Final Order No. DOH-13-2347- S -MQA

FILED DATE - 12-23-13
Department of Health
By: Angela Barton
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 2009-21490
LICENSE NO.: ME0043557

STEVEN LEMBERG, M.D.,

Respondent.
_________________________________/

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) on December 6, 2013, in Orlando, Florida, for the purpose of considering Respondent's offer to voluntarily relinquish his license to practice medicine in the State of Florida. (Attached hereto as Exhibit A.) Said written offer of relinquishment specifically provides that Respondent agrees never again to apply for licensure as a physician in the State of Florida.

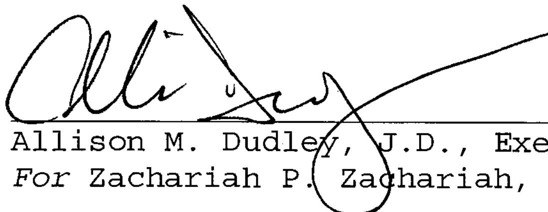
Upon consideration of the written offer of voluntary relinquishment, the charges, and the other documents of record, and being otherwise fully advised in the premises,

IT IS HEREBY ORDERED that Respondent's Voluntary Relinquishment of his license to practice medicine in the State of Florida is hereby ACCEPTED, and shall constitute discipline upon Respondent's license.

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

DONE AND ORDERED this 20th day of December, 2013.

BOARD OF MEDICINE



Allison M. Dudley, J.D., Executive Director
For Zachariah P. Zachariah, 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 STEVEN LEMBERG, M.D., 22560 Vistawood Way, Boca Raton, Florida 33428; to Lola M. Swaby, Esquire, 8668 Navarre Parkway, Suite 161, Navarre, Florida 32566; and by interoffice delivery to Doug Sunshine, Department of Health, 4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-3253 this 23 day of December, 2013.

Deputy Agency Clerk

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Angel Sanders
DATE AUG 20 2013

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,
Petitioner,

v. DOH Case No. 2009-21490

STEVEN LEMBERG, M.D.,
Respondent.
_______________________/

VOLUNTARY RELINQUISHMENT OF LICENSE

Respondent Steven Lemberg, M.D., license number ME 43557, hereby voluntarily relinquishes Respondent's license to practice medicine in the State of Florida and states as follows:

1. Respondent's purpose in executing this Voluntary Relinquishment is to avoid further administrative action with respect to this cause. Respondent understands that acceptance by the Board of Medicine (hereinafter the Board) of this Voluntary Relinquishment shall be construed as disciplinary action against Respondent's license pursuant to Section 456.072(1)(f), Florida Statutes. As with any disciplinary action, this relinquishment will be reported to the National Practitioner's Data Bank as disciplinary action. Licensing authorities in other states may impose discipline in their jurisdiction based on discipline taken in Florida.

2. Respondent agrees to never reapply for licensure as a Medical Doctor in the State of Florida.

3. Respondent agrees to voluntarily cease practicing medicine immediately upon executing this Voluntary Relinquishment. Respondent further agrees to refrain from

the practice of Medicine until such time as this Voluntary Relinquishment is presented to the Board and the Board issues a written final order in this matter.

4. In order to expedite consideration and resolution of this action by the Board in a public meeting, Respondent, being fully advised of the consequences of so doing, hereby waives the statutory privilege of confidentiality of Section 456.073(10), Florida Statutes, and waives a determination of probable cause, by the Probable Cause Panel, or the Department when appropriate, pursuant to Section 456.073(4), Florida Statutes, 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. By signing this waiver, Respondent understands that the record and complaint become public record and remain public record and that information is immediately accessible to the public. Section 456.073(10) Florida Statutes.

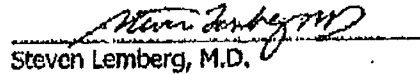
5. Upon the Board's acceptance of this Voluntary Relinquishment, Respondent agrees to waive all rights to seek judicial review of, or to otherwise challenge or contest the validity of, this Voluntary Relinquishment and of the Final Order of the Board incorporating this Voluntary Relinquishment.

6. Petitioner and Respondent hereby agree that upon the Board's acceptance of this Voluntary Relinquishment, each party shall bear its own attorney's fees and costs related to the prosecution or defense of this matter.

7. Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent in connection with the Board's consideration of this Voluntary Relinquishment. Respondent agrees that consideration of this Voluntary Relinquishment and other related materials by the Board shall not prejudice or preclude the

Board, or any of its members, from further participation, consideration, or resolution of these proceedings if the terms of this Voluntary Relinquishment are not accepted by the Board.

DATED this 17th day of August, 2013.

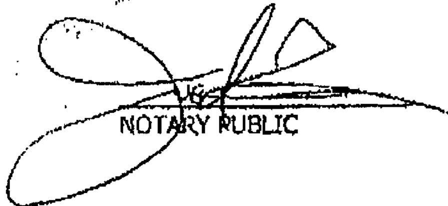


Steven Lemberg, M.D.

STATE OF Florida
COUNTY OF Palm Beach

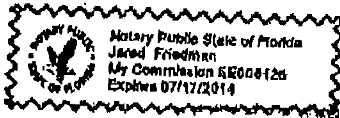
Before me, personally appeared Steven Lemberg, whose identity is known to me or who produced ______________________ (type of identification) and who, under oath, acknowledges that his signature appears above.

Sworn to and subscribed before me this 17 day of Aug, 2013.



NOTARY PUBLIC

My Commission Expires:



STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2009-21490**

STEVEN LEMBERG, M.D.,

RESPONDENT.

_______________________________/

ADMINISTRATIVE COMPLAINT

The Petitioner, Department of Health, by and through the undersigned counsel, and files this Administrative Complaint (Complaint) before the Board of Medicine against the Respondent, Steven Lemberg, M.D., and in support thereof alleges:

1. The 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, the Respondent was a licensed physician within the state of Florida, having been issued license number ME 43557.

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3. The Respondent's address of record is 22560 Vistawood Way, Boca Raton, Florida 33428.

4. The Respondent is not board certified in any specialty.

5. At all times material to this Complaint, the Respondent was employed at a pain management clinic called Coastal Pain Management (clinic), which was located in Palm Beach Gardens, Florida.

6. The Respondent became a dispensing practitioner on or about September 11, 2007. The Respondent dispensed drugs to his patients from the clinic.

Drug Definitions

7. The Respondent prescribed scheduled drugs to his patients as the primary means of controlling their pain. The Respondent prescribed a combination of high doses of an opiate in combination with other drugs to treat his patients.

8. Methadone is an opioid prescribed to treat pain. According to Section 893.03(2), Florida Statutes, methadone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States.

Abuse of methadone may lead to severe psychological or physical dependence.

9. Oxycodone is an opioid commonly prescribed to treat pain. According to Section 893.03(2), Florida Statutes, oxycodone is a Schedule II controlled substance that 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 psychological or physical dependence.

10. OxyContin is the brand name of an extended release formulation of oxycodone. OxyContin is prescribed for the management of moderate to severe pain when a continuous, round-the-clock analgesic is needed for an extended period of time. OxyContin Is designed to provide controlled delivery of oxycodone over 12 hours.

11. Roxicodone is the brand name of an immediate release formulation of oxycodone that has a three to four hour duration of action. Roxicodone is manufactured in 5 mg, 15 mg and 30 mg tablets.

12. Oxycodone/APAP is drug consisting of a combination of oxycodone and acetaminophen. (Acetaminophen is the drug sold over the counter under the brand name Tylenol.) According to Section 893.03(2),

Florida Statutes, oxycodone is a Schedule II controlled substance that 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 psychological or physical dependence.

13. Subutex and Suboxone are opioids called buprenorphine. Buprenorphine is commonly prescribed to treat pain. According to Section 893.03(5), Florida Statutes, buprenorphine is a Schedule V controlled substance that has a low potential for abuse relative to the substances in Schedule IV and has a currently accepted medical use in treatment in the United States. Abuse of buprenorphine may lead to limited physical or psychological dependence relative to the substances in Schedule IV.

14. Muscle relaxants may be used in pain management. Soma is the brand name for carisoprodol, a muscle relaxant prescribed to treat muscular pain. According to Section 893.03(4), Florida Statutes, carisoprodol is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States. Abuse of carisoprodol may lead to limited physical or psychological dependence relative to the substances in Schedule III.

15. The Respondent also prescribed benzodiazepines to his patients. Benzodiazepines are a class of drugs that cause sedation and can be habit forming. Benzodiazepines are typically prescribed to treat anxiety or insomnia. Valium and Xanax are two types of benzodiazepines.

16. Valium is the brand name of the drug diazepam and is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, diazepam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States. Abuse of diazepam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

17. Xanax is the brand name for alprazolam and is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, alprazolam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States. Abuse of alprazolam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

Standard of Care for Pain Management

18. To meet the standard of care, a doctor must obtain an adequate medical history, complete a physical examination, and then arrive at a diagnosis. The physician will order additional laboratory tests or imaging studies if they are warranted.

19. Pain management is treated in a multidisciplinary manner and additional specialists and ancillary providers are consulted when necessary.

20. Based on the patient's diagnosis and in concert with other healthcare providers and the patient, a pain management physician will create a treatment plan specific to the needs of each patient. At each subsequent visit, the patient's medical records are updated, examinations will be performed and tests will be ordered as needed. The treatment plan is periodically reviewed and updated to meet a patient's needs. Failure to prepare a treatment plan is below the standard of care.

21. A physician who meets the standard of care will reevaluate the patient for adverse drug reactions, patient compliance and the efficacy of each mode of therapy provided. The pain management physician must be vigilant in reevaluating and treating his patient.

22. A physician practicing pain management must also understand the pharmacology of the drugs that he or she prescribes in order to meet the standard of care. Opiates are manufactured in immediate release and extended release formulations. Immediate release formulations must be taken more frequently then extended release formulations. Immediate release formulations can last three to six hours in a patient's bloodstream, and therefore, they must be taken four to six times per day. Taking immediate release formulations several times a day results in inconsistent pain control because the level of a drug in a patient's bloodstream rises and drops several times a day.

23. An extended release formulation may contain a larger amount of a drug, the patient can be treated with a small number of pills relative to a large number of pills contained in an immediate release formulation.

24. Patients are more likely to be compliant with a drug treatment regimen consisting of a small number of extended release pills a few times a day than they are with taking a relatively large number of pills several times in a 24-hour period.

25. Scheduled drugs are dangerous, potent and subject to abuse. Based on a patient's family or personal history of addiction or substance

misuse, a patient may require a higher level of scrutiny if and when it is necessary for him or her to take addictive medications.

26. Immediate release formulations of opioids are more subject to abuse because they produce analgesia and euphoria in a short amount of time. A large number of pills of an immediate release formula are also easier to divert than a smaller number of extended release pills.

Facts Specific to Patient J.G.

27. J.G. was treated at the clinic approximately every four weeks from on or about January 29, 2009, through on or about November 30, 2009.

28. At the time of his first visit, J.G. was a 51 year-old man, employed as an automotive technician. He sought treatment for low back pain and left leg pain.

29. J.G.'s medical records included an MRI of his lumbar spine taken on or about September 12, 2007, and two pharmacy logs showing what J.G. had been dispensed from on or about March 31, 2008, through on or about January 5, 2009. There is a gap of approximately two months (September and October 2008) where no drugs were dispensed.

30. According to the pharmacy logs, the last time J.G. was dispensed an opioid was on or about December 9, 2008, when the patient was dispensed 168 tablets of oxycodone 30 mg. In addition, the pharmacy also dispensed 28 tablets of alprazolam 2 mg and blood pressure medication. All of these drugs had been prescribed by Dr. H., a physician at another practice.

31. According to the drug logs, the last time J.G. was dispensed a benzodiazepine was on or about January 5, 2009, when the pharmacy dispensed 28 tablets of alprazolam 2 mg. The alprazolam was prescribed by Dr. B., a physician at another practice.

32. Other than the MRI and two pharmacy logs, there were no other medical records from a previous or current healthcare provider.

33. The medical records do not contain any notes indicating that the Respondent consulted any of J.G.'s healthcare providers.

34. On or about January 29, 2009, J.G. self-reported his medical history. J.G. stated he had been in a six-month Alcoholics Anonymous program following an arrest for driving under the influence in 1990. J.G. denied any history of depression or anxiety.

35. On or about January 29, 2009, J.G. was drug tested at the clinic. J.G. tested positive for oxycodone and morphine. The drug tests results were irregular because J.G. had not been prescribed either drug in the preceding 30 days. The Respondent did not test the patient for benzodiazepines, and therefore did not confirm that the patient had been taking his benzodiazepines as prescribed. The Respondent did not discuss the patient's positive oxycodone or morphine results or document why he did not test the patient for benzodiazepines.

36. Despite the patient having a history of alcohol abuse and irregular drug test results, the Respondent did not evaluate or monitor the patient for substance abuse. The Respondent did not consult with or refer the patient to a specialist who managed patients with a history of substance abuse.

37. On or about January 29, 2009, the Respondent diagnosed J.G. with lumbar disk disease with spondylosis, thoracic disk disease with herniation at the T1-T11 levels and intractable back pain.

38. The Respondent's treatment plan for the patient consisted of prescribing the pain management medication at doses already determined by the previous physician, physical therapy and epidural or trigger point

injections. The Respondent stated that he referred the patient to his primary doctor for an evaluation of his blood pressure.

39. The Respondent did not delineate objectives in the patient's treatment plan that could be used to determine whether the patient's treatment was successful.

40. From on or about January 29, 2009, through on or about November 30, 2009, at each visit, the patient had spasms and tenderness in his cervical and lumbar spine. The patient's neurological evaluation was always normal and he never walked with a limp.

41. Pain is dynamic and it is unlikely that the patient had exactly the same physical examination results every month for eleven months. The Respondent did not conduct an adequate history or physical examination of the patient.

42. From January 29, 2009, through November 30, 2009, the Respondent prescribed 168 tablets of Roxicodone 30 mg, 28 tablets of Xanax 2 mg, and 28 tablets of hydrochlorothiazide at each visit.

43. The Respondent did not diagnose the patient with anxiety or provide any medical justification for prescribing the patient Xanax each month.

44. The Respondent did not prescribe any adjunctive drugs or extended release opioids for the patient.

45. The Respondent did not start J.G. at low doses and gradually increase his drug regimen.

46. The Respondent prescribed excessively high doses of Roxicodone and Xanax to the patient based on his medical history and physical examination.

47. On or about June 15, 2009, the Respondent documented discussing physical therapy with the patient, however, there is no documentation that a referral or prescription for physical therapy was ever made. The Respondent did not document the results of the patient's physical therapy.

48. On or about October 5, 2009, the Respondent noted that he referred J.G. to an orthopedist for an evaluation because the patient was having pain in his left leg and left foot. The Respondent did not document to whom he had referred the patient, if he did make a referral.

49. On or about November 2, 2009, the Respondent noted that the patient was experiencing more pain in his left leg. The Respondent noted

that the patient had made an orthopedic appointment in Wellington, Florida, but did not document who the orthopedist was.

50. On or about November 30, 2009, the Respondent noted that the patient was waiting to get health insurance to see the orthopedist and the patient would see the orthopedist by the end of December or the middle of January.

51. There are no other records for the patient after November 30, 2009.

52. The medical records do not justify the Respondent's treatment of the patient.

COUNT ONE (Standard of Care for Patient J.G.)

53. The Petitioner realleges and incorporates paragraphs 1-52 as if fully set forth in this count.

54. Section 458.331(1)(t)1., Florida Statutes (2008-2009), subjects a licensee to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes. Section 456.50(1)(g), Florida Statutes (2008-2009), states medical malpractice means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

55. The Respondent fell below the standard of care in one or more of the following ways:

a. The Respondent failed to consult with the patient's prior or current health care providers.

b. The Respondent improperly relied on the patient's self-reporting and failed to gather an adequate medical history of the patient.

c. The Respondent's physical examination(s) of the patient was inadequate.

d. The Respondent failed to assess or monitor the patient for substance abuse.

e. The Respondent failed to consult with or refer the patient to a specialist who was an expert at managing patients with a history of substance abuse.

f. The Respondent failed to offer the patient treatment modalities or failed to follow through with treatment modalities.

g. The Respondent failed to offer the patient extended release opioids or adjunctive medications.

h. The Respondent's treatement plan was inadequate or the Respondent failed to follow through with the treatement plans he made.

56. Based on the foregoing, the Respondent has violated Section 458.331(1)(t)1., Florida Statutes, (2008-2009), by committing medical malpractice and is subject to disciplinary action by the Board of Medicine.

COUNT TWO (Inappropriate Prescribing for Patient J.G.)

57. The Petitioner realleges and incorporates paragraphs 1-52 as if fully set forth in this count.

58. Section 458.331(1)(q), Florida Statutes (2008-2009), subjects a licensee to discipline for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, 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.

59. The Respondent prescribed a legend drug other than in the course of his professional practice by prescribing a legend drug inappropriately or in excessive or inappropriate quantities in one or more of the following ways:

a. The Respondent prescribed excessive quantities of the Roxicodone for the patient's pain based on the patient's medical records.

b. The Respondent inappropriately prescribed alprazolam without medical justification.

c. The Respondent started the patient at high doses of Roxicodone and Xanax and failed to start the patient at smaller doses and increase the patient's drug regimen over time.

60. Based on the foregoing, the Respondent violated Section 458.331(1)(q), Florida Statutes (2008-2009), by prescribing excessively and inappropriately and is subject to disciplinary action by the Board of Medicine.

COUNT THREE (Medical Records for Patient J.G.)

61. The Petitioner realleges and incorporates paragraphs 1-52 as if fully set forth in this count.

62. Section 458.331(1)(m), Florida Statutes (2008-2009), provides that a licensee is subject to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and 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.

63. Medical records are further defined by Rule 64B8-9.003, Florida Administrative Code, which is titled "Standards for Adequacy of Medical Records" and provides, in part:

> (2) A licensed physician shall maintain patient medical records in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.
>
> (3) The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment

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and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

64. The Respondent failed to maintain adequate medical records in one or more of the following ways:

a. The Respondent failed to document an adequate medical history and physical examination.

b. The Respondent failed to maintain patient medical records with sufficient detail to clearly demonstrate why he was treating the patient with Xanax.

c. The Respondent failed to maintain patient medical records with sufficient detail to clearly demonstrate why he was treating the patient with 168 tablets of Roxicodone 30 mg each month.

d. The Respondent did not document the results of the patient's physical therapy, or follow up with specialists.

e. The Respondent's medical records do not explain why he did not prescribe the patient any adjunctive drugs or extended release opioids.

f. The medical records do not justify Respondent's treatment of the patient.

65. Based on the foregoing, the Respondent violated Section 458.331(1)(m), Florida Statutes (2008-2009), by failing to keep adequate medical records and is subject to disciplinary action by the Board of Medicine.

Facts Specific to Patient R.D.

66. R.D. was treated at the clinic every four weeks from on or about September 18, 2007, through on or about August 5, 2009.

67. At the time of his first visit, R.D. was a 31 year-old man who sought treatment at the clinic for pain related to a motorcycle accident.

68. R.D.'s medical records included an MRI of the lumbar spine which had been taken on or about February 6, 2003. There were no other records or referrals from previous or current physicians.

69. On or about September 18, 2007, R.D. indicated that he had physical therapy, acupuncture and drug treatment to treat his pain. R.D. self-reported the he was taking Roxicodone 30 mg, Xanax 2 mg, Valium 10 mg, and Methadone 10 mg tablets.

70. On or about September 18, 2007, R.D. took a drug test at the clinic. R.D. tested positive for methadone and benzodiazepines, and tested negative for opiates

71. From on or about September 18, 2007, through on or about January 30, 2008, R.D. was treated by Dr. J. and Dr. S., who also practiced at the clinic. On or about January 30, 2008, Dr. J. prescribed 200 tablets of Roxicodone 30 mg, 30 tablets of oxycodone/APAP 10/325, 30 tablets of Restoril 30 mg. Restoril is a Schedule IV benzodiazepine prescribed to treat insomnia.

72. The Respondent treated R.D. from on or about February 26, 2008, through on or about August 5, 2009.

73. At each visit from on or about February 26, 2008, through on or about August 5, 2009, the Respondent found the patient had spasms and tenderness in his cervical and lumbar spine and the patient's neurological evaluation was always normal.

74. Pain is dynamic and it is unlikely that the patient had exactly the same physical examination results every month for 18 months.

75. On or about February 26, 2008, the Respondent diagnosed the patient with lumbar disk disease and intractable pain. The Respondent's treatment plan consisted of pain medication treatment and a surgical consultation. The Respondent also provided the patient a prescription for 30 tablets of Xanax 2 mg for anxiety.

76. The Respondent did not delineate objectives in the patient's treatment plan that could be used to determine whether the patient's treatment was successful.

77. From on or about February 26, 2008, through on or about August 5, 2009, the Respondent prescribed 180 to 200 tablets of Roxicodone 30 mg each month.

78. The Respondent prescribed excessively high doses of Roxicodone and Xanax to the patient based on his medical history and physical examination.

79. From on or about February 26, 2008, through on or about March 18, 2009, the Respondent prescribed 10 to 15 tablets of Methadone 10 mg per month, with the exception of March 8, 2009, when the

Respondent prescribed five tablets of Valium 5 mg. The Respondent stopped treating the patient with Methadone from on or about April 15, 2009, through on or about July 6, 2009, and then restarted the patient on Methadone on or about August 5, 2009. The Respondent did not document why he made changes to the patient's Methadone treatment.

80. Methadone can adversely affect a patient's heart function. The standard of care for a patient on Methadone is to monitor a patient's heart by ordering an electrocardiogram (EKG), however the Respondent did not order an EKG at any point during the patient's use of Methadone.

81. The Respondent did not prescribe any adjunctive drugs or extended release opioids.

82. The medical records did not justify Respondent's treatment of the patient.

83. On or about August 4, 2008, and on or about September 29, 2008, the Respondent informed the patient that he needed a new MRI. There were no referrals or prescriptions for an MRI in patient's medical records.

84. On or about October 27, 2008, the medical records indicate the patient would be getting a new MRI in two weeks, however, there were no MRIs for that time period

85. On or about April 15, 2009, the medical records indicated that the patient would be getting a surgical evaluation through the veteran's hospital, however, there are no medical records from a surgeon or any follow up consultation notes.

86. At his next visit, on or about June 8, 2009, the Respondent noted that R.D. was unable to get an MRI because he was waiting for the veteran's hospital to approve it.

87. On or about May 12, 2009, the medical records indicated that the Respondent discussed physical therapy with the patient and that a prescription for an MRI was given to the patient. There was no copy of the prescription for the MRI retained in the records, nor was there any documentation that a prescription for physical therapy had been provided to the patient.

COUNT FOUR (Standard of Care for Patient R.D.)

88. The Petitioner realleges and incorporates paragraphs 1-26 and 66-87, as if fully set forth in this count.

89. Section 458.331(1)(t)1., Florida Statutes (2008-2009), subjects a licensee to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes. Section 456.50(1)(g), Florida Statutes (2008-2009), states medical malpractice means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

90. The Respondent fell below the standard of care of in one or more of the following ways:

a. The Respondent failed to obtain an adequate medical history.

b. The Respondent failed to conduct an adequate physical examination of the patient.

c. The Respondent failed to consider or offer the patient extended release opioids or adjunctive medications.

d. The Respondent failed to monitor the patient's heart while prescribing Methadone.

e. The Respondent did not start the patient at low doses of Xanax and gradually increase his drug regimen.

f. The Respondent failed to follow up with a surgical consultation, physical therapy referrals or MRI.

g. The Respondent did not prepare an adequate treatment plan for the patient.

91. Based on the foregoing, the Respondent violated Section 458.331(1)(t)1., Florida Statutes (2008-2009), by committing medical malpractice and is subject to disciplinary action by the Board of Medicine.

COUNT FIVE (Inappropriate Prescribing for Patient R.D.)

92. The Petitioner realleges and incorporates paragraphs 1-26 and 66-87, as if fully set forth in this count.

93. Section 458.331(1)(q), Florida Statutes (2008-2009), subjects a licensee to discipline for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, 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.

94. The Respondent prescribed a legend drug other than in the course of his professional practice by prescribing a legend drug inappropriately or in excessive or inappropriate quantities in one or more of the following ways:

a. The Respondent prescribed inappropriately amounts of Roxicodone based on the patient's medical records.

b. The Respondent prescribed inappropriate amounts of Xanax based on the patient's medical records.

95. Based on the foregoing, the Respondent violated Section 458.331(1)(q), Florida Statutes (2008-2009), by prescribing excessively and inappropriately and is subject to disciplinary action by the Board of Medicine.

COUNT SIX (Medical Records for Patient R.D.)

96. The Petitioner realleges and incorporates paragraphs 1-26 and 66-87, as if fully set forth in this count.

97. Section 458.331(1)(m), Florida Statutes (2008-2009), provides that a licensee is subject to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising

physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and 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.

98. Medical records are further defined by Rule 64B8-9.003, Florida Administrative Code, which is titled "Standards for Adequacy of Medical Records" and provides, in part:

> (2) A licensed physician shall maintain patient medical records in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.
>
> (3) The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and

copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

99. The Respondent failed to maintain adequate medical records in one or more of the following ways:

a. The Respondent failed to document an adequate medical history and physical examination.

b. The Respondent failed to maintain medical records with sufficient detail to clearly demonstrate why he was prescribing Roxicodone 30 mg to the patient.

c. The Respondent failed to maintain medical records with sufficient detail to clearly demonstrate why he was prescribing Methadone 10 mg to the patient.

d. The Respondent failed to maintain medical records with sufficient detail to clearly demonstrate why he stopped and restarted the patient's Methadone.

e. The Respondent failed to maintain medical records with sufficient detail to clearly demonstrate why he was prescribing Xanax 2 mg to the patient.

f. The Respondent's medical records do not explain why he did not prescribe the patient any adjunctive drugs or extended release opioids.

g. The Respondent's medical records do not contain sufficient information to justify the drug treatment he provided the patient.

h. The Respondent's medical records do not contain and adequate treatment plan for the patient.

100. Based on the foregoing, the Respondent violated Section 458.331(1)(m), Florida Statutes (2008-2009), by failing to keep adequate medical records and is subject to disciplinary action by the Board of Medicine.

Facts Specific to Patient B.O.

101. B.O. was treated at the clinic every four weeks from on or about May 27, 2008, through on or about April 27, 2009.

102. At the time of her first visit, B.O. was a 53 year-old woman who delivered magazines for a living. B.O. suffered from pain since 2007,

when she had been injured at work. B.O. had been previously treated with medication and was getting some relief from massage therapy.

103. B.O.'s medical records from previous health care providers consisted of two pharmacy logs and three MRIs. B.O. did not have a referral.

104. B.O.'s pharmacy logs indicated that on or about May 8, 2008, the patient was dispensed 30 tablets of fluoxetine 20 mg and 60 tablets of alprazolam 2 mg. The patient's last prescription for an opioid was filled on or about March 20, 2008, when she was dispensed 50 tablets of oxycodone/APAP 10/325.

105. Fluoxetine is an non-schedule, legend antidepressant that is sold under the brand name Prozac. Fluoxetine is used to treat mental major depressive disorder, bulimia, obsessive-compulsive disorder and panic disorder.

106. The patient's medical records also included MRI's of her lumbar and cervical spine taken on or about January 19, 2009, and an MRI of her lumbar spine taken on or about January 24, 2008.

107. On or about May 27, 2008, B.O. provided her medical history. She reported a history of depression and anxiety attacks, for which she took fluoxetine and Xanax.

108. On or about May 27, 2008, B.O. stated she was taking her friend's pain medication and she was using marijuana.

109. On or about May 27, 2008, B.O. tested positive for marijuana and oxycodone at the clinic.

110. The standard of care for a patient who is taking another person's prescription pain medication and using illegal drugs is to evaluate the patient for substance abuse.

111. The Respondent failed to assess the patient for substance abuse.

112. The Respondent did not refer the patient to a pain management specialist who specializes in treating patients with substance abuse issues or with psychiatric problems.

113. On or about May 27, 2008, the Respondent diagnosed B.O. with low back pain, lumbar disk disease and degenerative disk disease.

114. The Respondent's treatment plan consisted of pain management medication, physical therapy, epidurals and a new MRI of the patient's neck.

115. The Respondent did not delineate objectives in the patient's treatment plan that could be used to determine whether the patient's treatment was successful.

116. The medical records do not contain any documentation that the Respondent actually prescribed physical therapy, epidurals or a new MRI of the patient's neck.

117. At each visit, the patient had spasms and tenderness in her cervical and lumbar spine. The patient's neurological evaluation was always normal and she never walked with a limp.

118. Pain is dynamic and it is unlikely that the patient had exactly the same physical examination results every month.

119. The Respondent did not obtain an adequate medical history or conduct physical examinations (or both) of the patient.

120. From on or about May 27, 2008, through on or about April 27, 2009, the Respondent prescribed 120 tablets of Roxicodone 30 mg per month.

121. On or about June 24, 2009, the Respondent noted that the patient only had 10 tablets of Xanax left and gave her a prescription for 20 tablets of Xanax 2 mg, based on the patient's previous prescription.

122. From July 22, 2008, through on or about April 27, 2009, the Respondent prescribed 30 tablets of Xanax 2 mg per month to the patient.

123. The Respondent did not document calling the previous prescribing physician to inquire if the patient was still getting Xanax from him or her.

124. On or about February 2, 2009, the Respondent started prescribing Soma for the patient after she was in a motor vehicle accident. From on or about February 2, 2009, through on or about April 27, 2009, the Respondent prescribed 15 tablets of Soma 350 mg each month.

125. The medical records do not contain any notes indicating that the Respondent had consulted any of the patient's health care providers.

126. The Respondent did not employ therapeutic interventions or modalities other than the use of Roxicodone, and later Soma, to treat the patient.

127. The Respondent did not prescribe any adjunctive drugs or extended release opioids. The Respondent did not start the patient at low doses and gradually increase his drug regimen.

128. The Respondent prescribed excessively high doses of Roxicodone and Xanax to the patient based on her medical history and physical examination.

129. The medical records do not justify Respondent's treatment of the patient.

COUNT SEVEN (Standard of Care for Patient B.O.)

130. The Petitioner realleges and incorporates paragraphs 1-26 and 101-129 as if fully set forth in this count.

131. Section 458.331(1)(t)1., Florida Statutes (2007-2009), subjects a licensee to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes. Section 456.50(1)(g), Florida Statutes (2007-2009), states medical malpractice means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

132. The Respondent fell below the standard of care of in one or more of the following ways:

a. The Respondent failed to obtain an adequate medical history or conduct physical examinations of the patient.

b. The Respondent failed to assess or monitor the patient for substance abuse.

c. The Respondent failed to refer the patient to a practitioner specializing in pain patients with a history of substance abuse and psychiatric problems.

d. The Respondent did not offer the patient alternative treatment.

e. The Respondent failed to provide the patient with adjunctive drugs or extended release opioids to treat her pain.

f. The Respondent failed to follow up with the patient's other physicians to see if they were also prescribing Xanax.

g. The Respondent's treatment plan was inadequate.

133. Based on the foregoing, the Respondent violated Section 458.331(1)(t)1., Florida Statutes (2007-2009), by committing medical malpractice and is subject to disciplinary action by the Board of Medicine.

COUNT EIGHT (Inappropriate Prescribing for Patient B.O.)

134. The Petitioner realleges and incorporates paragraphs 1-26 and 101-129 as if fully set forth in this count.

135. Section 458.331(1)(q), Florida Statutes (2007-2009), subjects a licensee to discipline for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, 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.

136. The Respondent prescribed a legend drug other than in the course of his physician's professional practice by prescribing a legend drug inappropriately or in excessive or inappropriate quantities in one or more of the following ways:

a. The Respondent inappropriately prescribed Roxicodone without any long acting extended release opioids.

b. The Respondent prescribed inappropriate quantities of Roxicodone for the patient.

c. The Respondent prescribed inappropriate quantities of Soma for the patient.

d. The Respondent inappropriately prescribed highly addictive controlled substances to a patient who exhibited signs of substance abuse.

137. Based on the foregoing, the Respondent violated Section 458.331(1)(q), Florida Statutes (2007-2009), by prescribing excessively and inappropriately and is subject to disciplinary action by the Board of medicine.

COUNT NINE (Medical Records for Patient B.O.)

138. The Petitioner realleges and incorporates paragraphs 1-29, and 101-129 as if fully set forth in this count.

139. Section 458.331(1)(m), Florida Statutes (2007-2009), provides that a licensee is subject to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and 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.

140. Medical records are further defined by Rule 64B8-9.003, Florida Administrative Code, which is titled "Standards for Adequacy of Medical Records" and provides, in part:

> (2) A licensed physician shall maintain patient medical records in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.
>
> (3) The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the

appropriate treatment of the patient.

141. The Respondent failed to maintain adequate medical records in one or more of the following ways:

a. The Respondent failed to document an adequate medical history and physical examinations.

b. The Respondent's medical records do not contain sufficient information to justify the treatment of the patient.

c. The Respondent's medical records do not contain adequate explanation of why non-drug treatment modalities were not offered to the patient.

d. The Respondent's medical records do not contain any documentation that he prescribed physical therapy, epidurals or an MRI, nor is there any explanation of why the Respondent did not follow through with the treatment plan for physical therapy, epidurals or an MRI.

e. The Respondent's medical records do not explain why he did not prescribe the patient any adjunctive drugs or extended release opioids.

f. The Respondent did not document an adequate treatment plan.

142. Based on the foregoing, the Respondent violated Section 458.331(1)(m), Florida Statutes (2007-2009), by failing to keep adequate medical records and is subject to disciplinary action by the Board of Medicine.

Facts Specific to Patient C.H.

143. C.H. was treated approximately once every four weeks at the clinic from on or about September 14, 2007, through on or about December 9, 2009.

144. On or about September 14, 2007, C.H. was a 49 year-old man employed as a building inspector. C.H. complained of pain in his knees, lower back and right leg. C.H. had arthritis and had undergone knee surgeries and back surgery. He reported having had injections, physical therapy, over the counter medications and opioid treatment. C.H. did not report having any mental health problems.

145. C.H.'s medical records included an MRI of his left knee taken on or about August 29, 2001; MRIs of the lumbar spine taken on or about September 4, 2001, and on or about March 28, 2007; and an x-ray of his

left knee taken on or about March 20, 2006, and an x-ray of the lumbar spine taken on about March 22, 2007. C.H. had no referral.

146. From on or about September 14, 2007, through on or about November 27, 2007, C.H. was treated by Dr. S., another doctor at the clinic.

147. The Respondent treated the patient from on or about December 19, 2007, through on or about December 9, 2009.

148. On or about December 19, 2007, C.H. was treated by the Respondent for the first time. The medical records indicated that C.H. reported that other physicians recommended that he get a knee replacement and a titanium cage for his back.

149. On or about December 19, 2007, C.H. diagnosed the patient with lumbar disk disease. The Respondent's treatment plan was to treat the patient with pain management medications at doses determined by the previous physician and watch the patient's tolerance.

150. From on or about December 19, 2007, through on or about December 9, 2009, at each visit, the patient had spasms and tenderness in his cervical and lumbar spine. The patient's neurological evaluation was

always normal and he never walked with a limp, had any decrease in his range of motion, no effusion or any pain upon movement in his knees.

151. Pain is dynamic and it is unlikely that the patient had exactly the same physical examination results every month for twelve months.

152. The Respondent did not conduct an adequate medical history or physical examination of the patient.

153. From on or about December 19, 2007, through on or about March 11, 2008, the Respondent prescribed 60 tablets of OxyContin 30 mg, 200 tablets of Roxicodone 30 mg and 30 tablets of Xanax 2 mg, per month.

154. The Respondent did not diagnose the patient with anxiety or provide any medical justification for prescribing the patient Xanax each month.

155. On or about January 15, 2008, the Respondent ordered a drug test on the patient. The patient's tests were inconsistent with his prescriptions in that the patient tested negative for benzodiazepines and positive for methadone. The patient also tested positive for oxycodone at levels that were higher than expected. The medical records indicated that

the patient may have tested positive for methadone because of dental problems.

156. The Respondent did not assess the patient for substance abuse or diversion despite the patient's irregular drug test results.

157. On or about April 8, 2008, the patient stopped taking Xanax of his own volition, but continued to take 200 tablets of Roxicodone 30 mg and 60 tablets of OxyContin 20 mg each month until on or about September 24, 2008.

158. On or about October 23, 2008, the patient stopped taking OxyContin because it was too expensive.

159. From on or about October 23, 2008, through on or about December 9, 2009, the Respondent prescribed 190 to 240 tablets of Roxicodone 30 mg per month to the patient.

160. Although there was a note on or about August 28, 2008, stating that the patient was to have a full knee replacement, there are no notes indicating that the surgery was actually completed.

161. There are no notes indicating that the Respondent ever consulted with any of the patient's previous or current physicians.

162. The Respondent did not prescribe any adjunctive drugs.

163. The Respondent prescribed excessively high doses of Roxicodone and Xanax to the patient based on his medical history and physical examination.

164. The medical records do not justify Respondent's treatment of the patient.

COUNT TEN (Standard of Care for Patient C.H.)

165. The Petitioner realleges and incorporates paragraphs 1-26 and 143-164, as if fully set forth in this count.

166. Section 458.331(1)(t)1., Florida Statutes (2007-2009), subjects a licensee to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes. Section 456.50(1)(g), Florida Statutes (2007-2009), states medical malpractice means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

167. The Respondent fell below the standard of care of in one or more of the following ways:

a. The Respondent performed inadequate physical examinations of the patient.

b. The Respondent failed to assess the patient for substance abuse despite her irregular drug screens.

c. The Respondent did not diagnose the patient with anxiety or provide any medical justification for prescribing the patient Xanax each month.

d. The Respondent did not offer the patient treatment modalities other than medication therapy.

e. The Respondent failed to consult with the patient's other physicians or follow up with specialists.

f. The Respondent did not prescribe any adjunctive drugs.

g. The Respondent did not provide the patient an adequate treatment plan.

168. Based on the foregoing, the Respondent violated Section 458.331(1)(t)1., Florida Statutes (2007-2009), by committing medical malpractice and is subject to disciplinary action by the Board of Medicine.

COUNT ELEVEN (Inappropriate Prescribing for Patient C.H.)

169. The Petitioner realleges and incorporates paragraphs 1-26 and 143-164 as if fully set forth in this count.

170. Section 458.331(1)(q), Florida Statutes (2007-2009), subjects a licensee to discipline for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, 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.

171. The Respondent prescribed a legend drug other than in the course of his professional practice by prescribing a legend drug inappropriately or in excessive or inappropriate quantities in one or more of the following ways:

a. The Respondent prescribed inappropriate quantities of Roxicodone for the patient.

b. The Respondent inappropriately prescribed Xanax without a diagnosis.

c. The Respondent inappropriately prescribed highly addictive controlled substances to a patient who exhibited signs of substances abuse.

172. Based on the foregoing, the Respondent violated Section 458.331(1)(q), Florida Statutes (2007-2009), by prescribing excessively and inappropriately and is subject to disciplinary action by the Board of Medicine.

COUNT TWELVE (Medical Records for Patient C.H.)

173. The Petitioner realleges and incorporates paragraphs 1-26 and 143-164 as if fully set forth in this count.

174. Section 458.331(1)(m), Florida Statutes (2007-2009), provides that a licensee is subject to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and 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.

175. Medical records are further defined by Rule 64B8-9.003, Florida Administrative Code, which is titled "Standards for Adequacy of Medical Records" and provides, in part:

> (2) A licensed physician shall maintain patient medical records in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.
>
> (3) The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

176. The Respondent failed to maintain adequate medical records in one or more of the following ways:

a. The Respondent failed to document an adequate medical history and physical examination.

b. The Respondent's medical records do not contain sufficient information to justify the treatment of the patient.

c. The Respondent's medical records do not contain adequate explanation of why non-drug treatment modalities were not offered to the patient.

d. The Respondent's medical records do not explain why he did not prescribe the patient any adjunctive drugs.

e. The Respondent failed to document an adequate treatment plan for the patient.

177. Based on the foregoing, the Respondent violated Section 458.331(1)(m), Florida Statutes (2007-2009), by failing to keep adequate medical records and is subject to disciplinary action by the Board of Medicine.

Facts Specific to Patient L.P.

178. L.P. was treated at the clinic approximately once every four weeks from on or about August 11, 2005, through on or about March 2, 2009.

179. At the time of his first visit, L.P. was a 41 year-old man employed as a nurse. L.P.'s medical records included an MRI of his lumbar spine performed on or about August 27, 2003, and on or about January 13, 2009; an MRI of the lumbar and pelvis performed on or about March 27, 2009. L.P.'s medical record, also included records from one or more other pain management clinic(s), but it is unclear how he arrived at the Respondent's practice.

180. On or about August 11, 2005, L.P. signed a form which stated that the clinic only accepted cash from pain management patients, even through the patient had health insurance.

181. The Respondent treated L.P. from on or about September 17, 2007, through on or about March 2, 2009.

182. On or about September 17, 2007, the Respondent's diagnosed the patient with lumbar disk disease with herniation at the L4-L5, L5-S1 levels, spondylosis and intractable pain. The Respondent's treatment plan

for the patient was to maintain the patient on the drugs prescribed by the previous physician.

183. From on or about September 17, 2007, through on or about March 2, 2009, the Respondent prescribed 220 to 240 tablets of Roxicodone 30 mg each month.

184. The Respondent did not prescribe any adjunctive drugs or extended release opioids.

185. From on or about September 17, 2007, through on or about March 2, 2009, the Respondent found that the patient had spasms and tenderness in his cervical and lumbar spine. The patient's neurological evaluation was normal and the patient never had a limp.

186. On or about March 30, 2009, L.P. stated that he wanted to reduce the amount of opiates he was taking. He was experiencing anxiety, nausea, delirium tremens and aches and pains. L.P. also cited cost as a factor in his desire to reduce his dependence on opiates.

187. On or about March 30, 2009, the Respondent diagnosed the patient with opioid dependency and his treatment plan was to start the patient on Suboxone. The Respondent prescribed four tablets of Subutex 8 mg and eight tablets of Suboxone 8 mg.

188. On or about April 2, 2009, the Respondent started the patient on a regimen of 30 tablets of Suboxone 8 mg.

189. From on or about April 14, 2009, through on or about December 14, 2009, the Respondent prescribed 50 to 60 tablets of Suboxone 8 mg each month.

190. The Respondent kept copies of prescriptions but no other medical records for the following dates: September 23, 2009, October 19, 2009, and November 16, 2009.

191. The Respondent did not consult with any specialists or refer the patient to a specialist who deals with patients with substance abuse and dependency.

192. The Respondent's medical records do not contain sufficient information to justify the treatment of the patient.

COUNT THIRTEEN (Standard of Care for Patient L.P.)

193. The Petitioner realleges and incorporates paragraphs 1-26 and 178-192 as if fully set forth in this count.

194. Section 458.331(1)(t)1., Florida Statutes (2007-2009), subjects a licensee to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes. Section 456.50(1)(g), Florida Statutes

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(2007-2009), states medical malpractice means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

195. The Respondent fell below the standard of care of in one or more of the following ways:

a. The Respondent performed inadequate physical examinations of the patient.

b. The Respondent failed to offer the patient treatment modalities other than medication therapy.

c. The Respondent failed to consider or prescribe any adjunctive drugs or extended release opioids.

d. The Respondent's failed to create an adequat treatement plan for the patient.

e. The Respondent failed to consult with specialists even though the patient was opioid dependent.

196. Based on the foregoing, the Respondent violated Section 458.331(1)(t)1., Florida Statutes (2007-2009), by committing medical malpractice and is subject to disciplinary action by the Board of Medicine.

COUNT FOURTEEN (Inappropriate Prescribing for Patient L.P.)

197. The Petitioner realleges and incorporates paragraphs 1-29 and 178-192, as if fully set forth in this count.

198. Section 458.331(1)(q), Florida Statutes (2007-2009), subjects a licensee to discipline for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, 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.

199. The Respondent prescribed a legend drug other than in the course of his professional practice by prescribing a legend drug inappropriately or in excessive or inappropriate quantities when he prescribed inappropriate quantities of Roxicodone for the patient.

200. Based on the foregoing, the Respondent violated Section 458.331(1)(q), Florida Statutes (2007-2009), by prescribing excessively

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and inappropriately and is subject to disciplinary action by the Board of Medicine.

COUNT FIFTTEEN (Medical Records for Patient L.P.)

201. The Petitioner realleges and incorporates paragraphs 1-26 and 178-192 as if fully set forth in this count.

202. Section 458.331(1)(m), Florida Statutes (2007-2009), provides that a licensee is subject to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and 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.

203. Medical records are further defined by Rule 64B8-9.003, Florida Administrative Code, which is titled "Standards for Adequacy of Medical Records" and provides, in part:

(2) A licensed physician shall maintain patient medical records in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.

(3) The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

204. The Respondent failed to maintain adequate medical records in one or more of the following ways:

a. The Respondent failed to document an adequate medical history and physical examination.

b. The Respondent's medical records do not contain sufficient information to justify the treatment of the patient.

c. The Respondent failed to document an adequate treatement plan.

d. The Respondent's medical records do not contain an adequate explanation of why non-drug treatment modalities were not offered to the patient.

e. The Respondent's medical records do not explain why he did not prescribe the patient any adjunctive drugs or extended release opioids.

f. The Respondent failed to keep medical records for the following dates: September 23, 2009, October 19, 2009, and November 16, 2009.

205. Based on the foregoing, the Respondent for violated Section 458.331(1)(m), Florida Statutes (2007-2009), by failing to keep adequate medical records and is subject to disciplinary action by the Board of Medicine.

AS TO ALL PATIENTS

206. The Respondent improperly relied upon each patient's self-reported medical history, a few studies, and at times, pharmacy drug logs. He did not consult with he patient's current or past health care providers.

207. The Respondent's physical examination findings are almost identical for each patient for each visit that they had, which is indicative of the Respondent not having adequately performed physical examinations, if he performed them at all.

208. The Respondent gave each patient similar or identical diagnoses.

209. The Respondent failed to provide his patient adjunctive medications or non-medical methods of pain control.

210. The Respondent failed to refer his patients to specialists, ancillary providers or the patient's other concurrent healthcare providers.

211. The Respondent's treatment was not tailored to each patient's needs. All of the patients were prescribed large numbers of the highest doses of Roxicodone 30 mg without starting them at lower doses. The Respondent also prescribed the highest doses of Xanax made, 2 mg tablets.

212. By prescribing high amounts of immediate release opioids and ordering his patients to take those drugs frequently, the Respondent demonstrated that he did not understand the pharmacotherapeutic ramifications of the drugs he was prescribing.

COUNT SIXTEEN (Prescribing without Skill and Safety)

213. The Petitioner realleges and incorporates paragraphs 1-213 as if fully set forth in this count.

214. Section 456.072(1)(gg), Florida Statutes (2007-2009), provides that a licensee is subject to discipline for engaging in a pattern of practice when prescribing medicinal drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients, a violation of any provision of this chapter, a violation of the applicable practice act, or a violation of any rules adopted pursuant to this chapter or the applicable practice act of the prescribing practitioner.

215. The Respondent engaged in a pattern of practice when prescribing drugs which demonstrates a lack of reasonable skill or safety to patients in one or more of the following ways:

a. The medical records, physical examination results, patient histories for each patient were inadequate and did not justify the Respondent's drug treatment regimens.

b. The Respondent prescribed excessive or inappropriate amounts of addictive, potent drugs to his patients.

c. The Respondent's treatment of his patients was not tailored to each patient's needs.

d. The Respondent demonstrated he did not have adequate knowledge of the pharmacotherapeutic ramifications of the drugs that he was prescribing.

216. Based on the foregoing, the Respondent violated Section 456.072(1)(gg), Florida Statutes (2007-2009), by engaging in a pattern of practice when prescribing medicinal drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients and is subject to disciplinary action by the Board of Medicine.

WHEREFORE, the Petitioner respectfully requests that the Board enter an order imposing one or more of the following penalties: permanent revocation or suspension of the 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 22nd day of January, 2013.

John H. Armstrong, MD, FACS, FCCP
State Surgeon General &
Secretary of Health, State of Florida

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DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Angel Sanders
DATE JAN 2 3 2013

PCP: January 18, 2012
PCP Members: Dr. Miguel; Dr. Averhoff; Mr. Levine

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 his 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 any other discipline imposed.