STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 2012-09032
LICENSE NO.: ME0055385

PETER SANCHEZ, M.D.,

Respondent.
_____/

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) pursuant to Sections 120.569 and 120.57(4), Florida Statutes, on June 4, 2021, via a duly noticed video conference meeting, for the purpose of considering a Settlement Agreement (attached hereto as Exhibit A) entered into between the parties in this cause. Upon consideration of the Settlement Agreement, the documents submitted in support thereof, the arguments of the parties, and being otherwise fully advised in the premises,

IT IS HEREBY ORDERED AND ADJUDGED that the Settlement Agreement as submitted be and is hereby approved and adopted in toto and incorporated herein by reference with the following clarification:

The costs set forth in Paragraph 3 of the Stipulated Disposition shall be set at $12,806.24.

Accordingly, the parties shall adhere to and abide by all the terms and conditions of the Settlement Agreement as clarified above.

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

DONE AND ORDERED this 11th day of June, 2021.

BOARD OF MEDICINE

Crystal Rinford (Jun 11, 2021 16:54 EDT)

Paul A. Vazquez, 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: Peter Sanchez, M.D., 401 69th Street, Apt. 807, Miami Beach, FL 33141; 4259 10th Avenue, North, Lake Worth, FL 33461 and Warren James Pearson, Esq., 1509 Twin Lakes Circle, Tallahassee, FL 32311; by email to: Chad Dunn, Assistant General Counsel, Department of Health, at **Chad.Dunn@flhealth.gov**; and Edward A. Tellechea, Chief Assistant Attorney General, at **Ed.Tellechea@myfloridalegal.com** this 17th day of June, 2021.

Deputy Agency Clerk

MEMORANDUM

DATE: June 11, 2021

TO: Joe Baker, Interim Bureau Chief
Bureau of Health Care Practitioner Regulation

FROM: Paul A. Vazquez
Executive Director, Board of Medicine

SUBJECT: Delegation of Authority

This is to advise you that while I am out of the office Friday afternoon, June 11, 2021, the following individual is delegated to serve as Acting Executive Director for the Board of Medicine:

Crystal Sanford Program Operations Administrator

Crystal can be reached at 850-245-4132.

PAV/rh

cc: Jessica Hollingsworth
Board of Medicine Staff
Board and Council Chairs

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **Case Number 2012-09032**

PETER SANCHEZ, M.D.,

RESPONDENT.
_____/

SETTLEMENT AGREEMENT

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

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

STIPULATED FACTS

1. At all times material hereto, Respondent was a licensed medical doctor in the State of Florida having been issued license number ME 55385.

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

3. For purposes of these proceedings, Respondent neither admits nor denies the allegations of fact contained in the Administrative Complaint.

STIPULATED CONCLUSIONS OF LAW

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

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

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

4. Petitioner agrees that the Stipulated Disposition is mutually decided amongst the parties in order to efficiently resolve legal disputes contained within Exhibit A and shall not constitute a finding of guilty for any purposes other than the resolution of case number 2012-09032.

STIPULATED DISPOSITION

1. **Reprimand** - The Board shall issue a Reprimand against Respondent's license.

2. **Fine** - The Board shall impose an administrative fine of ***twenty thousand dollars ($20,000.00)*** against Respondent's license which Respondent shall pay to: Payments, Department of Health, Compliance Management Unit, Bin C-76, P.O. Box 6320, Tallahassee, FL 32314-6320, within one (1) year from the date of filing of the Final Order accepting this Agreement ("Final Order"). **All fines shall be paid by cashier's check**

or money order. Any change in the terms of payment of any fine imposed by the Board **must be approved in advance by the Probation Committee of the Board**.

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

3. **Reimbursement of Costs** - Pursuant to Section 456.072, Florida Statutes, Respondent agrees to pay the Department for the Department's costs incurred in the investigation and prosecution of this case ("Department costs"). Such costs exclude the costs of obtaining supervision or monitoring of the practice, the cost of quality assurance reviews, any other costs Respondent incurs to comply with the Final Order, and the Board's administrative costs directly associated with Respondent's probation, if any. Respondent agrees that the amount of Department costs to be paid in this case is currently ***twelve thousand, two hundred seventeen dollars and sixty cents ($12,217.60) but shall not exceed fourteen thousand, two hundred seventeen dollars and sixty cents ($14,217.60).*** Respondent will pay such Department costs to: Payments, Department of Health, Compliance Management Unit, Bin C-76, P.O. Box

6320, Tallahassee, FL 32314-6320, within one (1) year from the date of filing of the Final Order. **All costs shall be paid by cashier's check or money order.** Any change in the terms of payment of costs imposed by the Board **must be approved in advance by the Probation Committee of the Board**.

RESPONDENT ACKNOWLEDGES THAT THE TIMELY PAYMENT OF THE COSTS IS HIS LEGAL OBLIGATION AND RESPONSIBILITY AND RESPONDENT AGREES TO CEASE PRACTICING IF THE COSTS ARE NOT PAID AS AGREED IN THIS SETTLEMENT AGREEMENT. SPECIFICALLY, IF RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION WITHIN ONE YEAR AND FIFTEEN DAYS OF THE DATE OF FILING OF THE FINAL ORDER THAT THE FULL AMOUNT OF THE COSTS NOTED ABOVE HAS BEEN RECEIVED BY THE BOARD OFFICE, RESPONDENT AGREES TO CEASE PRACTICE UNTIL RESPONDENT RECEIVES SUCH WRITTEN CONFIRMATION FROM THE BOARD.

4. **Laws and Rules Course** - Respondent shall document completion of a Board-approved laws and rules course within one (1) year from the date the Final Order is filed.

5. **Records Course** - Respondent shall document completion of a Board-approved medical records course within one year from the date the Final Order is filed.

6. **Drug Course** - Respondent shall document completion of a Board-approved drug prescribing course within one (1) year from the date the Final Order is filed.

7. **Continuing Medical Education – "Risk Management"** – Respondent shall complete this requirement and document such completion within one (1) year from the date the Final Order is filed. **Respondent shall satisfy this requirement in one of the two following ways:**

(a) Respondent shall complete five (5) hours of CME in "Risk Management" after first obtaining written advance approval from the Board's Probation Committee of such proposed course, and shall submit documentation of such completion, in the form of certified copies of the receipts, vouchers, certificates, or other official proof of completion, to the Board's Probation Committee; or

(b) Respondent shall complete (5) five hours of CME in risk management by attending one full day or eight (8) hours, whichever is more, of disciplinary hearings at a regular meeting of the Board of Medicine. In order to receive such credit, Respondent must sign in with the Executive Director of the Board before the meeting day begins, Respondent must remain in continuous attendance during the full day or eight (8) hours of disciplinary hearings, whichever is more, and Respondent must sign out with the Executive Director of the Board at the end of the meeting day or at such other earlier time as affirmatively authorized by the Board. Respondent may not receive CME credit in risk management for attending the disciplinary hearings portion of a Board meeting unless the Respondent is attending the disciplinary hearings portion for the **sole** purpose of obtaining the CME credit in risk management. In other words, Respondent may not receive such credit if appearing at the Board meeting for any other purpose, such as pending action against Respondent's medical license.

STANDARD PROVISIONS

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

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

3. **Continuing Medical Education** - Unless otherwise provided in this Agreement Respondent shall first submit a written request to the Probation Committee for approval prior to performance of said CME course(s). Respondent shall submit documentation to the Board's Probation Committee of having completed a CME course in the form of certified copies of the receipts, vouchers, certificates, or other papers, such as physician's recognition awards, documenting completion of this medical course within one (1) year of the filing of the Final Order in this matter. All such documentation shall be sent to the Board's Probation Committee, regardless of whether some or any of such documentation was provided previously during the course of any audit or discussion with counsel for the Department. CME hours required by this Agreement shall be in addition to those hours required for renewal of licensure. Unless otherwise approved by the Board's Probation Committee, such CME course(s) shall consist of a formal, live lecture format.

4. **Addresses** - Respondent must provide current residence and practice addresses to the Board. Respondent shall notify the Board in writing within ten (10) days

of any changes of said addresses and shall also comply with all statutory requirements related to practitioner profile and licensure renewal updates.

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

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

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

Board or any of its members from further participation, consideration or resolution of these proceedings.

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

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

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

SIGNED this 9th day of MARCH, 2021.

Peter Sanchez, M.D.

STATE OF FLORIDA
COUNTY OF Miami Dade

BEFORE ME personally appeared Peter Sanchez, whose identity is known to me or who produced Personally Known (type of identification) and who, under oath, acknowledges that his/her signature appears above.

SWORN TO and subscribed before me this 9th day of March, 2021.

MARCELINE JEAN
Notary Public - State of Florida
Commission # GG 27999
My Comm. Expires Nov 28, 20
Bonded through National Notary Assn.

NOTARY PUBLIC

My Commission Expires: 11/28/22

APPROVED this 15th day of March, 2021.

Corynn Alberto

By: Corynn Alberto
Assistant General Counsel
Department of Health

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.

[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

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DATE: NOV 21 2016

PCP Date: November 18, 2016
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.