STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

Petitioner,

v. **Case No. 2012-09787**

ZVI HARRY PERPER, M.D.,

Respondent.

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ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel and files this Administrative Complaint before the Board of Medicine against the Respondent, Zvi Harry Perper, M.D., hereinafter referred to as "Respondent," and in support thereof alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed physician in the state of Florida, having been issued license number ME 65525.

3. Respondent's address of record is 3025 Andrews Place, Boca Raton, Florida 33434.

4. Respondent does not hold any certifications from any specialty board recognized by the Florida Board.

5. At all times relevant to this complaint, Respondent practiced pain management at the Delray Pain Medical Center, located at 102 North Swinton Avenue, Delray Beach, Florida 33444.

FACTS RELATED TO PATIENT DM

6. From January 13, 2010, until December 17, 2010, Patient DM, a 24 year-old male, presented to Respondent for pain management. Patient DM presented with complaints of low back pain and right shoulder pain.

7. Respondent performed a cursory physical examination on Patient DM and obtained a medical history that did not contain any information regarding substance abuse or addiction. Respondent prescribed 210 tablets of Roxicodone 30 mg, 90 tablets of Soma 350 mg, 30 tablets of Ketoprofen 200 mg and 60 tablets of Xanax 2 mg.

8. Roxicodone, brand name for oxycodone, is commonly prescribed to treat pain. According to Section 893.03(2), Florida Statutes,

Roxicodone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of oxycodone may lead to severe psychological or physical dependence

9. Alprazolam (brand name Xanax) is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, alprazolam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.

10. Ketoprofen is a non-steroidal anti-inflammatory drug (NSAIDs). Ketoprofen works by reducing hormones that cause inflammation and pain in the body.

11. Soma is the brand name for carisoprodol, a muscle relaxant commonly prescribed to treat muscular pain. According to Section 893.03(4), Florida Statutes, carisoprodol is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the

United States, and abuse of carisoprodol may lead to limited physical or psychological dependence relative to the substances in Schedule III

12. Patient DM presented with previously performed lumbar and cervical x-rays that revealed nothing significant regarding DM's back pain.

13. Regardless, beginning on or about January 13, 2010, and continuing until December 10, 2013, Respondent regularly prescribed 224 tablets of Roxicodone 30 mg, 90 tablets of Roxicodone 15 mg, 90 tablets of Soma 350mg, 30-60 tablets of Xanax 2 mg, and "Serum" to DM.

14. During the period from January 2010 until December 2010, Respondent's medical records do not document an adequate medical justification for Respondent to prescribe the prolonged use of controlled substances to Patient DM.

15. Respondent's assessment of DM was consistently low back pain, and right shoulder and neck pain. The medical records contain no diagnostic attempt to verify or explain the patient's chronic complaint.

16. Respondent did not create a written treatment plan other than treatment with controlled substances for DM and he failed to create or document objectives to be used to determine the success of treatment with controlled substances.

17. Respondent did not document discussion with DM about the risks of long-term use of controlled substances.

18. Respondent did not refer Patient DM to a specialist or order additional testing to pursue the determination of the etiology of his back pain.

19. The prevailing professional standard of care at the time Respondent treated Patient DM required that Respondent conduct and create a complete physical and medical history including prior treatment of DM's chronic pain.

20. The prevailing professional standard of care required the pursuit of the etiology of DM's chronic pain either through additional testing or consultation with specialists.

21. The prevailing professional standard of care required that a physician counsel a patient regarding the risks of prolonged use of controlled substances for the treatment of pain and to try additional modalities of treatment other than just controlled substances.

22. The prevailing professional standard of care required a physician to create a treatment plan that provided an objective

methodology for determining the success of long-term treatment with controlled substances as well as alternative treatments.

COUNT ONE

23. Petitioner realleges and incorporates by reference the allegations in paragraphs 1 through 22 as if fully set forth herein.

24. Section 458.331(1)(t)1, Florida Statutes (2009-2010), subjects a physician to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes (2009-2010). "Medical malpractice" is defined by Section 456.50(1)(g), Florida Statutes (2009-2010), as "the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure." Section 456.50(1)(e), Florida Statutes (2009-2010), provides that the "level of care, skill, and treatment recognized in general law related to health care licensure" means the standard of care that is specified in Section 766.102(1), Florida Statutes (2009-2010), which states as follows:

> The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

25. Section 458.331(1)(t)1, Florida Statutes (2009-2010), directs the Board of Medicine to give "great weight" to this provision of Section 766.102, Florida Statutes (2009-2010).

26. From January of 2010 until December of 2010, Respondent failed to meet the prevailing professional standard of care by failing to do one or more of the following in the treatment of Patient DM:

a. By failing to perform a thorough physical examination and obtain an adequate medical history;

b. By failing to create a treatment plan and by failing to create or document any objective determination as to the success of the treatment of the patient;

c. By failing to establish sound clinical grounds to justify the need for the controlled substances he prescribed; and

d. By failing to refer DM for additional evaluations and consultations to pursue the determination of the etiology of Patient DM's pain.

27. Based on the foregoing, Respondent failed to meet the prevailing professional standard of care and, therefore, violated Section 458.331(1)(t)1, Florida Statutes (2009-2010).

COUNT TWO

28. Petitioner realleges and incorporates by reference the allegation in paragraphs 1 through 22 and paragraph 27.

29. Section 458.331(1)(m), Florida Statutes (2009-2010), subjects a licensee to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

30. Respondent failed to keep legible medical records that justified Respondent's course of treatment of Patient DM, specifically, by failing to document one or more of the following:

a. By failing to document the performance of a complete medical history and physical examination;

b. By failing to document the creation of a written treatment plan with objectives to determine the success of the treatment of the patient;

c. By failing to document any history related to drug abuse or dependence and by failing to document monitoring of his medication levels;

d. By failing to document the referral of Patient DM for additional evaluations and consultations to determine the etiology of his continued pain; and

e. By failing to keep legible medical records that justify the course of treatment solely with large quantities of controlled substances and no documentation of consideration of alternative treatment modalities for DM.

31. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2009-2010).

FACTS RELATED TO PATIENT BG

32. From on or about February 9, 2010, through February 10, 2011, Patient BG, a then 27 year-old male, presented to Respondent for treatment of low back pain due to a fall in 2007. Respondent's medical records indicate that BG had prior illicit use of controlled substances and that "no imaging available." However, Patient BG's medical records contain

an MRI of the lumbar spine performed on August 5, 2009, indicating small disc protrusions with no root effacement.

33. On or about February 9, 2010, Respondent diagnosed Patient BG with lumbar pain with "bulge multiple". Respondent ordered an MRI of DR's cervical spine.

34. Respondent prescribed 150 tablets of Roxicodone 30 mg, 90 tablets of Roxicodone 15 mg, 90 tablets of Soma 350 mg and 30 tablets of Xanax 2 mg.

35. In an in-office drug screen, Patient BG tested positive for benzodiapines, oxycodone and marijuana. Respondent's medical records contain no documentation of any discussion with the patient about the test results or source of the medication.

36. Between February of 2010 and February of 2011, Patient BG presented to Respondent monthly for follow-up. Beginning in June of 2010, Respondent increased Patient BG's dose of Roxicodone from 150 tablets of Roxicodone 30 mg monthly to 180 tablets 30 mg and continued his prescriptions for 90 tablets for Roxicodone 15 mg.

37. Respondent's records indicate in May and June of 2010, Patient BG was to have an MRI and lab tests. Subsequent records contain no documentation of the results of an MRI or lab test.

38. In addition to monthly prescriptions for Roxicodone, Respondent also prescribed Patient BG 30 2 mg tablets of Xanax monthly until October 21, 2010, when Respondent discontinued prescribing Xanax and added a prescription for 45 10 mg tablets of Valium. Respondent's medical records contain no explanation for the deletion of Xanax and the addition of Valium.

39. Valium is the brand name for diazepam and is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, diazepam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of diazepam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

40. Respondent's assessment of BG was consistently low back pain, and shoulder and neck pain. The medical records contain no diagnostic attempt to verify or explain the patient's chronic complaint.

41. Respondent did not create a written treatment plan other than treatment with controlled substances for BG and he failed to create or document objectives to be used to determine the success of treatment with controlled substances.

42. Respondent did not order or document discussion with BG about the risks of long-term use of controlled substances.

43. Respondent did not refer Patient BG to a specialist or order additional testing to pursue determination of the etiology of the patient's neck and back pain.

44. The prevailing professional standard of care required Respondent to pursue determination of the etiology of BG's chronic back, shoulder and neck pain either through additional testing or consultation with specialists.

45. The prevailing professional standard of care required Respondent to counsel DM regarding the risks of prolonged use of controlled substances for the treatment of pain and to prescribe additional modalities of treatment other than just controlled substances.

46. The prevailing professional standard of care required that when prescribing long term treatment with large quantities of controlled

substances, Respondent create a treatment plan for BG that provided a methodology for determining the success of long-term treatment with controlled substances and alternative treatments.

47. The prevailing professional standard of care required the monitoring of a patient with a history of illicit drug use by a physician prescribing controlled substances to that patient to ensure that he is not abusing or diverting his prescriptions.

COUNT THREE

48. Petitioner realleges and incorporates by reference the allegations in paragraphs 1 through 5 and 32 through 47 as if fully set forth herein.

49. Section 458.331(1)(t)1, Florida Statutes (2009-2010), subjects a physician to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes (2009-2010). Medical malpractice is defined by Section 456.50(1)(g), Florida Statutes (2009-2010), as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

50. Level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care that is specified

in Section 766.102(1), Florida Statutes (2009-2010), which states as follows:

> The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

51. Between February of 2010 and February of 2011, Respondent failed to meet the prevailing professional standard of care by doing one or more of the following in the treatment of Patient BG:

a. By failing to consult with or refer BG to a specialist to pursue the etiology of the patient's pain;

b. By failing to establish sound clinical grounds to justify the need for the therapy he prescribed; and

d. By failing to monitor BG for medication abuse and by failing to monitor his medication levels; and

e. By failing to create a treatment plan and by failing to create or document any objective determination as to the success of the treatment of the patient.

52. Based on the foregoing, Respondent failed to meet the prevailing professional standard of care and, therefore, violated Section 458.331(1)(t)1, Florida Statutes (2009-2010).

COUNT FOUR

53. Petitioner realleges and incorporates by reference the allegations in paragraphs 1 through 5 and paragraphs 32 through 47 and paragraph 51 as if fully set forth herein.

54. Section 458.331(1)(m), Florida Statutes (2009-2010), subjects a licensee to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

55. Respondent failed to keep legible medical records that justified Respondent's course of treatment of Patient BG, specifically, by failing to document one or more of the following:

a. By failing to document the performance of a complete medical history and physical examination;

b. By failing to document the creation of a written treatment plan with objectives to determine the success of the treatment of the patient;

c. By failing to document any clinical basis for the quantity of controlled substances prescribed to the patient;

d. By failing to document the referral of Patient BG for additional evaluations and consultations to assist in the determination of the etiology of the patient's chronic pain; and

e. By failing to keep legible medical records that justify his course of treatment;

56. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2009-2010).

FACTS RELATED TO PATIENT JV

57. Between October 19, 2009 and August 3, 2010, Patient JV presented to Respondent with complaints of chronic neck and back pain with radicular pain. JV presented with a MRI of the lumbar spine from October 8, 2009, which indicated an L4-5 superiorly extruded disc herniation and a MRI of the cervical spine which indicated a small disc herniation at C3-4.

58. Respondent performed a limited history and physical examination of the patient and prescribed 180 tablets of Roxicodone 30 mg, 120 tablets of Lorcet 10/325 mg, 90 tablets of Flexeril 20 mg, and 60 tablets of Ketaprofen 100 mg.

59. Lorcet contains hydrocodone and acetaminophen and is the brand name for a drug that contains hydrocodone and is prescribed to treat pain. According to Section 893.03(3), Florida Statutes, hydrocodone, in the dosages found in Lorcet, is a Schedule III controlled substance that has a potential for abuse less than the substances in Schedules I and II and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to moderate or low physical dependence or high psychological dependence.

60. Flexeril is indicated as an adjunct medication to rest and physical therapy for relief of muscle spasm associated with acute, painful musculoskeletal conditions. Improvement is manifested by relief of muscle spasm and its associated signs and symptoms, namely, pain, tenderness, limitation of motion, and restriction in activities of daily living. Flexeril should be used only for short periods (up to two or three weeks) because adequate evidence of effectiveness for more prolonged use is not available

and because muscle spasm associated with acute, painful musculoskeletal conditions is generally of short duration and specific therapy for longer periods is seldom warranted.

61. On or about November 17, 2009, JV presented to Respondent for follow-up. Respondent's medical records are primarily illegible but it is clear that the patient "Feels improvement". Regardless, Respondent increased her prescriptions to 210 tablets of Roxicodone 30 mg, added 120 tablets of Roxicodone 15 mg, deleted the previously prescribed Lorcet and continued Flexeril, Lyrica and Ketoprofen.

62. On December 19, 2009, JV presented to Respondent for a regular follow-up visit. Although the medical records indicated that JV was "improving with meds," Respondent continued to increase, add and delete medication with no explanation. Respondent added 30 tablets of OxyContin 40 mg to the 210 Roxicodone. Respondent also added prescriptions for Valium and Neurontin.

63. Respondent did not prescribe alternative or additional methods of treating JV's pain or anxiety other than long-term use of controlled substances.

64. Respondent did not refer JV for diagnostic testing or consultation to determine the etiology of her chronic pain.

65. Respondent did not create a written treatment plan or an objective method of assessing the success of JV's treatment with controlled substances.

66. Respondent failed to monitor JV's compliance of medication usage.

67. The prevailing standard of care required Respondent to pursue a determination of the etiology of Patient JV's chronic pain or refer her for further evaluation or consultation.

68. The prevailing professional standard of care required that Respondent create a treatment plan for Patient JV that provided for some objective methodology for determining the success of long-term treatment with controlled substances and consideration of other treatment modalities.

COUNT FIVE

69. Petitioner realleges and incorporates by reference the allegations in paragraphs 1 through 5 and 57 through 68 as if fully set forth herein.

70. Section 458.331(1)(t)1, Florida Statutes (2009-2010), subjects a physician to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes (2009-2010). Medical malpractice is defined by Section 456.50(1)(g), Florida Statutes (2009-2010), as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

71. Level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care that is specified in Section 766.102(1), Florida Statutes (2009-2010), which states as follows:

> The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

72. Between February of 2010 and February of 2011, Respondent failed to meet the prevailing professional standard of care by doing one or more of the following in the treatment of Patient JV:

a. By failing to consult with or refer JV to a specialist to pursue the etiology of the patient's pain;

b. By failing to establish sound clinical grounds to justify the need for the therapy he prescribed; and

d. By failing to monitor JV for medication abuse and by failing to monitor his medication levels; and

e. By failing to create a treatment plan and by failing to create or document any objective determination as to the success of the treatment of the patient.

73. Based on the foregoing, Respondent failed to meet the prevailing professional standard of care and, therefore, violated Section 458.331(1)(t)1, Florida Statutes (2009-2010).

COUNT SIX

74. Petitioner realleges and incorporates by reference the allegations in paragraphs 1 through 5 and paragraphs 57 through 69 and paragraph 72 as if fully set forth herein.

75. Section 458.331(1)(m), Florida Statutes (2009-2010), subjects a licensee to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that justify the course of treatment of the patient, including, but not limited to, patient histories;

examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

76. Respondent failed to keep legible medical records that justified Respondent's course of treatment of Patient JV, specifically, by failing to document one or more of the following:

a. By failing to document the performance of a complete medical history and physical examination;

b. By failing to document the creation of a written treatment plan with objectives to determine the success of the treatment of the patient;

c. By failing to document any clinical basis for the quantity of controlled substances prescribed to the patient;

d. By failing to document the referral of Patient JV for additional evaluations and consultations to assist in the determination of the etiology of the patient's chronic pain; and

e. By failing to keep legible medical records that justify his course of treatment;

77. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2009-2010).

FACTS RELATED TO PATIENT DP

78. On or about October 14, 2009, and continuing until April 20, 2010, Patient DP, a then 29 year-old male, presented to Respondent with a history of rod placement to replace a broken femur and complaints of chronic back and leg pain.

79. On this first visit, Patient DP submitted to an in-house urine drug screen. The results of the urine drug screen indicated that DP had cocaine, methadone and opiates in his system. Although Respondent's records are illegible, it is clear that they do not document either an explanation for the presence of any of the drugs present or a discussion between Respondent and the patient about the presence of an illegal substance in his system.

80. Regardless of the drug screen results, Respondent prescribed 180 tablets of Roxicodone 30 mg, 90 tablets of Roxicodone 15 mg, 60 tablets of Soma and 30 tablets of Xanax 2 mg to Patient DP.

81. Following Patient DP's initial visit, he presented to Respondent for follow-up on monthly basis until April of 2010. Regardless of the fact that on numerous dates DP's Patient Comfort Assessment Guide (PCAG)

indicated that he was getting no relief from the pain management regiment, Respondent did not alter or address the medication prescribed. Respondent consistently prescribed 180 tablets of Roxicodone 30 mg, 90 tablets of Roxicodone 15 mg, and either Xanax or Valium every month for Patient DP. Periodically, Respondent added or deleted prescriptions for either Soma or Ketoprofen to DP's medication regiment.

82. During several monthly visits, Patient DP indicated on the PCAG form that he had pain of 8 or 9 all day every day.

83. Respondent's records do not document any discussion with the patient regarding his pain assessment, any consideration of alternative treatment modalities, or referrals or consults regarding the determination of the etiology of the pain Patient DP reported.

84. The only diagnostic tests contained in Patient DP's medical records are 2006 x-rays performed following the repair of DP's right femur fracture. These x-rays revealed nothing significant regarding DP's current complaints.

85. Respondent did not create a written treatment plan or method of assessing the success of DP's treatment with controlled substances.

86. After Patient DP's initial drug screen, Respondent did not order drug screens for DP to insure that he was not abusing medication or using additional medication.

87. The prevailing professional standard of care at the time Respondent treated Patient DP required the performance of a thorough physical and the obtaining of a complete medical history including prior treatment for chronic pain.

88. The prevailing professional standard of care at the time Respondent treated Patient DP required the pursuit of the determination of the etiology of a patient's chronic pain through referral or consultation with specialist to rule out of the possibility that the patient's rod was either infected or loose and through additional testing.

89. The prevailing professional standard of care at the time Respondent treated Patient DP required the creation of a treatment plan that provided a methodology for determining the success of whatever treatment was provided and the consideration of multiple treatment modalities.

COUNT SEVEN

90. Petitioner realleges and incorporates by reference the allegations in paragraphs 1 through 5 and paragraphs 78 through 89.

91. Section 458.331(1)(t)1, Florida Statutes (2009), subjects a physician to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes (2009). Medical malpractice is defined by Section 456.50(1)(g), Florida Statutes (2009), as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

92. Level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care that is specified in Section 766.102(1), Florida Statutes (2009), which states as follows:

> The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

93. Respondent failed to meet the prevailing professional standard of care by failing to do one or more of the following in the treatment of Patient DP:

a. By failing to perform a complete medical history and physical examination;

b. By failing to create a treatment plan with objectives to determine the success of the treatment of the patient;

c. By failing to establish sound clinical grounds to justify the need for the therapy he prescribed;

d. By failing to monitor DP for medication abuse by failing to monitor his medication levels; and

e. By failing to refer DP for additional evaluations and consultations to determine the etiology of Patient DP's chronic pain;

94. Based on the foregoing, Respondent failed to meet the prevailing professional standard of care and, therefore, violated Section 458.331(1)(t)1, Florida Statutes (2009).

COUNT EIGHT

95. Petitioner realleges and incorporates by reference the allegations in paragraphs 1 through 5 and paragraph 78 through 89 and paragraph 93 as if fully set forth herein.

96. Section 458.331(1)(m), Florida Statutes (2009), subjects a licensee to discipline for failing to keep legible, as defined by department

rule in consultation with the board, medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

97. Respondent failed to keep legible medical records that justified Respondent's course of treatment of Patient DP, specifically, by failing to document one or more of the following:

a. By failing to document the performance of a complete medical history and physical examination;

b. By failing to document the creation of a written treatment plan with objectives to determine the success of the treatment of the patient;

c. By failing to document monitoring of medication levels;

d. By failing to document the referral of Patient DP for additional evaluations and consultations to determine the etiology of the patient's chronic pain; and

e. By failing to keep legible medical records that justify the course of treatment for DP.

98. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2009).

FACTS RELATED TO PATIENT KH

99. In June of 2009, Patient KH presented to the Delray Pain Management Clinic with complaints of back, neck, arms and leg pain and a history of a 2006 automobile accident. Physician MG conducted a brief physical examination, obtained a brief medical history and ordered an MRI of the lumbar and cervical spine. The physician prescribed 240 tablets of Roxicodne 30 mg, 120 tablets of Roxicodone 15 mg, 120 tablets of Percocet 10/325 mg and 60 tablets of Xanax 2 mg. Patient KH presented the physician with lumbar and cervical spine x-ray studies performed in 2007.

100. Between July 10, 2009 and January 27, 2011, Patient KH presented to Respondent monthly for follow-up treatment.

101. On July 10, 2009, Respondent prescribed 240 tablets of Roxicodne 30 mg, 120 tablets of Percocet 10/325 and 30 Xanax 2 mg and discontinued the previously prescribed 120 Roxicodone 15 mg with no documentation indicating the reason, although the patient described his pain level as 9 or 10 at the time of his appointment.

102. On or about August 13, and September 17, 2009, Patient KH presented to Respondent for follow-up treatment. Respondent prescribed 224 tablets of Roxicodone 30 mg, 60 tablets of Roxicodone 15 mg, 120 tablets of Percocet 10/650, 30 Xanax 2 mg and a muscle relaxer at each visit. Respondent's medical records contain no legible justification as to why he added the prescription for 224 Roxicodone tablets 30 mg.

103. On or about October 13, November 10, and December 9, 2009, Patient KH presented to Respondent for follow-up treatment. Respondent prescribed 224 Roxicodone 30 mg, 120 Percocet 10/325, 30 Xanax 2 mg and a muscle relaxer. Respondent's medical records for these dates contain no legible justification for why he deleted the previously prescribed 15mg Roxicodone, although the patient described his pain level at 10 at the time of his appointment.

104. On or about January 4, February 1, March 3, March 31, April 28, and May 28, 2010, Patient KH presented to Delray Pain Management for follow-up. Respondent continued Patient KH's prescriptions for 224 tablets of Roxicodone 30 mg, 30 tablets of Xanax 2 mg, and a muscle relaxer. Respondent's medical records contain no justification for the elimination of the previously prescribed Percocet.

105. From June 28, 2010, through September 3, 2010, Patient KH presented to Respondent for follow-up treatment. Respondent prescribed 210 tablets of Roxicodone 30 mg, 30 tablets of Xanax 2 mg and a non-steroidal anti-inflammatory drug. Respondent's medical records contain no justification or explanation for the change in Respondent's prescriptions.

106. On September 30, 2010 Patient KH presented to Respondent for follow-up. Respondent reduced Patient KH's prescription from 210 tablets of Roxicodone to 195 tablets. Respondent continued the prescriptions for Xanax and the non-steroidal anti-inflammatory. Respondent's patient records contain no explanation or justification for the reduction of Roxicodone.

107. On November 23, December 31, of 2010, and January 27, 2011, Patient KH presented to Respondent for follow-up. Respondent reduced Patient KH's prescription of Roxicodone to 180 tablets, deleted Xanax and he added a prescription for Valium. Respondent's patient records contain no explanation or justification for the reduction of Roxicodone and the switch from Xanax to Valium.

108. Respondent did not pursue or document the determination of the etiology of KH's pain and he did not refer or document the referral of the patient for diagnostic testing.

109. Respondent failed to create and document a written treatment plan or a method of assessing the success of KH's treatment with long-term use of controlled substances.

110. The prevailing professional standard of care required the pursuit of the etiology of Patient KH's chronic pain or referral for further evaluation or consultation.

111. The prevailing professional standard of care required that Respondent create and document a treatment plan for Patient KH that provided a methodology for determining the success of the treatment plan and consideration of mulitple treatment modalities.

COUNT NINE

112. Petitioner realleges and incorporates by reference the allegations in paragraphs 1 through 5 and 99 through 111 as if fully set forth herein.

113. Section 458.331(1)(t)1, Florida Statutes (2009-2010), subjects a physician to discipline for committing medical malpractice as defined in

Section 456.50, Florida Statutes (2009-2010). Medical malpractice is defined by Section 456.50(1)(g), Florida Statutes (2009-2010), as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

114. Level of care, skill, and treatment recognized in general law related to health care licensure" means the standard of care that is specified in Section 766.102(1), Florida Statutes (2009-2010), which states as follows:

> The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

115. Respondent failed to meet the prevailing professional standard of care by failing to do one or more of the following in the treatment of Patient KH:

a. By failing to perform a complete medical history and physical examination;

b. By failing to create a treatment plan with objectives to determine the success of the treatment of the patient;

c. By failing to establish sound clinical grounds to justify the need for the therapy he prescribed; and

d. By failing to refer KH for additional evaluations and consultations to determine the etiology of his chronic pain.

116. Based on the foregoing, Respondent failed to meet the prevailing professional standard of care and, therefore, violated Section 458.331(1)(t)1, Florida Statutes (2009-2010).

COUNT TEN

117. Petitioner realleges and incorporates by reference the allegations in paragraphs 1 through 5, paragraphs 99 through 111 and paragraph 115, as if fully set forth herein.

118. Section 458.331(1)(m), Florida Statutes (2009-2010), subjects a licensee to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

119. Respondent failed to keep legible medical records that justified Respondent's course of treatment of Patient KH by failing to document one or more of the following:

a. By failing to document the performance of a complete medical history and physical examination;

b. By failing to document the creation of a written treatment plan with objectives to determine the success of the treatment for the patient;

c. By failing to document the referral of Patient KH for additional evaluations and consultations for treatment of his chronic pain and his anxiety and depression;

d. By failing to keep legible medical records that justify the course of treatment for KH; and

e. By failing to monitor KH's use of his medication to insure no drug abuse or diversion.

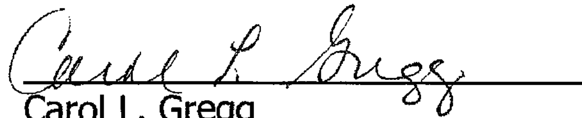
120. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2009-2010).

WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties:

permanent revocation or suspension of Respondent's license, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 10th day of January, 2014.

John H. Armstrong, MD, FACS
State Surgeon General and
Secretary of Health



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DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Angel Sanders
DATE JAN 13 2014

CLG

PCP Date: January 10, 2014
PCP Members: Drs. Avila and Averhoff and Ms. Goersch

NOTICE OF RIGHTS

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

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.