State Medical Board of Ohio

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Columbus, Ohio 43215
(614) 466-3934
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September 13, 2023

Anthony D. Martin, M.D.
955 Proprietors Rd. Ste. B
Worthington, OH 43085-3196

RE: Case No. 21-CRF-0205

Dear Dr. Martin:

Please find enclosed a certified copy of the Findings, Order and Journal Entry approved and confirmed by the State Medical Board meeting in regular session on September 13, 2023.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Any such appeal must be filed in accordance with all requirements specified in Section 119.12, Ohio Revised Code, and must be filed with the State Medical Board of Ohio and the Franklin County Court of Common Pleas within (15) days after the date of mailing of this notice.

THE STATE MEDICAL BOARD OF OHIO

Kim G. Rothermel, M.D.
Secretary

KGR:jlm
Enclosures

CERTIFIED MAIL NO – 9414 8149 0315 2968 0306 67
RETURN RECEIPT REQUESTED

Mailed 9/14/2023

CERTIFICATION

I hereby certify that the attached copy of the Findings, Order and Journal Entry approved by the State Medical Board, meeting in regular session on September 13, 2023, constitutes a true and complete copy of the Findings, Order and Journal Entry in the Matter of Anthony Martin, M.D., Case No. 21-CRF-0205, as it appears in the Journal of the State Medical Board of Ohio.

This Certification is made by the authority of the State Medical Board of Ohio in its behalf.

Kim G. Rothermel, M.D.
Secretary

(SEAL)

September 13, 2023
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	:	
	:	Case No. 21-CRF-0205
ANTHONY MARTIN, M.D.	:	

FINDINGS, ORDER AND JOURNAL ENTRY

This matter came on for consideration before the State Medical Board of Ohio on September 13, 2023, pursuant to a Notice of Opportunity for Hearing issued to Anthony Martin, M.D. on November 10, 2021. No request for hearing having been received within the statutorily mandated time period, Hearing Examiner Ronda Shamansky, Esq., on behalf of the Board, reviewed and summarized evidence supporting the Notice, and prepared Proposed Findings and a Proposed Order.

WHEREFORE, having reviewed Ms. Shamansky's Proposed Findings and Proposed Order, which is attached hereto and incorporated herein, the Board hereby adopts the Proposed Findings and Proposed Order.

It is hereby ORDERED that:

A. **SUSPENSION OF LICENSE**: Commencing on the thirty-first day following the date on which this Order becomes effective, the license of Anthony Martin, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time.

B. **FINE**: Within thirty days of the effective date of this Order, Dr. Martin shall remit payment in full of a fine of three thousand five hundred dollars ($3,500.00). Such payment shall be made via credit card in the manner specified by the Board through its online portal, or by other manner as specified by the Board.

C. **CONDITIONS FOR REINSTATEMENT OR RESTORATION**: The Board shall not consider reinstatement or restoration of Dr. Martin's license to practice medicine and surgery until all of the following conditions have been met:

1. **Payment of Fine**: Dr. Martin shall have fully paid the fine as set forth in Paragraph B of this Order.

2. **Application for Reinstatement or Restoration**: Dr. Martin shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.

3. **Additional Evidence of Fitness To Resume Practice**: In the event that Dr. Martin has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

4. **Post-Licensure Assessment Program**: Prior to submitting his application for reinstatement or restoration, Dr. Martin shall have undergone an assessment and completed the recommended educational activities, as developed for Dr. Martin by the Post-Licensure Assessment System [PLAS] sponsored by the Federation of State Medical Boards and the National Board of Medical Examiners, concerning the area of psychiatry. Dr. Martin's participation in the PLAS shall be at his own expense.

   a. Prior to the initial assessment by the PLAS, Dr. Martin shall furnish the PLAS copies of the Board's Order, including the Summary of the Evidence, Findings of Fact, and Conclusions of Law, and any other documentation from the hearing record that the Board may deem appropriate or helpful to that assessment.

   b. Should the PLAS request patient records maintained by Dr. Martin, Dr. Martin shall furnish copies of the patient records at issue in this matter along with any other patient records he submits. Dr. Martin shall further ensure that the PLAS maintains patient confidentiality in accordance with Section 4731.22(F)(5), Ohio Revised Code.

   c. Dr. Martin shall ensure that the written Assessment Report by the PLAS includes the following:

      - A detailed plan of recommended practice limitations, if any;
      - Any recommended education;
      - Any recommended mentorship or preceptorship;
      - Any reports upon which the recommendation is based, including reports of physical examination and psychological or other testing.

      Moreover, Dr. Martin shall ensure that, within 14 days of its completion, the written Assessment Report by the PLAS is submitted to the Board.

   d. Any Learning Plan recommended by the PLAS shall have been developed subsequent to the issuance of a written Assessment Report, based on an assessment and evaluation of Dr. Martin by the PLAS. Dr. Martin shall successfully complete the educational activities as recommended in the Learning Plan, including any final assessment or evaluation.

e. At the time he submits his application for reinstatement or restoration, Dr. Martin shall submit to the Board satisfactory documentation from the PLAS indicating that he has successfully completed the recommended educational activities.

5. **Medical Records Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Martin shall provide acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Martin submits the documentation of successful completion of the course(s) on maintaining adequate and appropriate medical records, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

6. **Controlled Substances Prescribing Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Martin shall provide acceptable documentation of successful completion of a course or courses dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Martin submits the documentation of successful completion of the course(s) dealing with the prescribing of controlled substances, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

D. **PROBATION**: Upon reinstatement or restoration, Dr. Martin's license shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least two years:

1. **Modification of Terms**: Dr. Martin shall not request modification of the terms, conditions, or limitations of probation for at least one year after imposition of these probationary terms, conditions, and limitations.

2. **Obey the Law**: Dr. Martin shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

3. **Declarations of Compliance**: Dr. Martin shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which Dr. Martin's license is restored or reinstated. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

4. **Personal Appearances**: Dr. Martin shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which Dr. Martin's license is restored or reinstated, or as otherwise directed by the Board. Subsequent personal appearances shall occur as otherwise directed by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

5. **Post-Licensure Assessment Program**: Dr. Martin shall practice in accordance with the Learning Plan developed by the PLAS, unless otherwise determined by the Board. Dr. Martin shall cause to be submitted to the Board quarterly declarations from the PLAS documenting Dr. Martin's continued compliance with the Learning Plan.

   Dr. Martin shall obtain the Board's prior approval for any deviation from the Learning Plan.

   If, in a manner not authorized by the Board, Dr. Martin fails to comply with the Learning Plan, Dr. Martin shall cease practicing medicine and surgery beginning the day following Dr. Martin's receiving notice from the Board of such violation and shall refrain from practicing until the PLAS provides written notification to the Board that Dr. Martin has reestablished compliance with the Learning Plan. Practice during the period of noncompliance shall be considered practicing medicine without a license, in violation of Section 4731.41, Ohio Revised Code.

6. **Practice Plan and Monitoring Physician**: Within 30 days of the date of Dr. Martin's reinstatement or restoration, or as otherwise determined by the Board, Dr. Martin shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Martin's activities will be directly supervised and overseen by a monitoring physician approved by the Board. The practice plan shall, as determined by the Board, reflect, but not be limited to, the PLAS Learning Plan. Dr. Martin shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

At the time Dr. Martin submits his practice plan, he shall also submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Martin and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Martin and his medical practice, and shall review Dr. Martin's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Martin and his medical practice, and on the review of Dr. Martin's patient charts. Dr. Martin shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Martin's declarations of compliance.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Martin shall immediately so notify the Board in writing. In addition, Dr. Martin shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Martin shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Martin's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Martin's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

7. **Required Reporting of Change of Address**: Dr. Martin shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

8. **Tolling of Probationary Period While Out of Compliance**: In the event Dr. Martin is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

E. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Martin's license will be fully restored.

F. **VIOLATION OF THE TERMS OF THIS ORDER**: If Dr. Martin violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his license.

G. **REQUIRED REPORTING TO THIRD PARTIES; VERIFICATION**:

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Martin shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training, and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Martin shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments.

   In the event that Dr. Martin provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.

   Further, within 30 days of the date of each such notification, Dr. Martin shall provide documentation acceptable to the Secretary and Supervising Member of the Board demonstrating that the required notification has occurred.

   This requirement shall continue until Dr. Martin receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Martin shall provide a copy of this Order by certified mail to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Administration, through which he currently holds any professional license or certificate. Also, Dr. Martin shall provide a copy of this Order by certified mail at the time of application to the proper licensing authority of any state or jurisdiction in which he applies

for any professional license or reinstatement/restoration of any professional license.

Additionally, within 30 days of the effective date of this Order, Dr. Martin shall provide a copy of this Order to any specialty or subspecialty board of the American Board of Medical Specialties or the American Osteopathic Association Bureau of Osteopathic Specialists under which he currently holds or has previously held certification.

Further, within 30 days of the date of each such notification, Dr. Martin shall provide documentation acceptable to the Secretary and Supervising Member of the Board demonstrating that the required notification has occurred.

This requirement shall continue until Dr. Martin receives from the Board written notification of the successful completion of his probation.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

Kim G. Rothermel, M.D.
Secretary

(SEAL)

September 13, 2023
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of	*	
		Case No. 21-CRF-0205
Anthony Martin, M.D.,	*	
		Hearing Examiner Shamansky
Respondent.	*	

AMENDED PROPOSED FINDINGS AND PROPOSED ORDER
(On Remand)

Basis for Action

Notice of Opportunity for Hearing ("Notice"): By letter dated November 10, 2021, the State Medical Board of Ohio ("Board") notified Anthony Martin, M.D., of its proposal to consider disciplinary action against his license to practice medicine and surgery in Ohio.

In the Notice, the Board alleged that during the time period from in or around July 2012 to in or around October 2018, Dr. Martin inappropriately treated and/or failed to appropriately treat; and/or failed to appropriately document his treatment; and/or departed from minimal standards of care for similar practitioners under the same or similar circumstances in his care of Patients 1 through 8, identified in a confidential patient key. The Board provided detailed examples of Dr. Martin's treatment of each of the eight patients, in support of its allegations.

The Board alleged that Dr. Martin's conduct constituted "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Ohio Revised Code Section ("R.C.") 4731.22(B)(6), as well as "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as that clause is used in R.C. 4731.22(B)(2).

The Board also notified Dr. Martin that, pursuant to R.C. 4731.225, it may impose a civil penalty for any violations that occurred after September 29, 2015 in an amount not to exceed twenty thousand dollars, in addition to any other action the Board may take under R.C. 4731.22.

The Board advised Dr. Martin of his right to a hearing in this matter if he requested one in writing within 30 days of the mailing of the Notice. (Exhibit 1.A)

No Timely Request for Hearing: On November 12, 2021, the Board mailed its Notice by certified mail, return receipt requested, to Dr. Martin at his address of record, 955 Proprietors Road, Suite B, Worthington, OH 43085-3193.

The Board received delivery confirmation from the U.S. Postal Service that the letter sent by certified mail to Dr. Martin at his address of record was successfully delivered on November 15, 2021.

Pursuant to R.C. 119.07, Dr. Martin had thirty days in which to submit a written request for a hearing. The thirtieth and final day upon which Dr. Martin could submit a written hearing request was Monday, December 13, 2021. The Board's Chief Legal Counsel attested in a sworn affidavit dated August 8, 2023, that the Board received a letter from Dr. Martin on December 28, 2021 requesting a hearing, but that the request was untimely. The Board responded to Dr. Martin's request on December 30, 2021, notifying him that because of the untimely nature of his request, the Board could not grant him a hearing. (Exhibits 1, 1.A, 1.B, 1.C) At its meeting on July 12, 2023, the Board voted to remand this matter back to the Hearing Examiner in order to correct the Proposed Finding to show that Dr. Martin did request a hearing, but that it was untimely.

The Board's Director of Licensure and Licensee Services verified in an affidavit dated January 5, 2022 that Dr. Martin's address of record at the time was 955 Proprietors Road, Suite B, Worthington, OH 43085. He further attested that Dr. Martin was issued license number 35.061371 on or about March 21, 1991, and that his license at that time was currently active.[1] (Exhibit 2)

Request for Proposed Findings and Proposed Order: In a memorandum dated August 9, 2023, the Board's Assistant Legal Counsel requested that a Hearing Examiner review the evidence as provided, and prepare a report of Proposed Findings and Proposed Order. (Exhibit 5)

Evidence Examined:

Exhibit 1: August 8, 2023 Affidavit of Kimberly Anderson, the Board's Chief Legal Counsel, attesting to the Board's service of the November 10, 2021 Notice of Opportunity for Hearing upon Dr. Martin and verifying that the Board did not receive a timely hearing request from Dr. Martin.

Exhibit 1.A: Certified copy of the November 10, 2021 Notice of Opportunity for Hearing issued to Dr. Martin alleging that his treatment of Patients 1 through 8 fell below the minimum standard of care.

Exhibit 1.B: Delivery confirmation from the U.S. Postal Service showing that the letter sent by certified mail to Dr. Martin's address of record was delivered on November 15, 2021.

[1] The Board's licensure records indicate that Dr. Martin renewed his license effective June 24, 2022, and that it remains active through July 1, 2024. (www.elicense.ohio.gov, accessed March 14, 2023.)

Exhibit 1.C: Copy of Dr. Martin's December 28, 2021 letter containing an untimely request for a hearing and the Board's December 30, 2021response.

Exhibit 2: January 5, 2022 Affidavit of Joseph Turek, the Board's Director of Licensure and Licensee Services, verifying that Dr. Martin's address of record is 955 Proprietors Road, Suite B, Worthington, OH 43085, and that his license is currently active.

Exhibit 3: February 8, 2022 Affidavit of Timothy Norris, the Board's Enforcement Attorney, attesting to the Board's investigation of the complaint against Dr. Martin, and attaching a flash drive containing the eight patient records and expert reports obtained during the investigation:

Exhibit 3.A: Certification that the accompanying flash drive contains the expert reports and the associated patient records for the patients identified as Patient 1 through Patient 8, and that they were complete and accurate. **(SEALED)**

Exhibit 4: February 16, 2022 certification from Kimberly Anderson, the Board's Chief Legal Counsel, attesting that the November 10, 2021 Notice of Opportunity for Hearing with confidential patient key is a true and complete copy as it appears in the records of the Board. **(SEALED)**

Exhibit 5: August 9, 2023 memorandum from Colin De Pew, Assistant Legal Counsel for the Board, attaching the above-referenced exhibits and requesting the preparation of Proposed Findings and a Proposed Order.

PROPOSED FINDINGS

1. During the time period from in or around July 2012 to in or around October 2018, Dr. Martin provided care in the routine course of his practice to Patients 1 through 8. He inappropriately treated and/or failed to appropriately treat; and/or failed to appropriately document his treatment of those patients, and/or departed from the minimal standards of care for similar practitioners under the same or similar circumstances, which included:

   - Inappropriate and/or excessive prescribing;
   - Inappropriate and/or inadequate monitoring of patients' medications, and inappropriate and/or inadequate management of patients' conditions;
   - A failure to appropriately and/or adequately explain or justify the reason(s) he prescribed the medications chosen and/or escalated the doses prescribed, and/or a failure to adequately document the same, especially for patients who were prescribed stimulants on a long-term basis; and/or
   - A failure to obtain or effectively document consent by patients and the parents of child patients when prescribing high dose stimulants.

This proposed finding is supported by the following evidence: Exhibits 3, 3.A.

2. Dr. Martin treated Patient 1 (AA), a five-year-old child, from on or about February 2014 through at least November 2016 for attention deficit hyperactivity disorder, for which he prescribed numerous medications including Vyvanse, Adderall, clonidine, mirtazapine, Celexa, and Trazodone. He prescribed a maximum daily dose of Vyvanse alongside a dose of Adderall, without appropriately documenting risk/benefit consent with the child's parent.

The records show that Dr. Martin practiced as a psychiatrist with Central Ohio Counseling, Inc., and was designated in the practice's records as "TMAR." Dr. Martin began seeing Patient 1 in February 2014 when the patient was almost five years old and weighed about 40 pounds. The notes of Dr. Martin's initial psychiatric evaluation on February 12, 2014 stated that the patient had previously been diagnosed with ADHD by a psychologist and was attending a special pre-kindergarten program for children with behavioral issues. Dr. Martin noted that Patient 1's pediatrician had put him on Risperdal, but he asked that the patient be titrated off that medication, reasoning that it is a dopamine blocker that would interfere with stimulants and mask his hyperactivity. Instead, he prescribed Clonidine 0.1 mg. for hyperactivity management and insomnia, making findings that Patient 1 met the criteria for ADHD and also diagnosing Oppositional Defiant Disorder ("ODD"). In the notes of the initial assessment, Dr. Martin noted that he discussed the medication's risks, benefits, and alternatives, and obtained informed consent. (Ex. 3.A, Chart of Patient 1 at 22-23, 87-88)

The chart includes a note that Patient 1's mother called on February 24, 2014 to say that her child had been "horrible" since discontinuing his Risperdal, and that she was giving him the Clonidine, but did not want to overmedicate him and make him "dopey." (Ex. 3.A, Chart of Patient 1 at 16) In response, Dr. Martin wrote another prescription for Clonidine 0.1 mg. on February 11, 2014, and wrote prescriptions for Vyvanse 30 mg. and Clonidine 0.1 mg. when he saw the patient again on February 25, 2014. (Ex. 3.A, Chart of Patient 1 at 90-91)

On February 26, 2014, Dr. Martin completed an Ohio Medicaid Managed Care Pre-Authorization Request, asking for approval of Vyvanse 30 mg. for Patient 1, and when asked to describe previous treatments and outcomes, Dr. Martin wrote, "Adderall XR - Failed." Shortly thereafter, the medication was approved for one year, from February 26, 2014 through February 26, 2015. (Ex. 3.A, Chart of Patient 1 at 10, 15) When he saw the child again a month later on March 24, 2014, he wrote prescriptions for Vyvanse 20 mg. and generic Adderall 10 mg. There is no legible rationale in the chart for the change in the patient's medications, nor of a discussion of the risks, benefits, and alternatives to those medications. (Ex. 3.A, Chart of Patient 1 at 85-86)

Dr. Martin continued prescribing Vyvanse 20 mg., as well as generic Adderall 10 mg., for Patient 1 for several months, and added a prescription for Celexa 20 mg. in September

2014 along with the other medications. This pattern continued, with the patient being seen every eight weeks, through November 12, 2014, when the Vyvanse was increased to 30 mg. The patient's weight was still noted as 40 pounds at the November 12, 2014 office visit, but there are no other exam findings noted, and no rationale documented for the change, nor a discussion of the change with the patient's mother. However, the notes of the next appointment in January 2015 noted that 30 mg. of Vyvanse worked better. (Ex. 3.A, Chart of Patient 1 at 35-36, 76-85)

Dr. Martin continued prescribing the Vyvanse 30 mg., generic Adderall 10 mg., and Clonodine 0.1 mg. from January 2015 through May 3, 2016, along with Celexa 20 mg. and trazodone 50 mg. ½ tablet at bedtime, after his sleep was noted to be worse. (Ex. 3.A, Chart of Patient 1 at 63-75) When the child's mother reported more violent and erratic behavior, Dr. Martin discontinued trazodone, and added mirtazapine 7.5 mg. at an office visit on June 28, 2016. He also continued prescribing Vyvanse 30 mg., generic Adderall 10 mg., and clonidine 0.1 mg. (Ex. 3.A, Chart of Patient 1 at 59-62) Some of Dr. Martin's office visit notes are left blank in the area for the date of the visit, and some of them are not in chronological order in the patient's chart. There are three separate undated progress notes that list trazodone among Patient 1's prescriptions around the time of the May 2016 note, but because they are not dated, it is difficult to tell if Patient 1 began taking trazodone earlier than May 3, 2016. The notes are also handwritten and difficult to read. (Ex. 3.A, Chart of Patient 1 at 51-53)

Those prescriptions continued through September 20, 2016, at an appointment in which his ADHD symptoms were noted to be better, but his ODD symptoms were worse, and he was sleeping less than 6 hours a night. No exam findings were noted at that appointment, but Dr. Martin again wrote prescriptions for Vyvanse 30 mg. and generic Adderall 10 mg., and renewed prescriptions for mirtazapine 7.5 mg. and clonidine 0.1 mg. with one year of refills. For the Vyvanse and Adderall prescriptions, Dr. Martin's chart shows that he typically saw the patient every 8 weeks, and gave his mother two prescriptions each for the Vyvanse and Adderall, each for 30 days, with a note on one of them not to fill it until a specified date about one month from the date it was written. (Ex. 3.A, Chart of Patient 1 at 57-61)

The State's expert, Philipp Dines, M.D., Ph.D., summarized Dr. Martin's care of Patient 1 as follows:

> This is a case of treatment of a difficult five-year-old child with behavioral disturbance. [Patient 1] was initially treated by Dr. Martin on 2-12-2014, and his last treatment date in the patient record provided was 11-12-2016. Diagnostic differential would include attention hyperactivity disorder and or mood and or psychotic disorder as well as cognitive evaluation. This is of course a challenging case and the child was initially treated by pediatrics with an antipsychotic, risperidone. A scale driven concrete limited diagnostic approach was used by Dr. AM and high dose

> amphetamines were the principal treatment involving combining Vyvanse at maximum dose with Adderall. This was supplemented with the blood pressure medication clonidine as well as antidepressants. Risk benefit consent with the parent is not clearly documented nor are there further reasoning as to possible consideration for substantial mood or psychotic disorders. A challenging case was managed in a rote manner with limited evidence of further diagnostic understanding of the probable complexity of the case. Interestingly, the parent initiated the request for psychological assessment and treatment expanding this management appropriately beyond simple rote medication management.

(Ex. 3.1A, Expert report, Patient AA at 1)

Dr. Dines concluded in his expert report that Dr. Martin's prescribing in this case did not meet the minimum standard of care:

> The management of this case [fell] below the standard of care for management of severe behavioral disturbance in a five year old child case.
>
> The prescribing of a maximum dose of Vyvanse combined with Adderall constituted a failure to maintain minimal standards applicable to the selection or administration of drugs in violation of O.R.C. 4731.22(B)(2). Clinical notes are skeletal and duplicative with documentation of limited analysis mostly based on use of scales. High dose amphetamine treatment with no clear discussion of risk benefit with parents in this child case. In this case
>
> Vyvanse(lisdexamfetamine) is prescribed at maximum recommended dose of 30 mg daily and then combined with Adderall 10 mg daily. These medications were further supplemented with substantial doses of clonidine (an adrenergic blocker) which also lowers blood pressure and low dose mirtazapine. The treatment supplementation was then changed to adding Celexa and Trazodone replacing mirtazapine but continuing clonidine. The child's mother wrote note seeking psychology referral for child psychotherapy.
>
> The treatment of [Patient 1] constituted a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, in violation of O.R.C. 4731.22(B)(6). A high dose of amphetamines and multiple medications increased the risk of adverse effects in {Patient 1], in the context of limited diagnostic analysis and no apparent indication of risk benefit consent process completed. The patient's mother had to seek supplemental treatment for [Patient 1's] condition.

(Expert Report, Patient AA at 1-2)

This proposed finding is supported by the following evidence: Exhibits 3, 3.A.

3. Dr. Martin treated Patient 2 (AB) from on or about July 2012 through at least October 2018 for attention deficit hyperactivity disorder. He did not document an appropriate effort related to consideration of differential diagnoses. He prescribed 120 mg. daily of Vyvanse as well as 30 mg. of Adderall, when the maximum dose of Vyvanse is 70 mg. This put Patient 2 at high risk for adverse side effects. No non-amphetamine-based treatment efforts are documented, nor is effective consent documented after fully informing the patient of the risks of taking high doses of amphetamines.

Patient 2 was 27 years old when he began seeing Dr. Martin in July 2012, and the initial psychiatric evaluation found that he met the criteria for ADHD combined type. Dr. Martin noted that Patient 2 had a lifelong history of ADHD, and that he was first medicated with stimulants in 2005. (Ex. 3.A, Chart of Patient 2 at 5, 11, 115-117, 119-120) The patient was a CPA who was referred to Dr. Martin after moving to Central Ohio from another Ohio city. On his patient questionnaire, he noted only positive symptoms, including for the questions that asked about his concentration, checking an option that indicated, "I can concentrate as well as ever." (Ex. 3.A, Chart of Patient 2 at 119-120, 123, 129)

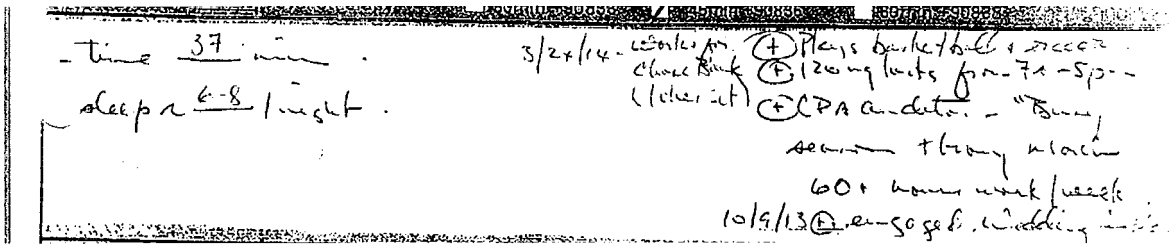
The patient was taking Vyvanse and Adderall at that time, and the notes of his first consultation state that he asked for an increase in his Vyvanse to 120 mg., and Dr. Martin noted, "ok." (Ex. 3.A, Chart of Patient 2 at 116) The notes of the initial visit state that Dr. Martin planned to continue the generic Adderall at 30 mg., along with the Vyvanse, as well as mirtazapine 7.5 mg. for insomnia. His office visit note for that date indicates that he discussed the risks, benefits, and alternatives of those medications and obtained informed consent. (Ex. 3.A, Chart of Patient 2 at 5, 11, 115-117) At that first visit, Dr. Martin wrote prescriptions for Vyvanse 60 mg., to be taken twice a day, as well as generic Adderall 30 mg. and mirtazapine 7.5 mg., 30 tablets each. (Ex. 3.A, Chart of Patient 2 at 121)

At Patient 2's next appointment on August 14, 2012, he reported that he was doing better on the higher dose of Vyvanse, which lasted from 5:45 a.m. to 2:00 p.m. Dr. Martin noted that the patient "asked for higher dose," but added, "I said no." (Ex. 3.A, Chart of Patient 2 at 113)

A month later in September 2012, Dr. Martin lowered the dose of generic Adderall to 20 mg. per day and wrote a script for that dosage, along with the Vyvanse 60 mg. to be taken twice a day. The notes of that appointment are limited, but indicate that the Vyvanse lasted from 7 a.m. to 5 p.m. and that the patient had gotten a promotion. No other rationale for the medication change is noted, nor any discussion of risks, benefits and alternatives. Dr. Martin continued the patient on a daily dose of 120 mg. of Vyvanse and generic Adderall 20 mg, writing two prescriptions for each, one of which was to be filled in October 2012

for each drug. (Ex. 3.A, Chart of Patient 2 at 111-112) When Dr. Martin saw Patient 3 eight weeks later on November 12, 2012, the patient requested an increase to 30 mg. of generic Adderall, with Dr. Martin noting that the patient said he "had a lot of work to do." (Ex. 3.A, Chart of Patient 2 at 109) Dr. Martin acquiesced and wrote prescriptions for Vyvanse 60 mg. taken twice a day, and generic Adderall, 30 mg. once a day, giving the patient two prescriptions for each medication, one to be filled the following month. (Ex. 3.A, Chart of Patient 2 at 110) There is no rationale noted in the progress notes for the increase in dosage, and very sparse notes of the patient's reaction to the medications, noting only that he was "Doing ok." (Ex. 3.A, Chart of Patient 2 at 109)

Dr. Martin continued prescribing Vyvanse 60 mg. taken twice a day, as well as generic Adderall 30 mg. taken once a day, for Patient 2 for more than five years, from January 2013 through October 8, 2018. During this time, he was seeing the patient every eight weeks, and giving him two months' worth of prescriptions for his medications at each visit, noting on the prescription the earliest date when each script could be filled. (Ex. 3.A, Chart of Patient 2 at 30-108) During this time, Dr. Martin changed the format of his notes for patient visits, changing from the "Physician Progress Notes for Medication" format to a format that resembled a billing format. (e.g., Ex. 3.A, Chart of Patient 2 at 93) The notes of the visits in that five-year timespan continued to be generally sparse, and except for the hours of sleep that the patient reported getting and the time the doctor spent with the patient, they appear to be the same progress notes copied from one visit to the next, as shown below:



(Ex. 3, Chart of Patient 2 at 34)

Even as of the April 2018 appointment, the progress notes still showed that Patient 2 had become engaged on 10/9/13 and a wedding was planned for May. (Ex. 3.A, Chart of Patient 2 at 36)

Several times during the course of Patient 2's treatment, insurers wrote to Dr. Martin asking for an explanation of his prescribing Vyvanse at a high dosage for this patient. In January 2015, Express Scripts notified Dr. Martin that his prior authorization for Vyvanse for Patient 2 had been approved for a two-year period, from December 21, 2014 through January 20, 2016. (Ex. 3.A, Chart of Patient 2 at 3) In January 2017, Express Scripts again required a pre-authorization for this medication, showing the following prescriptions that Dr. Martin had written for Patient 2 in the latter half of 2016:

Pharmacy Claims

Consideration	Date of Service	Drug Description	Strength	Qty	Days Supply	Prescriber	Pharmacy Name Phone Number
1	11 13 16	VYVANSE	60 MG	60	30	MARTIN, ANTHONY	CVS #06411 614.326.1288
1	10 17 16	VYVANSE	60 MG	60	30	MARTIN, ANTHONY	CVS #06411 614.326.1288
1	09 20 16	VYVANSE	60 MG	60	30	MARTIN, ANTHONY	CVS #06411 614.326.1288
1	08 24 16	VYVANSE	60 MG	60	30	MARTIN, ANTHONY	CVS #06411 614.326.1288
1	07 28 16	VYVANSE	60 MG	60	30	MARTIN, ANTHONY	CVS #06411 614.326.1288
1	07 01 16	VYVANSE	60 MG	60	30	MARTIN, ANTHONY	CVS #06411 614.326.1288
1	06 03 16	VYVANSE	60 MG	60	30	MARTIN, ANTHONY	CVS #06411 614.326.1288

(Ex. 3.A, Chart of Patient 2 at 7)

The letter from Express Scripts included the following statement that the dose prescribed for Patient 2 may have exceeded recommendations:

Safety and Health Consideration for Your Review

1. **Dosing Consideration: VYVANSE**

   Our claims record suggests that your patient is receiving VYVANSE at a dose that may exceed recommendations. Please consider the potential risks versus benefits for your patient and determine if changes in therapy are warranted.

   Reference(s):

   1. Vyvanse (lisdexamfetamine dimesylate) prescribing information. Shire US Inc. Lexington, MA; October 2016. http://www.accessdata.fda.gov/drugsatfda_docs/label/2016/021977s041s042lbl.pdf

(Ex. 3.A, Chart of Patient 2 at 7)

In response, on January 31, 2017, Dr. Martin faxed back a statement, confirming that the Vyvanse was not being used for a binge eating disorder, and explaining his rationale for continuing to prescribe 120 mg. of Vyvanse daily for Patient 2. (Ex. 3.A, Chart of Patient 2 at 9-10) That rationale stated:

> ADHD Combined Presentation F90.2. Other medications such as Ritalin and Adderall XR are too short acting and cause instability of meds. He has been doing well on this since 07/17/12. Please approve for multiple years.

(Ex. 3.A, Chart of Patient 2 at 9)

The State's expert, Philipp Dines, M.D., Ph.D., summarized Dr. Martin's care of Patient 2 as follows:

> I reviewed Dr. Anthony Martin's treatment of [Patient 2] which began on 7-7-2012, and continued through 10-8-2018. Dr. Martin upon the initial evaluation of [Patient 2] used scales to diagnose ADHD. The overall evaluation was lacking in detail relative to other possible diagnoses including bipolar disorder or related mood disorders. It was stated that this patient does not manifest mood disturbances, however, there was no further detailed report or analysis of the patient where by the diagnosis of ADHD was established or differentiated from other possible or overlapping diagnostic possibilities. Follow up progress notes are virtual duplicates throughout the term of service with almost no significant information about the clinical understanding or care of the patient.
>
> Dr. Anthony Martin treated [Patient 2] with doses of Vyvanse at almost double the maximum recommended dose at 120 mg when the recommended maximum is 70 mg daily. In addition, Dr. Anthony Martin prescribed 30 mg of Adderall additionally daily. These are prescribed treatments at very high levels above the recommended maximum for amphetamine treatment per day putting the patient [at] high risk for side effects. Risks involved and in particular at significantly higher doses were also not documented to have been explained in an appropriate consent process with the patient. In addition, treatment alternatives with other non-amphetamine alternatives were not documented to have occurred.

(Ex. 3.A, Expert Report of Patient AB at 1)

Dr. Dines concluded in his expert report that Dr. Martin's prescribing in this case did not meet the minimum standard of care:

> The treatment of [Patient 2] with 120 mg of Vyvanse and 30 mg of Adderall constituted a failure to maintain minimal standards applicable to the selection or administration of drugs in violation of O.R.C. 4731.22(B)(2). These high dose amphetamines put the patient at high risk for severe side effects, with no discussion of the high risk documented in order to demonstrate the patient's consent. No non-amphetamine treatment alternatives were documented to have occurred.
>
> The treatment of the [Patient 2] constituted a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, in violation of O.R.C. 4731.22(B)(6). There was no differential diagnosis that would rule out other possible or overlapping diagnostic possibilities, such as bipolar disorder or mood

> disorder. Follow up appointments were mostly duplicative and lacked a continued effort to gain more clinical understanding of the patient or his response to treatment.

(Ex. 3.A, Expert Report of Patient AB at 1-2)

This proposed finding is supported by the following evidence: Exhibits 3, 3.A.

4. Dr. Martin treated Patient 3 (A.D.) from on or about January 2013 through at least October 2018 for attention deficit hyperactivity disorder and social phobia. He prescribed amphetamines Vyvanse at 70 mg. per day, the maximum dosage, and Adderall at 30 mg. per day, and he failed to document consent regarding risk/benefit of high doses of amphetamines and failed to document an appropriate patient-specific pharmacological assessment.

   Patient 3 was a 20-year old restaurant worker when he began seeing Dr. Martin in May 2011. At that time, he was taking Dexedrine XR 15 mg and Dextrostat 10 mg. He noted on his intake form that he was also a college student with "80+ credits," and when he completed a symptom questionnaire, Patient 3 noted no negative symptoms, even in his responses to questions about concentration. Dr. Martin found that this patient met the criteria for ADHD and prescribed 30 tablets of Vyvanse 60 mg., along with 30 tablets of mirtazapine 15 mg., instructing him to discontinue the Dexedrine and Dextrostat and titrate up to the 60 mg. dose of Vyvanse within two days. (Ex. 3.A, Chart of Patient 3 at 171-178)

   When Patient 3 returned two weeks later, he reported to Dr. Martin that he "liked the smoothness" of Vyvanse, and that it lasted from 8 a.m. until 3 or 4 p.m. Dr. Martin wrote a 90-day prescription for Vyvanse at an increased dose of 70 mg. daily and scheduled him for a follow-up appointment in eight weeks. (Ex. 3.A, Chart of Patient 3 at 171-172) When the patient returned on July 5, 2011, he reported that he was "better on 70 mg." and Dr. Martin issued another 90-day script for Vyvanse 70 mg., in the form of three separate prescriptions, each for a different month. On October 24, 2011, the patient reported that he was studying late at night, so Dr. Martin augmented his Vyvanse 70 mg. with a prescription for generic Adderall 20 mg. (Ex. 3.A, Chart of Patient 3 at 164-166)

   In May 2012, the patient reported that the generic Adderall was "not strong enough," so Dr. Martin increased his dose to 30 mg., in conjunction with the prescription for Vyvanse 70 mg., noting that the patient asked for 90-day scripts. (Ex. 3.A, Chart of Patient 3 at 158-159)

   Patient 3 continued seeing Dr. Martin about every two months, and Dr. Martin continued prescribing Vyvanse for him, with only sparse progress notes which did not document any change in his condition or discussion of the risks and benefits of the medications. Although his weight was noted on most of the progress notes, vital signs and physical exam findings were usually absent.

Beginning in January 2013, there was a change in Dr. Martin's office visit notes. Rather than using the Physician Progress Notes for Medication form that he had previously used, the office visit notes began to look more like billing statements. (Ex. 3.A, Chart of Patient 3 at 151)

In April 2013, Patient 3 requested 90-day scripts, and asked if those could be picked up from the office. In an email dated April 16, 2013 to Dr. Martin, the patient reasoned that he was being seen only for five-minute appointments, and being able to pick up 90 days' worth of his prescriptions at a time would save him the extra co-pays:

> With all due respect, I would much appreciate if it could be made available for me to pick up, if possible, because I would prefer not to have to pay another $25 co-pay, when I already have appointments every two months and for most of them I am only there for five minutes.

(Ex. 3.A, Chart of Patient 3 at 16)

From March 2013 through December 2018, Dr. Martin was seeing Patient 3 about every eight or twelve weeks, and consistently writing 90-day scripts for Vyvanse 70 mg. and Adderall 30 mg. Typically, Dr. Martin would give the patient two or three scripts for each medication, with an instruction to the pharmacy not to fill the successive scripts until one month or two months later. This pattern of Dr. Martin seeing the patient about every two months and writing the same 90-day scripts for Vyvanse 70 mg. and generic Adderall 30 mg. continued for more than five years, through December 2018. (Ex. 3.A, Chart of Patient 3 at 84-149)

Several times during that span, Patient 3's insurance company, United Healthcare, questioned the continued prescribing of Vyvanse, and each time, Dr. Martin provided justification that resulted in the medication being authorized for an additional year. This began in January 2014, when the insurer conducted an audit and found the prescribing unusual, and repeated in May 2014 and March 2016. (Ex. 3.A, Chart of Patient 3 at 24, 41, 52, 58) A few years later, on August 16, 2018, the Kroger pharmacy rejected a Vyvanse prescription for a "pack size" of 100 on the basis of a "Drug-Diagnosis Mismatch," noting that prior authorization would be needed. (Ex. 3.A, Chart of Patient 3 at 24)

United Healthcare again wrote to Dr. Martin in August 2018, asking him for more information about his prescribing for Patient 3, in order to authorize continued approval of the Vyvanse. ((Ex. 3.A, Chart of Patient 3 at 58-64) Dr. Martin responded, offering the following list of previous medication trials for this patient:

Section D – Previous Medication Trials				
Medication Name	**Strength**	**Directions**	**Dates of Therapy**	**Reason for failure / discontinuation**
RITALIN	20MG	twice daily	take twice daily	Caused mood instability
CONCERTA	36MG	ONCE AM.	It doesn't last long enough	
ADDERALL XR	30MG	one daily	D.d not	last long enough

(Ex. 3.A, Chart of Patient 3 at 64)

In his response to the insurance company, Dr. Martin explained that the other drugs were too short-acting, and asked that the insurance company approve Vyvanse for "multiple years:"

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives
OTHER MEDICATIONS SUCH AS RITALIN, CONCERTA, ADDERALL XR ECT.... WERE TOO SHORT ACTING AND CAUSED MOOD INSTABILITY. HE HAS BEEN DOING WELL ON THIS MEDICATION SINCE 05/24/2011. PLEASE APPROVE FOR MULTIPLE YEARS IF POSSIBLE.

(Ex. 3.A, Chart of Patient 3 at 64)

Dr. Martin continued the same pattern of prescribing of Vyvanse 70 mg. and generic Adderall 30 mg. through August 2018, with no substantial office visit notes other than the approvals of the medications and copies of the scripts in the patient's chart, and giving pre-authorizations for the medications when Patient 3's insurance company requested it. The most recent approval of Vyvanse by United Healthcare was in two letters dated August 17, 2018 and August 18, 2018, in which United Healthcare authorized both the Vyvanse and the generic Adderall through August 18, 2019. (Ex. 3.A, Chart of Patient 3 at 21-25)

The State's expert, Philipp Dines, M.D., Ph.D., summarized Dr. Martin's care of Patient 3 as follows:

> I reviewed the treatment of [Patient 3] by Dr. Martin, which began on 1-14-2013 and continued through the last date of treatment in the patient record, which was 10-29-2018. Dr. Martin diagnosed [Patient 3] with social phobia and ADHD. Dr. Martin prescribed Vyvanse 70 mg a day and added Adderall at 30 mg a day. There are documented appointments almost every month, sometimes twice monthly, although clinical notes are

> minimal, duplicative and do not reflect appropriate assessment. Clinical notes are generic and non-specific.

(Ex. 3.A, Expert Report of Patient A.D. at 1)

Dr. Dines concluded in his expert report that Dr. Martin's prescribing in this case did not meet the minimum standard of care:

> The prescribing of a maximum dose of Vyvanse at 70 mg combined with Adderall at 30 mg constituted a failure to maintain minimal standards applicable to the selection or administration of drugs in violation of O.R.C. 4731.22(B)(2). A.D. was placed on the maximum dose of Vyvanse and the addition of Adderall meant the patient was exposed to elevated doses of total amphetamine per day beyond recommended daily dosages.
>
> The treatment of [Patient 3] constituted a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, in violation of O.R.C. 4731.22(B)(6). There is a failure to maintain minimal standards of care with regard to the pharmacological management of ADHD with amphetamines, consent and clinical documented care. Proper consent and weighing of risks versus benefits is not reflected as being executed with the patient in the clinical documentation.

(Ex. 3.A, Expert Report of Patient A.D. at 1)

This proposed finding is supported by the following evidence: Exhibits 3, 3.A.

5. Dr. Martin treated Patient 4 (E.L.) from on or about January 2013 through at least January 2017 for attention deficit hyperactivity disorder, post-traumatic stress disorder, panic disorder, and chronic depression. He treated Patient 4 with a high dose of multiple amphetamines, increasing to 50 mg. of Vyvanse twice daily and Adderall 30 mg. twice daily. He prescribed these doses without adequate documentation of clinical diagnostic analysis. He produced duplicative clinical notes visit to visit, without documenting how Patient 4 was managing these high doses. He prescribed two amphetamines concurrently, beyond recommended dosages.

   Patient 4 was a 49-year-old patient when she first saw Dr. Martin in July 2010. She related that she was first medicated at the age of 33 when she was having suicidal thoughts, and that she was seeking treatment for "ADD type symptoms" after her son was diagnosed with that disorder, and she realized she had the same symptoms. She also related that she had a history of a physically and sexually abusive relationship, and that she had been having panic attacks for about a month. Dr. Martin found that she met the criteria for ADHD combined type, and on July 21, 2010, he prescribed sertraline 100 mg., as well as Vyvanse

50 mg., which was to be titrated up over the course of one week to 1.5 tablets per day. In his scripts for Vyvanse, Dr. Martin authorized 60 capsules for the month of July 2010 and 60 capsules for the month of August 2010. (Ex. 3.A, Chart of Patient 4 at 138-147) Dr. Martin continued prescribing Vyvanse at 50 mg. twice a day, and added generic Adderall 30 mg. in October 2010, authorizing 60 capsules of Vyvanse and 30 Adderall tablets in each prescription. (Ex. 3.A, Chart of Patient 4 at 100-136)

In December 2012, Dr. Martin changed Patient 4's dose of Vyvanse to 70 mg., but at a once-daily dose, instead of 50 mg. taken twice daily, and he increased the dose of generic Adderall to 30 mg. taken twice a day. The notes are extremely limited and do not show a rationale for the medication change, or a discussion of the risks, benefits, and alternatives with the patient. (Ex. 3.A, Chart of Patient 4 at 100-101)

In January 2013, the format of Dr. Martin's office visit notes changed. He stopped using the "Physician Progress Notes for Medication" form that he had previously used, and began using a form that looks more like a billing statement. Also at that visit, the patient told Dr. Martin that her divorce was final, and her records from that time on have a different last name than the one she had previously used. (Ex. 3.A, Chart of Patient 4 at 99)

Dr. Martin continued the pattern of seeing Patient 4 every two months and prescribing Vyvanse 70 mg., once a day, and generic Adderall 30 mg. twice a day, for her from January 2013 through March 2015, along with an occasional script for sertraline with one year of refills. (Ex. 3.A, Chart of Patient 4 at 67-99)

At an office visit on March 24, 2015, Dr. Martin began prescribing 90 days' worth of medications for Patient 4, giving her three separate prescriptions to be filled in successive months, and seeing her every 12 weeks. The prescriptions remained the same, for 70 mg. of Vyvanse taken once a day, and 30 mg. of generic Adderall, taken twice a day. There was no rationale for the change in frequency with which she was seen documented in the patient's chart. (Ex. 3.A, Chart of Patient 4 at 67-69)

Dr. Martin continued prescribing 70 mg. of Vyvanse once a day, and 30 mg. of generic Adderall, twice a day, for Patient 4 through January 2017, seeing her every three months and authorizing 90 days' worth of prescriptions at each visit. His notes during that time, were essentially copied from one visit to the next, with only minor details changed on occasion. There was also no discussion of the risks, benefits, or alternatives to the continued course of treatment documented in the progress notes. (Ex. 3.A, Chart of Patient 4 at 47-67)

The State's expert, Philipp Dines, M.D., Ph.D., summarized Dr. Martin's care of Patient 4 as follows:

> I reviewed Dr. Martin's care of [Patient 4] from the first recorded treatment date of 1-30-2013 through the last recorded treatment date of 1-

> 24-2017. [Patient 4] was treated for ADHD, PTSD, panic disorder, and chronic depression with high doses of amphetamines. Dr. Martin prescribed a combination of Vyvanse at maximum dose of 70 mg daily combined with Adderall at a dose of 30 mg daily. The antidepressant sertraline was also prescribed. Vyvanse was subsequently increase to 50 mg twice daily (100 mg total daily) with Adderall 30 mg twice daily (60 mg total daily) both at maximum doses.
>
> I did not find sufficient clinical documentation to justify excessively high doses of amphetamines prescribed beyond recommended limits. Consent is vaguely referenced with not details provided.
>
> [Patient 4] is subjected to very high doses of amphetamines with increased risk of adverse serious morbidity or mortality while clinical diagnostic differential documentation was very limited. Mood factors may have played a greater role than was addressed.

(Ex. 3.A, Expert report of Patient E.L. at 1)

Dr. Dines concluded in his expert report that Dr. Martin's prescribing in this case did not meet the minimum standard of care:

> Dr. Martin's prescribing of high dosages of Adderall (up to 60 mg) and Vyvanse (up to 100mg) to [Patient 4] constituted a failure to maintain minimal standards applicable to the selection or administration of drugs in violation of O.R.C. 4731.22(B)(2). [Patient 4] was exposed to increase risk of adverse effects secondary to very high dose of amphetamines while documentation of clinical diagnostic analysis is very limited with clinical notes duplicative from visit to visit.
>
> Dr. Martin's treatment of [Patient 4] constituted a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, in violation of O.R.C. 4731.22(B)(6). Clinical documentation was limited, and patient consent was described vaguely and without detail. [Patient 4] was subjected to very high doses of amphetamines with increased risk of adverse serious morbidity or mortality while clinical diagnostic differential documentation was very limited. Mood factors may have played a greater role than was addressed, and these mood factors could have been exacerbated by two maximum daily amounts of amphetamines.

(Ex. 3.A, Expert report of Patient E.L. at 2)

This proposed finding is supported by the following evidence: Exhibits 3, 3.A.

6. Dr. Martin treated Patient 5 (C.M.) from on or about April 2014 through at least October 2018. Patient 5 had a documented history of a mood disorder, including cyclothymia, depression, mood swings, and hypomania. Patient 5 had previously been prescribed Depakote. Dr. Martin prescribed amphetamines at high levels, up to 90 mg of Adderall per day, above the 60 mg per day recommended maximum dose. He failed to document an appropriate differential diagnosis to rule out a mood disorder, even though prescribing a high dose of amphetamines to a patient with a mood disorder would not be recommended. He failed to document appropriate consent regarding risk/benefit of high doses of amphetamines and failed to document appropriate management of the amphetamine regimen by the patient.

Patient 5 was 37 years old when he first saw Dr. Martin in or about March 2014. In the notes of his Initial Psychiatric Evaluation, Dr. Martin noted that the patient had a lifelong history of ADHD and Panic Disorder, and that he was first medicated for it at age 16. Dr. Martin concluded that Patient 5 had ADHD combined type, and prescribed generic Adderall 30 mg. for him, to be taken three times a day, and authorizing 90 pills in each of the next two months' prescriptions. (Ex. 3.A, Chart of Patient 5 at 98-106)

In June 2014, the Kroger Pharmacy rejected Dr. Martin's prescription for generic Adderall at a dosage of 90 mg. per day. A handwritten note on the rejection notice states that prior authorization is needed for more than two tablets a day. (Ex. 3.A, Chart of Patient 5 at 25) In July 2014, Buckeye Community Health Plan notified Dr. Martin that generic Adderall was not FDA approved to treat ADHD at the requested dose (90 mg/day):

MEDICATION REQUEST	
Date:	07/21/2014
Drug:	**AMPHETAMINE CAP 30MG ER**
Status:	**Unable to approve**
Tracking ID:	4677370
Reviewer:	J. Buckner - PharmD, Clinical Pharmacist
Notes:	Unable to approve amphetamine ER. Amphetamine ER is not FDA approved to treat ADHD at requested dose (90mg per day). The maximum daily dose of amphetamine ER is 60mg per day (per UpToDate). Per health plan guideline CP.PMN.53 (Off-Label Use), further consideration for off-labeled use must be supported by one major multi-site study or 3 smaller studies published in JAMA, NEJM, Lancet, or peer reviewed specialty medical journals. Articles must support the current accepted medical standards of the specified diagnosis/disease state. Please fax the relevant clinical data as specified above for further consideration of your request. Thank you.

Please notify your patient of this decision to facilitate timely use of the approved medication or use of preferred drug list alternatives. If you would like a copy of the criteria used in this decision, call 1-866-399-0928. If you are submitting further information for this request, please fax your response to US Script at 1-866-399-0929. Please reference the above Tracking ID number if submitting information on a separate page or include a copy of this letter with the submission.

PROVIDER OPTIONS

Request for Reconsideration. A prior authorization form may be sent to US Script, Inc. by fax to 1-866-399-0929 with additional, clinically relevant information.

Request a peer-to-peer review. Decisions cannot be overturned unless new and pertinent clinical information is provided. Call 1-866-399-0928, Monday - Friday, 10:00AM - 8:00PM EST.

(Ex. 3.A, Chart of Patient 5 at 19)

At an office visit on October 14, 2014, the patient was noted to be "doing well," and Dr. Martin wrote that the patient "agrees to try Vyvanse," but no reason was given for adding that medication to his regimen. He issued prescriptions that day for Vyvanse 70 mg. once a day, along with generic Adderall, 30 mg. taken only once a. (Ex. 3.A, Chart of Patient 5 at 92-93) However, at an appointment on December 3, 2014, Dr. Martin noted that Vyvanse had not been approved by insurance, so he was reverting to prescribing generic Adderall 30 mg. three times a day, and he issued two scripts that day for the next two months, authorizing 90 pills in each. (Ex. 3.A, Chart of Patient 5 at 90-91)

Dr. Martin wrote a prior authorization request for the Vyvanse, asking Buckeye Health to approve it, and writing that the patient had previously tried Adderall XR and failed. In his rationale for the request, Dr. Martin wrote, "Patient has been on this med/dosage since 10/14 & is stable & doing well. Is able to focus without difficulty on this medication." (Ex. 3.A, Chart of Patient 5 at 6) Despite his request for prior authorization, in December 2014, Dr. Martin received notice from the Kroger pharmacy on November 30, 2014 that there was a third party rejection of his prescription for Vyvanse for Patient 5. The patient record includes a handwritten note that Dr. Martin had tried two times to get approval for Vyvanse for this patient, without success. (Ex. 3.A, Chart of Patient 5 at 4, 9-17)

After the request for Vyvanse was once again rejected, Dr. Martin continued prescribing generic Adderall 30 mg. three times a day for Patient 5 from December 2014 through early 2018, seeing the patient every two months. (Ex. 3.A, Chart of Patient 5 at 50-90) There was initially a rejection of the dose of generic Adderall 30 mg. at three times a day, with Kroger Pharmacy advising, "MAX DAILY DOSAGE = 2.00." (Ex. 3.A, Chart of Patient 5 at 8) However, Dr. Martin continued prescribing Adderall at 30 mg. three times a day in the months of February, March, and April 2015, and there is no indication that his prescriptions for 90 pills per month were not approved. That pattern continued for several years without any substantial changes in the patient's progress notes, and without documentation that Dr. Martin discussed the risks, benefits and alternatives of the treatment with the patient. (Ex. 3.A, Chart of Patient 5 at 60-89)

In June 2018, Dr. Martin reduced the dose of Patient 5's Adderall to 30 mg. twice a day, instead of three times a day. The next office visit notes on July 11, 2018 indicate that the dose has been lowered to "bid," and contains only a note that appears to state that the patient was using 3 doses only 10% of the time. (Ex. 3.A, Chart of Patient 5 at 46-47) Dr. Martin continued prescribing generic Adderall 30 mg. twice daily, through October 2018, seeing the patient every two months. (Ex. 3.A, Chart of Patient 5 at 39-42)

The State's expert, Philipp Dines, M.D., Ph.D., summarized Dr. Martin's care of Patient 5 as follows:

> I reviewed the treatment of [Patient 5] by Dr. Anthony Martin, which began with the first record provided on 4-21-2014 and continued through the last date of the patient record on 10-1-2018. Clinical documentation is

> duplicative with paucity of significant diagnostic evaluative content. However, there is a clinical document in the record from April 19, 2002 that references a history of cyclothymia, mood swings, hypomania, depression and past treatment with Depakote. The clinical records indicate that the patient was treated by Dr. Martin with amphetamines prescribed above recommended maxim[um] exposing the patient to increased risk with consent process not evidenced. Generic Adderall (dextroamphetamine) is prescribed at 30 mg three times a day for 90 mg daily dosage when the recommended maximum is 60 mg daily. In addition, if there is a cyclical mood disorder or bipolar disorder which is suggested by documentation in the record a regimen of high dose amphetamines would not be recommended and could exacerbate the mood disorder. The documentation does not reveal an appropriate diagnostic process to clarify ADHD or a mood disorder.

(Ex. 3.A, Expert report of Patient C.M. at 1)

Dr. Dines concluded in his expert report that Dr. Martin's prescribing in this case did not meet the minimum standard of care:

> The prescribing of 90 mg of generic Adderall (dextroamphetamine) constituted a failure to maintain minimal standards applicable to the selection or administration of drugs in violation of O.R.C. 4731.22(B)(2). A clinical document referenced a history of cyclothymia, mood swings, hypomania, depression, and past treatment with Depakote. Treating a patient with a cyclical mood disorder or bipolar disorder with high dose amphetamines could exacerbate the mood disorder. Assuming ADHD was the correct diagnosis, prescribing above the recommended dosage of Adderall is still associated with high risk, and there is no documentation of a proper risk assessment or obtaining consent from the patient for this type of treatment.
>
> The treatment of [Patient 5] constituted a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, in violation of O.R.C. 4731.22(B)(6). The diagnostic and treatment fell below the standard of care as did the management of amphetamine treatment. Also the standard for consent fell below the standard of care. There is no documentation of a discussion of the risks of high dose amphetamine treatment with the patient. The documentation does not demonstrate an appropriate diagnosis process to clarify ADHD or mood disorder, when the patient had a prior documented mood disorder diagnosis and course of treatment.

(Ex. 3.A, Expert report of Patient C.M. at 1-2)

This proposed finding is supported by the following evidence: Exhibits 3, 3.A.

7. Dr. Martin treated Patient 6 (K.R.) from on or about May 2013 through at least August 2018 for attention deficit hyperactivity disorder, and depression. He prescribed 70 mg. of Vyvanse and a twice daily dose of Adderall 30 mg. Patient 6 reported insomnia and anxiety, and he added Trazodone and melatonin. He failed to document appropriate consideration that the patient's sleep and anxiety were possibly exacerbated if not caused by doses of amphetamines above daily limits. He documented consent but failed to document an appropriate discussion about the risk/benefit of taking high doses of amphetamines.

   Patient 6 was 24 years old when she first saw Dr. Martin in May 2013. The notes of the initial psychiatric evaluation on May 20, 2013 state that she was first medicated for depressive symptoms at the age of 15, was treated for anxiety beginning at age 18, and was diagnosed with ADD at the age of 19. Her chief complaint at that time was difficulty focusing and following through. Dr. Martin found that Patient 6 met the criteria for ADHD combined type, and at that visit, he prescribed Vyvanse 70 mg. and generic Adderall 20 mg., along with sertraline 100 mg and mirtazapine, with each taken once a day. The notes of Dr. Martin's evaluation state that he discussed with the patient the risks, benefits, and alternatives to the treatment he was proposing. (Ex. 3.A, Chart of Patient 6 at 159-163)

   Patient 6 was seen again on June 17, 2013, and Dr. Martin noted that her depressive symptoms and anxiety were in partial remission. He wrote that she would continue her current medications and would see him again in four weeks. Although he wrote that she was sleeping better with mirtazapine, at that appointment Dr. Martin prescribed 60 tablets of Ambien 6.25 mg., to be taken once or twice a day, without documenting a rationale for the change. He also continued to prescribe the Vyvanse 70 mg. and generic Adderall 20 mg., both to be taken once a day. There was no documentation of discussion of the possible reasons for Patient 6's sleep issues, or any consideration of whether the other medications she was being prescribed could be contributing to her sleep disturbances. (Ex. 3.A, Chart of Patient 6 at 157-158)

   At Patient 6's next appointment on July 15, 2013, Dr. Martin recommended that Patient 6 substitute mirtazapine and melatonin for the Ambien; however, he continued prescribing Vyvanse 70 mg. and generic Adderall 20 mg., authorizing 30 pills in each prescription. (Ex. 3.A, Chart of Patient 6 at 155-156) When the patient was seen in September 2013, Dr. Martin's notes indicate that she had stopped taking sertraline and mirtazpine. At the appointment on September 9, 2013, he wrote prescriptions for two months' worth of Vyvanse 70 mg. and generic Adderall 20 mg., writing on the second prescription for each that it was not to be filled until October 7, 2013. (Ex. 3.A, Chart of Patient 6 at 153-154)

   This pattern continued from September 2013 through January 2015, with Dr. Martin seeing Patient 6 every two months, and issuing two months' worth of prescriptions for Vyvanse 70

mg. and generic Adderall 20 mg. at each visit, with instructions that each medication was to be taken once a day. (Ex. 3.A, Chart of Patient 6 at 132-152) The only notable change during that time was that Dr. Martin prescribed Ambien again in February 2014. (Ex. 3.A, Chart of Patient 6 at 148)

In March 2015, Dr. Martin began prescribing sertraline again, and also increased Patient 6's dose of generic Adderall to 30 mg. twice a day, along with the Vyvanse 70 mg., giving her scripts for those medications for the next two months. There was no documentation of the reasons for the change in medications, nor a discussion with the patient of the risks, benefits and alternatives. The notes of the March 11, 2015 office visit state that "new dosing schedule is working much better" and that the patient had a new job, which she thought she would like. (Ex. 3.A, Chart of Patient 6 at 129-131)

Dr. Martin continued prescribing Vyvanse 70 mg. once a day and generic Adderall 30 mg. twice a day through August 2015, seeing the patient every two months, and giving her two monthly prescriptions for each medication at her office visits. (Ex. 3.A, Chart of Patient 6 at 114-128) At a June 30, 2015 appointment, Dr. Martin again prescribed Ambien 6.25 mg. with five refills, and in his progress note for that visit he wrote, "I warned her again about the dangers of taking Ambien (told her the story of DUI, etc) but she insists on taking it." (Ex. 3.A, Chart of Patient 6 at 124) At an appointment on August 24, 2015, Patient 6 told Dr. Martin that she thought her albuterol inhalers were making it difficult for her to sleep. He prescribed trazodone 100 mg. and sertraline, in addition to her usual prescriptions for Vyvanse 70 mg. once a day, generic Adderall 30 mg. twice a day, and Ambien 6.25 mg. once a day. Dr. Martin's notes of that office visit are largely illegible and do not document the reasons for the medication change, but they do state that he discussed sleep hygiene with her. (Ex. 3.A, Chart of Patient 6 at 121-123)

In December 2015, Dr. Martin began writing 90 days' worth of prescriptions for Patient 6 at each office visit, even though he continued seeing her every two months, rather than every three months. At the appointment on December 14, 2015, he wrote three-month prescriptions for Vyvanse 70 mg. once a day (90 capsules); Adderall 30 mg. bid (180 tablets). This pattern continued through April 2018. (Ex. 3.A, Chart of Patient 6 at 79-115)

In an appointment on January 30, 2018, Patient 6 related to Dr. Martin that she was considering having a baby, and at that appointment, he noted that he discussed with her the risks and benefits of the medications she was taking during pregnancy. (Ex. 3.A, Chart of Patient 6 at 81)

The patient record shows multiple times during the course of Patient 6's treatment when a pharmacy wrote to Dr. Martin to remind him of the dangers about long-term use of Ambien. In September 2013; December 2013; May 2014; September 2014 and January 2015, CVS Caremark sent the following notice to his attention:

Long-Term Use of Non-Benzodiazepine (BZD) Sedative/Hypnotics

Background	Our available prescription claims suggest that your patient is being treated with long-term non-BZD sedative/hypnotic therapy for insomnia. Long-term administration may increase the risk of adverse effects.
Therapy Consideration	After evaluating the overall treatment goals for your patient and if medically appropriate, please consider*: - Tapering and discontinuing the non-BZD sedative/hypnotic. - Gradually decreasing the dose, frequency, or duration of the non-BZD sedative/hypnotic. *Close monitoring may be necessary to manage any potential adverse events associated with treatment changes.
Rationale	Although the frequency and severity of adverse effects are lower for non-BZDs than for BZDs, concerns with long-term use of non-BZDs exist.[1] Withdrawal symptoms (e.g. anxiety, rebound insomnia), habituation, and abuse may occur with non-BZD sedative/hypnotics.[2,3] Additionally, manufacturers' prescribing information include strengthened warnings concerning complex sleep-related behaviors (e.g. sleep-driving); discontinuation of non-BZDs is strongly suggested in patients who have experienced sleep-driving episodes.[4-6] High doses or prolonged administration requires gradual tapering to reduce the risk of withdrawal symptoms.[3] If a non-BZD is indicated, the lowest effective dose and shortest duration of therapy should be considered. Alternative treatment options, such as psychological/behavioral strategies, may also be considered.

If necessary, please provide your patient a new prescription.

(Ex. 3.A, Chart of Patient 6 at 6, 14, 25, 44, 47)

The chart does not contain any response by Dr. Martin to that notice, except for the possible change from Ambien to mirtazapine in August 2014. (Ex. 3.A, Chart of Patient 6 at 4)

In January 2015, CVS sent Dr. Martin a list of Patient 6's prescriptions, asking him to verify if he did or did not authorize the prescriptions below:

Fill Date	Drug Name & Strength	Dosage Form	QTY	D/S	Prescribed	Did NOT Prescribe
12/22/2014	AMPHETAMINE SALT COMBO 30 MG	TABLET	60	30	☐	☐
12/11/2014	ZOLPIDEM TARTRATE ER 6.25 MG	TAB MPHASE	60	30	☐	☐
12/08/2014	VYVANSE 70 MG	CAPSULE	30	30	☐	☐
11/24/2014	AMPHETAMINE SALT COMBO 30 MG	TABLET	60	30	☐	☐
11/13/2014	ZOLPIDEM TARTRATE ER 6.25 MG	TAB MPHASE	60	30	☐	☐
11/10/2014	VYVANSE 70 MG	CAPSULE	30	30	☐	☐

Fill Date	Drug Name & Strength	Dosage Form	QTY	D/S	Prescribed	Did NOT Prescribe
10/27/2014	AMPHETAMINE SALT COMBO 30 MG	TABLET	60	30	☐	☐
10/16/2014	ZOLPIDEM TARTRATE ER 6.25 MG	TAB MPHASE	60	30	☐	☐
10/13/2014	VYVANSE 70 MG	CAPSULE	30	30	☐	☐

Claims 7 to 9 of 9

(Ex. 3.A, Chart of Patient 6 at 42-43)

The letter informed Dr. Martin of the reasons for this request:

CVS/caremark is conducting a review of patient claims. This is to ensure that benefits are being administered according to the terms of coverage outlined in the patient's CVS/caremark plan. The patient listed above was identified through a claims review†as having unusual medication utilization patterns which may indicate possible drug over-utilization and may place them at risk for drug-induced adverse events. This letter provides you with medication claim information and is being sent to all prescribers who have written prescriptions for this patient.

We are enclosing a copy of your patient's medication profile, which according to our records, lists medications that were dispensed under the above patient's beneficiary ID number during a recent nine-month period. The targeted medication includes drugs with high abuse potential.

Based on this information, please verify and/or consider the following on the attached response form:

(1) The identified patient is your patient
(2) The identified medications were prescribed by you
(3) The identified medications are medically necessary due to a specific diagnosis (please provide diagnosis)
(4) Re-evaluation of current drug therapy

(Ex. 3.A, Chart of Patient 6 at 39)

The State's expert, Philipp Dines, M.D., Ph.D., summarized Dr. Martin's care of Patient 6 as follows:

> I reviewed Dr. Martin's care of Patient [6] from the first recorded treatment date on 5-20-2013 through the last recorded treatment date on 8-31-2018. On page 28 of 167 there is a prior diagnosis of bipolar disorder. Dr. Anthony Martin diagnosed ADHD and depression and ruled out bipolar disorder. Clinical progress notes are repetitive and limited. Multiple amphetamines (Vyvanse 70 mg and Adderall 30 mg twice daily) are combined both at maximum daily doses with unclear establishment of diagnosis. At the same time [Patient 6] is prescribed Sertraline and trazodone for sleep in addition to melatonin with a patient history of poor sleep. On page 121 of 167 [Patient 6] reports getting 5 hours of sleep and needing at least 6 hours of sleep. Symptoms of ADHD and depression can overlap with bipolar so that diagnostic error could occur. Dr. AM did postulate that the inhaler that [Patient 6] was using could be contributing to her insomnia which also could be a factor from page 123 of 167. Dr. AM then switched [Patient 6] to more medications, Ambien and mirtazapine from trazodone. [Patient 6] was still maintained on maximum doses of two amphetamines.

(Ex. 3.A, Expert report of Patient K.R. at 1)

Dr. Dines concluded in his expert report that Dr. Martin's prescribing in this case did not meet the minimum standard of care:

> Dr. Martin's prescribing of the combination of amphetamines at maximum doses for total exposure above recommended amounts constituted a failure to maintain minimal standards applicable to the selection or administration of drugs in violation of O.R.C. 4731.22(B)(2). The treatment subjected [Patient 6] to high risk of amphetamines with unclear benefit when using

> medications above approved limits. In addition, diagnosis was not well established. This may have resulted in unnecessary ancillary treatments with sedating antidepressants, sleep aids and melatonin to compensate for effects from the wrong medication treatment regimen. These medication effects from the possibly wrong treatment regimen would have been appropriately managed with less medications and risks in the event the patient had bipolar disorder and was managed with appropriate indicated treatments.
>
> Dr. Martin's treatment of [Patient 6] constituted a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, in violation of O.R.C. 4731.22(B)(6).
>
> Clinical notes were substantively impoverished and repetitive suggesting less than appropriate diagnostic work up and analysis. There is also lack of sufficient documentation of risk benefit disclosure and consent of treatments offered.
>
> The use of two amphetamines at maximum dose is a failure to conform to minimal standards putting the patient at high risk with unclear benefit. Further, the symptoms present may have represented a bipolar condition in which case the treatment would have been erroneous prompting additional treatment compensatory treatment that would otherwise have been unnecessary. In the event the diagnosis of ADHD is correct, subjecting the patient to maximum doses of two amphetamines would fall below minimal standards of care.
>
> Bipolar diagnosis would be a possible source of the insomnia and anxiety exacerbated by amphetamines and then necessitating treatment for insomnia which could have prompted the use of trazodone and melatonin. Here trazodone would possibly actually exacerbate the insomnia if [Patient 6] was actually bipolar but treated for ADHD and depression.
>
> Switching to Ambien and mirtazapine from trazodone to treat the insomnia also could inadvertently be compensating for effects in what might have been a bipolar case.

(Ex. 3.A, Expert report of Patient K.R. at 1-2)

This proposed finding is supported by the following evidence: Exhibits 3, 3.A.

8. Dr. Martin treated Patient 7 (L.R.) from on or about January 2013 through at least September 2016 for attention deficit disorder, dysthymia, anxiety disorder, post-traumatic

stress disorder chronic, borderline personality disorder, and a significant substance dependence history. Patient 7 also had a history of self-harm. He prescribed Vyvanse at 50 mg twice daily or 60 mg twice daily, beyond the recommended maximum dosage, as well as four antidepressants, either Wellbutrin, Zoloft, trazadone, and mirtazapine; or Celexa, trazadone, mirtazapine, and Rozarem. He also prescribed alprazolam on an as needed basis. He failed to document an appropriate risk/benefit analysis of a patient with these complications being managed at this dosage.

Patient 7 was 37 years old when she had her initial examination with Dr. Martin on March 9, 2010. This patient was the mother of Patient 1, the five-year-old child that Dr. Martin treated for ADHD and ODD. (Ex. 3.A, Chart of Patient 7 at 222-227) He noted in his initial evaluation that Patient 7 presented with ADD, borderline personality disorder, depression and anxiety and PTSD from a history of abuse. He also noted in his initial exam notes that she had "a very significant substance dependence hx." (Ex. 3.A, Chart of Patient 7 at 223) Dr. Martin further noted that she had "legal problems [related to] stealing pain meds from pts (she is a nurse.)" (Ex. 3.A, Chart of Patient 7 at 223) At the time of her initial visit, Patient 7 was taking bupropion, Celexa, trazodone, and Rozarem. Dr. Martin's plan was to reduce her bupropion to once a day, but continue her other medications and start mirtazapine and Concerta, along with having Dialectical Behavioral Therapy. He noted a prior history of bulimic behavior and "alcohol, cocaine, opiate (polysubstance dependence Hx)." (Ex. 3.A, Chart of Patient 7 at 223)

At Patient 7's initial visit in March 2010, Dr. Martin diagnosed ADHD combined type, and wrote several prescriptions for her, including: Concerta 36 mg., Celexa 40 mg., bupropion 150 mg., trazodone 100 mg., mirtazapine 15 mg. and Rozarem 8 mg. (Ex. 3.A, Chart of Patient 7 at 224-227) However, when she returned in March 2010 and reported a "zombie like effect," Dr. Martin discontinued the Concerta and prescribed Vyvanse 40 mg. once a day instead. (Ex. 3.A, Chart of Patient 7 at 220-221)

In April 2010, Dr. Martin increased Patient 7's dose of Vyvanse to 50 mg. once a day, and in May, he added generic Adderall 20 mg. once a day, while also increasing her sertraline to 150 mg. (Ex. 3.A, Chart of Patient 7 at 214-219)

The patient record contains copies of the actions taken by the Ohio Board of Nursing against Patient 7 based on criminal convictions for drug and alcohol offenses. The documents show that Patient 7 admitted that while she was working as a hospice nurse, she was calling in prescriptions and picking them up, for her own self-administration. The documents further show that she had had residential treatment for alcoholism for almost one year, and that she had two previous DUI convictions. (Ex. 3.A, Chart of Patient 7 at 31-43)

In September 2010, Dr. Martin began prescribing Vyvanse 50 mg. twice a day for Patient 7, giving her two prescriptions at that visit, each for 60 pills over the next two months. (Ex. 3.A, Chart of Patient 7 at 208)

Between September 2010 and August 2013, Dr. Martin prescribed Vyvanse 50 mg. twice a day, and also prescribed sertraline, bupropion, and trazodone in that timespan. Then, in August 2013, he increased her Vyvanse to 60 mg. taken twice a day, for a total of 120 mg. per day. (Ex. 3.A, Chart of Patient 7 at 166-206) During that same span of time, the patient had a spinal fusion surgery in June 2011 to remediate herniated discs, and Dr. Martin wrote several other prescriptions for her. In December 2012, Dr. Martin called in a prescription for bupropion 150 mg. once a day for one year. (Ex. 3.A, Chart of Patient 7 at 178) In a note at her visit on January 8, 2013, Dr. Martin wrote, "I offered to titrate her off Bupropion but she refused." (Ex. 3.A, Chart of Patient 7 at 174) He also prescribed generic Xanax (alprazolam), 5 pills with one refill, in 2013 shortly after her mother was diagnosed with terminal cancer. (Ex. 3.A, Chart of Patient 7 at 167)

Between August 2013 and September 2016, Dr. Martin prescribed Vyvanse 60 mg. twice daily for Patient 7, along with regularly-prescribed sertraline, bupropion, and trazodone with refills, and occasional small quantities of generic Xanax, five to ten pills at a time. (Ex. 3.A, Chart of Patient 7 at 133-166)

The patient record contains a copy of Patient 7's nursing license reinstatement agreement, which recited that Patient 7 had failed to include Dr. Martin in the list of her treating providers that she was required to disclose to her licensing board. It further states that she had a chemical dependency evaluation in February 2012 that found she had Polysubstance Dependence. (Ex. 3.A, Chart of Patient 7 at 121-123)

The patient record also contains a handwritten letter from Patient 7, in which she explained the following to Dr. Martin and asked for his assistance:

> I have made a huge mistake with the Xanax. I told you I occasionally took my sister's Xanax for anxiety and you kindly gave me an Rx for 10 pills and 0 refill. All was well until I received a phone call from the Nursing Board regarding my last drug urinalysis on November 20.

(Ex. 3.A, Chart of Patient 7 at 118)

The patient explained that a urine screen was positive for Ativan after she had taken some of her sister's medications, and that when she looked at her sister's prescription bottle, she found that it was for Ativan, and not Xanax. (Ex. 3.A, Chart of Patient 7 at 118-119)

She wrote this additional explanation, and she reminded Dr. Martin at the end of her identity, in case he did not remember who she was:

> The Board wants some kind of documentation for Ativan. * * * Do you possibly have any Ativan samples that you could write that you gave me?

> Or an Rx for Ativan?" * * * If you don't remember me, I am the one you saw in the lobby today when you 1st came in.

(Ex. 3.A, Chart of Patient 7 at 119-120)

Dr. Martin completed a Mental Health Professional Report for Patient 7 dated December 5, 2013 and did not indicate that he had prescribed Ativan for her. He listed her current medications that he was prescribing, except that he wrote that he had prescribed Vyvanse 50 mg. twice a day, whereas his prescriptions during that time show that he was prescribing 60 mg. of Vyvanse, twice a day. (Ex. 3.A, Chart of Patient 7 at 94, 162-164) Dr. Martin also wrote a letter to the Board of Nursing, explaining Patient 7's mistake, but not representing that he had ever prescribed Ativan for her. (Ex. 3.A, Chart of Patient 7 at 86-87)

Multiple times during Dr. Martin's treatment of Patient 7, he was asked to submit prior authorization forms, in order for Vyvanse 60 mg. twice a day to be approved. In November 2012, Dr. Martin submitted the following explanation to Molina Healthcare:

Patient Previous Medication(s) Relevent to this Request*

Please indicate previous treatment and outcomes below

	Drug Name	Strength	Dose	Directions	Duration & Reason for Discontinuation
1	Client has tried Concerta & Adderall (Generic) &				
2	failed. She's been on this medication since 2010				
3	& is having continued success on this med.				
4	Her previous Insurance Co. approved this med.				
5					

Relevant Medical Rationale for Request/Additional Clinical Information (Including diagnostic studies and lab results)*

URGENT! CLIENT IS OUT OF HER MEDICATION & NEEDS IT! Thank you.

(Ex. 3.A, Chart of Patient 7 at 15)

In response, Molina Healthcare approved the medication for Patient 7 for one year, from November 9, 2012 to November 9, 2013. (Ex. 3.A, Chart of Patient 7 at 11-15)

The chart shows that the same thing occurred in 2013, which resulted in the Vyvanse being approved for November 18, 2013 through November 18, 2014; and again in October 2014, which resulted in the Vyvanse being approved for October 23, 2014 through October 23, 2015, and again in 2016, which resulted in the Vyvanse being approved for January 12, 2016 through January 12, 2017. (Ex. 3.A, Chart of Patient 7 at 49-63)

The State's expert, Philipp Dines, M.D., Ph.D., summarized Dr. Martin's care of Patient 7 as follows:

> I reviewed Dr. Anthony Martin's treatment of [Patient 6] from the first recorded treatment date of 1-8-2013 through the last recorded treatment date of 9-20-2016. Dr. Martin treated [Patient 6] for ADD with a history of Borderline Personality Disorder, significant substance dependence or misuse, major depressive features with history of self-harm, and PTSD.
>
> [Patient 6] was treated with doses of Vyvanse at 50 mg twice daily or 60 mg twice daily over the recommended maximum of 70 mg a day with the four antidepressants, Wellbutrin, Zoloft, trazodone and mirtazapine or Celexa, trazodone, mirtazapine and Rozarem. [Patient 6] was also managed with alprazolam on an as needed basis. At the same time there have been questions about [Patient 6] and substance misuse. [Patient 6] has also come under professional scrutiny in her work for issues of alleged substance misuse. Consent is reported but the details of the risk and benefit analysis details are not documented as explicated.

Dr. Dines concluded in his expert report that Dr. Martin's prescribing in this case did not meet the minimum standard of care:

> Dr. Martin's prescribing of Vyvanse above daily max dosage and in combination with other drug constituted a failure to maintain minimal standards applicable to the selection or administration of drugs in violation of O.R.C. 4731.22(B)(2).
>
> Prescribing high doses of amphetamines above recommended limits and polypharmacy with benzodiazepines and multiple antidepressants should be avoided and even more so when treating a high-risk person with history of self- harm, Borderline Personality, significant history of substance dependence, PTSD, and mood disorders. This treatment regimen posed multiple significant risks of psychiatric and medical adverse outcomes.
>
> Dr. Martin's treatment of [Patient 6] constituted a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, in violation of O.R.C. 4731.22(B)(6). [Patient 6] is managed at doses of amphetamines that pose a risk to medical well-being and also represent a significant potential for misuse given [Patient 6's] history of self-harm and substance dependence. Treatment with amphetamines at greater than recommended doses for a diagnosis of ADD in [Patient 6] with a history of Borderline Personality Disorder, PTSD, significant substance misuse with major mood disorders would be a departure from standard of care. The risks involved in prescribing Vyvanse above maximum daily limits along with other drugs

including a benzodiazepine were not documented as having been discussed with the patient, nor is a risk benefit analysis in evidence.

(Ex. 3.A, Expert report of Patient L.R. at 1-2)

This proposed finding is supported by the following evidence: Exhibits 3, 3.A.

9. Dr. Martin treated Patient 8 from at least January 2013 through at least January 2017 for ADHD, dysthymia, and mild social phobia. He prescribed 70 mg. Vyvanse per day combined with 30 mg. of Adderall per day. These maximum dosage levels were prescribed without an appropriate risk benefit analysis or documented consent. The dosage of Vyvanse was later increased to 40 mg. twice daily, then 50 mg. twice daily. He combined these amphetamines with multiple antidepressants, including duloxetine (Cymbalta) at 60 mg. daily, mirtazapine, and sertraline. He failed to document appropriate disclosure of the risks to the patient of prescribing above the maximum recommended daily dosage of amphetamines, nor is consent sufficiently documented.

Patient 8 was 59 years old when she began seeing Dr. Martin in July 2011. In his initial psychiatric evaluation, Dr. Martin noted that she was first medicated for depressive symptoms at age 48, but that her depression had been in remission for two years. He also noted that she took lisinopril for hypertension and a medication for irritable bowel syndrome. At her first appointment, Dr. Martin found that Patient 8 met the criteria for ADHD combined type, and prescribed Vyvanse 70 mg. to be titrated up to that daily dose, starting with ¼ dose; as well as Cymbalta 60 mg., and mirtazapine 15 mg., to be taken once a day. (Ex. 3.A, I Chart of Patient 8 at 110-119)

When Patient 8 saw Dr. Martin for her next appointment on August 10, 2011, he increased her prescription of Vyvanse to 50 mg. b.i.d., for a total dose of 100 mg. per day. He continued that regimen while also prescribing Cymbalta and mirtazapine periodically with refills, until March 2012, when he reduced her dose of Vyvanse to 40 mg. twice a day, rather than 50 mg. twice a day. The patient had noted at her March 28, 2013 appointment that she thought the Vyvanse was too strong, as she had lost weight. Then, at her appointment in May 2013, Dr. Martin adjusted her dose of Vyvanse to 70 mg. once a day, while she continued the other medications in her regimen. (Ex. 3.A, Chart I of Patient 8 at 98-107)

From May 2013 to July 2013, Dr. Martin continued prescribing 70 mg. once a day for Patient 8, along with the Cymbalta and mirtazapine. In October 2013, the patient told Dr. Martin that she had to pay out of pocket for the Cymbalta, and at that appointment, he prescribed sertraline (Zoloft) instead. (Ex. 3.A, Chart I of Patient 8 at 80-85)

From December 2013 through August 2014, Dr. Martin continued prescribing Vyvanse 70 mg. once a day for Patient 8, along with her other medications. He was seeing her at 8-week intervals, and giving her two prescriptions for each medication at a time, writing on

one of them that it was not to be filled until the following month. (Ex. 3.A, Chart I of Patient 8 at 71-79)

In October 2014, Dr. Martin began prescribing generic Adderall 30 mg. once a day for Patient 8, in addition to the Vyvanse 70 mg. once a day, but he did not document a reason for the change, nor a discussion of the risks, benefits, and alternatives to that treatment. That pattern continued into May 2015. (Ex. 3.A, Chart I of Patient 8 at 60-69) By July 2015, Dr. Martin continued the same prescribing pattern, but he began seeing Patient 8 every three months, instead of every two months. He continued prescribing Vyvanse 70 mg. once a day and generic Adderall 30 mg. once a day through January 2017, along with a simultaneous prescription for Cymbalta with a year's worth of refills issued periodically. (Ex. 3.A, Chart I of Patient 8 at 44-59)

The exhibits contain two separate patient charts for Patient 8, along with a letter that explains the document labeled as Chart II:

> The [Patient 8] chart is the second original we have provided to you. This second original contains copies of the original, which is already in your possession. We did not copy all of the original the first time, thus those sections are missing. You will find them in the original chart we provided to you with your first request.

(Ex. 3.A, Letter about Additional Records)

Chart II begins with the initial evaluation and patient questionnaire that Patient 8 completed when she began her treatment with Dr. Martin in July 2011. (Ex. 3.A, Chart II of Patient 8 at 30-34) However, it continues beyond January 2017, where Chart I left off, and it shows that Dr. Martin continued his pattern of prescribing Vyvanse, Cymbalta, and generic Adderall for Patient 8.

Throughout 2017, Dr. Martin continued prescribing Vyvanse 70 mg. once a day and generic Adderall 30 mg. once a day, along with Cymbalta. The progress notes are generally copied from one visit to the next and provide very little documentation of Patient 8's ongoing condition, except for occasional notes, such as the one about her retirement. A note that stated she was scheduled to retire on May 31 was copied into the progress notes for appointments well beyond that date. (Ex. 3.A, Chart II of Patient 8 at 18-27) And, in a visit on December 12, 2017, Dr. Martin noted that Patient 8 had been diagnosed with an arrythmia, and would have an ablation, but he added, "Vyvanse ok [with] cardiologist." (Ex. 3.A, Chart II of Patient 8 at 17) Some of the office visit notes leave blank the place where Dr. Martin was to indicate the date of the visit. (Ex. 3.A, Chart II of Patient 8, e.g., at 13-14)

In November 2017, after Patient 8's insurer changed, Dr. Martin was also advised by an insurer that Patient 8 was provided a temporary supply of Vyvanse, as the drug was not

covered on their formulary. (Ex. 3.A, Chart II of Patient 8 at 6) Dr. Martin sought a pre-authorization of that medication, writing:

> Shorter acting agents, such as Adderall XR and Ritalin, etc. do not last long enough and cause mood instability. She has been doing well on this medication since 7/26/11. Please approve for multiple years if possible.

(Ex. 3.A, Chart II of Patient 8 at 11)

Patient 8's OARRS report appears in her second patient chart, demonstrating that Dr. Martin continued the pattern of prescribing Vyvanse 70 mg., and generic Adderall 30 mg. (dextroamp amphetamin) between March 27, 2016 and November 15, 2017. (Chart II of Patient 8 at 3-4)

The State's expert, Philipp Dines, M.D., Ph.D., summarized Dr. Martin's care of this Patient 8 as follows:

> I have reviewed Dr. Anthony Martin's treatment of Patient [8], beginning at the first treatment date in the record, 1- 15-2013, through the last date of treatment in the record, 1-3-2017. The patient was treated for ADHD, dysthymia, and mild social phobia. Dr. Martin initiated amphetamine treatment at the recommended maximum of Vyvanse. The patient was treated with combinations and or doses of amphetamines beyond recommended maxima. Amphetamine risk benefit disclosure with the patient in the clinical notes are not evidenced. High dose amphetamines are apparently prescribed for attention deficit and depression. Initiation of amphetamine treatment is at the recommended maximum of Vyvanse as well as Adderall at 30 mg. Treatment of 70 mg daily was increased to 80 mg and then to 100 mg. Dr. Martin also prescribed Cymbalta (duloxetine) 60 mg and mirtazepine.

(Ex. 3.A, Expert report of Patient R.V. at 1)

Dr. Dines concluded in his expert report that Dr. Martin's prescribing in this case did not meet the minimum standard of care:

> Dr. Martin's selection of drugs and dosage amounts constituted a failure to maintain minimal standards applicable to the selection or administration of drugs in violation of O.R.C. 4731.22(B)(2). Clinical notes exhibit substantial paucity of clinical data or clinical diagnostic process. There is a pattern of high dose amphetamine use either in single agent use above the recommended limit or maximum doses of one amphetamine combined with another amphetamine. Amphetamine treatment apparently is targeted

> to treatment of ADHD and to depression in combination with antidepressant treatment.
>
> Dr. Martin's treatment of Patient [8] constituted a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established, in violation of O.R.C. 4731.22(B)(6). Maximum doses of Vyvanse at 70 mg daily are combined with Adderall 30 mg daily putting the patient at risks of high dose amphetamines without clear risk benefit analysis or consent. Combinations of high dose amphetamines are outside the expected standards of care with amphetamines. Amphetamines were combined with various antidepressants including duloxetine at 60 mg daily, mirtazapine and sertraline. Later in the treatment the patient was prescribed Vyvanse above the recommended limit of 70 mg daily at a dose of 40 mg tablets, two in the morning daily then this was further increased to 50 mg tablets taken two tablets a day in the morning for a total dose of 100 mg when the recommended maximum is 70 mg daily. This is in combination with Cymbalta(duloxetine) and mirtazapine. Mirtazapine may have been prescribed with the possible dubious rationale to partially compensate for activation from high dose amphetamine activation secondary to the sedation side effects of mirtazapine. This is in addition to Cymbalta treatment as well. Mirtazapine is prescribed at the low dose. Management of amphetamines at high doses above recommended doses with little or no consent process falls below expected standard of care.

(Ex. 3.A, Expert report of Patient R.V. at 1-2)

This proposed finding is supported by the following evidence: Exhibits 3, 3.A.

10. (a) The acts, conduct, and/or omissions of Dr. Martin as described in Proposed Findings 1 through 9, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as that clause is used in R.C. 4731.22(B)(2).

(b) Because much of the conduct described in Proposed Findings 1 through 9 occurred after September 29, 2015, the Board is authorized to impose a fine for this violation pursuant to R.C. 4731.225. The Board's fining guidelines provide for a fine in the following range:

Minimum Fine: $2,500
Maximum Fine: $20,000

11. (a) The acts, conduct, and/or omissions of Dr. Martin as described in Proposed Findings 1 through 9, individually and/or collectively, constitute a "[d]eparture from, or the failure to

conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in R.C. 4731.22(B)(6).

(b) Because much of the conduct described in Proposed Findings 1 through 9 occurred after September 29, 2015, the Board is authorized to impose a fine for this violation pursuant to R.C. 4731.225. The Board's fining guidelines provide for a fine in the following range:

Minimum Fine: $3,500
Maximum Fine: $20,000

Comments on the Proposed Order

Because Dr. Martin did not make a timely request for a hearing, there is little information about his practice or his prescribing practices, and no evidence to show if there was any reason for his pattern of prescribing high doses of Vyvanse, at the same time as a high dose of generic Adderall for his patients, sometimes in conjunction with anti-depressants and sleep medications. There was also no opportunity to hear testimony from any expert witnesses, who could have elaborated on the level of risk presented to patients by these prescribing practices. Evaluating that aspect of the case therefore requires the expertise of the physicians on the Board.

The patient records are difficult to follow, sometimes written in illegible handwriting. Some of the records are not in chronological order, and several of the progress notes are undated. The prescriptions that appear in the charts nonetheless reveal a pattern in Dr. Martin's prescribing for his patients, in which he quickly transitioned them to a regimen of the maximum doses of Vyvanse and generic Adderall and sometimes exceeded those doses, regardless of what medications they were taking when they began seeing him. The progress notes frequently indicated that Dr. Martin spent about 40 minutes with the patient at each office visit, but the notes for many of each patient's visits appear to have been copied from one visit to the next, with only cursory additions at some appointments, and many notes about life events remained on subsequent progress notes after they were considerably out of date. Much of the time, the patient's progress was described simply as "doing okay."

Besides the very sparse nature of Dr. Martin's progress notes, there are other indications that he did not spend thoughtful, quality time with patients for whom he was prescribing high doses of stimulants, and did not discuss with them the effects of those medications on other aspects of their lives, such as their sleep habits. Patient 3 asked if his 90-day prescriptions could be picked up at Dr. Martin's office, since he wrote that he usually spent only five minutes at his appointments anyway. Similarly, Patient 7 felt the need to remind Dr. Martin of who she was in her handwritten letter in 2013, even when she had been seeing him for about three years by that time, and he had also treated her child. Patient 7's case is particularly concerning because Dr. Martin knew at the outset of her treatment that she had a serious substance use disorder, for which she had already had a criminal conviction, lost a job, and had her nursing license

suspended. Likewise, greater consideration should have been evidenced in the case of Patient 7's 5-year-old child, Patient 1, in prescribing high doses of controlled stimulants for this 40-pound child.

In most of the eight patient charts, there are multiple letters from insurance companies or pharmacies, asking for an explanation of Dr. Martin's high dosing of stimulants such as Vyvanse and Adderall, and reminding him of the dangers of the long-term use of sleep medications such as Ambien. Those served as reminders of the high dosing that he was prescribing for his patients, and should have prompted him to periodically re-evaluate whether his prescribing was in the best interests of his patients, and to document the consideration of the risks and benefits of those medications in his patients' charts. Each time, however, he wrote an explanation to the insurance company maintaining that he was following the best course of treatment for his patients, and did not materially change his charting practices. Although Dr. Martin typically explained to insurers that other medications, such as Ritalin and Adderall XR had "failed," in most cases there was no indication in the chart that he personally tried to manage the patient on the other drugs, unless he was referring to prior treatments that the patient related to him from other providers, which he did not adequately describe in his charts, if that occurred. Another troubling aspect of Dr. Martin's prescribing practices is that patients often told *him* the medications they wanted, and sometimes he acquiesced, as in the case of Patient 6, who "insisted" on long-term use of Ambien.

If there had been a hearing on this matter, it may have produced evidence about why Dr. Martin preferred using high doses of Vyvanse and generic Adderall over other treatment regimens, as well as evidence about whether he gave appropriate consideration to other methods of medication management. Without that evidence, the opinion of Dr. Dines in the expert reports demonstrates that Dr. Martin prescribed multiple amphetamines that exceeded acceptable levels of those medications for his patients without a valid reason, and without documenting that he discussed with the patient the risks, benefits, and alternatives to the medication being prescribed, beyond the initial visit with each patient. Because of the risk those practices presented to patients, the proposed order recommends a suspension of Dr. Martin's medical license, with additional training in the prescribing of psychiatric medications for patients with ADHD and related conditions before he returns to practice. It also requires a practice monitor upon his return to practice, if the Board sees fit to allow Dr. Martin a path back to the practice of psychiatry. However, whether and when Dr. Martin should return to practice is very much a question for the Board to determine, in the judgment of its physician members.

PROPOSED ORDER

It is hereby ORDERED that:

A. **SUSPENSION OF LICENSE**: Commencing on the thirty-first day following the date on which this Order becomes effective, the license of Anthony Martin, M.D., to practice

medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time.

B. **FINE**: Within thirty days of the effective date of this Order, Dr. Martin shall remit payment in full of a fine of three thousand five hundred dollars ($3,500.00). Such payment shall be made via credit card in the manner specified by the Board through its online portal, or by other manner as specified by the Board.

C. **CONDITIONS FOR REINSTATEMENT OR RESTORATION**: The Board shall not consider reinstatement or restoration of Dr. Martin's license to practice medicine and surgery until all of the following conditions have been met:

1. **Payment of Fine**: Dr. Martin shall have fully paid the fine as set forth in Paragraph B of this Order.

2. **Application for Reinstatement or Restoration**: Dr. Martin shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.

3. **Additional Evidence of Fitness To Resume Practice**: In the event that Dr. Martin has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

4. **Post-Licensure Assessment Program**: Prior to submitting his application for reinstatement or restoration, Dr. Martin shall have undergone an assessment and completed the recommended educational activities, as developed for Dr. Martin by the Post-Licensure Assessment System [PLAS] sponsored by the Federation of State Medical Boards and the National Board of Medical Examiners, concerning the area of psychiatry. Dr. Martin's participation in the PLAS shall be at his own expense.

   a. Prior to the initial assessment by the PLAS, Dr. Martin shall furnish the PLAS copies of the Board's Order, including the Summary of the Evidence, Findings of Fact, and Conclusions of Law, and any other documentation from the hearing record that the Board may deem appropriate or helpful to that assessment.

   b. Should the PLAS request patient records maintained by Dr. Martin, Dr. Martin shall furnish copies of the patient records at issue in this matter along with any other patient records he submits. Dr. Martin shall further ensure that the PLAS maintains patient confidentiality in accordance with Section 4731.22(F)(5), Ohio Revised Code.

   c. Dr. Martin shall ensure that the written Assessment Report by the PLAS includes the following:

- A detailed plan of recommended practice limitations, if any;
- Any recommended education;
- Any recommended mentorship or preceptorship;
- Any reports upon which the recommendation is based, including reports of physical examination and psychological or other testing.

Moreover, Dr. Martin shall ensure that, within 14 days of its completion, the written Assessment Report by the PLAS is submitted to the Board.

d. Any Learning Plan recommended by the PLAS shall have been developed subsequent to the issuance of a written Assessment Report, based on an assessment and evaluation of Dr. Martin by the PLAS. Dr. Martin shall successfully complete the educational activities as recommended in the Learning Plan, including any final assessment or evaluation.

e. At the time he submits his application for reinstatement or restoration, Dr. Martin shall submit to the Board satisfactory documentation from the PLAS indicating that he has successfully completed the recommended educational activities.

5. **Medical Records Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Martin shall provide acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Martin submits the documentation of successful completion of the course(s) on maintaining adequate and appropriate medical records, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

6. **Controlled Substances Prescribing Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Martin shall provide acceptable documentation of successful completion of a course or courses dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to

the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Martin submits the documentation of successful completion of the course(s) dealing with the prescribing of controlled substances, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

D. **PROBATION**: Upon reinstatement or restoration, Dr. Martin's license shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least two years:

1. **Modification of Terms**: Dr. Martin shall not request modification of the terms, conditions, or limitations of probation for at least one year after imposition of these probationary terms, conditions, and limitations.

2. **Obey the Law**: Dr. Martin shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

3. **Declarations of Compliance**: Dr. Martin shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which Dr. Martin's license is restored or reinstated. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

4. **Personal Appearances**: Dr. Martin shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which Dr. Martin's license is restored or reinstated, or as otherwise directed by the Board. Subsequent personal appearances shall occur as otherwise directed by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

5. **Post-Licensure Assessment Program**: Dr. Martin shall practice in accordance with the Learning Plan developed by the PLAS, unless otherwise determined by the Board. Dr. Martin shall cause to be submitted to the Board quarterly declarations from the PLAS documenting Dr. Martin's continued compliance with the Learning Plan.

   Dr. Martin shall obtain the Board's prior approval for any deviation from the Learning Plan.

If, in a manner not authorized by the Board, Dr. Martin fails to comply with the Learning Plan, Dr. Martin shall cease practicing medicine and surgery beginning the day following Dr. Martin's receiving notice from the Board of such violation and shall refrain from practicing until the PLAS provides written notification to the Board that Dr. Martin has reestablished compliance with the Learning Plan. Practice during the period of noncompliance shall be considered practicing medicine without a license, in violation of Section 4731.41, Ohio Revised Code.

6. **Practice Plan and Monitoring Physician**: Within 30 days of the date of Dr. Martin's reinstatement or restoration, or as otherwise determined by the Board, Dr. Martin shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Martin's activities will be directly supervised and overseen by a monitoring physician approved by the Board. The practice plan shall, as determined by the Board, reflect, but not be limited to, the PLAS Learning Plan. Dr. Martin shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

   At the time Dr. Martin submits his practice plan, he shall also submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Martin and who is engaged in the same or similar practice specialty.

   The monitoring physician shall monitor Dr. Martin and his medical practice, and shall review Dr. Martin's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

   Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Martin and his medical practice, and on the review of Dr. Martin's patient charts. Dr. Martin shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Martin's declarations of compliance.

   In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Martin shall immediately so notify the Board in writing. In addition, Dr. Martin shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Martin shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Martin's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Martin's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

7. **Required Reporting of Change of Address**: Dr. Martin shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

8. **Tolling of Probationary Period While Out of Compliance**: In the event Dr. Martin is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

E. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Martin's license will be fully restored.

F. **VIOLATION OF THE TERMS OF THIS ORDER**: If Dr. Martin violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his license.

G. **REQUIRED REPORTING TO THIRD PARTIES; VERIFICATION**:

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Martin shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training, and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Martin shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments.

   In the event that Dr. Martin provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.

Further, within 30 days of the date of each such notification, Dr. Martin shall provide documentation acceptable to the Secretary and Supervising Member of the Board demonstrating that the required notification has occurred.

This requirement shall continue until Dr. Martin receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Martin shall provide a copy of this Order by certified mail to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Administration, through which he currently holds any professional license or certificate. Also, Dr. Martin shall provide a copy of this Order by certified mail at the time of application to the proper licensing authority of any state or jurisdiction in which he applies for any professional license or reinstatement/restoration of any professional license.

   Additionally, within 30 days of the effective date of this Order, Dr. Martin shall provide a copy of this Order to any specialty or subspecialty board of the American Board of Medical Specialties or the American Osteopathic Association Bureau of Osteopathic Specialists under which he currently holds or has previously held certification.

   Further, within 30 days of the date of each such notification, Dr. Martin shall provide documentation acceptable to the Secretary and Supervising Member of the Board demonstrating that the required notification has occurred.

   This requirement shall continue until Dr. Martin receives from the Board written notification of the successful completion of his probation.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

Ronda Shamansky
Hearing Examiner