STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

Petitioner,

v. **CASE NUMBER 2012-09032**

PETER SANCHEZ, M.D.,

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

Petitioner, Department of Health, files this Administrative Complaint before the Board of Medicine against Respondent, Peter Sanchez, M.D., and in support thereof alleges:

1. Petitioner is the state agency 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 medical doctor within the state of Florida, having been issued license number ME 55385.

3. Respondent's address of record is 1680 Meridian Avenue, Suite 501, Miami Beach, Florida 33139.

4. At all times material to this Complaint, Respondent treated patients at All Care Family Health, a pain management clinic, at two locations in Boca Raton and Lake Worth, Florida.

Facts Specific to Patient T.B.

5. From on or about January 25, 2012, through on or about May 25, 2012 (treatment period), Respondent treated Patient T.B. (T.B.), an adult female, for complaints of chronic low back pain.

6. During T.B.'s treatment period, Respondent inappropriately prescribed, or prescribed inappropriate and/or excessive quantities of Roxicodone[1] and Clonazepam[2] to T.B.

7. During T.B.'s treatment period, Respondent failed to perform, or alternatively, did not create, keep or maintain adequate, legible documentation of performing, a complete history and physical examination of T.B.

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[1] Roxicodone is a brand name for Oxycodone. 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, and abuse of oxycodone may lead to severe psychological or physical dependence.

[2] Clonazepam is a benzodiazepine 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.

8. During T.B.'s treatment period, Respondent failed to consult with or alternatively, did not create, keep or maintain adequate, legible documentation of consulting with, T.B.'s previous health care providers.

9. During T.B.'s treatment period, Respondent failed to implement or alternatively, did not create, keep or maintain adequate, legible documentation of implementing, alternative treatment modalities for T.B. and instead treated her pain exclusively by prescribing large doses of controlled substances.

10. During T.B.'s treatment period, Respondent did not refer or alternatively, did not create, keep or maintain adequate, legible documentation of referring, T.B. to appropriate specialists.

11. On multiple visits during T.B.'s treatment period, Respondent documented a diagnosis of lumbar pain with myelopathy.[3]

12. Respondent failed to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of myelopathy for T.B.

[3] Myelopathy refers to a nervous system disorder that affects the spinal cord and may cause loss of sensation, hyper reflex reaction and loss of motor control.

13. On multiple visits during T.B.'s treatment period, Respondent documented a diagnosis of radiculopathy.[4]

14. Respondent failed to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of radiculopathy for T.B.

15. At all times material to this Complaint, the prevailing standard of care dictated that the Respondent do one or more of the following:

a. Not inappropriately prescribe, or not prescribe inappropriate and/or excessive quantities of Roxicodone and Clonazepam to T.B.;

b. Perform a complete history and physical examination of T.B.;

c. Consult with T.B.'s previous health care providers;

d. Implement alternative treatment modalities for T.B.'s pain, outside of prescribing large quantities of controlled substances;

e. Refer T.B. to appropriate specialists;

f. Not diagnose T.B. with myelopathy without physical exam findings to support the diagnosis; and/or

g. Not diagnose T.B. with radiculopathy without physical exam findings to support the diagnosis.

[4] Radiculopathy refers to a disease of the root of a nerve, such as from a pinched nerve or a tumor, which can cause loss of sensation, loss of motor strength, and loss of reflexes in the affected nerve distribution.

Facts Specific to Patient C.D.

16. From on or about August 25, 2011, through on or about June 27, 2012 (treatment period), Respondent treated Patient C.D. (C.D.), an adult male, for complaints of chronic low and mid back pain.

17. During C.D.'s treatment period, Respondent inappropriately prescribed, or prescribed inappropriate and/or excessive quantities of, Oxycodone[5] and Xanax[6] to C.D.

18. During C.D.'s treatment period, Respondent failed to perform, or alternatively, did not create, keep or maintain adequate, legible documentation of performing, a complete history and physical examination of C.D.

19. During C.D.'s treatment period, Respondent did not consult with, did not create, keep or maintain adequate, legible documentation of consulting with, appropriate specialists regarding C.D.'s condition.

[5] 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, and abuse of oxycodone may lead to severe psychological or physical dependence.

[6] Xanax is the brand name for alprazolam, a benzodiazepine commonly 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, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.

20. On multiple visits during C.D.'s treatment period, Respondent documented a diagnosis of lumbar pain with myelopathy.

21. Respondent failed to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of myelopathy for C.D.

22. On multiple visits during C.D.'s treatment period, Respondent documented a diagnosis of radiculopathy.

23. Respondent failed to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of radiculopathy for C.D.

24. At all times material to this Complaint, the prevailing standard of care dictated that Respondent:

a. Not inappropriately prescribe, or not prescribe inappropriate and/or excessive quantities of Oxycodone and Xanax to C.D.;

b. Perform a complete history and physical examination of C.D.;

c. Consult with appropriate specialists regarding C.D.'s condition;

d. Not diagnose C.D. with myelopathy without physical exam findings to justify the diagnosis; and/or

e. Not diagnose C.D. with radiculopathy without physical exam findings to justify the diagnosis.

Facts Specific to Patient I.K.

25. From on or about August 25, 2011, through on or about April 24, 2013, (treatment period), Respondent treated Patient I.K. (I.K.), an adult male, for complaints of chronic back pain.

26. During I.K.'s treatment period, I.K.'s records reflect that he had a history of intravenous drug abuse and depression.

27. Despite I.K.'s history of intravenous drug abuse and depression, during I.K.'s treatment period, Respondent inappropriately prescribed, or prescribed inappropriate and/or excessive quantities of Dilaudid[7], Valium[8], and Oxycodone to I.K.

28. During I.K.'s treatment period, Respondent did not refer, or alternatively did not create, keep or maintain adequate, legible documentation of referring, I.K. for drug detoxification or counseling to treat his addiction.

29. During I.K.'s treatment period, Respondent did not refer, or alternatively did not create, keep or maintain adequate, legible

[7] Dilaudid is the brand name for hydromorphone and is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, hydromorphone 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 hydromorphone may lead to severe psychological or physical dependence.

[8] 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, and abuse of diazepam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

documentation of referring, I.K. for psychiatric counseling to treat his depression.

30. During I.K.'s treatment period, Respondent did not consider, or alternatively did not create, keep or maintain adequate, legible documentation of considering, the use of alternative, less-addictive medications to treat I.K.'s pain.

31. On multiple visits during I.K.'s treatment period, Respondent documented a diagnosis of lumbar pain with myelopathy.

32. Respondent failed to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of myelopathy for I.K.

33. On multiple visits during I.K.'s treatment period, Respondent documented a diagnosis of radiculopathy.

34. Respondent failed to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of radiculopathy for I.K.

35. All times material to this Complaint, the prevailing standard of care dictated that Respondent:

a. Not inappropriately prescribe, or not prescribe inappropriate and/or excessive quantities of Dilaudid, Valium and Oxycodone to I.K.;

b. Refer I.K. for drug detoxification or counseling to treat his addiction;

c. Refer I.K. for psychiatric counseling to treat his depression;

d. Consider the use of alternative, less-addictive medications to treat I.K.'s pain;

e. Not diagnose I.K. with myelopathy without physical exam findings to justify the diagnosis; and/or

f. Not diagnose I.K. with radiculopathy without physical exam findings to justify the diagnosis.

Facts Specific to Patient J.K.

36. From on or about August 24, 2011 through on or about March 7, 2012 (treatment period), Respondent treated Patient J.K. (J.K.), an adult male, for complaints of neck and back pain.

37. During J.K.'s treatment period, Respondent inappropriately prescribed, or prescribed inappropriate and/or excessive quantities of Oxycodone and Xanax to J.K.

38. During J.K.'s treatment period, Respondent failed to perform, or alternatively, did not create, keep or maintain adequate, legible documentation of performing, a complete history and physical examination of J.K.

39. During J.K.'s treatment period, Respondent did not consult with, or alternatively, did not create, keep or maintain adequate, legible documentation of consulting with, appropriate specialists regarding J.K.'s condition.

40. On or about March 7, 2012, Respondent documented a diagnosis of post-traumatic stress disorder (PTSD) for J.K.

41. Respondent failed to create, keep or maintain adequate, legible documentation of any history which supported a diagnosis of PTSD.

42. On multiple visits during J.K.'s treatment period, Respondent documented a diagnosis of myelopathy.

43. Respondent failed to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of myelopathy for J.K.

44. On multiple visits during J.K.'s treatment period, Respondent documented a diagnosis of radiculopathy.

45. Respondent failed to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of radiculopathy for J.K.

46. All times material to this Complaint, the prevailing standard of care dictated that Respondent:

a. Not inappropriately prescribe, or not prescribe inappropriate and/or excessive quantities of Oxycodone and Xanax to J.K.;

b. Perform a complete history and physical examination of J.K.;

c. Consult with appropriate specialists regarding J.K.'s condition;

d. Not diagnose J.K. with PTSD without any history to support the diagnosis;

e. Not diagnose J.K. with myelopathy without physical exam findings to justify the diagnosis; and/or

f. Not diagnose J.K. with radiculopathy without physical exam findings to justify the diagnosis.

Facts Specific to Patient J.M.

47. From on or about March 2, 2012, through on or about April 2, 2013 (treatment period), Respondent treated Patient J.M. (J.M.), an adult male, for complaints of chronic back pain.

48. During J.M.'s treatment period, Respondent inappropriately prescribed, or prescribed inappropriate and/or excessive quantities of Clonazepam, Roxicodone and Methadone[9] to J.M.

49. During J.M.'s treatment period, Respondent failed to perform, or alternatively, did not create, keep or maintain adequate, legible documentation of performing, a complete history and physical examination of J.M.

50. During J.M.'s treatment period, Respondent did not consult with, or did not create, keep or maintain adequate, legible documentation of consulting with, appropriate specialists regarding J.M.'s condition.

51. On multiple visits during J.M.'s treatment period, Respondent documented a diagnosis of myelopathy.

52. Respondent failed to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of myelopathy for J.M.

53. On multiple visits during J.M.'s treatment period, Respondent documented a diagnosis of radiculopathy.

[9] Methadone is an opioid commonly used 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, and abuse of methadone may lead to severe psychological or physical dependence.

54. Respondent failed to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of radiculopathy for J.M.

55. At all times material to this Complaint, the prevailing standard of care dictated that Respondent:

a. Not inappropriately prescribe, or not prescribe inappropriate and/or excessive quantities of Roxicodone, Methadone, and Clonazepam to J.M.;

b. Perform a complete history and physical examination of J.M.;

c. Consult with appropriate specialists regarding J.M.'s condition;

d. Not diagnose J.M. with myelopathy without physical exam findings to justify the diagnosis; and/or

e. Not diagnose J.M. with radiculopathy without physical exam findings to justify the diagnosis.

Section 458.331(1)(t)1., Florida Statutes (2011-2012)
Applicable to Counts I-V

56. Section 458.331(1)(t)1., Florida Statutes (2011-2012), subjects a licensee to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes. Section 456.50(1)(g), Florida Statutes (2011-2012), 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. Section 766.102, Florida Statutes (2011-2012), provides that the prevailing 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.

COUNT I

57. Petitioner re-alleges and incorporates paragraphs one (1) through fifteen (15) and fifty-six (56), as if fully set forth herein.

58. Respondent fell below the prevailing standard of care in his treatment of T.B. in one or more of the following ways:

a. By inappropriately prescribing, or prescribing inappropriate and/or excessive quantities of Roxicodone and Clonazepam to T.B. during his treatment period;

b. By failing to perform a complete history and physical examination of T.B.;

c. By failing to consult with T.B.'s previous health care providers;

d. By failing to implement alternative treatment modalities for T.B.'s pain, outside of prescribing large quantities of controlled substances to T.B.;

e. By failing to refer T.B. to appropriate specialists;

f. By diagnosing T.B. with myelopathy without physical exam findings to justify the diagnosis; and/or

g. By diagnosing T.B. with radiculopathy without physical exam findings to justify the diagnosis.

59. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2011-2012).

COUNT II

60. Petitioner re-alleges and incorporates paragraphs one (1) through four (4), sixteen (16) through twenty-four (24) and fifty-six (56), as if fully set forth herein.

61. Respondent fell below the prevailing standard of care in his treatment of C.D. in one or more of the following ways:

a. By inappropriately prescribing, or prescribing inappropriate and/or excessive quantities of Oxycodone and Xanax to C.D. during C.D.'s treatment period;

b. By failing to perform a complete history and physical examination of C.D.;

c. By failing to consult with appropriate specialists regarding C.D.'s condition;

d. By diagnosing C.D. with myelopathy without physical exam findings to justify the diagnosis; and/or

e. By diagnosing C.D. with radiculopathy without physical exam findings to justify the diagnosis.

62. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2011-2012).

COUNT III

63. Petitioner re-alleges and incorporates paragraphs one (1) through four (4), twenty-five (25) through thirty-five (35) and fifty-six (56), as if fully set forth herein.

64. Respondent fell below the prevailing standard of care in his treatment of I.K. in one or more of the following ways:

a. By inappropriately prescribing, or prescribing inappropriate and/or excessive quantities of Dilaudid, Valium and Oxycodone to I.K. during I.K.'s treatment period;

b. By failing to refer I.K. for drug detoxification or counseling to treat his addiction;

c. By failing to refer I.K. for psychiatric counseling to treat his depression;

d. By failing to consider the use of alternative, less-addictive medications to treat I.K.'s pain;

e. By diagnosing I.K. with myelopathy without physical exam findings to justify the diagnosis; and/or

f. By diagnosing I.K. with radiculopathy without physical exam findings to justify the diagnosis.

65. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2011-2012).

COUNT IV

66. Petitioner re-alleges and incorporates paragraphs one (1) through four (4), thirty-six (36) through forty-six (46) and fifty-six (56), as if fully set forth herein.

67. Respondent fell below the prevailing standard of care in his treatment of J.K. in one or more of the following ways:

a. By inappropriately prescribing, or prescribing inappropriate and/or excessive quantities of Oxycodone and Xanax to J.K. during J.K.'s treatment period;

b. By failing to perform a complete history and physical examination of J.K.;

c. By failing to consult with appropriate specialists regarding J.K.'s condition;

d. By diagnosing J.K. with PTSD without any history to support the diagnosis;

e. By diagnosing J.K. with myelopathy without physical exam findings to justify the diagnosis; and/or

f. By diagnosing J.K. with radiculopathy without physical exam findings to justify the diagnosis.

68. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2011-2012).

COUNT V

69. Petitioner re-alleges and incorporates paragraphs one (1) through four (4) and forty-seven (47) through fifty-six (56), as if fully set forth herein.

70. Respondent fell below the prevailing standard of care in his treatment of J.M. in one or more of the following ways:

a. By inappropriately prescribing, or prescribing inappropriate and/or excessive quantities of Clonazepam, Roxicodone and Methadone to J.M. during J.M.'s treatment period;

b. By failing to perform a complete history and physical examination of J.M.;

c. By failing to consult with appropriate specialists regarding J.M.'s condition;

d. By diagnosing J.M. with myelopathy without physical exam findings to justify the diagnosis; and/or

e. By diagnosing J.M. with radiculopathy without physical exam findings to justify the diagnosis.

71. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2011-2012).

Section 458.331(1)(m), Florida Statutes (2011-2012) and/or
Section 458.331(1)(nn), Florida Statutes (2011-2012)
Applicable to Counts VI through X

72. Section 458.331(1)(m), Florida Statutes (2011-2012), 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.

73. Section 458.331(1)(nn), Florida Statutes (2011-2012), provides that violating any provision of Chapter 458 or 456, or any rules adopted pursuant thereto constitutes grounds for disciplinary action by the Board of Medicine.

74. Rule 64B8-9.003(d)(3), Florida Administrative Code, provides that medical records 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.

COUNT VI

75. Petitioner re-alleges paragraphs one (1) through fourteen (14) and seventy-two (72) through seventy-four (74), as if fully set forth herein.

76. Respondent failed to keep legible medical records which justified the course of treatment and/or failed to satisfy the requirements of Rule 64B8-9.003(d)(3), Florida Administrative Code, for T.B. in one or more of the following ways:

a. By failing to create, keep or maintain adequate, legible documentation of performing a complete history and physical examination of T.B.;

b. By failing to create, keep or maintain adequate, legible documentation of consulting with T.B.'s previous health care providers;

c. By failing to create, keep or maintain adequate, legible documentation of implementing alternative treatment modalities for T.B.;

d. By failing to create, keep or maintain adequate, legible documentation of referring T.B. to appropriate specialists;

e. By failing to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of myelopathy for T.B.; and/or

f. By failing to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of radiculopathy for T.B.

77. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2011-2012) and/or Section 458.331(1)(nn), Florida Statutes (2011-2012).

COUNT VII

78. Petitioner re-alleges paragraphs one (1) through four (4), sixteen (16) through twenty-three (23) and seventy-two (72) through seventy-four (74), as if fully set forth herein.

79. Respondent failed to keep legible medical records which justified the course of treatment and/or failed to satisfy the requirements of Rule 64B8-9.003(d)(3), Florida Administrative Code, for C.D. in one or more of the following ways:

a. By failing to create, keep or maintain adequate, legible documentation of performing a complete history and physical examination of C.D.;

b. By failing to create, keep or maintain adequate, legible documentation of consulting with appropriate specialists regarding C.D.'s condition;

c. By failing to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of myelopathy for C.D.; and/or

d. By failing to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of radiculopathy for C.D.

80. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2011-2012) and/or Section 458.331(1)(nn), Florida Statutes (2011-2012).

COUNT VIII

81. Petitioner re-alleges paragraphs one (1) through four (4), twenty-five (25) through thirty-four (34) and seventy-two (72) through seventy-four (74), as if fully set forth herein.

82. Respondent failed to keep legible medical records which justified the course of treatment and/or failed to satisfy the requirements of Rule 64B8-9.003(d)(3), Florida Administrative Code, for I.K. in one or more of the following ways:

a. By failing to create, keep or maintain adequate, legible documentation of referring I.K. for drug detoxification or counseling to treat I.K.'s addiction;

b. By failing to create, keep or maintain adequate, legible documentation of referring I.K. for psychiatric counseling to treat I.K.'s depression;

c. By failing to create, keep or maintain adequate, legible documentation of considering the use of alternative, less-addictive medications to treat I.K.'s pain;

d. By failing to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of myelopathy for I.K.; and/or

e. By failing to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of radiculopathy for I.K.

83. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2011-2012) and/or Section 458.331(1)(nn), Florida Statutes (2011-2012).

COUNT IX

84. Petitioner re-alleges paragraphs one (1) through four (4), thirty-six (36) through forty-five (45) and seventy-two (72) through seventy-four (74), as if fully set forth herein.

85. Respondent failed to keep legible medical records which justified the course of treatment and/or failed to satisfy the requirements of Rule 64B8-9.003(d)(3), Florida Administrative Code, for J.K. in one or more of the following ways:

a. By failing to create, keep or maintain adequate, legible documentation of performing a complete history and physical examination of J.K.;

b. By failing to create, keep or maintain adequate, legible documentation of consulting with appropriate specialists regarding J.K.'s condition;

c. By failing to create, keep or maintain adequate, legible documentation of any history which supported a diagnosis of PTSD for J.K.;

d. By failing to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of myelopathy for J.K.; and/or

e. By failing to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of radiculopathy for J.K.

86. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2011-2012) and/or Section 458.331(1)(nn), Florida Statutes (2011-2012).

COUNT X

87. Petitioner re-alleges paragraphs one (1) through four (4), forty-seven (47) through fifty-four (54), and seventy-two (72) through seventy-four (74), as if fully set forth herein.

88. Respondent failed to keep legible medical records which justified the course of treatment and/or failed to satisfy the requirements of Rule

64B8-9.003(d)(3), Florida Administrative Code, for J.M. in one or more of the following ways:

a. By failing to create, keep or maintain adequate, legible documentation of performing a complete history and physical examination of J.M.;

b. By failing to create, keep or maintain adequate, legible documentation of consulting with appropriate specialists regarding J.M.'s condition;

c. By failing to create, keep or maintain adequate, legible documentation of physical findings which justified a diagnosis of myelopathy for J.M.; and/or

d. By failing to create, keep or maintain adequate, legible documentation of physical exam findings which justified a diagnosis of radiculopathy for J.M.

89. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2011-2012) and/or Section 458.331(1)(nn), Florida Statutes (2011-2012).

Section 458.331(1)(q), Florida Statutes (2011-2012)
Applicable to Counts XI through XV

90. Section 458.331(1)(q), Florida Statutes (2011-2012), 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.

COUNT XI

91. Petitioner re-alleges paragraphs one (1) through six (6), fifteen (15) and ninety (90), as if fully set forth herein.

92. Respondent prescribed a legend drug other than in the course of his professional practice by prescribing Roxicodone and Clonazepam inappropriately, or in inappropriate and/or quantities, to T.B. during T.B.'s treatment period.

93. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2011-2012).

COUNT XII

94. Petitioner re-alleges paragraphs one (1) through four (4), sixteen (16) through seventeen (17), twenty-four (24), and ninety (90), as if fully set forth herein.

95. Respondent prescribed a legend drug other than in the course of his professional practice by prescribing Oxycodone and Xanax inappropriately, or in inappropriate and/or excessive quantities, to C.D. during C.D.'s treatment period.

96. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2011-2012).

COUNT XIII

97. Petitioner re-alleges paragraphs one (1) through four (4), twenty-five (25) through twenty-seven (27), thirty-five (35) and ninety (90), as if fully set forth herein.

98. Respondent prescribed a legend drug other than in the course of his professional practice by prescribing Dilaudid, Valium and Oxycodone inappropriately, or in inappropriate and/or excessive quantities, to I.K. during I.K.'s treatment period.

99. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2011-2012).

COUNT XIV

100. Petitioner re-alleges paragraphs one (1) through four (4), thirty-six (36) through thirty-seven (37), forty-six (46), and ninety (90), as if fully set forth herein.

101. Respondent prescribed a legend drug other than in the course of his professional practice by prescribing Oxycodone and Xanax inappropriately, or in inappropriate and/or excessive quantities, to J.K. during J.K.'s treatment period.

102. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2011-2012).

COUNT XV

103. Petitioner re-alleges paragraphs one (1) through four (4), forty-seven (47) through forty-eight (48), fifty-five (55) and ninety (90), as if fully set forth herein.

104. Respondent prescribed a legend drug other than in the course of his professional practice by prescribing Clonazepam, Roxicodone and Methadone inappropriately, or in inappropriate and/or excessive quantities, to J.M. during J.M.'s treatment period.

105. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2011-2012).

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 21st day of November, 2016.

Celeste Philip, MD, MPH
Surgeon General & Secretary

Corynn Alberto

Corynn Alberto
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PCP Members: Georges El-Bahri, M.D.; Merle P. Stringer, M.D.; Donald Mullins

NOTICE OF RIGHTS

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

A request or petition for an administrative hearing must be in writing and must be received by the Department within 21 days from the day Respondent received the Administrative Complaint, pursuant to Rule 28-106.111(2), Florida Administrative Code. If Respondent fails to request a hearing within 21 days of receipt of this Administrative Complaint, Respondent waives the right to request a hearing on the facts alleged in this Administrative Complaint pursuant to Rule 28-106.111(4), Florida Administrative Code. Any request for an administrative proceeding to challenge or contest the material facts or charges contained in the Administrative Complaint must conform to Rule 28-106.2015(5), Florida Administrative Code.

Mediation under Section 120.573, Florida Statutes, is not available to resolve this Administrative Complaint.

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.