A Division of the Agency for Health Care Administration

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GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

April 16, 2010

CERTIFIED MAIL
RETURN RECEIPT REQUESTED
7008 3230 0003 5047 0592

Steven L. Kaplan, MD
9075 SW 87th Avenue
Suite 411
Miami, FL 33176

RE: Termination of Medicaid Provider Agreement
Provider Number 0482994-00

Dear Dr. Kaplan:

Section 7 of the Medicaid Provider Agreement states that either party may terminate the agreement upon thirty (30) days written notice by either party.

Please be advised that the Agency has elected to exercise its termination rights under Section 7 of the provider agreement. You are hereby notified that your Medicaid Provider Agreement is terminated, without cause, thirty (30) days from the date of this letter.

Should you have any questions with regard to the above action, you may contact this agency's General Counsel's office at (850) 922-5873.

Sincerely,

Alan Strowd, Chief
Medicaid Contract Management

AS/pm
cc: Betty Clark, Medicare Registration Department

Medicaid Contract Management
2562 Executive Center Circle E
Montgomery Bldg., Suite 100
Tallahassee, Florida 32301

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Final Order No. DOH-10-1134-850-MQA
FILED DATE - 5.7.10
Department of Health
By: Brandi Gray
Deputy Agency Clerk

STATE OF FLORIDA
DEPARTMENT OF HEALTH

IN RE: The Emergency Suspension of the License of
Steven L. Kaplan, M.D.
License Number: ME 46745
Case Number: 2009-21127

ORDER OF EMERGENCY SUSPENSION OF LICENSE

Ana M. Viamonte Ros, M.D., M.P.H., State Surgeon General, ORDERS the emergency suspension of the license of Steven L. Kaplan, M.D., to practice as a physician in the State of Florida. Dr. Kaplan holds license number ME 46745. His address of record is 9075 SW 87th Avenue, Suite 411, Miami, Florida 33176. The following Findings of Fact and Conclusions of Law support the emergency suspension of Dr. Kaplan's license to practice as a physician in the State of Florida.

FINDINGS OF FACT

1. The Department of Health (Department) is the state department charged with regulating the practice of medicine, pursuant to Chapters 20, 456, and 458, Florida Statutes. Section 456.073(8), Florida Statutes (2009), authorizes the State Surgeon General to summarily suspend Dr. Kaplan's license to practice as a physician in the State of Florida.

2. At all times material to this Order, Dr. Kaplan was licensed to practice as a physician in the State of Florida, pursuant to Chapter 458, Florida

Statutes.

3. At all times material to this Order, Dr. Kaplan practiced psychiatric medicine. At least one quarter to one third of Dr. Kaplan's patients were and are developmentally disabled and many of his patients resided in residential facilities. Approximately 25% of Dr. Kaplan's patients were minors.

4. Developmental disability is a term used to describe life-long, disabilities attributable to mental and/or physical impairments, manifested prior to age 18. The term is used most commonly to refer to disabilities affecting daily functioning in three or more of the following areas: capacity for independent living, economic self-sufficiency, learning, mobility, receptive and expressive language, self-care, and self-direction. Section 393.063(9), Florida Statutes, defines developmental disability as a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.

5. In May of 2006, David Glatt, the owner and operator of Rainbow Ranch Group Home, contacted Dr. Kaplan and asked him to provide psychiatric services to several residents at Rainbow Ranch. Rainbow Ranch was a residential facility for the developmentally disabled located in Weston, Florida. Mr. Glatt was not a licensed health care provider.

6. Between May 27, 2006, and May 10, 2007, Dr. Kaplan provided

psychiatric services to Patient DM, a developmentally disabled eleven (11) year-old male, who had been placed at Rainbow Ranch at the request of his mother.

7. On May 27, 2006, Patient DM presented to Dr. Kaplan for the first time. David Glatt was present during Patient DM's appointment. David Glatt gave Dr. Kaplan a verbal history on Patient DM. Mr. Glatt informed Dr. Kaplan that Patient DM had a long history of hospitalizations, changes in living arrangements, and repeated violent episodes. In addition, Patient DM presented with a history of seizures. Patient DM had previously been prescribed numerous medications by various psychiatrists and other doctors to address his behavior and illness. Patient DM was currently being prescribed 750 mg of Depakote, 600 mg of Seroquel, 20 mg of Zyprexa and 0.5 mg of clonazepam by a psychiatrist at Children and Adolescents Psychiatric Clinic at Jackson Memorial Hospital.

8. Depakote is used to treat seizure disorders, certain psychiatric conditions (manic phase of bipolar disorder), and may also be used for other mental disorders such as schizophrenia.

9. Seroquel (generic quetiapine) is an oral antipsychotic drug used for treating schizophrenia and bipolar disorder. Although the mechanism of action of quetiapine is unknown, like other anti-psychotics, it inhibits communication between nerves of the brain.

10. Zyprexa (generic olanzipine) is used to treat schizophrenia and bipolar disorder. The use of the drug for extended periods should periodically be

re-evaluated to determine the long-term usefulness of the drug for an individual patient. There may be an increased risk of increased blood sugar levels and diabetes with this medication. Therefore, patients should be tested during treatment for elevated blood sugar. Additionally, persons with risk factors for diabetes, including obesity or a family history of diabetes, should have their fasting levels of blood sugar tested before starting treatment.

11. Clonazepam is commonly prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, clonazepam 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, and abuse of clonazepam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

12. Dr. Kaplan's notes for Patient DM's visit on May 27, 2006, indicate previous diagnosis as "pervasive developmental disorder, seizures, schizophrenia, depression, psychosis, mild MR [mild mental retardation], and IED, Intermitten Explosive Disorder."

13. After a brief discussion with Patient DM and Mr. Glatt, Dr. Kaplan continued the previously prescribed medication for Patient DM and gave him 3 prescription refills for Zyprexa, Seroquel and Depakote and 11 refills for clonazepam.

14. Dr. Kaplan did not conduct a physical examination of Patient DM, did not create a treatment plan, did not document a complete mental health history or medical history, and did not conduct a psychiatric assessment.

15. Dr. Kaplan did not request or review any of Patient DM's medical or hospitalization records prior to prescribing the above listed medications. Dr. Kaplan was aware when Patient DM presented to him the first time that the child had been seen by other psychiatrists and he made no attempt to contact any of them to determine their basis for diagnosis and prescribing.

16. In addition, Dr. Kaplan was told by David Glatt that Patient DM's mother had abandoned the child. However, Dr. Kaplan had an extensive history of treating developmentally disabled children and knew that consent from a parent or guardian was required for treatment. Dr. Kaplan made no attempt to verify who had the legal authority to consent to treatment for Patient DM or verify that the mother had in fact abandoned DM and was not available to assist in the treatment of her child. Dr. Kaplan received no consent for treatment of Patient DM.

17. At the time Dr. Kaplan initially prescribed medication for Patient DM, Dr. Kaplan did not have or review recent blood test results and he did not order blood tests or levels to determine the effects of medication on Patient DM. Dr. Kaplan assumed that "these things" were being done by Patient DM's primary care physician who was seeing him twice a year. Dr. Kaplan never saw results of

any blood tests, he never asked if the tests were being done and he never discussed such tests with Patient DM's primary care physician. In fact, there were no blood tests done to determine the effects of the prescribed medication on Patient DM during the time that Dr. Kaplan treated him.

18. Although Dr. Kaplan asserts that his next visit with Patient DM was on June 10, 2006, Dr. Kaplan has no medical records documenting such a visit. The only documentation Dr. Kaplan has regarding this alleged visit is a note in his appointment book with the name "Glatt." Dr. Kaplan did write prescriptions for all of Patient DM's medications with refills on June 10, 2006.

19. Dr. Kaplan also asserts that he saw Patient DM on July 8, 2006, but his only documentation regarding that visit is a notation on his calendar with "Glatt, ALF." Dr. Kaplan failed to document anything regarding that visit, but prescription records show that Dr. Kaplan changed the instructions regarding the time that Patient DM was to take Depakote. Dr. Kaplan based that decision to change the instructions on David Glatt's observation that DM was lethargic and sleepy and hard to get up in the morning, although there is no documentation of that conversation.

20. On or after July 24, 2006, a Medicaid contract company notified Dr. Kaplan that a review of his prescribing practices for four (4) minors, including Patient DM, indicated that he was prescribing an anti-psychotic at a higher than recommended dose for 45 or more days. Because Dr. Kaplan was prescribing

two (2) anti-psychotic drugs to Patient DM, he did not know which of the two (2) drugs the notice was referring to and made no attempt to find out. Dr. Kaplan did not respond to the notice, nor did he follow-up with Patient DM through laboratory testing, communication with DM's former psychiatrists, or further assessment.

21. On August 4, 2006, Patient DM was admitted to Baptist Children's Hospital with complaints of vomiting and bleeding from the gums. Patient DM was diagnosed with symptoms of mild thrombocytopenia – probably due to Depakote. The treating physician reduced Patient DM's dosage of Depakote for the three (3) days that Patient DM was hospitalized.

22. Contrary to statements made previously, Dr. Kaplan asserts that on August 11, 2006, David Glatt brought Patient DM to his office. Dr. Kaplan did not document DM's office visit on that day. However, Dr. Kaplan did write prescriptions for Patient DM.

23. On August 21, 2006, Rainbow Ranch personnel took Patient DM to Dr. Kaplan's office so that Dr. Kaplan would refill Patient DM's prescription for Zyprexa. Dr. Kaplan wrote a prescription for Zyprexa with refills for 11 months, even though he had written a 30 day prescription for Zyprexa with 3 refills on June 20, 2006. Dr. Kaplan did not document Patient DM's visit that day, nor did he document any explanation as to why Patient DM needed refills when he had already written sufficient prescription refills through September of 2006. Dr.

Kaplan did not order blood levels. Dr. Kaplan made no arrangements for a follow-up visit with Patient DM in an appropriate period of time.

24. On November 29, 2006, Dr. Kaplan wrote prescriptions for Patient DM without seeing him or documenting any information about his current condition. Dr. Kaplan issued a refill authorization for 0.5 mg of clonazepam with 11 refills even though Dr. Kaplan had written Patient DM a prescription for 0.5 mg of clonazepam with 11 refills on May 27, 2006. Dr. Kaplan did not document justification for his authorization for refills of clonazepam on November 29, 2006, when he had already prescribed enough clonazepam refills to last through May of 2007.

25. On January 3, 2007, Dr. Kaplan wrote prescriptions for Depakote and Seroquel with 11 refills. Dr. Kaplan wrote these prescriptions even though he had not seen Patient DM since August of 2006. Dr. Kaplan did not document any information indicating Patient DM's current condition.

26. The next time Dr. Kaplan saw Patient DM was on May 10, 2007. Dr. Kaplan's medical notes document reports of "increased sleep in the day, school feels he's over medicated. Hyper. Needy. Pesty. Needs redirection. Will make a couple of changes so he won't be sleepy in school." In response to the reports from Patient DM's school, Dr. Kaplan adjusted the time medication was administered.

27. Dr. Kaplan made no arrangements for a follow-up visit with Patient DM after the May 10, 2007, visit. Dr. Kaplan did not inquire about whether changing the times that Patient DM had been getting his medication had resulted in any effect on Patient DM's sleepiness during the school day. Dr. Kaplan did not order blood work or medication levels to determine the effect of the prescribed medication on Patient DM.

28. In November of 2009, the Department received a complaint that Dr. Kaplan had practiced below the standard of care in treating Patient DM. The Department conducted a full investigation into the allegations against Dr. Kaplan, obtained Patient DM's medical records and Dr. Kaplan's notes regarding his treatment of Patient DM. The full investigation and records were provided to a Department medical expert for review and an opinion as to whether or not Dr. Kaplan violated any provision of Chapter 458, the Medical Practice Act.

29. A Department expert reviewed Dr. Kaplan's medical records for Patient DM and the Department's investigative materials and submitted a written report of her findings. The expert found that Dr. Kaplan fell below the standard of care in that he did not obtain relevant data such as records from previous providers and laboratory tests as part of his assessment of Patient DM. Dr. Kaplan failed to complete or arrange for a physical examination before prescribing medications that were potentially harmful to the patient and included atypical anti-psychotics, a benzodiazepine, and an anticonvulsant. Dr. Kaplan

relied solely on the Rainbow Ranch owner's assessment of the patient's complaints and symptoms. Dr. Kaplan's records for Patient DM do not contain sufficient information to identify the patient, support the diagnosis, justify Dr. Kaplan's treatment and document the course of results of treatment accurately. The medical records do not include an adequate patient history. In addition, Dr. Kaplan's medical records do not demonstrate any evidence of Patient DM's psychotic symptoms and have no documentation regarding the diagnosis of seizure disorder

30. Dr. Kaplan also fell below the standard of care when he continued to prescribe Depakote without getting laboratory values (liver function tests, complete blood count, complete metabolic panel and Depakote level) to monitor the drug levels and potential physiologic side effects on Patient DM. In regard to managing Patient DM over time, Dr. Kaplan fell below the standard of care when he documented only two (2) visits of this patient over a year's course of treatment. A review of Patient DM's Rainbow Ranch records demonstrate that DM was being mismanaged physically at the ranch and if Dr. Kaplan had engaged in appropriate and close follow up, it would be reasonable to infer that Dr. Kaplan would have noticed and reported it. Finally, the expert opined, "A patient that is as medically and psychiatrically complicated as this patient needed to be followed."

31. Section 120.60(6), Florida Statutes, authorizes the Department to suspend a physician's license if the Department finds that the physician presents an immediate serious danger to the public health, safety, or welfare.

32. Section 458.331(1)(t)1., Florida Statutes (2005-2006), subjects a licensee to discipline, including suspension, for committing medical malpractice. Medical malpractice is defined in Section 456.50, Florida Statutes, to mean the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. For purposes of Section 458.331(1)(t)1., Florida Statutes, the Board shall give great weight to the provisions of Section 766.102, Florida Statutes, which provide that the prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

33. Dr. Kaplan violated Section 458.331(1)(t)1., Florida Statutes (2005 -2006), by committing medical malpractice by failing to obtain relevant data such as records from previous providers and laboratory tests as part of his assessment of Patient DM, by failing to complete or arrange for a physical examination before prescribing medications that were potentially harmful to the patient, by relying solely on the Rainbow Ranch owner's assessment of the patient's complaints and symptoms, by prescribing Depakote without getting laboratory

values (liver function tests, complete blood count, complete metabolic panel and Depakote level) to monitor the drug levels and potential physiologic side effects on Patient DM, and by failing to monitor Patient DM closely enough to observe that he was being mismanaged physically at the ranch.

34. Section 458.331(1)(m), Florida Statutes (2005-2006), subjects a licensee to discipline, including suspension, for 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.

35. Dr. Kaplan violated Section 458.331(1)(m), Florida Statutes (2005-2006) by failing to keep legible medical records that justify his course of treatment for Patient DM by failing to identify the patient, support the diagnosis, document a complete patient history, examination results, by failing justify his course of treatment or the results of the course of treatment and by failing to document any evidence of psychotic symptoms or of seizure disorder.

36. Dr. Kaplan has demonstrated a disregard for the duties and responsibilities imposed upon a physician practicing in the State of Florida and for the health and welfare of Patient DM. Dr. Kaplan's conduct constitutes a breach of the trust and confidence that the State of Florida placed in him by issuing him a license to practice medicine. This breach is particularly compelling in Dr. Kaplan's

case because his failure to meet the standard of care and failure to adequately document justification for his treatment occurred while practicing medicine and treating a vulnerable patient who did not have the ability to ensure his own well-being while under Dr. Kaplan's care. Dr. Kaplan unreasonably relied solely on the reports of a virtually unknown non-health care provider for information regarding Patient DM's complex condition and care. Further, approximately a quarter to a third of Dr. Kaplan's patients are developmentally disabled. Dr. Kaplan's actions in treating Patient DM demonstrate his inability and/or unwillingness to practice medicine in a way that adequately protects patients who may not be able to protect themselves. Dr. Kaplan's actions demonstrate such general lack of medical judgment and understanding of his role as a physician that the safety of the public cannot be insured by any means other than the suspension of Dr. Kaplan's license.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the State Surgeon General concludes as follows:

1. The Department has jurisdiction over this matter pursuant to Sections 20.43 and 456.073(8), Florida Statutes, and Chapter 458, Florida Statutes.

2. Dr. Kaplan violated Section 458.331(1)(t)1., Florida Statutes (2005-2006), by committing medical malpractice in treating Patient DM.

3. Dr. Kaplan violated Section 458.331(1)(m), Florida Statutes (2005-2006), by failing to keep legible medical records, 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.

4. Dr. Kaplan's continued practice as a physician constitutes an immediate serious danger to the health, safety, or welfare of the public and this summary procedure is fair under the circumstances to adequately protect the public.

WHEREFORE, in accordance with Section 120.60(6), Florida Statutes, it is ORDERED THAT:

1. The license of Steven L. Kaplan, M.D., license number ME 46745, is immediately suspended.

2. A proceeding seeking formal discipline of the license of Steven L. Kaplan, M.D., to practice as a physician will be promptly instituted and acted upon in compliance with Sections 120.569 and 120.60(6), Florida Statutes.

DONE and ORDERED this 7 day of May, 2010.

Ana M. Viamonte Ros, M.D., M.P.H.,
State Surgeon General
Department of Health

NOTICE OF RIGHT TO JUDICIAL REVIEW

Pursuant to Sections 120.60(6), and 120.68, Florida Statutes, the Department's findings of immediate danger, necessity, and procedural fairness shall be judicially reviewable. Review proceedings are governed by the Florida Rules of Appellate Procedure. Proceedings are commenced by filing one copy of a Petition for Review, in accordance with Florida Rule of Appellate Procedure 9.100, with the Department of Health and a second copy of the petition accompanied by a filing fee prescribed by law with the District Court of Appeal within 30 days of the date this Order is filed.