prescribing controlled substances for pain control and failed to review the effectiveness of treatment.

FACTS RELATING TO PATIENT D.R. (also known as D.B.)

75. From 1999 through 2003, Patient D.R. presented to the Respondent for chronic pain syndrome and recurrent chronic depression. Patient D.R. presented as potentially suicidal and as a possible drug abuser.

76. In spite of Patient D.R.'s potential for suicide and drug abuse, Respondent repeatedly prescribed controlled substances, including, but not limited to, OxyContin, Roxicet, Roxicodone, and Tylox with no record of any discussion or monitoring of Patient D.R. and her use of her prescription drugs.

77. Respondent did not obtain or document a complete medical history or conduct a physical examination prior to or during the time he prescribed controlled substances for pain control.

78. During the four (4) years that Respondent treated Patient D.R., Respondent prescribed numerous controlled substances and legend drugs but failed to adequately treat or control the Patient D.R.'s chronic pain and depression.

79. Respondent's medical records for Patient D.R. contain no information regarding Respondent's attempts to determine the etiology of Patient D.R.'s chronic pain or any additional evaluations, testing or imaging.

80. Respondent's medical records for Patient D.R. fail to justify his course of treatment and indicate an inadequate monitoring of a suicidal patient prescribed controlled substances.

81. Respondent failed to prepare a written treatment plan to control Patient D.R.'s chronic pain prior to prescribing controlled substances and failed to review the treatment plan to determine the effectiveness of treatment.

FACTS RELATING TO PATIENT V.P.

82. From 1993 until 2002, Patient V.P. presented to the Respondent for treatment of depression, pancreatitis, hypertension, diabetes, and chronic obstructive pulmonary disease.

83. Between 1993 and 2002, Respondent prescribed numerous controlled substances and legend drugs to Patient V.P., including, but not limited to, Methadone, OxyContin, Insulin, Roxicet, Percocet, Celexa, Paxil, Elavil and Duragesic Patch. However, Respondent's records demonstrate that Respondent failed to adequately treat or control the patient's blood pressure, diabetes, or chronic pain and failed to conduct adequate follow-up and analysis of the effectiveness of the prescribed medications.

84. Between 1993 and 2002, Respondent did not obtain or document a complete medical history or conduct a physical examination of Patient V.P. prior to or during prescribing controlled substances for pain control.

85. Respondent's medical records for Patient V.P. fail to adequately document justification for his treatment of Patient V.P.

86. Respondent failed to prepare a written treatment plan and failed to review treatment to determine effectiveness.

87. Even after Respondent was made aware that Patient V.P. was obtaining opioids from multiple physicians, Respondent failed to discuss, monitor, or terminate the prescribing of opioids for Patient V.P.

FACTS RELATING TO PATIENT J.N.

88. From 1990 until 2002, Patient J.N. presented to Respondent for treatment of chronic recurrent back pain with weakness in his lower extremities, hypertension, depression, and coronary artery disease.

89. During the time that Respondent treated Patient JN, Respondent prescribed numerous controlled substances and legend drugs, including but not limited to, OxyContin, MS Contin, Methadone, Vicodin, Percocet, Remeron, Serzone, Roxicet, and Klonopin.

90. During the 12 years that Respondent treated J.N., Respondent did not obtain or document a complete medical history or conduct a physical examination prior to or during prescribing controlled substances for pain control.

91. Respondent's records demonstrate that Respondent failed to adequately treat or control the patient's pain, hypertension, depression or coronary artery disease. Further, Remeron is known to cause weight gain and elevation of blood sugar and is contraindicated for a patient with diabetes.

92. Respondent's medical records for Patient J.N. fail to justify his course of treatment and prescribing practices.

93. Respondent failed to prepare a written treatment plan to control Patient J.N..'s chronic pain, depression, hypertension or coronary artery disease and prior to prescribing controlled substances to control pain.

94. Respondent failed to monitor the results of his prescribing or the effectiveness of the drugs he prescribed or to recommend consultations or treatment by other physicians when Patient J.N..'s condition did not improve.

FACTS RELATING TO PATIENT V.L.

95. From 1998 until 2002, Patient V.L. regularly presented to Respondent for treatment for chronic pain, osteoporosis, and recurrent major depression.

96. During the four (4) years that Respondent treated Patient V.L., Respondent prescribed numerous controlled substances and legend drugs, including but not limited to OxyContin, Vicodin, Roxicodone, Wellbutrin, and Valium.

97. During the time that Respondent treated Patient V.L., Respondent did not obtain or document a complete medical history or conduct a physical examination prior to or during the time he prescribed controlled substances for pain control.

98. Respondent's treatment with controlled substances failed to control the patient's chronic pain. Respondent failed to conduct adequate

review and analysis of the effectiveness of the prescribed medications and failed to refer the patient for consultation or further evaluation when she did not get relief from his treatment.

99. Respondent's records for Patient V.L. fail to justify his course of treatment and his prescribing practices.

100. Respondent failed to prepare a written treatment plan to control the patient's pain and depression.

101. Even after concerns were raised with Respondent about Patient V.L.'s possible drug abuse, Respondent failed to discuss the concerns with the patient and failed to conduct any follow-up monitoring of Patient V.L.'s drug usage.

FACTS RELATING TO PATIENT G.B.

102. From 1999 until 2002, Patient G.B. presented to Respondent with chronic pain and depression.

103. During the three (3) years that Respondent treated Patient G.B., Respondent prescribed numerous controlled substances and legend drugs, including, but not limited to, Valium, Methadone, and OxyContin but failed to adequately treat or control the patient's chronic pain and failed to conduct adequate follow-up and analysis of the effectiveness of the prescribed medications.

104. Even though Patient G.B. presented with a history of chronic depression and continued to complain about depression while being treated by Respondent, Respondent never prescribed any antidepressant for Patient G.B. and failed to document his justification for not doing so.

105. Respondent did not obtain or document a complete medical history or conduct a physical examination prior to or during the time he prescribed controlled substances for pain control.

106. Respondent's medical records for Patient G.B. failed to adequately document justification for his treatment or his prescribing practices.

FACTS RELATING TO PATIENT P.C.2.

107. From 1999 until 2003, Patient P.C.2. presented to Respondent with chronic pain syndrome related migraine headaches and musculoskeletal pain, agoraphobia, and chronic depression.

108. Between about 2000 and 2003, Respondent prescribed numerous controlled substances and other legend prescription drugs for Patient P.C.2., including but not limited to, OxyContin, Methadone, Effexor, Topomax, Xanax, Lorcet and Percocet.

109. Respondent did not obtain or document a complete medical history or conduct a physical examination prior to or during the time he prescribed controlled substances for pain control.

110. Respondent routinely changed Patient P.C.2.'s prescriptions but failed to justify the prescription changes in the medical records.

111. Respondent's records for Patient P.C.2. fail to justify his course of treatment and his course of prescribing.

112. Respondent failed to prepare a written treatment plan or to periodically review the effectiveness of his treatment with controlled substances.

113. Even though concerns were raised about Patient P.C.2. abusing her medications, Respondent failed to address the issue with Patient P.C.2..

FACTS RELATING TO PATIENT D.C.

114. From 2000 until 2003, Patient D.C. presented to Respondent with chronic pain syndrome and chronic depression related to chronic pain.

115. During the three (3) years that Respondent treated Patient D.C., Respondent prescribed numerous controlled substances and legend drugs, including, but not limited to, Wellbutrin, MS Contin, Zoloft, Lortab, Methadone, Xanax and Roxicodone but failed to adequately treat or control

the patient's chronic pain and failed to conduct adequate follow-up and analysis of the effectiveness of the prescribed medications.

116. Respondent did not obtain or document a complete medical history or conduct a physical examination prior to or during the time he prescribed controlled substances for pain control.

117. Respondent's records for Patient D.C. fail to justify his course of treatment.

118. Respondent failed to prepare a written treatment plan prior to prescribing controlled substances for pain management and major depressive disorder. Respondent failed to periodically review the effectiveness of the treatment.

FACTS RELATING TO PATIENT C.P.

119. From 1999 until 2003, Patient C.P. presented to Respondent for treatment of chronic pain syndrome, reflex sympathetic dystrophy, and major depressive disorder. She also presented with a diagnosis of chronic obstructive pulmonary disease.

120. During the time that Patient C.P. was treated by Respondent, Respondent did not prescribe any antidepressants to treat her major depressive disorder and continued to prescribe OxyContin and Methadone to treat her pain, although her pain was poorly controlled.

121. Respondent did not obtain or document a complete medical history or conduct a physical examination prior to or during the time he treated the patient with controlled substances for pain control.

122. Respondent also prescribed Coumadin, a blood thinner, for Patient C.P. but failed to adequately monitor the effect of the medication.

123. Respondent's records for Patient C.P. fail to justify his course of treatment.

124. Respondent failed to prepare a written treatment plan prior to prescribing controlled substances for pain management and failed to periodically review the effectiveness of the treatment.

COUNT ONE

125. Petitioner realleges and incorporates paragraphs one (1) through one hundred and twenty-six (126) as if fully set forth herein.

126. Section 458.331(1)(t), Florida Statutes (1994) through (2003), subjects a licensee to discipline for gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

127. Rule 64B8-9.013, Florida Administrative Code (FAC), establishes standards of care for physicians in the treatment of pain and provides in relevant part:

> **64B8-9.013 Standards for the Use of Controlled Substances for the Treatment of Pain.**
> (1) Pain management principles.
> (a) The Board of Medicine recognizes that principles of quality medical practice dictate that the people of the State of Florida have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment as well as statutory requirements for prescribing controlled substances.
> * * *
> (c) The Board recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The medical management of pain including intractable pain should be based on current knowledge and research and includes the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.
> (d) The Board of Medicine is obligated under the laws of the State of Florida to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug

diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.
(e) The Board will consider prescribing, ordering, administering, or dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain or if based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with applicable state or federal law.
(f) Each case of prescribing for pain will be evaluated on an individual basis. The Board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these standards, if good cause is shown for such deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's individual needs including any improvement in functioning, and recognizing that some types of pain cannot be completely relieved.
(g) The Board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors. The following standards are not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of professional practice.

* * *

(3) Standards. The Board has adopted the following standards for the use of controlled substances for pain control:
(a) Evaluation of the Patient. A complete medical history and physical examination must be conducted and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the

pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

(b) Treatment Plan. The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

(c) Informed Consent and Agreement for Treatment. The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician should employ the use of a written agreement between physician and patient outlining patient responsibilities, including, but not limited to:

1. Urine/serum medication levels screening when requested;
2. Number and frequency of all prescription refills; and
3. Reasons for which drug therapy may be discontinued (i.e., violation of agreement).

(d) Periodic Review. At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician's evaluation of the patient's progress. If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

(e) Consultation. The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation, and may require consultation with or referral to an expert in the management of such patients.
(f) Medical Records. The physician is required to keep accurate and complete records to include, but not be limited to:
1. The medical history and physical examination, including history of drug abuse or dependence, as appropriate;
2. Diagnostic, therapeutic, and laboratory results;
3. Evaluations and consultations;
4. Treatment objectives;
5. Discussion of risks and benefits;
6. Treatments;
7. Medications (including date, type, dosage, and quantity prescribed);
8. Instructions and agreements; and
9. Periodic reviews.
Records must remain current and be maintained in an accessible manner and readily available for review.
(g) Compliance with Controlled Substances Laws and Regulations. To prescribe, dispense, or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual: An Informational Outline of the Controlled Substances Act of 1970, published by the U.S. Drug Enforcement Agency, for specific rules governing controlled substances as well as applicable state regulations.

128. Respondent engaged in gross and repeated malpractice and failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable

under similar conditions and circumstances in Respondent's treatment of patients P.C., T.D., F.E., S.H., G.B., C.H., T.M., J.M., K.C., G.P., M.S., D.B., V.P., J.N., V.L., D.C., and C.P. in one or more of the following ways:

a. By failing to document a complete medical history and conduct a complete physical examination on Patients P.C., T.D., F.E., S.H., G.B., C.H., T.M., J.M., K.C., G.P., M.S., D.B., V.P., J.N., V.L., D.C., and C.P. prior to or during the time he prescribed controlled substances for pain control.

b. By failing to prepare a written treatment plan for Patients P.C., T.D., F.E., S.H., G.B., C.H., T.M., J.M., K.C., G.P., M.S., D.B., V.P., J.N., V.L., D.C., and C.P.

c. By failing to periodically review the effectiveness of the treatment of Patients P.C., T.D., F.E., S.H., G.B., C.H., T.M., J.M., K.C., G.P., M.S., D.B., V.P., J.N., V.L., D.C., and C.P.

e. By repeatedly prescribing OxyContin on a PRN or an "as needed basis."

f. By failing to comply with the standards of practice for the use controlled substances for the treatment of pain as stablished in Rule 64B8-9.013, FAC, as set out in subparagraphs a, b, and c above.

129. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes (1994) through (2003), by engaging in gross and repeated malpractice and by failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

COUNT TWO

130. Petitioner realleges and incorporates paragraphs one (1) through one hundred and twenty-eight (128) as if fully set forth herein.

131. Section 458.331(1)(m), Florida Statutes (1994) through (2003), provides that failing to keep legible, as defined by department rule in consultation with the board, medical records that justify the course of treatment of the patient including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations constitutes grounds for disciplinary action by the Board of Medicine.

132. Respondent failed to maintain adequate medical records for Patients P.C., T.D., F.E., S.H., G.B., C.H., T.M., J.M., K.C., G.P.,M.S., D.B., V.P., J.N., V.L., D.C., and C.P that include the minimum required information outlined in Rule 64B8-9.013, Florida Administrative Code, by failing to include the results of a complete physical examination of the above-described patients and the

patients's comprehensive medical history, by failing to document a written treatment plan and by failing to document any review, modification or evaluation of treatment based on the patients's progress.

133. Respondent failed to maintain medical records that adequately justify Respondent's prescribing practices to all of the above-described patients.

134. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (1994) through (2003), by not keeping adequate medical records to justify the administration and maintenance of the aforementioned prescription drug programs and failing to include the minimum information required by Rule 64B8-9.013, FAC.

COUNT THREE

135. Petitioner realleges and incorporates paragraphs one (1) through one hundred twenty-eight (128), one hundred and thirty-two (132) and one hundred and thirty-three (133), as if fully set forth herein.

136. Section 458.331(1)(q), Florida Statutes, (1994) through (2003), provides that prescribing, dispensing, administering, or otherwise preparing a controlled substance other than in the course of the physician's professional practice constitutes grounds for disciplinary action by the Board of Medicine. For the purpose of this paragraph, it shall be legally presumed that

prescribing, dispensing, administering, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his or her intent.

137. Respondent inappropriately prescribed controlled substances for the above listed patients by prescribing without conducting a complete physical and without a complete medical history, without adequately monitoring those patients with a history of substance abuse, without documenting the basis for the increase and/or decrease of controlled substances, and by prescribing to patients with chronic pain controlled substances, primarily OxyContin, over an extended period of time to be taken on a PRN or "as needed basis".

138. Based on the foregoing, Respondent has violated Section 458.331.(1)(q), Florida Statutes (1994) through (2003), by prescribing, dispensing, administering, mixing, or otherwise preparing controlled substances other than in the course of Respondent's professional practice.

WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand,

placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 2nd **day of** July, **2007.**

Ana M Viamonte Ros, M.D., M.B.A.
Secretary, Department of Health

Carol L. Gregg
Florida Bar # 181515
Assistant General Counsel
DOH Prosecution Services Unit
4052 Bald Cypress Way, Bin C-65
Tallahassee, FL 32399-3265
(850) 245-4640
(850) 245-4680 FAX

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK: Rachel R
DATE 7-2-07

PCP: Waiver of Probable Cause 6/5/2007

PCP Members:

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. CASE NO. 2005-01205

PHILIP K. SPRINGER, M.D.,

RESPONDENT.
_____/

WAIVER OF FINDING OF PROBABLE CAUSE
AND WAIVER OF CONFIDENTIALITY

1. A confidential Uniform Complaint Form was filed in the referenced case with the Department of Health. A copy of an Administrative Complaint, which will be filed, along with this waiver, with the office of the agency clerk of the Department of Health, is attached as Exhibit A.

2. Pursuant to Section 456.073(10), Florida Statutes, I, Philip K. Springer, M.D., license number ME 17474, have been advised of my right to a finding of probable cause and of the confidentiality provisions of Section 456.073(4) and (10), Florida Statutes. I understand that if I choose not to waive the privilege of confidentiality or the right to a determination of probable cause by the Probable Cause Panel or by the Department, the complaint and all information obtained pursuant to the department's investigation would be confidential until 10 days after probable cause has been found to exist by the Probable Cause Panel or by the Department. I also understand that if there

_____
Initials

is no finding by a Probable Cause Panel or the Department that probable cause exists, then in the absence of my waiver of probable cause and waiver of confidentiality, the complaint and all information obtained pursuant to the investigation would remain confidential.

3. I, Philip K. Springer, M.D., being fully advised of the consequences of so doing, hereby admit probable cause exists for a violation of Section 458.331(1)(nn), Florida Statutes; waive the statutory privilege of confidentiality; and waive the right to a determination of probable cause by the Probable Cause Panel, or the Department when appropriate, regarding the complaint, the investigative report of the Department of Health, and all other information obtained pursuant to the Department's investigation in the above-styled action in order to expedite consideration and resolution of this action by the Florida Board of Medicine in a public meeting.

By signing this waiver, I understand that the complaint and all information obtained pursuant to the investigation by the Department, as well as the Administrative Complaint, will immediately become a public record that is immediately accessible to the public. Section 456.073(10) Florida Statutes.

I AFFIRM THAT I HAVE READ AND UNDERSTOOD THE FOREGOING AND CONSENT TO ALL TERMS HEREIN.

PHILIP K. SPRINGER, M.D.

Initials

STATE OF FLORIDA
COUNTY OF BRADFORD

Sworn to and subscribed before me this 5th day of JUNE, 2007, by PHILIP K. SPRINGER who is personally known to me or who had produced _____ (type of identification) as identification.

Karen J. Redding

NOTARY PUBLIC, STATE OF FLORIDA

Karen J. Redding
Commission #DD370129
Expires: Nov 12, 2008
Bonded Thru
Atlantic Bonding Co., Inc.

(Print, Type of Stamp Commissioned Name of Notary Public)

_____
Initials