BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

GEORGIA COMPOSITE MEDICAL BOARD, **Petitioner,**	:	
	:	Docket No.: OSAH-CSBME-PHY-1606610-Walker
v.	:	
SAMUEL MINTLOW, M.D., **Respondent.**	:	Agency Reference No.: 028824

INITIAL DECISION

I. Procedural History

On August 11, 2015, the Georgia Composite Medical Board (hereinafter "Petitioner" or "Board") issued a Statement of Matters Asserted seeking final disciplinary action against Respondent's license to practice medicine. An administrative hearing was held on October 19, 2015. Petitioner was represented by J. David Stubins, Esq. Respondent failed to appear.[1] After considering the evidence presented at the final disciplinary hearing, the undersigned recommends that Respondent's license be **REVOKED**.

[1] The evidence at hearing demonstrated that the Board attempted to serve Respondent by making the following diligent efforts: (1) After failing to contact Respondent via mail, the Board attempted to personally serve Respondent on September 23, 2015, at the address he had listed with the Board, 3241 Linda's Circle, Conyers, Georgia; (2) Jason O'Toole, a senior agent with the Board, verified the Linda's Circle address through the tax assessor of Rockdale County and law enforcement sources; (3) while attempting personal service at the Linda's Circle address, O'Toole observed in the driveway a black 1997 Infiniti Q45 previously determined to be registered to Respondent; (4) O'Toole also observed that a package addressed to Respondent that he had seen during his previous visit to the Linda's Circle address on February 4, 2015, was no longer at the front stoop, but a letter from the Attorney General served by O'Toole on that date was lying partially decomposed on the stoop; (5) during the September 23, 2015, visit to the Linda's Circle address, O'Toole did not get a response at the door and left the notice of hearing and a copy of the Statement of Matters Asserted on the windshield of the Infiniti Q45. Under O.C.G.A. § 43-1-19(k), if the licensee or applicant cannot, after diligent effort, be located, the division director shall be deemed to be the agent for service and service upon that director shall be deemed to be service upon the licensee or applicant. On September 23, 2015, LaSharn Hughes, the Board's executive director and custodian of records, was served on Respondent's behalf. (Transcript at pp. 5-27; Exhibits P-1 through P-7).

II. Findings of Fact

A. Background

1.

Respondent holds a license to practice as a physician in the State of Georgia, and has held such certificate at all times relevant to the issues presented for hearing. Respondent's license expires in December 2015. (Statement of Matters Asserted ¶ 1; Transcript at p.7 (hereinafter T.)).

2.

In April 2011, Respondent was hired to work at Liberty Wellness Center (or "the clinic") in Norcross, Georgia. (T. 8, 31). The clinic was co-owned by Charles Lang and Mark DelPercio. (T. 93-94).

3.

Liberty Wellness Center was located in an unmarked building. Neither the building nor its signage identified the clinic. (T. 62).

4.

The clinic's waiting room was crowded, typically holding at least 70 individuals. Individuals would have to stand or sit on the floor because there was no available seating. (T. 49, 55). The examination room consisted of a massage table that served as an examination table. (T. 44, 49-50).

5.

Only two people worked at Liberty Wellness Center, Respondent and the clinic's co-owner, DelPercio. DelPercio's duties included arranging appointments, handling patient check-ins, collecting payments, making copies of prescriptions, and taking patients' blood pressure and weight. He did not have any medical training. (T. 41, 43, 48, 50-54, 76-77).

B. Drug Enforcement Agency Investigation

6.

From June 2011 to June 2012, the Drug Enforcement Agency ("DEA") conducted an investigation into Liberty Wellness Center. (T. 29, 91-93, 114).

7.

DEA task force officers Samuel Vickery and Matthew Lawson testified as to their involvement in the DEA investigation. The investigation included visits to the clinic by both officers, who posed as patients. (T. 28-116).

8.

Officer Vickery testified that he visited the clinic four times pretending to be a patient with lower back pain. He recorded his visits via a hidden video camera. At the time of the undercover visits, Vickery did not have back problems and was not taking any medication for back pain. (T. 32-36; Exhibits P-8 through P-11).

9.

During Officer Vickery's surveillance of the clinic and his undercover visits:

- While monitoring the clinic's parking lot, he observed several patients arrive at the clinic in out-of-state vehicles, with four to five individuals riding in each car. (T. 30-32).
- He noted patients paid $300 in cash for each visit. (T. 51-52).
- At his first appointment, Vickery presented Magnetic Resonance Imaging (hereinafter "MRI") to Respondent; Respondent noted that the MRI "didn't show

much." (T. 47). Respondent did not request Vickery provide prior medical or pharmacy records. (T. 33-34, 38-40).

- During all of his visits, Vickery submitted samples for urine screen drug tests. However, Respondent only addressed the test results with Respondent in one instance, to state that Respondent had not tested positive for any drugs. Vickery testified that a negative urine screen test would suggest that a patient was selling the medications he was being prescribed, rather than taking them as directed. (T. 40-42, 59-60, 66).
- Vickery also informed Respondent that he had previously gotten his medication "off the street," and that he was "hooked on the stuff." He told Respondent that he only wanted medication and did not want to pursue other avenues of relief, and scratched his hand and fidgeted to simulate withdrawal symptoms. At no time did Respondent address these comments or behaviors with Vickery. (T. 42-43, 46-47).
- Vickery's first visit lasted approximately thirty minutes. Respondent spent a few minutes pointing out parts on a model of a spine on his desk. However, Respondent spent "the majority of the time" discussing Vickery's need to drink water to rehydrate the discs in his back. (T. 43-44, 47, 52).
- The physical examination lasted approximately two minutes. Respondent did not ask Vickery to take off his shirt. Respondent tested Vickery's knee reflex, had him lie down and lift up his right leg, and then had Vickery lay face down while he pushed on his spine. Vickery only expressed pain one time while Respondent was pushing on his spine. (T. 44-46).

- At the end of the first visit, Respondent prescribed Vickery 90 tablets of oxycodone 30mg, a Schedule II narcotic; 30 tablets of Xanax 1mg, a Schedule IV drug; and Naproxen. (T. 47-48).
- During Vickery's second visit to the clinic, Respondent's examination lasted approximately six seconds, with Respondent running his fingers down Vickery's back and asking how he was doing. (T. 57-58).
- At the second visit, Vickery began what he characterized as "negotiations" with Respondent regarding his prescriptions. Vickery also informed Respondent that he was not using the anti-inflammatory medication Naproxen because it was "no good" for him and he was "throwing alcohol on top of it," but Respondent "just kind of [blew] right by that." Vickery told Respondent that he wanted something to "break through pain" and asked for "oxycodone 15 milligrams" to replace the Naproxen. Respondent did not agree, but instead offered to increase the oxycodone 30mg from 90 tablets to 120 tablets. Vickery also asked Respondent to switch out the oxycodone prescription for Opana, a Schedule II drug that is more potent and expensive. Respondent told Vickery that he would not prescribe Opana on top of the oxycodone 30mg, and he continued to refuse even after Vickery offered Respondent money. Respondent ultimately prescribed 90 tablets of Opana 40mg, 30 tablets of Xanax 1mg, and Naproxen. (T. 57-59, 63-67).
- During Vickery's third visit to the clinic, Respondent's examination, which lasted about eleven seconds, consisted of running his fingers up and down Vickery's back while Vickery was seated in a chair in Respondent's office. There was no further discussion of Vickery's medical condition. (T. 67-69, 71).

- At the third visit, Vickery offered Respondent $200 to write a prescription of Xanax for a friend, which Respondent declined. However, Respondent increased Vickery's prescription for Xanax from 30 tablets to 45 tablets, based on Vickery's request for more Xanax to "get [him] through the whole month," and on Vickery's claim that his previous doctor had prescribed a higher dosage. Respondent also prescribed an additional 40 tablets of Percocet 10/325, based solely on Vickery's request for the medication. Additionally, Respondent again prescribed Opana. (T. 69-71).
- During Vickery's fourth visit to the clinic, Respondent examined Vickery in his office by pushing on his back and asking whether it hurt. Vickery responded that it did not hurt, and that he was "having a good day." The exam lasted fifty to fifty-five seconds. (T. 77-79).
- At the fourth visit, Vickery told Respondent that he had spoken with others waiting in the lobby about oxycodone 30mg tablets, and was told that they were available at Stacy's Pharmacy. Stacy's Pharmacy appeared to have an agreement with Liberty Wellness Center, whereby DelPercio would call the pharmacy to inform it how many patients were being sent its way with prescriptions to fill. (T. 77-78, 80).
- Vickery testified that he went back to the clinic a fourth time specifically to ask for 25-milligram tablets of oxycodone, which are not commercially available. Vickery wanted such a dosage so he would have a reason to go to Stacy's Pharmacy, a pharmacy that compounded doses that were not commercially available, so that he could "see what they charge and how they operate." The pharmacy was under investigation by the DEA. (T. 78, 80).

- Also during the fourth visit, Vickery told Respondent that his pain level was about three out of ten. At this point, Respondent informed Vickery that he did not really need medication, and he and Vickery engaged in a back-and-forth exchange during which Vickery asserted that he did need the drugs. Vickery told Respondent "I can be in more pain if I need to be . . . ." Respondent laughed repeatedly during their conversation. (T. 79-84).
- At the end of the fourth visit, Respondent prescribed Vickery 90 tablets of oxycodone 25mg, which were increased from 60 tablets upon Vickery's request; 30 tablets of Xanax 1mg; and 30 tablets of SOMA. When Respondent noted that Vickery had not been taking his previously prescribed medication, Vickery first said that he took the medication the other day, then said "just don't ask, doc." Respondent again reacted to the comment by laughing. (T. 81-82).

10.

Officer Lawson testified that he served as the DEA case agent for the investigation into Liberty Wellness Center. (T. 85, 92).

11.

Officer Lawson also posed as a patient during two visits to the clinic. (T. 105). During these undercover visits:

- Lawson maintained to Respondent that he was experiencing a pain level of five, and gave "noncommittal answers" regarding pain during the examinations. (T. 106).
- Lawson did not provide Respondent any medical records except for an MRI he obtained, pursuant to DelPercio's instructions, from Georgia Imaging. Georgia

Imaging was located in a trailer and referred its clients to Liberty Wellness Center. (T. 106-108).

- Respondent prescribed oxycodone 15mg during Lawson's first visit, and agreed to increase the prescription to oxycodone 30mg during the second visit. (T. 109-10).

12.

After further investigation, the DEA determined that a significant number of the Liberty Wellness Center's patients came from Tennessee. Based on 880 patient medical records that were seized from the clinic, 688 of the patients came from Tennessee, and only 54 lived in Georgia. Lawson testified that Lang, the clinic's co-owner, was from Tennessee and would round up individuals he knew to be traffickers and send them to his clinic. (T. 95-99, 102; Exhibit P-12).

13.

Out of the 880 patient files reviewed by the DEA, 874 patients received oxycodone and 6 did not. Officer Lawson testified that patients who were receiving "virtually the same prescription" constitutes a red flag for a pain clinic that is improperly prescribing medication. (T. 113-14; Exhibit P-12).

14.

Based on the DEA's investigation into Liberty Wellness Center, the deputy assistant administrator of the DEA's Office of Diversion Control issued Respondent an Order to Show Cause on July 2, 2013. The Show Cause Order proposed the revocation of Respondent's DEA Certificate, which authorized him to dispense controlled substances in schedules II through V, and the denial of any pending application to renew or modify his registration. Specifically, the Show Cause Order alleged the following:

(a) Through April of 2012, Liberty Wellness Center unlawfully distributed controlled substances, including oxycodone, hydrocodone, Xanax, and SOMA, for no legitimate medical purpose, through prescriptions issued under Respondent's DEA registration;

(b) Between August 2, 2011, and December 1, 2011, the DEA conducted several undercover visits to the clinic, during which time Respondent issued controlled substances prescriptions to undercover officers for other than legitimate medical purposes or outside the usual course of professional practice (citing 21 C.F.R. § 1306.04(a) and O.C.G.A. § 16-13-41(f)); and

(c) Respondent violated Georgia medical practice standards by failing to maintain appropriate patient records that supported the prescribing of controlled substances and by failing to conduct appropriate physical examinations or maintain substantial supporting documentation to support large doses of narcotic medications (citing Ga. Comp. R. & Regs. rr. 360-3-.02(7) and 360-3-.02(14)).

(Statement of Matters Asserted, Exhibit 1 at 3630-31).

15.

An Administrative Law Judge for the DEA conducted an evidentiary hearing in Atlanta, Georgia, on October 8 and 9, 2013, during which both parties had the opportunity to submit evidence, call witnesses, and conduct cross-examinations. Following the hearing, both parties submitted briefs containing their proposed findings of fact. (Statement of Matters Asserted, Exhibit 1 at 3631).

16.

During the hearing, the Administrative Law Judge heard testimony from three DEA task force officers—including officers Vickery and Lawson—who testified as to their roles in their investigation into Liberty Wellness Center. The Administrative Law Judge also heard testimony from the Government's expert witness, Thomas E. Hurd, M.D., and Respondent's expert witness, Carol A. Warfield, M.D. (Statement of Matters Asserted, Exhibit 1 at 3631-47).

17.

On December 18, 2013, the Administrative Law Judge for the DEA issued his recommendation that Respondent's DEA Certificate be revoked, with the following finding:

> [B]etween February 2011 and April 2012, . . . Respondent issued prescriptions . . . for controlled substances, including oxycodone and Xanax to [ten patients] and to [three] undercover DEA agents . . . under conditions that were inconsistent with the usual course of professional practice for [a] physician in Georgia and that were not for a legitimate medical purpose."

Both parties filed exceptions to the Administrative Law Judge's decision. (Statement of Matters Asserted, Exhibit 1 at 3631).

18.

On December 30, 2014, the Deputy Administrator with the DEA's Office of Diversion Control adopted the Administrative Law Judge's ultimate conclusions. Pursuant to 21 U.S.C. §§ 823(f) and 824(a)(4), the Judge ordered that Respondent's DEA Certificate be revoked, and that any application to renew or modify the same registration be denied. (Statement of Matters Asserted, Exhibit 1 at 3653).

19.

As a result of the investigation, Respondent and the clinic's owners faced felony charges. Respondent ultimately pled guilty to a misdemeanor. (T. 90).

C. Investigation by Board

20.

Carlos Jorge Giron has been a physician for approximately twenty-three years. He holds a B.S. from the University of Miami and an M.D. from the University of South Florida College of Medicine. He has practiced pain management and anesthesiology in Georgia since July of 1996. Dr. Giron has worked at the Pain Institute of Georgia in Macon as a staff physician, its medical

director, and its CEO and president. He is certified by the American Academy of Pain Management, is the founder and former executive director of the Georgia Society of Interventional Pain Physicians, and a member of the Medical Association of Georgia Task Force on Prescription Drug Monitoring. He also has published articles, lectured, and provided expert testimony in the field of pain management. Dr. Giron has been designated by the Board as a pain specialist and serves as a peer reviewer for the Board. (T. 115-26; Exhibit P-13).

21.

In 2012, the Board contacted Dr. Giron and requested that he review records for nine of Respondent's patients and determine whether or not Respondent's treatment conformed to the minimal standards of acceptable and prevailing medical practice. (T. 152-53; Exhibit P-14).

22.

Dr. Giron reviewed the patient records. (Exhibit P-14). Based on his review, Dr. Giron concluded that although Respondent's diagnoses met the minimum standard of acceptable and prevailing practice of medicine in the State of Georgia, his treatment and documentation for these patients constituted a departure from or a failure to conform to the minimum standards of acceptable and prevailing practice. (T. 154, 173; Exhibit P-14).

23.

On August 11, 2015, the Board issued a Statement of Matters Asserted charging that Respondent's treatment of nine patients—identified as A.C., A.F., B.M., J.B., J.S., R.C., S.M., T.H. and T.P.—departed from and failed to conform to the minimal standards of acceptable and prevailing medical practice. (Statement of Matters Asserted ¶ 14).

24.

The Board requested that Dr. Giron review the videos recorded during the officer's undercover visits to Liberty Wellness Center, which were played during the hearing. Dr. Giron testified that,

based on his review, the care provided by Respondent to Vickery was below the minimum standard of care. (T. 125-26). Specifically, Dr. Giron concluded the following:

- There was no sufficient justification for Respondent to start Vickery on a prescription of opioids, particularly since Vickery did not claim that he was in much pain. Respondent also issued prescriptions in doses that were excessive for Vickery's discussed condition. (T. 126-29, 138-40, 149-51, 160-61).
- The exams performed by Respondent were "cursory." (T. 127). A proper examination would include a thorough examination of the lower back; palpation; listening to the heart, lungs, and abdomen; a visual inspection for mal-alignments or other abnormalities; having the patient perform certain maneuvers to check for range of motion; and an evaluation of the musculature surrounding the lumbar spine. (T. 127-30, 132).
- Respondent did not address Vickery's initial complaint of shoulder pain. (T. 127).
- During Vickery's visit, Respondent did not review the MRI film itself or perform any neurologic examination. (T. 131).
- Respondent failed to exercise due diligence by obtaining Vickery's previous medical records or pharmacy records. (T. 134-35).
- Respondent failed to explore other treatment options beyond medication, such as physical therapy or surgical consultations. (T. 136-37).
- Respondent's reference to water as a possible treatment to rehydrate Vickery's discs was not a reasonable treatment option. (T. 137-38).
- Respondent failed to follow up on Vickery's urine drug screen tests, even after he commented that one of the tests came back negative for the drugs, which indicates

that the patient is noncompliant and has misused or abused the prescription. The standard of care calls for a physician, at the very least, to not increase medication at that point. (T. 142-4).

- Respondent failed to adequately respond to Vickery's comments that he needed to have drugs and that he got "stuff" off the street, nor did he adequately document Vickery's requests for prescriptions for other people. The standard of care calls for such instances to be documented extensively. (T. 147-48).
- Respondent should have discussed drug prevention or drug abuse programs in light of Vickery's noncompliance with the prescriptions, the negative urine drug screen tests, and the requests for medication for other people. (T. 148-49).

25.

Dr. Giron also discussed his review of the patient records provided by the Board. All of the patients presented with some form of back pain and were prescribed opioids during their first visit to the clinic. (T. 154, 162; Exhibits P-14 through P-24).

26.

In his Peer Review Report, Dr. Giron concluded that Respondent's diagnostic methods were within minimum standards, but that his treatment and documentation for these patients constituted a departure from or a failure to conform to the minimum standards of acceptable and prevailing practice of medicine in the State of Georgia. (T. 154, 173; Exhibit P-14).

27.

Dr. Giron originally had concluded that Respondent did meet the minimum standard of care regarding the patients' diagnoses because, although documentation was sparse, the examinations of the nine patients did focus on the affected area of the presenting complaints. (Exhibit P-14).

After observing Respondent's examinations of Officer Vickery, Dr. Giron determined that possibly he should reassess this conclusion, given the amount of time spent on the examinations and the lack of a neurologic exam. Dr. Giron testified that the examinations only focused on tenderness in the lumbar spine and did not include any assessment of function, range of motion, muscle tone, muscle strength, or gait. (T. 158).

28.

Second, with regard to the patients' treatment, Dr. Giron testified that Respondent breached the standard of care for all of the patients by failing to engage in interventional care or other treatment options, failing to justify the medications he prescribed, and failing to exercise vigilance against possible abuse and addiction. (T. 173-74).

29.

According to Dr. Giron, Respondent failed to engage in interventional care or other treatment options, and instead primarily offered pharmacologic treatments to the patients. As to the pharmacologic treatments, Respondent "[v]ery rarely" addressed the side effects a patient might have in response to the drugs he or she was prescribed. Respondent did offer trigger point injections as a consideration to several patients, but only patient S.M. received such an injection. Furthermore, Respondent did not notate why he gave S.M. the trigger point injection, nor did he record the substance or dosage of the injection. Respondent also failed to document any adequate medical justification for the reduction of S.M.'s oxycodone prescription following the trigger-point injection. (T. 162-66, 168; Exhibits P-14 & P-15).

30.

Respondent failed to adequately justify the medications or doses he prescribed to his patients. In several instances, Respondent prescribed oxycodone in 25-milligram doses, which are not

available commercially in the United States and thus are "[e]xtremely unusual" to prescribe.[2] (T. 138-39; Transcript, Exhibit P-14). Also, Respondent repeatedly acquiesced to requests for more pain medication without offering any medical justification for the increases, or without substantiating the patient's complaints. (T. 166-68; Exhibit P-14).

31.

Dr. Giron also testified that Respondent failed to exercise vigilance against possible abuse and addiction among his patients. Although urine drug screen tests were performed during the nine patients' first visits to the clinic, no further testing was performed on subsequent visits. Also, in instances where the urine drug screens showed negative results, Dr. Giron did not act on this indicator of noncompliance by asking the patients why they were no longer taking the prescribed drugs. (T. 159, 167; Exhibit P-14). Additionally, Respondent's patient records do not include any references to the involvement of counseling, psychological evaluations, or any type of care dealing with drug dependence. (T. 166-68). The records further show that three of the patients—J.S., S.M., and B.M.—were simultaneously prescribed oxycodone, Xanax, and SOMA. Dr. Giron testified that this "cocktail" of medication is not optimal for treatment purposes, because SOMA is a sedative that can add to the intensity of the high from a narcotic such as oxycodone, and Xanax helps ease the coming down from the high. Dr. Giron stated that there was no legitimate purpose for this combination of drugs, in the quantities and frequencies in which they were prescribed, and "in instances where there was lack of documentation for the actual medical justification." (T. 169-71; Exhibit P-14).

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[2] Initially in his Peer Review Report, Dr. Giron noted that the prescribing of oxycodone in 25-milligram doses "reflects that [Respondent] was either uneducated or unaware that such a dose did not exist at the time he prescribed them." (Exhibit P-14). However, at the hearing, Dr. Giron referred to Officer Vickery's testimony about a compound pharmacy providing oxycodone in 25-milligram doses, and stated that Respondent's prescription of 25-milligram doses still was "very concerning" because it "speaks more of somebody who had ulterior motives." (T. 138-39).

32.

Regarding recordkeeping for all nine patients, Dr. Giron noted that Respondent's records do not include past medical histories, past surgical histories, social histories, reviews of systems, or family histories, as are standard in any medical practice. Dr. Giron testified that these types of previous records are essential to ensure a patient's safety and possibly prevent abuse of narcotics. Dr. Giron also noted that several of the patients' MRIs were ordered close to the time of the patients' first appointments at Liberty Wellness Center, which is extremely unusual in current-day medical practices. (T. 155-58; Exhibit P-14).

III. Conclusions of Law

1.

The Board bears the burden of proof in this matter. Ga. Comp. R. & Regs. r. 616-1-2-.07(1). The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. r. 616-1-2-.21(4).

2.

Professional licensing boards may discipline a licensee upon a finding by a majority of the entire board that the licensee has engaged in unprofessional conduct that fails to conform to the minimal reasonable standards of acceptable and prevailing practice. O.C.G.A. § 43-1-19(a)(6).

3.

In turn, under O.C.G.A. § 43-34-8(a), the Board has the authority to discipline a physician upon a finding that the licensee has:

> (7) Engaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice need not have resulted in actual injury to any person. As used in this paragraph, the term "unprofessional conduct" shall include any departure from, or

failure to conform to, the minimum standards of acceptable and prevailing medical practice and shall also include, but not be limited to, the prescribing or use of drugs, treatment, or diagnostic procedures which are detrimental to the patient as determined by the minimum standards of acceptable and prevailing medical practice or by rule of the board;

...

(21) Failed to comply with federal laws and standards relating to the practice of medicine or other health care profession regulated under this chapter, the regulations of drugs, the delivery of health care, or other related laws;

...

4.

Pursuant to Ga. Comp. R. & Regs. r. 360-3-.02, unprofessional conduct includes:

(1) Prescribing controlled substances for a known or suspected habitual drug abuser or other substance abuser in the absence of substantial justification.

...

(7) Failing to maintain appropriate patient records whenever Schedule II, III, IV or V controlled substances are prescribed. Appropriate records, at a minimum, shall contain the following:

(a) The patient's name and address;

(b) The date, drug name, drug quantity and patient's diagnosis necessitating the Schedule II, III, IV or V controlled substances prescription; and

(c) Records concerning the patient's history.

...

(14) Failing to use such means as history, physical examination, laboratory, or radiographic studies, when applicable, to diagnose a medical problem.

...

(18) Any other practice determined to be below the minimum standards of acceptable and prevailing practice.

As specifically regards pain management, Ga. Comp. R. & Regs. r. 360-3-.06(2) provides that the minimum standards of practice include, but are not limited to the following:

> (c) When initially prescribing a controlled substance for the treatment of pain or chronic pain, a physician shall have a medical history of the patient, a physical examination of the patient shall have been conducted, and informed consent shall have been obtained.
>
> ...
>
> (d) When a physician is treating a patient with controlled substances for pain or chronic pain for a condition that is not terminal, the physician shall obtain or make a diligent effort to obtain any prior diagnostic records relative to the condition for which the controlled substances are being prescribed and shall obtain or make a diligent effort to obtain any prior pain treatment records . . . . If the physician has made a diligent effort and is unable to obtain prior diagnostic records, then the physician must order appropriate tests to document the condition requiring treatment for pain or chronic pain. If the physician has made a diligent effort and the prior pain treatment records are not available, then the physician must document the efforts made to obtain the records and shall maintain the documentation of the efforts in his/her patient record.
>
> (e) When a physician determines that a patient for whom he is prescribing controlled scheduled substances is abusing the medication, then the physician shall make an appropriate referral for treatment for substance abuse.
>
> (f) When prescribing a Schedule II or III controlled substance for 90 (ninety) days or greater for the treatment of chronic pain arising from conditions that are not terminal or patients who are not in a nursing home or hospice, a physician must have a written treatment agreement with the patient and shall require the patient to have a clinical visit at least once every three (3) months, while treating for pain, to evaluate the patient's response to treatment, compliance with the therapeutic regiment and any new condition that may have developed and be masked by the use of Schedule II or III controlled substances.
>
> ...
>
> (g) When prescribing a Schedule II or III controlled substance for 90 (ninety) days or greater for the treatment of chronic pain arising from conditions

that are not terminal or patients who are not in a nursing home or hospice a physician must monitor compliance with the therapeutic regimen.

...

(h) The physician shall respond to any abnormal result of any monitoring and such response shall be recorded in the patient record.

6.

The Board is also authorized to take disciplinary action pursuant to Ga. Comp. R. & Regs. r. 360-3-.03 for violations of laws, rules, and regulations which relate to or in part regulate the practice of medicine. These laws, rules, and regulations include, but are not limited to, the following:

(2) The Georgia Controlled Substances Act (O.C.G.A. T. 16, Ch. 13, Art. 2);

...

(4) The Federal Controlled Substances Act (21 U.S.C. Ch. 13);

...

(6) The Rules of the Georgia Composite Medical Board, Ch. 360, Rules and Regulations of the State of Georgia;

...

(8) The Code of Federal Regulations Relating to Controlled Substances (21 C.F.R. par. 1306);

...

7.

Pursuant to O.C.G.A. § 43-34-8(b)(1), if the Board finds cause for discipline, it may, under Ga. Comp. R. & Regs. r. 360-3-.01, deny, revoke, suspend, fine, reprimand, or otherwise limit the license of a physician. See also O.C.G.A. §§ 43-1-19(d), 43-34-8(b)(1).

8.

The Board proved, by a preponderance of the evidence, that Respondent engaged in unprofessional conduct or a practice harmful to the public in violation of O.C.G.A. §§ 43-1-19, 43-34-8 and Ga. Comp. R. & Regs. r. 360-3-.02. These practices departed from, or failed to conform to, the minimum standards of acceptable and prevailing medical practice.

9.

As an initial matter, Respondent failed to adequately take Officer Vickery's medical history, perform necessary physical examinations, and make diagnoses before prescribing controlled substances. There was no documentation in the record reflecting that, in conjunction with prescribing controlled substances, Respondent sought alternative treatments or medications, or that he evaluated the officer's responses to the medications prescribed. Although Respondent at one point told Officer Vickery that he did not appear to need drugs, Respondent continued to give the undercover officer prescriptions.

10.

Not only did Officer Vickery's negative drug screen reflect that he had not taken his medications as prescribed, but Vickery repeatedly requested new drugs such as Opana, negotiated for higher doses despite reporting minimal pain, presented withdrawal symptoms such as scratching and fidgeting, and asked Respondent twice to write out prescriptions for other people. Despite these signs of misuse and abuse of prescription drugs, Respondent continued to prescribe controlled substances and failed to document any of these instances, both violations of the standard of care under Ga. Comp. R. & Regs. r. 360-3-.06(2).

11.

Based on the medical records of patients A.C, B.M., J.B., J.S., R.C., S.M., T.H. and T.P., Respondent's treatment and recordkeeping did not meet the minimum standard of care. With the exception of patient S.M., Respondent primarily offered pharmacologic treatment options, prescribed without any justification and often at the request of the patients themselves. He also failed to observe or act upon indications of possible misuse or abuse of medications. These actions proved detrimental to the patients' health because he enabled their potential addictions, or detrimental to the public's health because he allowed patients to distribute the drugs illegally. As for treatment records, Respondent did not make any attempt to include patients' past medical histories, including pharmacy logs of prior medications. This lack of diligence in obtaining prior medical history is a violation of the standard of care under Ga. Comp. R. & Regs. r. 360-3-.06(2).

12.

The aforementioned violations provide sufficient justification to revoke Respondent's license. Further, in revoking Respondent's DEA Certificate, the DEA's Office of Diversion Control found that Respondent had violated federal regulation 21 C.F.R. § 1306(a), which requires that prescriptions for controlled substances be issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." The DEA further concluded that Respondent had violated O.C.G.A. § 16-13-41(f), which requires prescriptions to be issued by a physician "in the usual course of his professional practice" and "for a legitimate medical purpose," as well as Ga. Comp. R. & Regs. rr. 360-3-.02(7) and 360-3-.02(14), which pertain to recordkeeping. Such violations constitute grounds for disciplinary action, pursuant to Ga. Comp. R. & Regs. r. 360-3-.03.

IV. Decision

Based on the aforementioned Findings of Fact, the Board has proven by a preponderance of the evidence its allegations that Respondent engaged in unprofessional conduct that failed to conform to the minimal standards of acceptable and prevailing practice and engaged in conduct that violated O.C.G.A. § 43-1-19, 43-34-8, and Ga. Comp. R. & Regs. rr. 360-3-.02 and 360-3-.03. For the reasons stated, the undersigned recommends Respondent's license be **REVOKED.**

SO ORDERED, this 2 **day of** December, **20**15

RONIT WALKER
Administrative Law Judge