STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL REGULATION,

Petitioner,

CASE NO. 0081328

v.

CARLOS CASADEMONT, M.D.,

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW, the Petitioner, Department of Professional Regulation, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against Carlos Casademont, M.D., hereinafter referred to as "Respondent," and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.30, Florida Statutes, Chapter 455, Florida Statutes, and Chapter 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0016836. Respondent's last known address is 7100 West 20th Avenue, Suite 301, Hialeah, Florida 33016.

3. Respondent's licensed speciality is psychiatry.

COUNT ONE

FACTS PERTAINING TO PATIENT #1

4. Petitioner realleges and incorporates paragraphs one (1) through three (3) as if fully set forth herein.

5. From on or about June 10, 1976 until on or about October 20, 1987, Respondent provided care and treatment for Patient #1.

6. Patient #1 had been treated for narcotic abuse at St. Luke's Rehabilitation Center and Model City Methadone Clinic.

7. Respondent's medical records acknowledged Patient #1's history of narcotic abuse by referring to the treatment Patient #1 received at St. Luke's Rehabilitation Center and the Model City Methadone Clinic.

8. Respondent's medical records reveal that Patient #1 was taking Methadone (70mg/day) when Respondent assumed his care on or about June 10, 1976.

9. Respondent documented the patient's concurrent use of Dilaudid and Methadone, and indicated that Methadone use ended on or about October 28, 1976.

10. Respondent's medical records do not reflect an adequate psychiatric assessment, diagnosis or treatment plan for Patient #1, in that: Respondent failed to document as assessment of the parameters of the patient's psychiatric symptoms; Respondent failed to document a psychotherapeutic process involving Patient #1; Respondent failed to document a diagnosis concerning the patient's psychological state; and Respondent failed to document a treatment plan for Patient #1.

11. Respondent consistently prescribed Dilaudid to Patient #1 during the treatment period designated in paragraph number five (5).

12. Dilaudid is a "legend drug" as defined by Section 465.003(7), Florida Statutes, which contains hydromorphone, a Schedule II controlled substance, as listed in Chapter 893, Florida Statutes.

13. Respondent prescribed Valium (10mg tablets) to Patient #1 routinely from 1976 through 1979 and periodically from 1980 through 1987.

14. Valium is a "legend drug" as defined by Section 465.003(7), Florida Statutes, which contains diazepam a Schedule IV controlled substance as listed in Chapter 893, Florida Statutes.

15. Respondent's treatment of Patient #1 fell below the acceptable level of care, in that: Respondent prescribed Dilaudid and Valium to Patient #1 and such substances potentiated the patient's addiction; Respondent failed to refer Patient #1 to a drug rehabilitation program; and Respondent failed to institute a psychotherapy program for Patient #1 even though Respondent's records reflect a long treatment period.

16. Respondent prescribed, dispensed, administered, supplied, sold, gave, mixed, or otherwise prepared legend drugs, inappropriately or in excessive or inappropriate quantities not in the best interest of Patient #1, including, but not limited to, the following: Respondent prescribed Dilaudid, a Schedule II controlled substance, to Patient #1 for a period of eleven years;

Respondent prescribed Dilaudid to Patient #1 who was concurrently taking Methadone; and Respondent prescribed Valium, a Schedule IV controlled substance, over a period of eleven years to Patient #1 who had a history of narcotic abuse.

17. Based upon the preceding allegations, Respondent violated Section 458.331(1)(q), Florida Statutes, in that he is guilty of by 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 intent.

COUNT TWO

18. Petitioner realleges and incorporates paragraphs one (1) through three (3) and paragraphs five (5) through sixteen (16) as if fully set forth herein.

19. Respondent failed to keep written medical records justifying the course of treatment of Patient #1 including, but not limited to, the following: Respondent failed to document an assessment of the parameters of the patient's psychiatric symptoms; Respondent failed to document a diagnosis concerning the patient's psychological state; Respondent failed to document a psychotherapeutic process involving Patient #1; Respondent

failed to document a treatment plan for Patient #1; Respondent failed to document any justification for prescribing Dilaudid to Patient #1 while he was concurrently using Methadone; and Respondent failed to document any justification for prescribing Valium to Patient #1 when such a substance would potentiate the patient's addiction.

20. Based on the preceding allegations, Respondent violated Section 458.331(1)(m), Florida Statutes, in that Respondent failed to keep written medical records justifying the course of treatment of Patient #1 including, but not limited to, patient histories, examination results and test results.

COUNT THREE

21. Petitioner realleges and incorporates paragraphs one (1) through three (3), paragraphs five (5) through sixteen (16) and paragraph nineteen (19), as if fully set forth herein.

22. Respondent failed to practice medicine with that level of care, skill and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances in that: Respondent continually prescribed Dilaudid from 1976 through 1987 to Patient #1 who had a history of narcotic abuse; From 1976 through 1979, Respondent routinely prescribed Valium to Patient #1 who had a history of narcotic abuse; Respondent prescribed controlled substances which potentiated the patient's addiction; Respondent failed to refer Patient #1 to a detoxification program; and Respondent failed to institute a psychotherapy program for Patient #1.

23. Based on the preceding allegations, Respondent violated Section 458.331(1)(t), Florida Statutes, in that Respondent is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

COUNT FOUR

FACTS PERTAINING TO PATIENT #2

24. Petitioner realleges and incorporates paragraphs one (1) through three (3) as if fully set forth herein.

25. On or about May 10, 1984 through on or about February 14, 1987, Respondent provided medical care and treatment for Patient #2.

26. Respondent's medical records reveal the following diagnoses for Patient #2: psychotic depression; post traumatic stress disorder with psychosis; and schizophrenic, chronic paranoid.

27. Respondent's medical records reveal that Patient #2 routinely complained of headaches and skeletal pain subsequent to a motor-vehicle accident.

28. On or about October 17, 1984, Respondent referred Patient #2 to an orthopedic surgeon who attempted to surgically correct the patient's problem.

29. Subsequent to the date noted in paragraph number twenty-eight (28), the Respondent failed to refer Patient #2 to

either an orthopedic surgeon or a neurologist for his continued complaints of chronic headaches and skeletal pain.

30. During 1986 the Respondent treated Patient #2 with the following legend drugs: Feldene, an anti-inflammatory analgesic; Meclomen, a nonsteroidal anti-inflammatory analgesic; Haldol, a major tranquilizer and antipsychotic agent; Akineton, an anticholinergic agent which is used as adjunct therapy for Parkinsonism; and Motrin, a nonsteroidal anti-inflammatory agent.

31. A prescription profile revealed that the Respondent treated Patient #2 with the following controlled substances: Halcion; Tranxene; Percodan; Percocet; Tylenol #4; and Vicodin.

32. Halcion is a "legend drug" as defined by Section 465.003(7), Florida Statutes which contains triazolam, a controlled substance listed in Schedule IV of Chapter 893, Florida Statutes. Halcion is a hypnotic which acts to depress the central nervous system.

33. Tranxene is a "legend drug" as defined by Section 465.003(7), Florida Statutes, which contains chlorzepate a controlled substances listed in Schedule IV of Chapter 893, Florida Statutes. Tranxene is an anti-anxiety agent which acts to depress the central nervous system.

34. Percodan and Percocet are "legend drugs" as defined by Section 465.003(7), Florida Statutes, which contain oxycodone, a controlled substance listed in Schedule II of Chapter 893, Florida Statutes. Percodan and Percocet are narcotic analgesics which depress the central nervous system.

35. Tylenol #4 is a "legend drug" as defined by Section 465.003(7), Florida Statutes, which contains codeine, a controlled substance listed in Schedule III of Chapter 893, Florida Statutes. Tylenol #4 is a narcotic analgesics which depress the central nervous system.

36. Vicodin is a "legend drug" as defined by Section 465.003(7), Florida Statutes, which contains hydrocodone, a controlled substance listed is Schedule III of Chapter 893, Florida Statutes. Vicodin is a narcotic analgesic which depress the central nervous system.

37. The Respondent prescribed the controlled substances noted in paragraph number thirty-one (31) as follows:

DATE	DRUG	AMOUNT DISPENSED
02/18/86	Percodan	120
03/06/86	Percocet	30
03/13/86	Percocet	30
03/18/86	Percodan	120
03/20/86	Percocet	35
03/27/86	Percocet	45
04/03/86	Percocet	20
05/01/86	Tylenol #4	45
07/03/86	Vicodin	75
07/30/86	Tylenol #4	80
09/03/86	Tylenol #4	75
12/15/86	Tylenol #4	80

38. Respondent failed to document his prescriptions for Percodan and Percocet to Patient #2.

39. Percodan, Percocet, Tylenol #4 and Vicodin each interact with other narcotic analgesics, antipsychotics, anti-anxiety agents, or other central nervous system depressants to produce exaggerated central nervous system depression. Therefore, when prescribing combinations of these drugs, the dosage of one or both agents should be reduced.

40. Respondent failed to adjust the dosage of the drugs noted in paragraphs thirty (30) and thirty-one (31) when used in combinations concurrently.

41. Respondent prescribed, dispensed, administered, supplied, sold, gave, mixed, or otherwise prepared legend drugs, inappropriately or in excessive or inappropriate quantities not in the best interest of Patient #2, including, but not limited to, the following: Respondent concurrently prescribed to Patient #2 both legend drugs and controlled substances which depressed the central nervous system without adjusting the dosage of either agent; Respondent failed to document his prescriptions to Patient #2 for either Percodan or Percocet, both Schedule II controlled substances; and Respondent inappropriately prescribed narcotics to treat the patient's complaints of pain when such complaints should have prompted referral to a specialist for appropriate treatment.

42. Based on the preceding allegations, Respondent violated Section 458.331(1)(q), Florida Statutes, in that he is guilty of 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 intent.

COUNT FIVE

43. Petitioner realleges and incorporates paragraphs one (1) through three (3) and paragraphs twenty-four (24) through forty-one (41) as if fully set forth herein.

44. Respondent failed to practice medicine with that level of care, skill and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances in that: Respondent inappropriately treated Patient #2's complaints of pain with narcotic analgesics; Respondent failed to document prescribing controlled substances (Percodan and Percocet) to Patient #2; and Respondent failed to refer Patient #2 to a specialist for appropriate treatment of his continued complaints of chronic headaches and skeletal pain.

45. Based on the preceding allegations, Respondent violated Section 458.331(1)(t), Florida Statutes, in that Respondent is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

COUNT SIX

46. Petitioner realleges and incorporates paragraphs one (1) through three (3), paragraphs twenty-four (24) through forty-one (41) and paragraph forty-four (44) as if fully set forth herein.

47. Respondent failed to keep written medical records justifying the course of treatment of Patient #2 including, but not limited to, the following: Respondent failed to document prescribing Percocet and Percodan, both Schedule II controlled substances, to Patient #2; Respondent failed to document any justification for his failure to refer Patient #2 to a specialist for treatment of chronic complaints of pain; and Respondent failed to document any justification for either his concurrent use of combinations of drugs which act to depress the central nervous system or his failure to adjust the dosage of such drugs.

48. Based on the preceding allegations, Respondent violated Section 458.331(1)(m), Florida Statutes, in that Respondent failed to keep written medical records justifying 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.

COUNT SEVEN

FACTS PERTAINING TO PATIENT #3

49. Petitioner realleges and incorporates paragraphs one (1) through three (3) as if fully set forth herein.

50. On or about July 9, 1984, until on or about October 19, 1987, the Respondent provided medical care and treatment for Patient #3.

51. Respondent's medical records reveal that Patient #3 is a seventy-two year old male who has suffered from arthritis in

his left hip since 1945. Patient #3 had refused hip replacement surgery in the past.

52. Respondent's medical records reveal that the patient's primary complain was pain.

53. The Respondent noted on the patient's initial visit that Patient #3 had taken Percodan for pain relief in the past.

54. The Respondent failed to refer Patient #3 to a specialist (Arthrologist, Orthopedist or Pain Treatment Center) for treatment of his complaint of chronic pain.

55. Respondent's medical records do not reflect a psychiatric assessment, diagnosis or treatment plan for Patient #3.

56. The Respondent continually prescribed Percodan to Patient #3 for the entire treatment period from on or about July 9, 1984 through October 19, 1987.

57. Percodan, a narcotic analgesic, is a Schedule II controlled substance as defined in Chapter 893, Florida Statutes. Percodan acts to depress the central nervous system; and, therefore, when it is used in combination with other central nervous system depressants the dosage of one or both agents should be reduced to avoid additive central nervous system depressant effects.

58. The Respondent prescribed Xanax to Patient #3 on or about November 6, 1984 until on or about December 5, 1984.

59. Xanax is a "legend drug" as defined by Section 465.003(7), Florida Statutes, which contains alprazolam, a

controlled substance listed in Schedule IV of Chapter 893, Florida Statutes. Xanax has central nervous system depressant effects, and such effects are potentiated when Xanax is used in combination with other central nervous system depressants.

60. Respondent failed to document a diagnosis or treatment plant for Patient #3's anxiety condition.

61. Respondent prescribed Ativan to Patient #3 on or about December 5, 1984.

62. Ativan, an antianxiety agent, is a Schedule IV controlled substance as defined in Chapter 893, Florida Statutes. Ativan has a tranquilizing effect on the central nervous system, and it interacts with other central nervous system depressants to potentiate their effects.

63. Ativan is a "legend drug" as defined by Section 465.003(7), Florida Statutes, which contains larozepam, a controlled substance listed in Schedule IV of Chapter 893, Florida Statutes.

64. Centrax is a "legend drug" as defined by Section 465.003(7), Florida Statutes, which contains prazepam, a controlled substance listed in Schedule II of Chapter 893, Florida Statutes. Centrax has been shown to depress the central nervous system, and it interacts with other central nervous system depressants to potentiate their effects.

65. Respondent failed to follow-up on treatment rendered to Patient #3 in that Respondent failed to document any change in the patient's condition following treatment with antianxiety agents.

66. Respondent failed to document any adjustment in dosage of drugs which were central nervous system depressants and which were used in combination, thereby potentiating their central nervous system depressant effects.

67. Respondent prescribed Meclomen to Patient #3 on or about February 18, 1986.

68. Meclomen is a "legend drug" as defined in Section 465.003(7), Florida Statutes. This drug is a nonsteroidal agent which is indicated for relief of the signs an symptoms of acute and chronic rheumatoid arthritis and osteoarthritis.

69. Respondent prescribed Meclomen to Patient #3 for a condition which is neither assessed nor diagnosed in Respondent's medical records.

70. The Respondent failed to follow-up on treatment rendered to Patient #3 in that Respondent failed to document any change in the patient's condition subsequent to treatment with Meclomen.

71. Respondent prescribed Lomotil to Patient #3 from on or about July 14, 1987 through October 19, 1987.

72. Lomotil is a "legend drug" as defined by Section 465.003(7), Florida Statutes which contains diphenoxylate, a controlled substance listed in Schedule V of Chapter 893, Florida Statutes. Lomotil is effective as adjunctive therapy in the management of diarrhea; however, diphenoxylate hydrochloride, the major chemical element of Lomotil, is chemically related to the narcotic meperidine (Demerol).

73. Respondent prescribed Lomotil to Patient #3 for a condition which is neither assessed nor diagnosed in Respondent's medical records.

74. The Respondent failed to follow-up on treatment rendered to Patient #3 in that Respondent failed to document any change in the patient's condition following treatment with Lomotil.

75. Respondent failed to correlate the treatment rendered to the patient's complaint or condition in that: Respondent prescribed various antianxiety agents to Patient #3 and failed to document a medical reason for such prescription; and Respondent prescribed Lomotil to Patient #3 but failed to document a medical reason for such prescription.

76. Respondent prescribed, dispensed, administered. supplied, sold, gave, mixed, or otherwise prepared legend drugs, inappropriately or in excessive or inappropriate quantities not in the best interest of Patient #3, including, but not limited to, the following: Respondent prescribed Percodan, a Schedule II controlled substance, to Patient #3 inappropriately and excessively in that Respondent failed to refer the patient to a specialist for appropriate treatment for his chronic pain; Respondent prescribed Xanax, Ativan and Centrax, all Schedule IV controlled substances to Patient #3 inappropriately in that Respondent failed to document an anxiety related diagnosis for Patient #3; Respondent prescribed Meclomen, a nonsteroidal agent to Patient #3 inappropriately in that Respondent failed to refer the patient to a specialist for appropriate treatment of his

condition; and Respondent prescribed Lomotil, a Schedule V controlled substance, to Patient #3 inappropriately in that Respondent neither assessed nor diagnosed a condition which necessitated treatment with Lomotil.

77. Based on the preceding allegations, Respondent violated Section 458.331(1)(q), Florida Statutes, in that he is guilty of 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 intent.

COUNT EIGHT

78. Petitioner realleges and incorporates paragraphs one (1) through three (3) and paragraphs forty-nine (49) through seventy-six (76) as if fully set forth herein.

79. Respondent failed to practice medicine with that level of care, skill and treatment which a reasonable prudent similar physician recognizes as acceptable under similar conditions and circumstances in that Respondent failed to refer Patient #3 to a specialist for treatment of his chronic pain; Respondent failed to provide a psychiatric assessment, diagnosis or treatment plan for Patient #3; Respondent continually prescribed Percodan a

Schedule II controlled substance, to Patient #3 in combination with central nervous system depressants without adjusting the dosage of either agent in order to avoid the drugs potentiating effects; Respondent regularly prescribed to Patient #3 antianxiety agents (which were Schedule IV controlled substances) for a condition which was neither assessed nor diagnosed by Respondent; Respondent prescribed Lomotil, a Schedule V controlled substance, to Patient #3 for a condition which was neither assessed nor diagnosed by Respondent; Respondent failed to follow-up on treatment rendered to Patient #3 by failing to document any change in the patient's condition following treatment; and Respondent failed to correlate the treatment rendered to the patient's complaint or condition by failing to document a medical reason for the treatment.

80. Based on the preceding allegations, Respondent violated Section 458.331(1)(t), Florida Statutes, in that Respondent is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

COUNT NINE

81. Petitioner realleges and incorporates paragraphs one (1) through three (3), paragraphs forty-nine (49) through seventy-six (76) and paragraph seventy-nine (79) as if fully set forth herein.

82. Respondent failed to keep written medical records justifying the course of treatment of Patient #3 including, but not limited to, the following; Respondent failed to document any justification for his failure to refer Patient #3 to a specialist for treatment of chronic complaints of pain; Respondent failed to document a psychiatric assessment, diagnosis or treatment plant for Patient #3; Respondent failed to document any justification for his continued prescribing of Percodan, a Schedule II controlled substance, to Patient #3; Respondent failed to document a diagnosis or treatment plan for the patient's anxiety condition which he treated with various antianxiety agents; Respondent failed to document any justification for either his concurrent use of combinations of drugs which act to depress the central nervous system or his failure to adjust the dosage of such drugs; Respondent failed to document any follow-up on treatment rendered to Patient #3; and Respondent failed to document a medical reason for his prescribing either antianxiety agents or Lomotil to Patient #3.

83. Based on the preceding allegations, Respondent violated Section 458.331(1)(m), Florida Statutes, in that Respondent failed to keep written medical records justifying 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.

COUNT TEN

FACTS PERTAINING TO PATIENT #4

84. Petitioner realleges and incorporates paragraphs one

(1) through three (3) and paragraph thirty-two (32) and thirty-four (34).

85. From on or about November 4, 1980 through October 22, 1987, Respondent provided medical care and treatment for Patient #4.

86. The Respondent's medical records reveal the following diagnoses for Patient #4: Chronic schizoaffective disorder; Chronic renal disease secondary to nephropathy; arterial hypertension secondary to nephropathy; and Chronic severe headaches, possibly secondary in part to nephropathy and hypertension.

87. Patient #4 complained of severe headaches during the entire treatment period noted in paragraph eighty-five (85).

88. Respondent prescribed controlled substances continually to Patient #4 including, but not limited to, the following: Percocet; Tylenol #3: Tylox; Placidyl; Noludar; and Halcion.

89. Placidyl is a "legend drug" as defined by Section 465.003(7), Florida Statutes, which contains ethchloruynol, a controlled substances listed in Schedule IV of Chapter 893, Florida Statutes. Placidyl and Halcion are hypnotics which are used for short term treatment of insomnia. These drugs act to depress the central nervous system, and their concomitant use with other central nervous system depressants produce exaggerated depressant effects.

90. Noludar is "legend drug" as defined by Section 465.003(7), Florida Statutes, which contains methypryton, a

controlled substance listed in Schedule II of Chapter 893, Florida Statutes. Noludar is a central nervous system depressant, and its concomitant use with other central nervous system depressants produce exaggerated depressant effects.

91. Tylox is a "legend drug" as defined by Section 465.003(7), Florida Statutes, which contains oxycodone a controlled substance listed in Schedule II of Chapter 893, Florida Statutes. Tylox and Percocet are narcotic analgesics which act to depress the central nervous system. These drugs interact with other narcotic analgesics, antipsychotics, antianxiety agents or other central nervous system depressants and produce exaggerated depressant effects. Therefore, when prescribing combinations of these drugs, the dose of one or both agents should be reduced.

92. Tylenol #3 is a"legend drug" as defined by Section 465.003(7), Florida Statutes, which contains codeine, a controlled substance listed in Schedule III of Chapter 893. Florida Statutes. Tylenol #3 is a narcotic analgesic which acts to depress the central nervous system. This drug interacts with other central nervous system depressants to produce exaggerated central nervous system depression.

93. During the entire treatment period, Respondent prescribed the controlled substances noted in paragraph eighty-eight (88) concomitantly in various combinations to Patient #4, including the concurrent prescription of both Tylenol #3 and Percocet.

94. The Respondent failed to document any adjustment in the dosage of the central nervous system depressant drugs which were used in combinations which potentiated their depressant effects.

95. Respondent failed to document any justification for his failure to refer Patient #4 to a specialist, his long-term prescription of narcotic substances to Patient #4 or his concurrent prescription of Tylenol #3 and Percocet.

96. Respondent failed to document any justification for his failure to adjust the dosage of concomitantly used central nervous system depressants.

97. Respondent prescribed, dispensed, administered, supplied, sold, gave, mixed, or otherwise prepared legend drugs, inappropriately or in excessive or inappropriate quantities not in the best interest of Patient #4, including, but not limited to, the following: Respondent prescribed Tylox and Percocet, Schedule II controlled substances, and Tylenol #3, a Schedule III controlled substance, inappropriately or excessively in that Respondent failed to refer the patient to a specialist for appropriate treatment for her chronic headaches; and Respondent inappropriately prescribed controlled substances in that he prescribed these drugs which were central nervous system depressants concurrently, without adjusting the dosage, in disregard to their exaggerated depressant effects.

98. Based on the preceding allegations, Respondent violated Section 458.331(1)(q), Florida Statutes in that he is guilty of 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 intent.

COUNT ELEVEN

99. Petitioner realleges and incorporates paragraphs one (1) through three (3) and paragraphs eighty-four (84) through ninety-seven (97) as if fully set forth herein.

100. Respondent failed to keep written medical records justifying the course of treatment of Patient #4 including, but not limited to, the following: Respondent failed to document any adjustment in the dosage of central nervous system depressants which were prescribed in combinations to Patient #4; Respondent failed to document any justification for his failure to adjust the dosage of concomitantly used central nervous system depressants which were prescribed to Patient #4; Respondent failed to document any justification for his failure to refer Patient #4 to a specialist for appropriate treatment for her chronic pain; Respondent failed to document any justification for his long term prescription of narcotic substances to Patient #4; and Respondent failed to document any justification for his concurrent prescription of Tylenol #3 and Percocet.

101. Based on the preceding allegations, Respondent violated Section 458.331(1)(m), Florida Statutes, in that Respondent failed to keep written medical records justifying the course of treatment of Patient #4 including, but not limited to, patient histories; examination results; test results.

COUNT TWELVE

102. Petitioner realleges and incorporates paragraph one (1) through three (3), paragraphs eighty-four (84) through ninety-seven (97), and paragraph one hundred (100) as if set forth herein.

103. Respondent failed to practice medicine with that level of care, skill and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances in that Respondent failed to refer Patient #4 to a specialist for appropriate treatment of her chronic headaches.

104. Based on the preceding allegations, Respondent violated Section 458.331(1)(t), Florida Statutes, in that Respondent is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

WHEREFORE, Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an

administrative fine, issuance of a reprimand, placement of the Respondent on probation, and/or any other relief that the Board deems appropriate.

SIGNED this 14th day of September, 1990.

Larry Gonzalez, Secretary

By: Stephanie A. Daniel
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:

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Department of Professional Regulation
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CLERK

DATE 9-17-90

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION,

Petitioner,

v.

DPR Case No. 0081328
90-08262
90-14808

CARLOS CASADEMONT, M.D.,

Respondent.
_____/

CONSENT AGREEMENT

Carlos Casademont, M.D., referred to as the "Respondent", and the Department of Professional Regulation, 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.

STIPULATED FACTS

1. At all times material hereto, Respondent was a licensed physician in the State of Florida having been issued license number ME 0016836.

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

3. 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 physician, he is subject to the provisions of Chapters 455 and 458, Florida Statutes, and the jurisdiction of the Department and the Board.

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

STIPULATED DISPOSITION

1. CONSENT AGREEMENT. This Consent Agreement operates to encompass the cases of DPR v. Carlos Casademont, M.D., 90-14808 and 90-08262, for which Respondent has waived a finding of Probable Cause in order to facilitate review of this Agreement by the Board.

2. FUTURE CONDUCT. Respondent shall not in the future violate Chapters 455, 458 and 893, Florida Statutes, or the rules promulgated pursuant thereto.

3. FINE. The Board shall impose an administrative fine in the amount of $8,000.00 against the Respondent. The fine shall be paid by the Respondent to the Executive Director of the Board within 180 days of its imposition by Final Order of the Board.

4. REPRIMAND. The Respondent shall receive a reprimand from the Board of Medicine.

5. PROBATION. Effective on the date of the filing of the Final Order incorporating the terms of this Agreement,

Respondent's license to practice medicine shall be placed on probation for a period of 3 years.

A. RESTRICTIONS DURING PROBATION. During the period of probation, Respondent's license shall be restricted as follows:

i. INDIRECT SUPERVISION. Respondent shall practice only under the indirect supervision of a Board-approved physician, hereinafter referred to as the "monitor". In this regard, Respondent shall allow the monitor access to Respondent's medical records, calendar, patient logs or other documents necessary for the monitor to supervise Respondent as detailed below.

ii. Respondent may prescribe Schedule II-V controlled substances only in compliance with the restrictions set forth below:

a. During the first year of probation the Respondent shall not prescribe Schedule II controlled substances outside of a hospital setting.

b. During the first year of probation Respondent may prescribe methylphenidate (Ritalin) to selected patients after review of the medical records by his monitor and with the monitor's approval.

c. Respondent shall utilize sequentially numbered triplicate prescriptions.

d. Respondent shall immediately provide one copy of each prescription to the monitor.

e. Respondent shall provide one copy of each prescription to the Department's investigator within one month

after issuing said prescription.

f. After one year, if reports from the monitor are satisfactory, Respondent may prescribe Schedule II controlled substances, subject to the monitor's review.

B. OBLIGATIONS/REQUIREMENTS OF PROBATION. During the period of probation, Respondent shall comply with the following obligations and requirements:

i. Respondent shall appear before the Probation Committee of the Board of Medicine at the first Committee meeting after probation commences; at the last meeting of the Committee preceding scheduled termination of the probation semiannually; and at such other times as requested by the Committee. Respondent shall be noticed by the Board staff of the date, time and place of the Committee meeting whereat Respondent's appearance is required. Failure of Respondent to appear as requested or directed shall be considered a violation of the terms of this Agreement, and shall subject the Respondent to disciplinary action.

ii. Respondent shall attend 30 hours of Category I Continuing Medical Education courses per year in the area of psychiatry, 10 in the area of chronic pain management and 5 in record keeping and risk management. Respondent shall submit a written plan to the Chairman of the Probation Committee for course approval prior to the completion of said courses. In addition, Respondent shall submit documentation of completion of these courses in his required reports. These hours shall be in addition to those hours required for renewal of licensure. Unless otherwise approved by the Board or the Chairman of the Probation Committee,

said courses shall consist of a formal live lecture format.

iii. Respondent shall complete the course, "Protecting Your Medical Practice, Clinical, Legal and Ethical Issues in Prescribing Abusable Drugs", sponsored by the Florida Medical Association and the University of South Florida, or a Board-approved equivalent, during the first year of probation.

If Respondent has successfully completed the course by the time this Consent Agreement is presented the provision shall be deemed complied with.

iv. Respondent shall be responsible for ensuring that the monitor submits all required reports.

C. RESPONSIBILITIES OF THE MONITORING PHYSICIAN. The Monitor shall:

i. Review 25% percent of Respondent's active patient records at least once a month, for the purpose of ascertaining the thoroughness of Respondent's medical records, documentation of his diagnoses and treatment plans, and to ascertain that Respondent's care and treatment of his patients are within the standard of care of a similar physician practicing in the State of Florida. The monitor shall go to Respondent's office once every month and shall review Respondent's calendar or patient log and shall select the records to be reviewed.

iii. Submit reports on a semiannual basis, in affidavit form, which shall include:

a) A brief statement of why Respondent is on probation.

b) A description of Respondent's practice

(type and composition).

c) A statement addressing Respondent's compliance with the terms of probation.

d) A brief description of the monitor's relationship with the Respondent.

e) A statement advising the Board of any problems which have arisen.

f) A summary of the dates the monitor went to Respondent's office, the number of records reviewed, and the overall quality of the records reviewed.

iv. Maintain contact with the Respondent on a frequency of at least once per month. In the event that the monitor is not timely contacted by Respondent, then the monitor shall immediately report this fact to the Board, in writing.

v. Respondent's monitor shall appear before the Probation Committee at the first meeting of said committee following commencement of the probation, and at such other times as directed by the Committee. It shall be Respondent's responsibility to ensure the appearance of his monitor to appear as requested or directed. Failure of the monitor to appear as requested or directed shall constitute a violation of the terms of this Stipulation and shall subject the Respondent to disciplinary action.

D. REPORTS FROM RESPONDENT. The Respondent shall submit quarterly reports, in affidavit form, the contents of which may be further specified by the Board, but which shall include:

i. A brief statement of why Respondent is on

probation.

ii. A description of practice location.

iii. A description of current practice (type and composition).

iv. A brief statement of compliance with probationary terms.

vi. A description of the relationship with monitoring physician.

vii. A statement advising the Board of any problems which have arisen.

viii. A statement addressing compliance with any restrictions or requirements imposed.

E. STANDARD PROVISIONS. Respondents probation shall be governed by the attached "provisions regarding monitoring/supervising physicians", Exhibit B, which is incorporated as if fully set forth herein.

6. It is expressly understood that this Agreement is subject to the approval of the Board and the Department. In this regarding the foregoing paragraphs (and only the foregoing paragraphs) shall have no force and effect unless a Final Order is entered incorporating the terms of this Agreement, by the Board.

7. Respondent shall pay all costs necessary to comply with the terms of the Final Order issued based on this Stipulation. Such costs include, but are not limited to, the cost of preparation of investigative reports detailing compliance with the terms of this Stipulation, and the Board's administrative costs directly associated with Respondent's probation. See Section 458.331(2),

Florida Statutes.

8. Respondent shall appear before the Board at the meeting of the Board where this Agreement is considered. Respondent, in conjunction with the consideration of this Agreement by the Board, shall respond to questions under oath from the Board, Board Staff or Department Staff.

9. Should this Agreement be rejected, no statement made in furtherance of this Agreement by the Respondent may be used as direct evidence against the Respondent in any proceeding; however, such statements may be used by the Petitioner for impeachment purposes.

10. Respondent and the Department fully understand that this joint Agreement and subsequent Final Order incorporating same will in no way preclude additional proceedings by the Board and/or the Department against the Respondent for acts or omissions not specifically set forth in the Administrative Complaint attached as Exhibit "A" herein and/or Case Nos. 90-14808 and 90-08262.

11. 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.

12. Upon the Board's adoption of this Agreement, the parties hereby agree that each party will bear his 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 or Board of Medicine in connection with this

matter.

13. This Agreement is executed by the Respondent for the purpose of avoiding further administrative action with respect to this cause. 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. Furthermore, should this Consent 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.

SIGNED this 28th day of August, 1991.

(Respondent's Name)

Sworn to and subscribed
before me this 28th day
of August, 1991.

NOTARY PUBLIC

NOTARY PUBLIC STATE OF FLORIDA
MY COMMISSION EXP. NOV. 6,1992
BONDED THRU GENERAL INS. UND.

My Commission Expires:

APPROVED this 28th day of August, 1991.

George Stuart
Secretary

By: Larry G. McPherson, Jr.
Chief Attorney
Medical Section

PROVISIONS REGARDING MONITORING/SUPERVISING PHYSICIANS

Provisions governing physicians ordered to work under supervision of monitoring or supervising physician.

I. DEFINITIONS:

A. INDIRECT SUPERVISION is supervision by a monitoring physician (monitor) whose responsibilities are set by the Board. Indirect supervision does not require that the monitor practice on the same premises as the Respondent, however, the monitor shall practice within a reasonable geographic proximity to Respondent, which shall be within 20 miles unless otherwise provided by the Board and shall be readily available for consultation. The monitor shall be Board-certified in the Respondent's specialty area, unless otherwise provided by the Board.

B. DIRECT SUPERVISION is supervision by a supervising physician (supervisor) whose responsibilities are set by the Board. Direct supervision requires that the supervisor and Respondent work in the same office. The supervising physician shall be board-certified in the Respondent's specialty area, unless otherwise provided by the Board.

C. PROBATION COMMITTEE or "committee" are members of the Board of Medicine designated by the Chairman of the Board to serve as the Probation Committee.

II. STANDARD TERMS.

A. The Respondent shall not practice medicine without a monitor/supervisor unless otherwise ordered by the Board.

B. The monitor/supervisor must be a licensee under

Chapter 458, Florida Statutes, in good standing and without restriction or limitation on his license. In addition, the Board or Committee may reject any proposed monitor/supervisor on the basis that he has previously been subject to any disciplinary action against his medical license in this or any other jurisdiction, is currently under investigation, or is the subject of a pending disciplinary action. The monitor/supervisor must be actively engaged in the same or similar specialty area unless otherwise provided by the Board or Committee. The Board or Committee may also reject any proposed monitor/supervisor for good cause shown.

III. MECHANISM FOR APPROVAL OF MONITOR/SUPERVISOR:

A. TEMPORARY APPROVAL. The Board confers authority on the Chairman of the Board's Probation Committee to temporarily approve Respondent's monitor/supervisor. To obtain this temporary approval, Respondent shall submit to the Chairman of the Probation Committee the name and curriculum vitae of the proposed monitor/supervisor at the time this agreement is considered by the Board. **Once a Final Order adopting this Agreement is filed, Respondent shall not practice medicine without an approved monitor/supervisor. Temporary approval shall only remain in effect until the next meeting of the Probation Committee.**

B. FORMAL APPROVAL.

1. Respondent shall have the monitor/supervisor with him at his first probation appearance before the Probation Committee. Prior to consideration of the monitor/supervisor by the Committee, the Respondent shall provide

to the monitor/supervisor a copy of the Administrative Complaint and Final Order in this case. Respondent shall submit a current curriculum vitae and description of the current practice from the propose monitor/supervisor to the Board office no later than fourteen days before the Respondent's first scheduled probation appearance.

2. Respondent's monitor/supervisor shall appear before the Probation Committee at its first meeting following commencement of the probation, and at such other times as directed by the Committee. It shall be Respondent's responsibility to ensure that the appearance of his monitor/supervisor as requested or directed. Failure of the monitor/supervisor to appear as requested or directed shall constitute a violation of the terms of this Stipulation and shall subject the Respondent to disciplinary action.

C. CHANGE IN MONITOR/SUPERVISOR. In the event that Respondent's monitor/supervisor is unable or unwilling to fulfill his responsibilities as a monitor/supervisor as described above, then the Respondent shall immediately advise the Board of this fact. Respondent shall immediately submit to the Chairman of the Board's Probation Committee, the name of a temporary monitor/supervisor for consideration. Respondent shall not practice pending approval of this temporary monitor/supervisor by the Chairman of the Probation Committee. Furthermore, Respondent shall make arrangements with his temporary monitor/supervisor to appear before the Probation Committee at its next regularly scheduled meeting, for consideration of the monitor/supervisor by

the Committee. Respondent shall only practice under the auspices of the temporary monitor/supervisor (approved by the Chairman) until the next regularly scheduled meeting of the Probation Committee whereat the issue of the Committee's approval of the Respondent's new monitor/supervisor shall be addressed.

IV. CONTINUITY OF PRACTICE

A. TOLLING PROVISIONS. In the event the Respondent leaves the State of Florida for a period of thirty days or more or otherwise does not engage in the active practice of medicine in the State of Florida, then certain provisions of Respondent's probation (and only those provisions of the probation) shall be tolled as enumerated below and shall remain in a tolled status until Respondent returns to active practice in the State of Florida.

1. The time period of probation shall be tolled.

2. The provisions regarding supervision whether direct or indirect by another physician, and required reports from the monitor/supervisor shall be tolled.

3. The provisions regarding preparation of investigative reports detailing compliance with this Stipulation shall be tolled.

B. ADDRESSES. Respondent must keep current residence and business addresses on file with the Board. Respondent shall notify the Board within ten (10) days of any changes of said addresses. Furthermore, Respondent shall notify the Board within ten (10) days in the event that Respondent leaves

the active practice of medicine in Florida.

C. ACTIVE PRACTICE. In the event that Respondent leaves the active practice of medicine for a period of one year or more, the Probation Committee may require Respondent to appear before the Probation Committee and demonstrate his ability to practice medicine with skill and safety to patients prior to resuming the practice of medicine in this State.

V. BOARD ADDRESS. Unless otherwise directed by the Board office, all reports, correspondence and inquiries shall be sent to: Board of Medicine, 1940 North Monroe Street, Tallahassee, Florida 32399-0792, Attn: Final Order Compliance Officer.

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL REGULATION,

Petitioner,

v. Case No.9014808
9008262

CARLOS CASADEMONT, M.D.,

Respondent.
_____/

WAIVER OF PROBABLE CAUSE

In order to facilitate review of the Stipulation between parties, the Respondent hereby waives a finding of probable cause in this case so that the Board of Medicine may take final agency action. The Respondent understands that the waiver or probable cause in this matter, operates to make this matter a public record, regardless of the Board's action on the Stipulation.

_____
Carlos Casademont, M.D.

MBR:pc

FILED
Department of Professional Regulation
AGENCY CLERK

DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

CLERK L. Wilson

DATE 9-24-91

DEPARTMENT OF PROFESSIONAL REGULATION,

Petitioner,

v.

DPR CASE NUMBERS: 0081328
90-14808
90-08262

LICENSE NUMBER: ME 0016836

CARLOS CASADEMONT, M.D.,

Respondent.
_____/

FINAL ORDER

THIS MATTER came before the Board of Medicine (Board) pursuant to Section 120.57(3), Florida Statutes, on September 20, 1991, in Ft. Lauderdale, Florida, for consideration of a Consent Agreement (attached hereto as Exhibit A) entered into between the parties in the above-styled case. Upon consideration of the Consent Agreement, the documents submitted in support thereof, the arguments of the parties, and being otherwise advised in the premises,

IT IS HEREBY ORDERED AND ADJUDGED that the Consent Agreement as submitted be and is hereby approved and adopted in toto and incorporated by reference herein. Accordingly, the parties shall adhere to and abide by all of the terms and conditions of the Consent Agreement.

This Final Order takes effect upon filing with the Clerk of the Department.

DONE AND ORDERED this 20th day September, 1991.

BOARD OF MEDICINE

ZACHARIAH P. ZACHARIAH, M.D.
CHAIRMAN

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been provided by certified U.S. Mail to Carlos Casademont, M.D., 7100 West 20th Avenue, Suite 301, Hialeah, Florida 33016, and Lee Sims Kniskern, Esquire, 100 Almeria Avenue, Suite 360, Coral Gables, Florida 33134-4635 and by interoffice delivery to Larry G. McPherson, Jr., Chief Medical Attorney, Department of Professional Regulation, Northwood Centre, 1940 North Monroe Street, Tallahassee, Florida 32399-0792, at or before 5:00 P.M., this 24th day of September, 1991.

DOROTHY J. FAIRCLOTH
Executive Director