STATE OF FLORIDA

DEPARTMENT OF HEALTH

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK:
DATE 5-9-13

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO.: 2009-24503**

FERNANDO MENDEZ-VILLAMIL, M.D.,

RESPONDENT.

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AMENDED ADMINISTRATIVE COMPLAINT

Petitioner, the Department of Health, by and through its undersigned counsel, files this Administrative Complaint (Complaint) before the Board of Medicine (Board) against Respondent, Fernando Mendez-Villamil, M.D., and in support alleges:

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

2. At all times material to this Complaint, Respondent was a licensed physician within the State of Florida, having been issued license number ME 75685.

3. Respondent is not board certified in any of the specialty boards recognized by the Florida Board of Medicine.

4. Respondent's address of record is 1898 SW 22nd Street, Suite B Miami, Florida, 33145.

5. At all times material hereto, Respondent, while practicing medicine in the State of Florida, treated three (3) patients for psychiatric conditions, they are referred to throughout by their initials as AT, FB, and WS.

6. At all times material hereto, Respondent prescribed to these three (3) patients one or more of the following legend drugs, including controlled substances; Ativan, Abilify, Seroquel, Depakote, Lexapro, Provigil, Pexeva, Adderall, Restoril, Risperdal, Xanax, Valium, Zoloft, and Zyprexa.

7. The above mentioned legend drugs, including controlled substances, are more particularly defined as follows;

a. Dextroamphetamine is used as part of a treatment program to control symptoms of attention deficit hyperactivity disorder (ADHD; more difficulty focusing, controlling actions, and remaining still or quiet than other people who are the same age) in adults and children. According to Section 893.03(4), Florida Statutes, amphetamine 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, and abuse of the substance may lead to severe psychological or physical dependence;

b. Abilify is the brand name for aripiprazole. Aripiprazole is an atypical antipsychotic that is used to treat the symptoms of schizophrenia. In addition, it is used to treat episodes of manic-depressive disorder and to treat depression when symptoms cannot be controlled by an antidepressant alone;

c. Seroquel is the brand name for quetiapine, an atypical antipsychotic that is used to treat the symptoms of schizophrenia. In addition, it is used to treat episodes of manic-depressive disorder and to treat depression;

d. Provigil is the brand name for modafinil. Modafinil is in a class of medications called wakefulness promoting agents. It is used to treat excessive sleepiness caused by narcolepsy;

e. Xanax (alprazolam) is an anti-anxiety agent benzodiazepine, used primarily for short-term relief of mild to moderate anxiety and nervous tension and is a schedule IV legend drug controlled pursuant to Chapter 893.03, Florida Statutes and has a low potential for abuse which may lead to limited physical or psychological dependence and has a currently accepted medical use in treatment in the United States;

f. Risperdal (risperidone) an antipsychotic agent, which may act by a combination of dopamine and serotonin antagonism;

g. Zyprexa (olanzapine) - A drug used to treat certain mental disorders. It is a type of antipsychotic and a type of monoamine antagonist;

h. Depakote, known as Valproic acid is used alone or with other medications to treat certain types of seizures. Valproic acid is also used to treat mania (episodes of frenzied, abnormally excited mood) in people with bipolar disorder;

i. Adderall is the combination of dextroamphetamine and amphetamine and it is used as part of a treatment program to control symptoms of attention deficit hyperactivity disorder (ADHD). According to Section 893.03(4), Florida Statutes, amphetamine 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, and abuse of the substance may lead to severe psychological or physical dependence;

j. Ativan, known as Lorazepam is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation. Lorazepam comes as a tablet and concentrate (liquid) to take by mouth. According to Section 893.03(4), Florida Statutes, Lorazepam is a Schedule IV controlled substance and 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 the substance may lead to limited

physical or psychological dependence relative to the substances in Schedule III;

k. Restoril, known as Temazepam is used on a short-term basis to treat insomnia (difficulty falling asleep or staying asleep). Temazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow sleep. According to Section 893.03(4), Florida Statutes, Temazepam is a Schedule IV controlled substance and 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 the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III;

l. Valium is the brand name for 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;

m. Zoloft (sertraline hydrochloride) is a medication used in treating a variety of mental health disorders including social anxiety disorder (SAD);

n. Lexapro (escitalopram oxalate) is a selective serotonin reuptake inhibitor (SSRI) proven effective in the treatment of depression and generalized anxiety disorder (GAD);

o. Pexeva and Paxil are the brand names for paroxetine. Paroxetine is in a class of medications called selective serotonin-reuptake inhibitors (SSRIs). It is indicated for the treatment of obsessions and compulsions in patients with obsessive compulsive disorder (OCD). It is also used to treat depression, panic disorder and social anxiety disorder.

8. Global Assessment of Functioning (GAF) is a scale used to assess psychiatric status. The GAF scale ranges from 1 (lowest level of functioning) to 100 (highest level) and measures psychological, social, and occupational functioning. It is widely used in studies of treatment effectiveness.

FACTS SPECIFIC TO PATIENT AT

9. Respondent treated AT from April 2005 through September 2010, (the treatment period); AT was 3 years old when he began treatment. Respondent's working diagnoses of AT included ADHD (attention deficit hyperactivity disorder) with a rule out of mental retardation.

10. In terms of Respondent's diagnosis of AT, the following matters were noteworthy;

a. Respondent did not refer or document a referral to an appropriate specialist for an evaluation for mental retardation;

b. Respondent did not substantiate or document a medical justification for a diagnosis of ADHD;

c. There is no supporting documentation in the medical record to justify the diagnosis of hyperactivity.

11. During the treatment period, anomalies in Respondent's medical records for AT included;

a. In the note on October 20, 2007, Respondent prescribed the patient Abilify for impulsivity. Respondent documents that the patient's insight and judgment are good. Respondent also

documents that this now 5 year old is able to take care of himself. In light of the foregoing, there is no medical justification to change the medication. In light of the foregoing, the medical record does not justify the prescription of an antipsychotic medication for symptoms of ADHD.

b. On the progress note dated October 7, 2008, Respondent gave the patient a GAF of 58. Respondent documented that the patient is able to care for himself and that he has good insight and judgment;

c. In the notes dated August 2009 through October 2009, Respondent documented the GAF ranging from 63 to 44. Respondent failed to provide any basis for this significant change in the patient's chart considering that this supposed change happened comparatively quickly over a mere two months time;

d. On the note of August 4, 2009, Respondent initially documented in the patient record a GAF of 0. Respondent whited out the initial GAF and then changed the GAF to 63 without explanation or justification;

e. In the note dated October 6, 2009, Respondent noted that the patient has "aggressive behavior." There is no basis or justification for Respondent's subsequent note in the chart when Respondent documented that the patient's insight and judgment are good and that he is now able to care for himself;

f. Per prescriptions in the record, patient AT was on up to 3 different medications (an antipsychotic, an antihypertensive, a stimulant and an antihistamine) prescribed by the Respondent at any given time.

12. During the treatment period, Respondent continued to prescribe AT up to 3 different medications at any given time, which included an antipsychotic, an antihypertensive, a stimulant and an antihistamine, in excessive or inappropriate quantities or combinations.

13. Respondent's failed to justify or document the justification for prescribing the amount, frequency, or combination of the prescriptions issued.

FACTS SPECIFIC TO PATIENT FB

14. Respondent's initial evaluation of patient FB occurred on October 17, 2002 whereupon he diagnosed FB with schizophrenia of the paranoid type.

15. Over the course of his treatment, FB was placed on multiple antipsychotics, antidepressants, and sedative hypnotic medications.

16. There was no medical justification for the choice of medications prescribed to patient FB, given the symptoms the medications were prescribed to treat.

17. On multiple occasions, FB's medical records reflect different handwriting in the chart notes on the same day and notes inscribed with different pens.

18. There was no medical justification in patient FB's medical records for the timing of FB's visits with Respondent.

19. The GAF in FB's chart was whited out and changed from zero with a slash through it (meaning that it cannot be assessed) to 40 without any supporting documentation justifying why the change was made.

20. On the progress note dated December 26, 2006 Respondent documented that the patient is "stable on medications" though is

"somewhat depressed D/C (discontinued) Zoloft start Lexapro", on this date the GAF was at 40 (serious symptoms) and Respondent noted that the patient was to come back in two months; no reason was given in the record for such a delay in seeing the patient given his current condition or why, despite the fact that FB was currently "stable", the medication was changed.

21. Despite Respondent having prescribed patient FB medications with known side effects such as diabetes over the previous five years, on April 10, 2007 Respondent belatedly first documented asking the patient about symptoms of diabetes such as thirst, frequency of urination, and weight gain.

22. As such, Respondent inappropriately delayed the exploration of the potential for onset of diabetes.

23. Respondent's progress note of June 16, 2007 stated that he will "treat patient with atypicals to avoid NMS TD EPS so clearly related to typicals". This note appears to be out of place and not part of the actual medical record in that the patient had been prescribed atypicals for the last five years. There is nothing in the medical record to justify such a

belated note without laboratory test results or other rationale supporting that position.

24. On June 16, 2007, Respondent changed FB's medication to Pexeva, an antidepressant, without any medical justification in the record.

25. Despite the fact that Respondent documented on or about January 08, 2008 that FB had a GAF score that decreased to 36, Respondent's treatment plan was to "continue present treatment..." and "Referral to day treatment program".

26. There is no medical justification for these two contrary treatment plans to be contained in the same progress note for the same time.

27. Given the circumstances, there is no medical justification for sending an actively psychotic and decompensating patient for participation in a day treatment program with the expectation of any therapeutic gain.

28. In addition, Respondent documented in FB's chart that while the patient is very depressed, experiencing auditory hallucinations, and failing to function at a baseline, the patient still possesses good insight and judgment and is stable on medications.

29. On the same dated progress note where Respondent documented whether or not the patient is able to care for himself, Respondent circled "yes" and "no".

30. On the progress note dated June 16, 2007, there are different pens used in this note. The first note stated that the patient is stable on meds, but the note inscribed with a different pen stated that he was not stable and the medications needed to change. Additionally, the GAF was decreased to 35. At the end of the note where the treatment plan is indicated, Respondent documented "continue present treatment." Again, this was another inconsistent documentation in the patient's chart without medical justification.

31. On the progress note dated April 30, 2008, Respondent documented that per the PCP, there were no lab changes, however, the primary care physician's statement was not documented on the lab sheet that was kept in the patient's chart.

32. Per copies of prescriptions in the record, patient FB was on 4 different medications (an antidepressant, 2 sedative

hypnotics, and an antipsychotic) prescribed by the Respondent at any given time without medical justification.

33. In Respondent's sworn deposition testimony, Respondent stated that, FB had multiple medication changes even though Respondent stated the patient was stable.

34. Respondent also documented that there were no labs and no weights but that he obtained this information from the patient himself who was diagnosed as psychotic.

35. Given FB's clearly documented problem with verbalization, FB was an inappropriate candidate for the group therapy prescribed for him by Respondent.

36. On the Patient Sign-In sheets for FB, the following anomalies existed suggesting that Respondent documented the medical records after the event without justification or entered the documentation with an improper purpose;

a. June 5, 2010, it was documented that Respondent saw the patient in evaluation from 11:00 am to 11:15 am. Although, the patient didn't sign in until 11:05 am;

b. August 13, 2009, it was documented that FB must have signed in before 1:00pm in the afternoon and 10:15 am in the morning, however, his progress note documented that FB was seen in treatment from 2:10 pm - 2:20 pm in the afternoon;

c. April 29, 2009, it was documented that FB was seen in treatment from 10 a.m. to 10:10 a.m. However, the patients that signed in before him signed in at 6 o'clock and 7 o'clock either in the morning or in the evening;

d. September 3, 2008, it was documented that FB had signed in some time after 6:30. However, it was documented in his progress note on that day that his appointment was from 5:00 pm to 5:10 pm.

FACTS SPECIFIC TO PATIENT WS

37. Upon review of the chart, the initial evaluation of patient WS was done on February 19, 1999, and the documentation shows thereafter that patient WS was seen in evaluation in 15 minute sessions.

38. The diagnoses listed were schizophrenia, paranoid type, and moderate mental retardation.

39. On the progress note dated July 6, 2007, it was documented, "stable on meds, continue present meds." However, there was a change in different ink on that note as well as a change in the GAF.

40. On the progress note dated January 4, 2008, Respondent documented, "per PCP, no lab abnormalities secondary to psychotropics." However, Respondent did not document this information from the above date on the sheet Respondent usually documented patient weights and labs.

41. On the progress note dated August 21, 2009, Respondent documented that the patient's insight and judgment were good, though at the same time Respondent documented that the patient was "not sleeping. Hit one of the staff, verbally abusive... group home placement." Respondent also documented that WS was able to care for himself, however the patient was in group home placement at the time.

42. Per prescriptions in the record, Respondent prescribed WS 5 different medications (an anticonvulsant, a sedative hypnotic, 2 antipsychotics, and an antihistamine) at any given time.

43. Respondent admitted in sworn deposition testimony regarding WS, he documented that WS had mental retardation and schizophrenia.

44. Respondent reported that he received records from a previous provider but did not keep a copy in the chart.

45. Respondent testified, in deposition, that although Respondent ordered a Depakote level per his report, there was no Depakote level in the chart. He stated that it was not in the chart because the patient didn't bring in the blood work.

46. Conventional routine practice is for the lab to send a copy of the lab results via fax and/or via mail to the office of the physician that ordered the test.

47. In addition, Respondent stated, that he obtained the Depakote level of 68 because WS's mother told him that was the level.

48. Respondent documented that WS was admitted to the hospital. Respondent stated that he was the person that admitted WS to the hospital and implied that he saw the patient while in the hospital.

49. However, there was no documentation in the chart that Respondent actually saw WS while in the hospital.

50. On the Patient Sign-In sheets for WS, there were no actual arrival times documented on this patient's sign-in sheet in order to confirm or deny when the patient actually attended the appointments.

STANDARD OF CARE AND MAINTENANCE OF RECORDS

51. The prevailing professional standard of care regarding the maintenance of medical records requires that:

a. The records are legible and clearly document the chief complaint, any examinations, diagnoses and treatment for the patient including the treatment rationale for the patient over the course of the doctor patient relationship;

b. Make an actual attempt to obtain records from previous and/or other providers and once records are obtained from

previous providers, those records are placed in the patient's chart;

c. The physician keep a copy of the lab results in the patient's chart;

d. Once a patient is seen in the hospital, a physician will obtain the records from the hospital and place or document the hospital records in the patient's medical chart.

52. In addition, the prevailing professional standard of care requires that the physician:

a. Rule out and document a medical reason for the patient's behavioral symptoms;

b. If a medical cause is suspected as the reason for psychiatric symptoms, make referrals for appropriate consultations with specialists when indicated for a patient;

c. After consultation is complete, obtain and document relevant data that one would need to appropriately diagnose, treat, and manage a psychiatric patient, such as medical records from prior or other providers and laboratory test results;

d. If medication is deemed medically appropriate, inform and document that the physician informed the patient or the patient's guardian or caregiver of the risks, benefits, and potential side effects of the medication;

e. Suggest and document alternative courses of treatment and follow up on those courses of treatment;

f. Not make treatment decisions only relying on lab results reported by the patient or the patient's caregiver. The provider must substantiate that information with the actual lab results;

g. Perform or consult another qualified provider to perform a physical examination on the patient before prescribing medications that have potential physiological side effects;

h. Provide and document the medical justification and potential side effects for the prescribed psychotropic medications throughout the course of treatment with that medication.

COUNT ONE

53. Petitioner reincorporates and realleges paragraphs 1 through 52 as if fully set forth herein.

54. Section 458.331(1)(t), Florida Statutes (2006, 2007, 2008, and 2009), subjects a doctor to discipline for committing medical malpractice as defined in Section 456.50. Section 456.50, Florida Statutes (2006, 2007, 2008, and 2009), defines medical malpractice as 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. Level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care specified in Section 766.102. Section 766.102(1), Florida Statutes (2008), defines the standard of care to mean "[t]he 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."

56. Respondent failed to meet the prevailing professional standard of care in regard to the treatment of Patient AT, in one or more of the following ways:

a. By failing to refer patient AT to specialists for developmental issues;

b. By failing to appropriately and timely obtain lab testing given the medications that the Respondent was prescribing this patient;

c. By failing to substantiate or rule possible medical reasons for the patient's behavioral symptoms;

57. Respondent failed to meet the prevailing professional standard of care in regard to the treatment of patient FB in one or more of the following ways:

a. By inappropriately waiting until April 10, 2007 to first ask and document in the file whether the patient had been suffering any symptoms of diabetes such as, weight gain, thirst and/or frequency in urination, despite the fact that Respondent had been prescribing, in the preceding five years, medications where diabetes was a known potential side effect;

b. By failing to perform a physical examination before prescribing medication that has potential physiological side effects;

c. By inappropriately referring the patient in January 2008 to a day treatment program despite the fact that the patient was actively psychotic and decompensating;

d. By failing to appropriately and timely obtain lab testing given the medications that Respondent was prescribing this patient;

58. Respondent failed to meet the prevailing professional standard of care in regard to the treatment of Patient WS, in one or more of the following ways:

a. By failing to appropriately and timely obtain lab testing given the medications that the Respondent was prescribing this patient;

b. By making treatment decisions relying on what was reported by the patient and not substantiating that information.

59. Based on the foregoing, Respondent has violated Section 458.331(1) (t), Florida Statutes (2006, 2007, 2008, and 2009).

COUNT TWO

60. Petitioner reincorporates and realleges paragraphs 1 through 52 as if fully set forth herein.

61. Section 458.331(1)(m), Florida Statutes (2006, 2007, 2008 and 2009), subjects a licensee 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.

62. During the treatment period, Respondent failed to maintain medical records justifying the course of treatment for AT, FB, and WS in one or more of the following ways:

a. By failing to document whether he informed the patient or patient's caregiver of the risks and side effects of the medication prescribed;

b. By failing to document the medical justification for changes in the patients' GAF scores;

c. By failing to document the presence of one or more recognized medical indications for the use of a controlled substance;

d. By failing to document the extent of controlled substances being prescribed;

e. By failing to document appropriate diagnoses and symptoms to warrant the medications prescribed;

f. By failing to document the basis for changing various medications.

63. During the treatment period Respondent failed to maintain medical records pursuant to the requirements of 458.331(1)(m), Florida Statute in one or more of the following ways:

a. By inappropriately deleting or amending notes and records after the fact;

b. By inappropriately documenting amended, altered or invented facts such as GAF scores and/or lab results;

c. By inaccurately indicating dates and times of the patients' visits;

d. By documenting records that were internally inconsistent and/or contradictory without justifying the course of treatment to the patients;

e. By failing to keep copies of previous or other providers in the patients' charts;

f. By failing to keep laboratory tests and results in the patients' charts;

g. By failing to maintain hospital records in the patients' charts.

64. Based on the foregoing, Respondent has violated Section 458.331(1) (m), Florida Statutes (2006, 2007, 2008, and 2009).

COUNT THREE

65. Petitioner reincorporates and realleges paragraphs 1 through 51 as if fully set forth herein.

66. Section 458.331(1)(q), Florida Statutes (2006, 2007, 2008 and 2009), provides as follows: 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 is grounds for discipline by the Board of Medicine. For 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 intent.

67. During the treatment period, Respondent prescribed controlled substances or legend drugs to patients AT, FB, and WS in excessive or inappropriate quantities and or combinations.

68. Respondent inappropriately prescribed to patient FB two different antidepressant medications, two sedative hypnotic medications and an antipsychotic medication.

69. Respondent inappropriately prescribed Abilify, an atypical antipsychotic, to AT for impulsivity and symptoms of ADHD.

70. Respondent inappropriately prescribed to WS an anti-convulsant, a sedative hypnotic, and two antipsychotic medications.

71. Based on the foregoing, Respondent has violated Section 458.331(1) (q), Florida Statutes (2006, 2007, 2008 and 2009).

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

SIGNED this 9th day of May, 2013.

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

André Ourso
Assistant General Counsel
Fla. Bar No. 91570
Florida Department of Health
Office of the General Counsel
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265
Telephone: (850) 245-4444 x8154
Facsimile: (850) 245-4684
Email: Andre_Ourso@doh.state.fl.us

ACO

PCP Members: Dr. Avila, Dr. Nuss & Mr. Mullins
PCP: 01-11-13

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 to any other discipline imposed.