FILED
APR 30 2010
KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	Docket No. 09-HA00049
Pravin G. Sampat, M.D.	)	
Kansas License No. 04-18013	)	

FINAL ORDER

Now this 16th day of April, 2010, the above captioned matter came before the Kansas State Board of Healing Arts (Board) on the Board's own Motion to Review the Initial Order of the Presiding Officer. The petitioner appears by and through Janith Lewis. The respondent, Pravin G. Sampat, M.D., appears in person and through counsel Pedro Irigonegaray and Elizabeth Herbert. The Board, after reviewing the pleadings, motions, transcripts, the file and being duly apprised of the premises, proceeded as follows:

WHEREUPON, Disciplinary Panel 23, consisting of Dr. Beezley, Dr. Conley, Dr. Leinwetter, and Ms. Ice, recuse themselves from review of the Initial Order. Board member Nancy Welsh, M.D. recuses herself from review of the Initial Order.

WHEREUPON, the Board heard the oral argument from counsel, asked questions of counsel, the respondent and generally assessed the credibility of the parties and the evidence.

WHEREUPON, the Board went into Executive Session for attorney client privileged matters to review the evidence, the statements of attorneys for the parties, the statements of the respondent, to discuss the Initial Order and review the law with its Counsel.

WHEREUPON, the Board approved and adopted in total the FINDINGS OF FACT made by the Presiding Officer in the INITIAL ORDER. The FINDINGS OF FACT made in the INITIAL ORDER are incorporated into this FINAL ORDER by reference.

WHEREUPON, the Board approved and adopted in total the CONCLUSIONS OF LAW made by the Presiding Officer in the INITIAL ORDER. The CONCLUSIONS OF LAW made in the INITIAL ORDER are incorporated by into this FINAL ORDER.

WHEREUPON, the Board reviewed the remedial ORDER made by the Presiding Officer in the INITIAL ORDER. The Board finds as follows:

1. The Board was created by the Legislature to implement the Healing Arts Act. The purpose of the Healing Arts Act is to ensure that the public is properly protected against unprofessional, improper, unauthorized and unqualified practice of the healing arts and from unprofessional conduct by persons licensed to practice under the act. K.S.A. 65-2801
2. The Board developed Guidelines for the Imposition of Disciplinary Sanctions in August 2008 to further the implementation of the Healing Arts Act and general public protection.
3. The evidence supports by clear and convincing evidence that Respondent violated the Healing Arts Act by:
    a. Prescribing, selling, administering, distributing or giving a controlled substance to a person for other than a medically accepted or lawful purpose, contrary to K.S.A. 65-2836(p);
    b. Engaging in conduct likely to deceive, defraud or harm the public, contrary to K.S.A. 65-2837(b)(12);
    c. Failing to transfer patient records to another licensee when requested to do so by the subject patient or by such patient's legally designated representative, contrary to K.S.A. 65-2837(b)(20);
    d. Prescribing, dispensing, administering, distributing a prescription drug or substance, in including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice, contrary to K.S.A. 65-2837(b)(23); and
    e. Failing to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent

findings, examination results and test results, contrary to K.S.A. 65-2837(b)(25).

4. That the above violations of the Healing Arts Act and evidence in the record constitutes aggravating circumstances including: serious potential for injury, abuse of trust, was intentional and not inadvertent and was done for personal gain. Respondent has been a licensed physician of medicine and surgery in the State of Kansas since 1979; his age and experience have not provided him with the tools or insight to prevent intentional violations of the Healing Arts Act. Respondent's intentional conduct and lack of remorse contributes to a diminished perception of public protection. Finally, the ill repute such intentional conduct brings to the profession is significant.
5. The remedies made by the Presiding Officer in the INITIAL ORDER depart from the Board's Disciplinary Guidelines. The Board desires to be consistent in its protection of the public and the rehabilitation of licenses. See Guidelines for the Imposition of Disciplinary Sanctions, August, 2008.
6. The Board does not have evidence before it to adequately determine the present moral fitness of the Respondent, the potential for successful rehabilitation of the Respondent, or the Respondent's present competence in medical skills.
7. The Respondent shall be INDEFINITELY SUSPENDED from the practice of medicine and surgery. Such suspension shall remain in effect unless or until Respondent provides the Board with satisfactory evidence that he has the ability to practice the healing arts with reasonable skill and safety to patients and is sufficiently rehabilitated to warrant the public trust.
8.

(confidential)

9. The Respondent is ORDERED to attend and complete the intensive medical records course from CPEP or other similar program at the Respondent's own cost. The Respondent shall provide evidence to the Board that he has successfully completed the record keeping course.
10.

(confidential)

11. The Respondent is ORDERED to convert his medical practice billing records system to a computer based billing record system of the Respondent's choice with the cost paid by the Respondent.
12. The Respondent is ORDERED to provide evidence that his continuing medical education is current. The Respondent is ORDERED to maintain continuing medical education requirements as provided by state law, rules and regulations.
13. The Respondent is ORDERED to pay the costs associated with this matter in the amount of $3,622.33. The Board finds that the Board's order in this case is adverse to the Respondent and that the costs are authorized by statute. Further

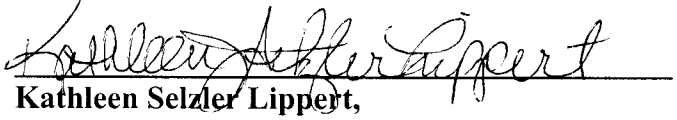
that the costs are reasonable, appropriate, and necessary to investigate, litigate and protect the public against violations of the Healing Arts Act. Cost may be paid in full at any time or may be paid in 48 equal monthly installments of $75.47 due on the first of every month beginning June 1, 2010 and concluding May 1, 2014.

14. The Board incorporates the remainder of the Presiding Officer's INITIAL ORDER by reference.

PLEASE TAKE NOTICE that this is a final order. A final order is effective upon service. A party to an agency proceeding may seek judicial review of a final order by filing a petition in the District Court as authorized by K.S.A. 77-601, et seq. Reconsideration of a final order is not a prerequisite to judicial review. A petition for judicial review is not timely unless filed within 30 days following service of the final order. A copy of any petition for judicial review must be served upon Kathleen Selzler Lippert, the Board's Interim Executive Director, at 235 SW Topeka Blvd., Topeka, KS 66603.

IT IS SO ORDERED.

FOR THE KANSAS STATE BOARD OF HEALING ARTS



Kathleen Selzler Lippert,
Interim Executive Director

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that I served a true and correct copy of the FINAL ORDER by United States mail, postage prepaid, on this 30th day of April, 2010, to the following:

Pravin G. Sampat, M.D.
Licensee / Respondent
4025 SW Indian Hills Rd.
Topeka, Kansas 66610

Elizabeth R. Herbert
Pedro Irigonegaray
Attorney for Licensee / Respondent
1535 SW 29th Street
Topeka, Kansas 66611-1901

And the original was hand-filed with:

Kathleen Selzler Lippert
Interim Executive Director
Kansas Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66603-3068

And a copy was hand-delivered to:

Janith Lewis
Stacy Bond
Associate Litigation Counsel
Kansas Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66603

Cathy A. Brown

FILED
MAR 26 2010
KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	
Pravin G. Sampat, M.D.	)	Docket No. 09-HA-00049
Kansas License No. 04-18013	)	
	)	

INITIAL ORDER

NOW this January 29, 2010 the above captioned matter comes before the Board of Healing Arts, Merle Hodges, M.D., Presiding Officer, on the Amended Petition of the petitioner to discipline the respondent for violation of the Kansas Healing Arts Act, K.S.A. 65-2801 et seq. The petitioner appears by and through Janith Davis, Associate Litigation Counsel and Stacy Bond, Assistant Litigation Counsel. The respondent appears in person and by Pedro Irigonegaray and Elizabeth R. Herbert of Irigonegaray and Associates, Attorneys at Law. There are no other appearances.

WHEREUPON, the respondent moved the Presiding Officer for an Order to close the hearing to the public to maintain patient privacy pursuant to K.S.A. 65-2839a(d). Without objection from the petitioner, the hearing was closed to the public.

WHEREUPON, the Presiding Officer took judicial notice of the Emergency Hearing held on March 6, 2009 and adopted the FINDINGS OF FACT which came from that hearing, to wit:

1. Respondent was issued license number 04-18013 to practice medicine and surgery by the Board on approximately February 1, 1979, and having last renewed such license on approximately July 1, 2008. The respondent's license was temporarily

suspended. The respondent has applied for a license which is pending upon the outcome of this hearing.

2. This matter was initiated on October 2, 2008, when a Petition and Motion for Ex Parte Emergency Order of Suspension and for Emergency Proceedings and Proposed Order were filed by the Board, which included allegations that Respondent violated the Healing Arts Act, specifically: K.S.A. 65-2836(b), in that Respondent has committed acts of unprofessional and dishonorable conduct; K.S.A. 65-2836(p) in that he has prescribed, sold, administered, distributed, or given a controlled substance to any person for other than medically accepted or lawful purpose; K.S.A. 65-2837(b)(12) in that he committed conduct likely to deceive, defraud, or harm the public; and K.S.A. 65-2837(b)(23) by prescribing, dispensing, administering or distributing a prescription drug or substance, including a controlled substance, in an improper or inappropriate manner, or for other than a valid medical purpose, or not in the course of the Respondent's professional practice.

3. On December 21, 2009, Petitioner filed a First Amended Petition, which added Counts V, VI, VII, and VIII to the Petition, which included additional allegations that Respondent violated the Healing Arts Act, specifically: K.S.A 65-2836(b) in that Respondent has committed acts of unprofessional or dishonorable conduct; K.S.A. 65-2837(b)(22) in that he charged an excessive fee for services rendered; K.S.A. 65-2837(b)(33) in that he engaged in conduct which violates patient trust and exploits the licensee-patient relationship for personal gain; K.S.A. 65-2837(b)(20) in that he failed to transfer patient records to another licensee when requested to do so by the subject patient or by such patient's legally designated representative; K.S.A. 65-2837(b)(25) in that he

failed to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results and test results; and K.S.A. 65-2836(k) in that he has violated any lawful rule and regulation promulgated by the board or violated any lawful order or directive of the board previously entered by the board, as further defined by K.A.R. 100-24-2, which states in pertinent part, "[e]ach licensee shall maintain the patient record for a minimum of 10 years from the date the licensee provided the professional service recorded."

4. Respondent currently holds a suspended medical license and at all times relevant to this proceeding, the Board has retained jurisdiction over Respondent's license in this State.

5. The Board of Healing Arts staff investigated multiple cases regarding Respondent which led to the filing of a disciplinary action against Respondent's medical license in Kansas.

6. Carol Baldwin is a special investigator for the Kansas Board of Healing Arts. (Tr. Vol. 1, p. 185, lines 3-12).

7. Ms. Baldwin investigated this matter involving the Respondent. (Tr. Vol. 1, p. 185, lines 22-25; p. 186, line 1).

8. This matter was continued by mutual agreement until March 6, 2009.

9. A formal hearing on the emergency suspension was held March 6, 2009, and the proceedings were conducted by Presiding Officer, Merle Hodges, M.D. During the hearing, Petitioner presented evidence in support of its allegations in the form of documents and testimony of several witnesses.

10. Petitioner's witnesses included Carol Baldwin, Special Investigator II, Patient #1, Gheraldene (Gerry) Donahue, Pam Long and Respondent, Pravin Sampat, M.D. The respondent cross-examined each of the Petitioner's witnesses.

11. Respondent testified on his own behalf, as well as offering documents and testimony of witnesses including Brenda Bingham and Eleanor Reams.

Patient #1

12. Respondent provided medical care and treatment to Patient #1, including prescribing medications, between January 1, 2007 and May 2008. (Tr. Vol. 1, p. 102, line 25; p. 103, lines 1-4, 17-25; p. 287, lines 18-22).

13. Patient #1 was seen in Respondent's office. (Exhibit 8c).

14. Respondent made house calls to Patient #1 to provide her medical care and treatment. (Exhibit 8c).

15. Respondent's primary diagnosis of Patient #1 were migraine headaches and anxiety. (Tr. Vol. 1, p. 103, lines 5-9).

16. Darvocet® and Percocet® were the primary medications that Respondent prescribed to Patient #1 between January 1, 2007 and May 2008. (Tr. Vol. 1, p. 104, line 3).

17. The dosage strengths of the Darvocet and Percocet the respondent prescribed to Patient #1 did not vary substantially from January 1, 2007 through May 2008. (Tr. Vol. 1, p. 106, lines 13-17).

18. Respondent's medical records indicate that Patient #1 continued to complain about migraines and other consistent pain between January 1, 2007 and May

2008. Patient #1 testified that her pain was "overwhelming" and "devastating". (Exhibit 8c; Tr. Vol. 1, p. 305, lines 2-7).

19. Pursuant to an investigative subpoena issued by the Board in June 2008, Respondent produced a handwritten ledger card for Patient #1, hereinafter described as "ledger #1." (Exhibit 8b).

20. Respondent testified that he created ledger #1 with the help of his assistant Brenda Bingham. (Tr. Vol. 1, p. 121, lines 4-25).

21. Ms. Bingham testified that she was not involved in the creation of ledger #1 and that she had never seen ledger #1. Ms. Bingham stated that she recognized the handwriting on ledger #1 as Respondent's handwriting. (Tr. Vol. 1, p. 281, lines 15-25; p. 282, lines 1-4).

22. The Presiding Officer concludes that Ledger #1 was created solely by the Respondent without the help of Brenda Bingham.

23. The respondent testified whenever he received a payment from Patient #1, whether cash, or check, it would be documented on the ledger card. (Tr. Vol. 1, p. 125, lines 7-15).

24. Ledger #1 does not reflect whether the payments the respondent received from Patient #1 were in the form of cash or checks. (Tr. Vol. 1, p. 125, lines 16-18; Exhibit 8b).

25. Ledger #1 reflects that Patient #1 nearly always maintained a zero balance. (Tr. Vol. 1, p. 123, lines 4-25; p. 124, lines 1-14; Exhibit 8b).

26. Ledger #1 details that Respondent saw Patient #1 in his office on January 15, 2007. Ledger #1 states Patient #1 was charged $55 for the visit. Patient #1 paid $55

to respondent. Patient #1 did not owe Respondent any previous amounts, and she had a zero balance. (Tr. Vol. 1, p. 128, lines 1-25; p. 129, lines 7-12; Exhibit 8b, Sampat 1196).

27. Respondent's medical chart for Patient #1 details that he made a house call to Patient #1 on January 15, 2007. The medical chart reflects that Patient #1 was diagnosed with a migraine and was given a prescription for 25 tablets of 5mg Percocet. (Tr. Vol. 1, p. 129, lines 21-25; p. 130, lines 1-10; Exhibit 8c, Sampat 1242).

28. Patient #1's bank statement, details that she wrote a check in the amount of $300 to Respondent, on January 15, 2007, which Respondent endorsed. (Tr. Vol. 1, p. 130, lines 11-25; p. 131, lines 1-6; Exhibit 7, Sampat 853).

29. Respondent acknowledged that ledger #1 indicates that Patient #1 paid him $300 more than she owed him on January 15, 2007. (Tr. Vol. 1, p. 133, lines 15-25; p. 134, lines 1-9; p. 131, lines 7-10).

30. The Presiding Officer concludes Respondent charged $300 to Patient #1 on January 15, 2007 for a prescription to purchase 25 tablets of 5mg Percocet. The Presiding Officer further concludes Patient #1 paid the Respondent $300 for the prescription to purchase 25 tablets of 5mg Percocet on January 15, 2007.

31. Ledger #1 details that Respondent saw Patient #1 in his office on February 6, 2007, that she was charged $75 for the office visit, she paid $75, and she did not owe him any previous amounts. Nothing appears in the balance column. (Tr. Vol. 1, p. 134, lines 10-25; p. 135, lines 1-7; Exhibit 8b, Sampat 1196).

32. Respondent's medical chart for Patient #1 detail's that he made a house call to Patient #1 on February 6, 2007. The medical chart reflects that Patient #1 was

diagnosed with acute migraine headache, chronic anxiety, intolerance to medications and was given a prescription for 21 tablets of Percocet 5mg/325mg. (Tr. Vol. 1, p. 134, lines 10-25; p. 135, lines 1-23; Exhibit 8c, Sampat 1240).

33. Patient #1's bank statement, details that she wrote a check in the amount of $660 to Respondent, on February 6, 2007, which Respondent endorsed. (Tr. Vol. 1, p. 136, lines 1-21; Exhibit 7, Sampat 846).

34. Respondent acknowledged that ledger #1 indicates that Patient #1 paid him $660 more than she owed him on February 6, 2007. (Tr. Vol. 1, p. 136, lines 22-25; p. 137, lines 1-6).

35. The Presiding Officer concludes Respondent charged $660 to Patient #1 on February 6, 2007 for a prescription to purchase 21 tablets of 5mg Percocet 5mg/325 mg. The Presiding Officer further concludes Patient #1 paid the Respondent $660 for the prescription to purchase 21 tablets of 5mg/325 mg Percocet on February 6, 2007.

36. Patient #1's bank statement, details that she wrote a check in the amount of $1000 to Respondent, on May 16, 2007, which Respondent endorsed. (Tr. Vol. 1, p. 140, lines 1-16; Exhibit 7, Sampat 830).

37. Ledger #1 does not indicate that Respondent provided any medical care or treatment to Patient #1 on May 16, 2007, and Respondent testified that Patient #1 was not seen on May 16, 2007. (Tr. Vol. 1, p. 137, lines 7-10; p. 138, line 15; Exhibit 8b).

38. Ledger #1 indicates that Patient #1 was seen in Respondent's office on May 19, 2007, that she was charged $75 for the visit, and she paid $75. (Exhibit 8b).

39. To the contrary, Respondent's medical chart for Patient #1 details that he made a house call to Patient #1 on May 16, 2007. The medical chart reflects that Patient

#1 was diagnosed with back pain, status post surgery, migraine headaches, left knee pain, history of chronic anxiety and stress, and was given a prescription for 60 tablets of Darvocet N, 25mg. (Tr. Vol., p. 138, lines 20-25; p. 139, lines 1-6; Exhibit 8c, Sampat 1234).

40. The Presiding Officer concludes the Respondent made a house call to Patient #1 on May 16, 2007. The Presiding Officer further concludes the respondent charged Patient #1 $1000 on May 16, 2007 for a prescription to purchase 60 tablets of Darvocet N, 5mg. The Presiding Officer further concludes Patient #1 paid the Respondent $1000 for the prescription to purchase 60 tablets of Darvocet N, 25 mg on May 16, 2007.

41. Ledger #1 also indicates that Patient #1 was seen in Respondent's office on May 21, 2007, that she was charged $55 for this visit, and she paid $55. (Exhibit 8b, Sampat 1196).

42. Respondent's medical chart for Patient #1 indicates that he saw Patient #1 in his office on May 21, 2007. The respondent diagnosed Patient #1 with acute anxiety, stress, back pain, and history of migraines. Patient #1 was given a prescription for 30 pills of Xanax 0.25mg. (Tr. Vol. 1, p. 139, lines 8-24; Exhibit 8c, Sampat 1233).

43. Ledger #1 does not indicate Patient #1 had any balance or owed him any amounts in May 2007. (Tr. Vol. 1, p. 137, lines 16-20).

44. Ledger #1 indicates that Patient #1 paid Respondent $1000 more in May 2007 than she owed him. (Tr. Vol. 1, p. 136, lines 22-25; p. 137, lines 1-6).

45. Ledger #1 does not indicate that Respondent gave Patient #1 any refunds. (Tr, Vol. 1, p. 131, lines 7-10).

46. The Presiding Officer concludes the Respondent saw Patient #1 at his office on May 21, 2007. The Presiding Officer further concludes the respondent charged Patient #1 $1000 on May 21, 2007 for a prescription to purchase 30 tablets of Xanax 0.25 mg. The Presiding Officer further concludes Patient #1 paid the Respondent $1000 for the prescription to purchase 30 tablets of Xanax, 0.25 mg on May 21, 2007.

47. Patient #1's bank statement, details that she wrote a check in the amount of $100 to Respondent, on September 6, 2007, which Respondent endorsed. (Tr. Vol. 1, p. 143, lines 24-25; p. 144, lines 1-7; Exhibit 7, Sampat 800).

48. Ledger #1 does not indicate that Respondent provided any medical care or treatment to Patient #1 on September 6, 2007. Ledger #1 does not reflect any appointment for Patient #1 on September 6, 2007. (Tr. Vol. 1, p. 141, lines1-8; Exhibit 8b).

49. Respondent's medical chart for Patient #1 indicates that Patient #1 was seen by Respondent in his office on September 6, 2007. The medical chart reflects that Patient #1 was diagnosed with acute migraine headaches, tachycardia, rule out supraventricular tachycardia, and was given a prescription for 25 tablets of Percocet 5mg. (Tr. Vol. 1, p. 141, lines 19-25; p. 142, lines 1-14; Exhibit 8c, Sampat 1226).

50. The Presiding Officer concludes the Respondent saw Patient #1 at his office on September 6, 2007. The Presiding Officer further concludes the respondent charged Patient #1 $100 on September 6, 2007 for a prescription to purchase 25 tablets of Percocet, 5mg. The Presiding Officer further concludes Patient #1 paid the Respondent $100 for the prescription to purchase 25 tablets of Percocet, 25 mg on September 6, 2007.

51. Ledger #1 also indicates that Patient #1 was seen in Respondent's office on September 15, 2007, that she was charged $55 for the visit, and she paid $55. (Exhibit 8b).

52. Respondent's medical record for Patient #1 indicates that Patient #1 was seen by Respondent in his office on September 15, 2007. Patient #1 was diagnosed with acute migraine headaches. The respondent ruled out acute sinusitis, meningitis and was given a prescription for 30 Percocet 5mg. (Tr. Vol. 1, p. 143, lines 2-10, Exhibit 8c, Sampat 1225).

53. Patient #1's bank statement, details that she wrote a check to herself for cash on September 15, 2007 in the amount of $500. (Tr. Vol. 1, p. 145, lines 8-20; p. 146, lines 4-20, Exhibit 7, Sampat 805).

54. Ledger #1 does not indicate Patient #1 owed any balance or any prior amounts to the Respondent in September 2007. (Tr. Vol. 1, p. 141, lines 15-18; Exhibit 8b).

55. The Presiding Officer concludes the Respondent saw Patient #1 at his office on September 15, 2007. The Presiding Officer further concludes the respondent charged Patient #1 $500 on September 15, 2007 for a prescription to purchase 30 tablets of Percocet, 5mg. The Presiding Officer further concludes Patient #1 paid the Respondent $500 for the prescription to purchase 25 tablets of Percocet, 25 mg on September 15, 2007.

56. Ledger #1 indicates that Respondent made a house call to Patient #1 on March 25, 2008, that she was charged $300 for the house call, that she paid $273.80, and owed a balance of $26.20. (Tr. Vol. 1, p. 147, lines 11-22; Exhibit 8b).

57. Respondent's medical chart for Patient #1 indicates that Respondent made a house call to Patient #1 on March 25, 2008. Patient #1 was diagnosed with acute migraine headaches, status post auto accident, and was given a prescription for Percocet. (Tr. Vol. 1, p. 149, lines 5-19; Exhibit 8c, Sampat 1207).

58. Respondent did not record the dosage amount or the quantity given of the Percocet to Patient #1. (Tr. Vol. 1, p. 149, lines 20-25; p. 150, lines 1-4).

59. Patient #1's bank statement details that she wrote a check in the amount of $100 to Respondent, on March 25, 2008, which Respondent endorsed. (Tr. Vol. 1, p. 150, lines 14-20; Exhibit 7, Sampat 778).

60. The Presiding Officer concludes the Respondent saw Patient #1 at her home on March 25, 2008. The Presiding Officer further concludes the respondent charged Patient #1 $100 on March 25, 2008 for a prescription to purchase Percocet. The Presiding Officer further concludes Patient #1 paid the Respondent $100 for the prescription to purchase Percocet, 25 mg on March 25, 2008.

61. Patient #1's bank statement also details that she wrote a check to herself for cash, on March 25, 2008, in the amount of $500. (Tr. Vol. 1, p. 151, lines 2-14; Exhibit 7, Sampat 778).

62. Respondent acknowledged that ledger #1 does not indicate Patient #1 owed any balance or any amounts prior to owing $26.20 on March 25, 2008. (Tr. Vol. 1, p. 147, lines 23-25; p. 148, line 1).

63. The Presiding Officer concludes the Respondent made a house call to Patient #1 on March 25, 2008. The Presiding Officer further concludes the respondent charged Patient #1 $800 on March 25, 2008 for a prescription to purchase an unknown

quantity of Percocet, 5mg. The Presiding Officer further concludes Patient #1 paid the Respondent $800 for the prescription to purchase an unknown quantity of Percocet on March 25, 2008.

64. Ledger #1 indicates that Respondent made a house call to Patient #1 on the next day, March 26, 2008. Ledger #1 does not indicate whether Patient #1 was charged for that house call. (Tr. Vol. 1, p. 151, lines 15-25; p. 152, line 1; Exhibit 8b).

65. Respondent's medical chart for Patient #1 indicates s that Respondent made a house call to Patient #1 on March 26, 2008. Patient #1 was diagnosed with acute migraine headaches and status post auto accident, other diagnoses same like depression and chronic stress and she was given a prescription for 20 tablets of Percocet 5mg. (Tr. Vol. 1, p. 153, lines 4-15; Exhibit 8c, Sampat 1206).

66. The March 26, 2008 prescription for Percocet was the second Percocet prescription Respondent had written to Patient #1 in two days.

67. Respondent's March 26, 2008, medical chart for Patient #1 details that Respondent gave Patient #1 instruction's to go to the hospital but she stated that she could not afford to go to the hospital. (Tr. Vol. 1, p. 153, lines 16-18; Exhibit 8c, Sampat 1206)

68. Respondent also testified that he told Patient #1 to go to the hospital, on March 26, 2008, and she responded that she could not afford to go to the hospital. (Tr. Vol. 1, p. 154, lines 3-10).

69. In spite of Patient #1's inability to afford to go to the hospital on March 26, 2008, her bank statement details that she wrote two separate checks to the

Respondent, in the amount of $400 each, on that date. (Tr. Vol. 1, p. 154, lines 17-25; p. 155, lines 1-11; Exhibit 7, Sampat 778).

70. Respondent acknowledged cashing both of these checks, on the same day they were received from Patient #1, and getting $800. (Tr. Vol. 1, p. 418, lines 2-5).

71. The Presiding Officer concludes the Respondent made a house call to Patient #1 on March 26, 2008. The Presiding Officer further concludes the respondent charged Patient #1 $800 on March 26, 2008 for a prescription to purchase an unknown quantity of Percocet, 5mg. The Presiding Officer further concludes Patient #1 paid the Respondent $800 for the prescription to purchase twenty tablets of Percocet on March 26, 2008 by writing two checks to the Respondent in the amount of $400 each.

72. Ledger #1 details that Respondent saw Patient #1 in his office on December 5, 2007, and that she was charged $45 for the visit and paid $45. There is no indication of any balance owing or any previous balance. (Tr. Vol. 1, p. 156, lines 23-25; p. 157, lines 1-16; Exhibit 8b, Sampat 1197).

73. Respondent's medical chart for Patient #1 indicates that Patient #1 was seen at Respondent's office on December 5, 2007. Patient #1 was diagnosed with acute migraine and chronic anxiety and was given a prescription for 25 tablets of 50mg Darvocet. (Tr. Vol. 1, p. 158, lines 2-15; Exhibit 8c, Sampat 1216).

74. Patient #1's bank statement details that she wrote a check to herself for $900 cash on December 5, 2007, the same day that she received the Darvocet prescription from Respondent. (Tr. Vol. 1, p. 159, lines 3-13; Exhibit 7, Sampat 790).

75. The Presiding Officer concludes Patient #1 saw the respondent on December 5, 2007. The Presiding Officer further concludes the respondent charged

Patient #1 $900 on December 5, 2007 for a prescription to purchase a prescription for 25 tablets of 50mg Darvocet. The Presiding Officer further concludes Patient #1 paid the Respondent $900 for the prescription to purchase a prescription for 25 tablets of 50mg Darvocet on December 5, 2007.

76. Ledger #1 details that Respondent saw Patient #1 in his office on December 7, 2007, and that she was charged $55 for the visit and paid $55. There is no indication of any balance owing or any previous balance. (Tr. Vol. 1, p. 159, lines 14-25; p. 160, lines 1-2; Exhibit 8b, Sampat 1197).

77. Respondent's medical chart for Patient #1 details that Respondent made a house call to Patient #1 on December 7, 2007. The medical chart reflects that Patient #1 was diagnosed with acute migraine and chronic anxiety and was given a prescription for 30 tablets of Darvocet N 100mg. (Tr. Vol. 1, p. 160, lines 8-15; Exhibit 8c, Sampat 1215).

78. Patient #1's bank statement details that she wrote a check to herself for $1,050 cash on December 7, 2007, the same day that she received the Darvocet prescription from Respondent. (Tr. Vol. 1, p. 160, lines 16-25; p. 161, lines 1-4).

79. The Presiding Officer concludes Patient #1 saw the respondent on December 7, 2007 at his office. The Presiding Officer further concludes the respondent charged Patient #1 $1,050 on December 5, 2007 for a prescription to purchase a prescription for 30 tablets of Darvocet N 100 mg. The Presiding Officer further concludes Patient #1 paid the Respondent $1,050 for the prescription to purchase a prescription for 30 tablets of Darvocet N 100 mg. on December 7, 2007.

80. Ledger #1 details that Respondent saw Patient #1 in his office on December 12, 2007, and that she was charged $55 for the visit, and paid $55. Ledger #1 indicates there was a zero balance on December 12, 2007. (Tr. Vol. 1, p. 161, lines 5-20; Exhibit 8b, Sampat 1197).

81. Contrary to ledger #1, Respondent's medical chart for Patient #1 details that Respondent made a house call to Patient #1 on December 12, 2007. The medical chart reflects that Patient #1 was diagnosed with migraine headaches, intolerant to other medications like NSAID's, Tylenol, could not get help from Ultram, and was given a prescription for 30 tablets of Darvocet N. (Tr. Vol. 1, p. 161, lines 21-25; p. 162, lines 1-12; Exhibit 8c, Sampat 1214).

82. Patient #1's bank statement details that she wrote a check to herself for $800 cash on December 12, 2007, the same day that she received the Darvocet prescription from Respondent. (Tr. Vol. 1, p. 162, lines 16-25; p. 163, lines 1-2; Exhibit 7, Sampat 791).

83. The Presiding Officer concludes Patient #1 saw the Respondent for medical treatment on December 12, 2007, however, it is unclear where the medical treatment was rendered to Patient #1. The Presiding Officer further concludes the respondent charged Patient #1 $800 on December 12, 2007 for a prescription to purchase a prescription for 30 tablets of Darvocet N. The Presiding Officer further concludes Patient #1 paid the Respondent $800 for the prescription to purchase a prescription for 30 tablets of Darvocet N mg. on December 12, 2007.

84. Ledger #1 contains an entry for Patient #1 for December 17, 2007. This entry details that Patient #1 was charged $55 and paid $55, however there is no indication

whether Patient #1 had an office visit or received a house call on December 17, 2007. Further, there is no indication of any balance owing or any previous balance. (Tr. Vol. 1, p. 163, lines 11-24; Exhibit 8b, Sampat 1197).

85. Respondent's medical chart for Patient #1 indicates that Respondent made a house call to Patient #1 on December 17, 2007. During this house call, Patient #1 was diagnosed with acute migraine headaches, history of left knee replacement, chronic anxiety, stress, and was given a prescription for 30 tablets of Darvocet N 100mg. (Tr. Vol. 1, p. 164, lines 6-15; Exhibit 8c, Sampat 1213).

86. Patient #1's bank statement details that she wrote a check to herself for $800 cash on December 17, 2007, the same day that she received the Darvocet prescription from Respondent. (Tr. Vol. 1, p. 164, lines 18-25; p. 165, lines 1-6, Exhibit 7, Sampat 792).

87. The Presiding Officer concludes Patient #1 saw the Respondent for medical treatment on December 17, 2007, however, it is unclear where the medical treatment was rendered to Patient #1. The Presiding Officer further concludes the respondent charged Patient #1 $800 on December 17, 2007 for a prescription to purchase a prescription for 30 tablets of Darvocet N. The Presiding Officer further concludes Patient #1 paid the Respondent $800 for the prescription to purchase a prescription for 30 tablets of Darvocet N mg. on December 17, 2007.

88. On October 12, 2008, Respondent created a ledger card. (Petitioner's Exhibit 9). Exhibit 9 was created by Respondent to show what the correct charges were to Patient #1. (Tr. Vol. 1, p. 170, lines 1-5).

89. At an undisclosed time later in October 2008, Respondent created a ledger sheet, hereinafter referred to as "ledger #2." (Petitioner's Exhibit 10).

90. Ledger #2 was created by Respondent in anticipation of a meeting during late October 2008, between Respondent and his attorney, and board attorneys. (Tr. Vol. 1, p. 166, lines 10-25; p. 167, lines 1-22; Exhibit 10).

91. Respondent created ledger #2, "to show that [ledger #1] was wrong and this one, you know, was accurate reflecting all the charges." (Tr. Vol. 1, p. 168, lines 1-4).

92. Respondent further testified that he created ledger #2 using his medical charts and established charges for office visits and house calls. (Tr. Vol. 1, p. 168, lines 5-22; p. 169, lines 1-7).

93. Respondent later said that ledger #2 was "probably" created from Exhibit 9. (Tr. Vol. 1, p. 170, lines 6-12).

94. Respondent acknowledged that the medical charts he referred to in creating ledger #2, in October 2008, were the same medical charts that he submitted to the Board, pursuant to subpoena, back in June 2008. (Tr. Vol. 1, p. 169, lines 8-13).

95. Respondent acknowledged that neither ledger #2 (Exhibit 10) nor Exhibit 9 reflect any payments made by Patient #1. (Tr. Vol. 1, p. 115, lines 4-6; p. 170, lines 14-17).

96. Respondent testified that a few days before the hearing he created yet another document, a chart, related to his care and treatment of Patient #1. (Tr. Vol. 1, p. 116, lines 1-3)

97. This chart was admitted into evidence as Petitioner's Exhibit 15. It details date, place of service, medicine prescribed, milligram amount, dosage per day amount, amount of charges, payments received from Patient #1, and PDR recommended. (Tr. Vol. 1, p. 116, lines 1-3).

98. Respondent testified that the column, on Exhibit 15, reflecting payments received from Patient' #1 came from copies of Patient #1's checks that the Board provided to him during discovery in this matter. (Tr. Vol.1, p. 115, lines 15-25).

99. Respondent asserts that Patient #1 owed him money for care and treatment between January 1, 2007 and May 2, 2008, (Tr. Vol. 1, p. 178, lines 24-25). Respondent is uncertain how much Patient #1 owed him and has no verification of how much Patient #1 paid to him. (Tr. Vol. 1, p. 177, lines 19-25; p. 178, lines 19-23).

100. Respondent never sent Patient #1 a bill for any charges, although she owed him money. (Tr. Vol. 1, p. 171, lines 2-5).

101. Respondent never stopped treating Patient #1, even though she owed him money. (Tr. Vol. 1, p. 173, lines 18-21).

102. Patient #1 testified that she never received a statement from Respondent because she paid Respondent every time she saw him. (Tr. Vol 1, p. 296, lines 1-4). Patient #1 further testified that she was never told during any office visit or any house call, by either Respondent or his staff, that she owed any money to Respondent. (Tr. Vol. 1, p. 296, lines 9-19).

103. Patient #1 testified that on the dates she wrote checks to Respondent and also received prescriptions from Respondent, those checks were given to the Respondent for the prescriptions he had written to her. (Tr. Vol. 1, p. 306, lines 3-9).

104. Patient #1 also testified that on the dates she wrote checks to herself for cash, and saw Respondent and received prescriptions from him, the cash was given to Respondent for the prescriptions he had written to her. (Tr. Vol. 1, p. 306, lines 10-16).

105. Respondent never gave Patient #1 receipts for any cash or checks that she gave to him. (Tr. Vol. 1, p. 300, lines 6-13).

106. From January 1, 2007 through May, 2008, Patient #1 had medical insurance coverage through Humana and her insurance premiums were automatically deducted from her bank account every month. (Tr. Vol. 1, p. 291, lines 13-25; p. 292, lines 1-7; Exhibit 7).

107. Respondent knew Patient #1 had insurance and Respondent was aware that she was insured, but Respondent did not want to be bothered with Patient #1's insurance. (Tr. Vol. 1, p. 363, lines 23-25; p. 364, lines 1-5; p. 352, lines 1-2).

108. Respondent never called Patient #1's prescriptions directly in to the pharmacy, but always gave her a written paper prescription. (Tr. Vol. 1, p. 300, lines 17-25).

109. Respondent would not make a house call to Patient #1 unless Respondent knew that Patient #1 had money at her house ready to give to him. (Tr. Vol. 1, p. 298, lines 16-18).

110. Brenda Bingham testified that she prepared four written notations of phone messages that had been left for the Respondent, including two phone messages from Patient #1 to Respondent on April 10, 2008. (Tr. Vol. 1, p. 283, lines 13-20; Exhibit 8a, Sampat 1185). One of those phone messages left by Patient #1 read, "Please call, she has the money".

111. Patient #1 testified that the money she was referencing in that message was money to purchase a prescription from Respondent. (Tr. Vol. 1, p. 297, lines 12-23).

WHEREUPON, a hearing was held this January 29, 2010 before the Board of Healing Arts, Merle Hodges, M.D., Presiding Officer, on the Amended Petition of the petitioner to discipline the respondent for violation of the Kansas Healing Arts Act, K.S.A. 65-2801 et seq. The petitioner appears by and through Janith Davis, Associate Litigation Counsel and Stacy Bond, Assistant Litigation Counsel. The respondent appears in person and by Pedro Irigonegaray and Elizabeth R. Herbert of Irigonegaray and Associates, Attorneys at Law. There are no other appearances.

Patient #2

112. Respondent was the primary care physician for Patient #2 during the 1990's and continued to provide care and treatment to Patient #2, as his primary care physician into the 2000's. Respondent was Patient #2's primary care physician in March 2006, when Patient #2 suffered a stroke. (Tr. Vol. II, p.36, lines 10-15; p. 37, lines 4-7).

113. As a result of the stroke, Patient #2 was admitted to Stormont Vail Hospital on March 3, 2006, and remained at Stormont Vail for approximately ten (10) days. (Tr. Vol. II, p. 37, lines 8-18).

114. While Patient #2 was hospitalized at Stormont Vail, Respondent visited him daily. (Tr. Vol. II, p. 38, lines 18-22; p. 43, lines 19-25; p. 44, line 1).

115. Patient #2 was released from Stormont Vail to St. Francis Hospital's Rehabilitation Unit where he remained hospitalized for approximately fifteen (15) days. (Tr. Vol. II, p. 37, lines 19-21; p. 38, lines 1-12).

116. While Patient #2 was hospitalized at St. Francis Hospital's Rehabilitation Unit, Respondent visited him on occasion. (Tr. Vol. II, p. 39, lines 2-5; p. 44, lines 2-7).

117. Patient #2 was released from St. Francis Hospital's Rehabilitation Unit on approximately March 28, 2006. (Tr. Vol. II, p. 46, lines 20-25).

118. After Patient #2 was released from St. Francis Hospital's Rehabilitation Unit, Respondent continued to provide care and treatment to Patient #2 as his primary care physician. (Tr. Vol. II, p. 40, lines 16-19; p. 45, lines 7-10).

119. In late April 2006, Patient #2 was hospitalized for surgery to open a carotid artery and was hospitalized again in early May 2006 with stoke-like symptoms. (Tr. Vol. II, p. 48, lines 13-24).

120. Respondent remained Patient #2's primary care physician during this time period. (Tr. Vol. II, p. 49, lines 1-7).

121. In April 2006, and again in May 2006, Patient #2 requested Respondent write a letter to excuse Patient #2 from jury duty because of the stroke he had suffered. (Tr. Vol. II, p. 36, lines 16-23).

122. Respondent composed a three sentence letter, dated May 8, 2006, which read, "Mr. (confidential) is under my medical care. He has sustained acute stroke and will be unable to serve on jury duty in the future. If you need any additional information, P[sic]lease call me." (Tr. Vol. II, p. 100, lines 19-25; p. 101, lines 1-3; Exhibit 20, Sampat 3346).

123. Respondent charged Patient #2 a sum of $75 for the letter. (Exhibit 22, Sampat 3439).

124. Respondent testified that it took "probably about 25 minutes" to review his medical records before writing the jury letter for Patient #2 and that he did not remember using any information other than his medical records to write the jury letter. (Tr. Vol. II, p. 101, lines 13-19).

125. Respondent further testified that he reviewed Patient #2's office medical chart and, contrary to earlier testimony, stated that he also reviewed records from St. Francis and Stormont Vail, to see what else he could list for Patient #2 to be excused permanently. Specifically, Respondent stated, "Patient was recovering from the stroke, so there was not the only excuse to put down for the permanent, but if he had some other problems I could have put it down, and so, there was no other reason for me to write any extra things on the letter. I just put down whatever I thought at that time might help him for the complete permanent jury duty excuse." (Tr. Vol. II, p. 225, lines 1-25).

126. The Presiding Officer concludes the information provided by respondent on behalf of Patient #2 and the charges made to Patient #2 were reasonable. A licensee has the ability to earn a reasonable fee for his services. The fees charged by the licensee to Patient #2 were reasonable for the services provided.

General Findings of Fact Regarding Patient #3

127. Between approximately January 2002 and June 14, 2006, Respondent provided care and treatment to Patient #3.

128. During the time that Respondent provided care and treatment to Patient #3, Patient #3 had COPD and a descending aortic aneurysm. (Tr. Vol. II, p. 61, lines 3-10).

129. Documents contained in Respondent's medical records reflect Patient #3 underwent endovascular surgery to repair his abdominal aortic aneurysm, bilateral common iliac artery aneurysms and left internal iliac artery aneurysm in 2003. (Exhibit 34, Sampat 150).

130. During the time Respondent was primary care physician for Patient #3, Patient #3 had medical insurance coverage. (Tr. Vol. II, p. 82, lines 5-7).

131. Patient #3 never received bills from Respondent. He would make payments in person, by check, based on what Respondent told him to pay. (Tr. Vol. II, p. 81, lines 24-25; p. 82, lines 1-15).

Patient #3 Records

132. Respondent has produced three (3) separate billing documents for Patient #3.

133. Pursuant to an investigative subpoena issued by the Board on May 17, 2007, Respondent produced records which contained a copy of a handwritten billing ledger for Patient #3, hereinafter described as "original ledger". (Exhibit 34, Sampat 410-423).

134. On September 25, 2007, Mrs. McIntire sent Respondent a letter in which she requested he provide legible billing records. Specifically, Mrs. McIntire advised Respondent,

> "[t]he billing records you provided were illegible, due to unreadable handwriting, non detailed professional services provided and trailing information off the page. The Board will need the billing statements to be clear, concise, and legible. Please resubmit the billing statements to include the date of service, professional service provided, the charge of the service, the amount paid and by whom it was paid, including any write-offs. This will need to be clear, concise, detailed and legible."

(Exhibit 31).

135. In response, Respondent submitted three (3) typed pages of entries, in column form, hereinafter described as "the billing records," which were received by Mrs. McIntire on November 2, 2007. (Exhibit 33, Sampat 103-105). Respondent's cover letter accompanying the billing records reads, in pertinent part,

> This is in response to your inquiry dated September 25, 2007 and I am enclosing all the charges to [Patient #3] as follows:
>
> Page 1 indicates all the ancillary charges for the forms filled, letters written, services approved, and plan of care supervision, review of materials brought by [Patient #3] from other places like life line [sic] screening.
>
> Page 2, 3 indicates office and hospital medical services, charges billed and paid by united health care [sic], adjustments taken, [Patient #3]'s responsibility, and payments from [Patient #3].

(Exhibit 33, Sampat 101-102).

136. At the hearing, Respondent testified that the billing records were made as a result of his anger at Patient #3 for filing a complaint against him. He stated that he only created the billing records to demonstrate to the Board the extent of services he had provided to Patient #3 that were not charged. (Tr. Vol. II, p. 127, lines 21-25; p. 128, lines 1-25; p. 129, lines 1-19; p. 130, lines 8-16).

137. Nowhere in the cover letter submitted with the billing records in November 2007, does Respondent pronounce that the billing records are anything other than what the Investigator requested- a resubmission of the original billing statements in clear, concise, legible, and detailed form.

138. Respondent included no disclaimer that the billing records were created to demonstrate what he could have charged Patient #3 as opposed to actual charges to Patient #3.

139. At the hearing, Respondent repeatedly testified that the charges reflected in the billing records were not charged to Patient #3. (Tr. Vol. II, p. 129, lines 11-16; p. 130, lines 3-10; p. 232, lines 23-25; p.233, lines 1-3; p. 261, lines 13-25; p. 262, lines 1-3).

140. In contrast, Respondent also repeatedly testified that he did charge Patient #3 for some of the charges that are reflected in the billing records. (Tr. Vol. II, p. 135, lines 7-25; p. 136, lines 1-25, p. 137, line1; p. 141, lines 2-9; p. 262, lines 6-15; p. 266, lines 20-25; p. 267, lines 1-25; p. 279, lines 11-19).

141. However, payments that Patient #3 made are not reflected in the billing records. (Exhibit 33).

142. Respondent acknowledged that he created the billing records from Patient #3's medical chart and the original ledger. (Tr. Vol. II, p. 235, lines 7-10).

143. Further, some of the charges that appear in the billing records are identical to charges that appear in yet a third ledger created by Respondent in January 2010.

144. Respondent produced this third ledger, hereinafter referred to as the "2010 ledger," at the hearing. (Respondent's Exhibit 127).

145. Respondent testified that he created the 2010 ledger after getting the Board's Amended Petition, because he "realized there was [sic] problem," and the 2010 ledger clarifies the services provided with the correct date and charge. (Tr. Vol. II, p. 228, lines 14-17; p. 233, lines 8-11; p. 234, lines 4-13).

146. The hearing was the first time Respondent ever indicated that the billing records contained errors, although the billing records had been submitted to the Board over two years earlier, in November 2007.

147. Respondent testified that he used Patient #3's medical chart (Exhibit 34) to create the 2010 ledger (Tr. Vol. II, p. 234, lines 14-25; p. 235, lines 1).

148. This same medical chart was available to Respondent at the time he first responded to the Board's investigation in June 2007.

149. The 2010 ledger reflects no payments made by Patient #3. (Respondent's Exhibit 127).

150. Similar to the three (3) billing documents Respondent created for Patient #1 (Exhibits 8b, 9, 10), the 2010 ledger is the third billing document Respondent has created regarding Patient #3.

151. Respondent claims that the efficiency of his office changed after the death of a staff member in December 2003, and that his billing records became disorganized as a result of new people he employed. (Tr. Vol. II, p. 173, lines 4-25, p. 174, lines 1-17). Nevertheless, Respondent's counsel stipulated that Respondent has the responsibility for supervising and "taking care of" his office staff. (Tr. Vol. II, p. 178, lines 15-17).

152. However, Eleanor Reams, a former staff member in Respondent's office testified that Respondent put the charges in the ledgers himself. (Tr. Vol. II, p. 216, lines 19-22). Therefore, Respondent was solely responsible for what the ledgers and billing statements of his patient's reflected.

153. The Presiding Officer concludes the respondent prepared various billing records which reflect numerous charges the respondent has no intention of submitting to

Patient #3. The three sets of billing records prepared and submitted to Board staff do not accurately describe the services rendered.

Failure to transfer records

154. Around the end of August or the beginning of September 2006, Patient #3 chose Dennis Artzer, M.D. to be his new primary care physician.

155. On September 18, 2006, Patient #3 executed an authorization for release of private health information to Respondent through Dr. Artzer. Patient #3 specifically requested that Respondent release all of his medical records to Dr. Artzer. (Exhibit 26; Tr. Vol. II, p.77, lines 1-3).

156. However, Respondent failed to timely release all of Patient #3's records as Patient #3 requested. (Tr. Vol. II, p. 103, lines 5-25; p. 104, lines 1-25; p. 105, lines 1-16).

157. In September 2006, Respondent sent Patient #3's history, physicals, admissions, notes, and surgery records to Dr. Artzer. (Tr. Vol. II, p. 104, lines 23-25; p. 105, lines 1-2).

158. Respondent testified that he did not send, "disability forms, other letters to like Westar, other referral letters from rehabilitations, orthopedic doctors, or from, you know, from like United Healthcare letters, you know, that we got notices." (Tr. Vo. II, p. 105, lines 3-9).

159. Respondent said that his office also called Patient #3 several times to see how many records Patient #3 wanted transferred to Dr. Artzer and to see if Patient #3 wanted him to send, "all the records regarding this Westar or disability forms filled or faxed, prescriptions or what...other stuff... ." Respondent stated that he left messages

for Patient #3 about the costs of transferring the whole of his records to Dr. Artzer. (Tr. Vol. II, p.109, lines 3-14, p.282, lines 7-25; p. 283, lines 9-14).

160. Respondent also sent a letter to Patient #3, dated October 31, 2006, inquiring how many years of records to send to Dr. Artzer. (Exhibit 28).

161. Respondent usually charges his patients to have their medical records transferred to a new provider. (Tr. Vol. II, p. 284, lines 9-12).

162. Nicole Goodrow, who has been employed as the office manager for Dr. Artzer since April 2006, testified that Respondent did not send all of the records when requested and that Dr. Artzer received approximately thirty (30) pages of records from Respondent on October 12, 2006. (Tr. Vol. II, p. 192, lines 15-19; p. 195, lines 20-22).

163. Thereafter, Dr. Artzer's office received a subsequent set of records, of at least 300 pages, during the spring/summer of 2007. Respondent hand-delivered these records to Dr. Artzer's office. (Tr. Vol. II, p. 193, lines 3-13).

164. Patient #3 had filed an initial complaint with the Board, regarding Respondent's failure to release his records to Dr. Artzer, on or about April 16, 2007 (Exhibit 24), and Respondent was notified of the Board's investigation on or about May 16, 2007. (Exhibit 32, Sampat 97-98).

165. Respondent's delivery of the remainder of Patient #3's records occurred only after Respondent was aware of the Board's investigation into his conduct.

166. Prior to October 4, 2006, Patient #3 had also requested a set of medical records for himself and communicated to Respondent that he was willing to pay for the copying of those records. (Tr. Vol. II, p. 66, lines 17-23; Exhibit 27).

167. However, Respondent never sent Patient #3 a copy of his records. (Tr. Vol. II, p. 66, lines 24-25; p. 67, line 1; p. 89, lines 9-11).

168. Patient #3 testified that he did not know what documents and information were in his medical record, or how many records were contained in his medical record, as kept by Respondent. (Tr. Vol. II, p. 89, lines 9-20).

169. Despite Patient #3's direction that Respondent release all of his records to his new physician, Respondent failed to transfer Patient #3's records in a timely manner.

170. Respondent's original transmission to Dr. Artzer of approximately thirty (30) pages is obviously much less than the total of Patient #3's medical record (Exhibit 34), and appears to be far less than what would be necessary to facilitate adequate continuity of care, especially given Patient #3's complex medical history.

171. The Presiding Officer concludes the respondent failed to provide documents to the licensee's former patient and to the licensee's former patient's new physician.

Westar Energy Letters

172. Patient #3's health situation requires him to use oxygen and to use a concentrator at night that requires electricity. (Tr. Vol. II, p. 68, lines 23-25; p. 69, line 1; p.79, lines 5-9).

173. Patient #3 requested Respondent write a letter to Westar Energy regarding his need for electricity. (Tr. Vol. II, p.68, lines 20-22; p. 79, lines 2-4).

174. The billing records submitted by Respondent reflect that he charged Patient #3 a sum of $50 each for "Letter to Westar Energy" on March 10, 2005 and June 22, 2005. (Exhibit 33, Sampat 103).

175. Respondent testified that the medical records (Exhibit 34) he sent to the Board for Patient #3, pursuant to investigative subpoena, were complete except that they did not contain insurance reimbursements. (Tr. Vol. II, p. 110, lines 16-24; p. 111, lines 17-24; p.140, lines 12-21).

176. However, Patient #3's medical records did not contain any letters to Westar Energy on March 10, 2005 or June 22, 2005.

177. The medical records contained a letter to Westar Energy, dated July 21, 2005, consisting of two sentences that read, "[Patient #3] is under my medical care for severe COPD. He needs continuous oxygen for life support so will need a generator for any loss of power to his house any time." (Exhibit 34, Sampat 189).

178. Respondent testified that he charged Patient #3 a sum of $50 for writing the July 21, 2005, letter to Westar Energy. (Tr. Vol. II, p. 137, lines19-21).

179. Respondent further testified that the July 21, 2005, Westar Energy letter was representative of a letter to Westar Energy dated July 15, 2005, for which Patient #3 was charged a sum of $100 (Tr. Vol. II, p. 184, lines 21-25; p. 185, line 1), and the original ledger reflects that Respondent charged Patient #3 a sum of $100 for a letter to Westar Energy on July 15, 2005. (Tr. Vol. II, p. 183, lines 18-25; p. 184, lines 1-14; Exhibit 34, Sampat 419).

180. However, there is no letter to Westar Energy, dated July 15, 2005, in Respondent's records. (Exhibit 34). There is a second letter to Westar Energy, dated September 29, 2005, that is virtually identical to the July 21, 2005 Westar letter. (Exhibit 34, Sampat 275).

181. Patient #3 and his wife both testified they were not advised that Respondent would charge Patient #3 for writing to Westar. (Tr. Vol. II, p. 69, lines 16-19; p. 80, lines 4-8).

182. In an effort to justify charging Respondent for the Westar letters, Respondent testified that he had to review Patient #3's chart, his pulmonary function test, his ABG's, "probably my exam that I may have found," and hospitalization records in order to write the initial letter to Westar Energy. (Tr. Vol. II, p.139, lines 8-25; p. 140, lines 1-25; p. 141, line 1).

183. However, at the time Patient #3 asked Respondent to write the first letter to Westar Energy, Respondent was Patient #3's primary care physician and, by his own admission, Respondent had been treating Patient #3 for a long period of time. (Tr. Vol. II, p. 226, lines 15-19).

184. As such, Respondent would have been aware of the severe nature of Patient #3's COPD.

185. Further, the billing records reflect that Respondent charged Patient #3 for completing disability forms on April 16, 2005, April 29, 2005, June 23, 2005, July 14, 2005, July 15, 2005, and twice on July 21, 2005, which is the same day Respondent authored the first letter to Westar Energy. (Exhibit 33, Sampat 103).

186. The Presiding Officer concludes the letters written to Westar Energy by the respondent on behalf of the respondent's patient were a reasonable exercise of the respondent's duties as Patient #3's physician. A physician has the ability to charge a reasonable fee for services including writing letters and filling out forms for his patient. In this case, the fees charged were reasonable.

Review of Letter from another Physician

187. The billing records reflect that Respondent charged Patient #3 a sum of $50 to "Review letter Dr. Hance" on November 7, 2003. (Exhibit 33, Sampat 103).

188. Medical records submitted by Respondent, for Patient #3, include a one (1) page letter from Kirk Hance, M.D. to Nason Lui, M.D., dated November 5, 2003, detailing the surgery Dr. Hance performed on Patient #3 and Patient #3's appearance for a post-operative appointment. (Exhibit 34, Sampat 150).

189. The letter was written to Dr. Lui and only copied to Respondent and Respondent acknowledges that Dr. Hance's letter did not require him to take any action. (Tr. Vol. II, p. 125, lines 7-9).

190. Patient #3 and his wife both testified they were not advised that Respondent would charge Patient #3 for reviewing letters from other physicians who were providing care to Patient #3. (Tr. Vol. II, p. 70, lines 16-22; p. 80, lines 24-25; p. 81, lines 1-3).

191. Respondent testified that he did not "bill" Patient #3 for reading letters (Tr. Vol. II, p. 133, lines 11-18) and the "Paid by Patient" column in the billing records reflects a zero for all charges, which would seem to support Respondent 's testimony that he did not bill Patient #3. (Exhibit 33, Sampat 103-104).

192. Although Respondent acknowledged that he did charge, and Patient #3 did pay, for the letters sent to Westar Energy (Tr. Vol. II, p. 135, lines 20-22; p. 136, lines 20-25; p. 137, line 1), Patient #3's payments for the Westar letters are not reflected in the billing records. (Exhibit 33, Sampat 103).

193. Likewise, Respondent acknowledged that Patient #3 was paying for disability forms and letters to be filled out and sent. (Tr. Vol. II, p. 268, lines 2-4). However, the billing record does not reflect any of Patient #3's payments for these services either. (Exhibit 33, Sampat 103-104).

194. Respondent's statement is rendered even less persuasive, considering Respondent only verbally told Patient #3 how much was owed and never sent Patient #3 any billing statements showing actual charges. (Tr. Vol. II, p. 134, lines 16-24).

195. Respondent testified that none of the charges reflected in Exhibit 34, Sampat 103 and 104, could have been billed to Patient #3's insurance. (Tr. Vol. II, p. 142, lines 18-22).

196. The Presiding Officer concludes the letters reviewed by the respondent on behalf of the respondent's patient were a reasonable exercise of the respondent's duties as Patient #3's physician. A physician has the ability to charge a reasonable fee for services including reviewing medical information from other health care providers, writing letters and filling out forms for his patient. In this case, the fees charged were reasonable.

197. The Presiding Officer concludes the 2010 ledger and its predecessors reflect numerous charges the respondent had no intention of billing Patient #3.

Review United Healthcare Letters

198. The billing records reflect that Respondent charged Patient #3 a sum of $50 twice on March 8, 2005 to "Review letter united healthcare". (Exhibit 33, Sampat 103).

199. No letter from United Healthcare, dated March 8, 2005, appears in Patient #3's medical record. (Exhibit 34).

200. However, Patient #3's medical record does include one (1) letter from United Healthcare, dated March 9, 2005. This letter is a carbon copy of a benefits notification letter sent to Patient #3. It notified Respondent that a Care Coordinator may contact him after Patient #3's discharge from inpatient care. (Exhibit 34, Sampat 247).

201. Respondent testified that the March 5, 2008 entries in the billing records were errors and that the details of March 5, 2008, are correctly reflected in the 2010 ledger. (Tr. Vol. II, p. 263, lines 4-10).

202. The 2010 ledger reflects that Respondent called United Healthcare on March 8, 2005, regarding approval for an admission and charged Patient #3 a sum of $50 for this phone call. It also reflects, "Review letter united healthcare 3/9/05 Error" and reflects $0 charge. (Respondent's Exhibit 127, REM0001).

203. The Presiding Officer concludes the 2010 ledger and its predecessors reflect numerous errors and charges the respondent had no intention of billing Patient #3.

Review of Lab

204. The billing records reflect that Respondent charged Patient #3 $25 to "Review Lab by Dr. Hance" on December 8, 2004.

205. Patient #3's medical records include a one (1) page letter from Dr. Hance to Respondent, dated December 6, 2004. This letter describes the findings of a CT angiogram performed by Dr. Hance, but the letter does not reflect that other records were sent to Respondent. The letter does not request any action by Respondent. (Exhibit 34, Sampat 156).

206. Respondent testified that Dr. Hance's letter is not the document referenced in the billing entry, that there was no lab, and that the entry in the billing records was incorrect. (Tr. Vol. II, p. 125, lines 17-25; p.126, lines 1-13).

207. Although the 2010 ledger as a whole carries no evidentiary weight, it bears noting that the 2010 ledger also reflects the exact same entry "Review Lab by Dr. Hance" and the $25 charge. (Respondent's Exhibit 127, REM0001).

208. Patient #3 and his wife both testified they were not advised that Respondent would charge Patient #3 for reviewing lab results. (Tr. Vol. II, p. 71, lines 1-4; p. 81, lines 20-23).

209. The Presiding Officer concludes the 2010 ledger and its predecessors reflect numerous charges the respondent had no intention of billing Patient #3 and are inaccurate.

Apria Healthcare

210. The billing records reflect that Respondent charged Patient #3 a sum of $25 to "Review and approve Apria health..." on July 13, 2005. (Exhibit 33, Sampat 103).

211. Patient #3's medical records include a confirmation of verbal orders from Apria Healthcare on July 11, 2005, which consists of a one (1) sentence request by Respondent for Apria to evaluate Patient #3 for an oxygen conserving device. Respondent signed the confirmation of verbal order on July 13, 2005, which stated "evaluate patient for oxygen-conserving device to maintain SAO2 greater or equal to 90%." (Exhibit 34, Sampat 299).

212. Respondent acknowledged that he charged Patient #3 a sum of $25 for making the verbal order. (Tr. Vol. II, p. 141, lines 2-9).

213. When questioned about the level of review necessary to make the order, Respondent testified that he had to "see what was [Patient #3's] oximetry before or ABG's, arterial blood gas level." (Tr. Vol. II, p. 142, lines 13-17).

214. The Presiding Officer concludes a physician has the ability to charge a reasonable fee for services including reviewing forms for his patient and making subsequent orders on behalf of his patient. In this case, the fees charged were reasonable.

WHEREUPON, the Presiding Officer, after review of the records and after hearing the testimony of the witnesses, made the following CONCLUSIONS OF LAW AND OF FACT:

215. The Board must prove its allegations by a preponderance of the evidence. "In all civil actions, the party asserting the affirmative of an issue is entitled to prevail upon the production by him of a preponderance of evidence." *People's Bank of Minneapolis v. Reid* et al. 86 Kan. 245, 120 P. 339 (1912). The case before the Presiding Officer is a civil action.

216. Clear and convincing evidence is where the "fact finder believes that the truth of the facts asserted is highly probable." *In re B.D.- Y.,* 286 Kan. 686, 187 P.3d 594, (2008). Clear and convincing evidence is a higher evidentiary standard than a preponderance of the evidence. *Id.*

217. The Presiding Officer finds the Board presented clear and convincing evidence sufficient to prove the allegations contained in the Board's Amended Petition as follows.

PATIENT #1

218. The Respondent's testimony that payments from Patient #1 were for amounts owed for office visits and house calls were self-serving, unpersuasive and lacked credibility.

219. Patient #1 gave payments to Respondent above and beyond the reasonable amount of any care and treatment she received.

220. Patient #1 had medical insurance coverage from January 1, 2007 through May 2008, which covered office visits and house calls, in whole or in part.

221. Respondent created ledger #1 and submitted it pursuant to an investigative subpoena from the Board in June 2008 as part of Patient #1's medical records.

222. After an investigation began and Respondent's license had been suspended by emergency *ex parte* order, Respondent created subsequent ledgers.

223. The Presiding Officer finds that Patient #1's testimony, regarding cash and check payments she made to Respondent for the purchase of written prescriptions, is credible, persuasive, clear and convincing.

224. The Presiding Officer concludes the evidence is clear and convincing that from January 1, 2007, through May 2008, Respondent sold prescriptions to Patient #1, in exchange for checks and cash.

225. Pursuant to K.S.A 65-2836, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Respondent's license to practice medicine and surgery for violation of the Kansas Healing Arts Act.

226. Respondent has violated the Healing Arts Act with regard to Patient #1, specifically:

a. K.S.A. 65-2836(b), in that he has committed acts of unprofessional or dishonorable conduct;
b. K.S.A. 65-2836(p), in that he has prescribed, sold, administered, distributed or given a controlled substance to any person for other than medically accepted or lawful purpose;
c. K.S.A. 65-2837(b)(12), in that he has committed conduct likely to deceive, defraud or harm the public;
d. K.S.A. 65-2837(b)(23), by prescribing, dispensing, administering or distributing a prescription drug or substance, including a controlled substance, in an improper or inappropriate manner, or for other than a valid medical purpose, or not in the course of his professional practice.

227. Respondent violated K.S.A 65-2836(b), by committing acts of unprofessional or dishonorable conduct, as defined by statute at K.S.A 65-2837(b).

228. Respondent violated K.S.A 65-2837(b)(12), in that he committed conduct likely to deceive, defraud or harm the public, when he sold written prescriptions for Darvocet and Percocet to Patient #1 for various sums of money.

229. Respondent violated K.S.A. 65-2837(b)(23), in that he prescribed a prescription drug in an improper or inappropriate manner, when he sold written prescriptions for Darvocet and Percocet to Patient #1 for various sums of money.

230. Respondent violated K.S.A. 65-2836(p), in that he prescribed a controlled substance to Patient #1 for other than a medically accepted or lawful purpose.

PATIENT #2

231. At the time Respondent was asked to write the jury excuse letter for Patient #2, he was providing care and treatment to Patient #2 and was well aware of the acute nature of Patient #2's medical condition during March, April and May 2006.

232. During March 2006, Patient #2 had suffered an acute stroke and was hospitalized. Respondent visited Patient #2 daily during his first hospitalization and was

aware of Patient #2's subsequent hospitalization at a rehabilitation hospital. In late April 2006 and May 2006, Patient #2 was hospitalized again on two separate occasions. Throughout this time period, Respondent was Patient #2's primary care physician and was well aware of the severity of his health condition, and specifically the effects of the acute stroke.

233. Given the severity of Patient #2's health, and the proximity of his acute stroke and subsequent hospitalization to his request for a jury excuse, Respondent was prudent in conducting a review of Patient #2's medical records to write the May 8, 2006 letter.

234. A physician has the privilege to earn a living. The $75 charge for writing the jury letter was not excessive and was justified under the circumstances.

235. The Presiding Officer finds the respondent did not violate the Kansas Healing Arts and finds in favor of the Respondent with regard to the allegations relating to Patient #2 and the reasonable charge Dr. Sampat wrote on behalf of Patient #2 to relieve Patient #2 from jury duty.

PATIENT #3

Patient Records

236. Patient #3 chose a new primary care physician and properly executed an authorization for Respondent to release his medical records to the new physician.

237. Patient #3 specifically requested that Respondent release all of his medical records to the new physician.

238. Only after the Board began an investigation into Patient #3's complaint against Respondent, did Respondent transfer Patient #3's whole medical record to Dr. Artzer.

239. The transfer of the whole record occurred approximately ten (10) months after Patient #3 first executed the authorization of release.

240. Respondent failed to release Patient #3's medical records in a timely and appropriate manner.

241. K.S.A. 65-4971(a), states in pertinent part,

> Subject to applicable law, copies of health care records shall be furnished to a patient, a patient's authorized representative or any other person or entity authorized by law to obtain or reproduce such records, within 30 days of the receipt of the authorization, or the health care provider shall notify the patient or the patient's authorized representative of the reasons why copies are not available.

242. Respondent's eventual transmission of Patient #3's entire medical record was done approximately ten (10) months after Patient #3's initial request and only after the Board had initiated an investigation against Respondent.

243. Respondent's acts and conduct in failing to transfer all of Patient # 3's medical records to Dr. Artzer, constitutes acts and conduct in violation of K.S.A. 65-2836(b) in that Respondent has committed an act of unprofessional or dishonorable conduct or professional incompetency, as further defined by K.S.A. 65-2837(b)(20) failure to transfer patient records to another licensee when requested to do so by the subject patient or by such patient's legally designated representative.

244. The respondent does not deny that he failed to timely provide a complete copy of Patient #3's file to Dr. Artzer when requested. There is no apparent reason for Respondent's waiting until the following Spring or Summer to provide the complete file

to Patient #3 and Dr. Artzer. After Patient #3 ignored a call or two from Dr. Sampat it was time for the respondent to reproduce the file in its entirety to Patient #3 and Dr. Artzer. (See respondent's proposed Findings of Fact and Conclusions of Law, page 21, paragraph 17). Failure of the respondent to reproduce his file to Dr. Artzer and Patient #3 constituted dishonorable conduct in violation of K.S.A. 65-4971(a), K.S.A. 65-2836(b) and K.S.A. 65-2837(b)(20).

Letter to Westar

245. Patient #3's health condition renders him oxygen dependent and necessitates his use of an oxygen concentrator.

246. Respondent wrote a letter to Westar Energy for Patient #3 advising them of Patient #3's need for electricity in the event of a power loss.

247. The letter consisted of two (2) sentences and was not detailed.

248. At the time Respondent wrote the letter, he had been Patient #3's longtime physician and had knowledge of Patient #3 severe COPD and continuous need for oxygen.

249. Respondent charged Patient #3 a sum of $50 for the initial letter to Westar Energy and charged Patient #3 a sum of $100 for a nearly identical letter sent later.

250. Respondent's acts and conduct in charging Patient #3 sums of $50 and $100, for the letters to Westar Energy were reasonable charges for a doctor to charge a patient. The Presiding Officer finds no violation of Kansas law.

Charges for reading letters from other physicians

251. While Respondent was Patient #3's primary care physician, he was copied on correspondence from other physicians and specialists who treated Patient #3.

252. Respondent charged Patient #3 a sum of $50 for reviewing a one (1) page letter from Dr. Hance to Dr. Lui.

253. The letter required no action by Respondent.

254. Receiving and even reading letters from another physician, for a patient, is inherent to patient care and part of the evaluation and management of the patient.

255. Respondent's acts and conduct in charging Patient #3 a sum of $50 to review a one page letter from Dr. Hance to Dr. Lui, do not constitute activity in violation of K.S.A. 65-2836(b).

256. As primary care physician for Patient #3, Respondent received courtesy copies of benefits notification letters from Patient #3's insurance provider.

257. Respondent twice charged Patient #3 a sum of $50 for reviewing such letters.

258. These letters required no action by Respondent.

259. Receiving and reviewing letters from another physician, for a patient, is inherent to patient care and part of the evaluation and management of the patient.

260. Respondent's acts and conduct in twice charging Patient #3 a sum of $50 to review benefits notification letters is not an act of unprofessional or dishonorable conduct or professional incompetency.

Review of Laboratory tests

261. While Respondent was Patient #3's primary care physician, he received results from lab work performed by other physicians and specialists who treated Patient #3.

262. Respondent charged Patient #3 a sum of $25 for reviewing a one (1) page letter from Dr. Hance, which described the findings of a CT angiogram performed by Dr. Hance.

263. The letter required no action by Respondent.

264. Receiving and reviewing letters and lab work from another physician, for a patient, is inherent to patient care and part of the evaluation and management of the patient.

265. Respondent's acts and conduct in charging Patient #3 a sum of $50 to review a letter from Dr. Hance discussing CT angiogram results, does not constitute acts and conduct which violate K.S.A. 65-2836(b).

Verbal Orders

266. Due to Patient #3's oxygen dependence, Respondent called Apria Healthcare and gave them a verbal order to evaluate Patient #3 for an oxygen-conserving device.

267. Respondent charged Patient #3 a sum of $25 for making and confirming the verbal order to Apria Healthcare.

268. Given Patient #3's severe COPD and oxygen dependence, a verbal order of this kind was inherent to Patient #3's care and part of the management of this patient.

269. Respondent's acts and conduct in charging Patient #3 a sum of $25 to make and confirm the verbal order does not violate Kansas law or the Board's regulations.

Billing Records

270. The respondent submitted three different office billing records, none of which accurately reflected the services which were provided to Patient #3.

271. The respondent's book keeping problems arose after the death of Gloria, the respondent's nurse and office manager.

272. The respondent failed to maintain patient records by preparing a billing document which reflected numerous charges he had no intention of actually submitting to Patient 3.

273. The respondent admits the recreation of billing records is "unprofessional conduct." (See respondent's proposed findings of fact and conclusions of law, page 21, paragraph 17). The respondent's actions violate K.S.A. 65-2836(b) as defined by K.S.A. 65-2837(b)(25) as "unprofessional conduct."

CONCLUSIONS OF LAW AND REMEDIAL ACTION

274. Respondent's return to unrestricted practice of medicine and surgery would constitute an immediate danger to the public heath, safety or welfare.

275. The Presiding Officer finds the respondent has not been practicing medicine since the petitioner initiated this action on October 2, 2008. As such the respondent has not practiced medicine for over one year. The Presiding Officer finds the SUSPENSION on his license is lifted subject to the terms articulated in this INITIAL ORDER.

276. The Presiding Officer finds the respondent shall be issued a LIMITED LICENSE to practice medicine and surgery after fulfilling the following requirements as more fully articulated in this INITIAL ORDER and any FINAL ORDER which may be issued by the entire Board.

WHEREBY, the respondent is ORDERED to take the following REMEDIAL ACTIONS prior to being issued a LIMITED LICENSE to practice MEDICINE AND SURGERY:

277. The respondent shall attend and successfully complete records and boundaries courses from the Center for Personalized Education for Physicians (CPEP) or other similar program at the respondent's own cost. The respondent shall prove to the Board that he has successfully completed the programs.

278. The respondent shall convert his medical practice billing records system to a computer based billing record system of the respondent's choice with the cost paid by the respondent.

279. The respondent must prove to the Board that his continuing medical education is current. The respondent must maintain continuing medical education requirements as required by state law and the Board's rules and regulations.

280. The petitioner is ordered to submit a Statement of Costs on or before May 15, 2010.

281. The respondent shall pay the costs associated with this matter to be paid in 48 equal monthly installments due on the first of every month beginning June 1, 2010 and concluding May 1, 2014.

WHEREBY, the respondent's LICENSE to practice MEDICINE AND SURGERY, shall be LIMITED as follows:

282. The respondent shall not have authority to prescribe either Class II or Class III narcotic prescriptions.

283. All of the respondent's medical practice billing records shall be monitored, at the respondent's expense, for twenty four consecutive months by a licensee chosen by the respondent and approved by the Board or its designated representative. The monitor of the respondent's medical records shall report once monthly to the Board the monitor's findings regarding the Board's order.

284. The above order is a disciplinary action by the Board and is reportable to all applicable bodies.

IT IS SO ORDERED.

Pursuant to K.S.A. 77-527, either party may appeal this INITIAL ORDER. A petition for review may preclude further judicial review. If neither party requests a review, this INITIAL ORDER becomes final and binding on the 30th day following its mailing. Petitions for Review shall be mailed or personally delivered to: Kathleen Selzler Lippert, Acting Executive Director, Kansas Board of Healing Arts, 235 SW Topeka, KS 66603.

DATED: March 26, 2010.

Merle D. Hodges by

Merle D. Hodges, M.D.
Presiding Officer

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Initial Order was served by depositing the same in the United States mail, first class postage prepaid, this 26th day of March, 2010, addressed to:

Pravin Sampat
4025 SW Indian Hills Rd.
Topeka, KS 66610

Elizabeth R. Herbert
Pedro Irigonegaray
1535 SW 29th Street
Topeka, KS 66611-1901

Janith A. Lewis
Stacy Bond
Kansas Board of Healing Arts
235 SW Topeka Blvd.
Topeka, KS 66603-3068

And the original was filed with:

Kathleen Selzler Lippert
Acting Executive Director
Kansas Board of Healing Arts
235 SW Topeka Blvd.
Topeka, KS 66603

Cathy A. Brown