

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

FILED
JUN 19 2014
KS State Board of Healing Arts
CAB

In the Matter of)
) KSBHA Docket No. 14-HA00014
Stewart Grote, D.O.) OAH Docket No. 14HA0003
Kansas License No. 05-22108)

CONSENT ORDER

COMES NOW, the Kansas State Board of Healing Arts, (“Board”), by and through Seth K. Brackman, Associate Litigation Counsel, and Anne Barker Hall, Associate Litigation Counsel, (“Petitioner”), and Stewart Grote, D.O. (“Licensee”), by and through his counsel, Mark Lynch, Holbrook & Osborn, P.A., and move the Board for approval of a Consent Order affecting Licensee’s license to practice osteopathic medicine and surgery in the State of Kansas. The Parties stipulate and agree to the following:

1. Licensee’s last known mailing address to the Board is: **Confidential**
Lansing, Kansas, 66043.
2. Licensee is or has been entitled to engage in the practice of osteopathic medicine and surgery in the State of Kansas, having been issued License No. 05-22108 on approximately December 4, 1987, and having last renewed such license on September 30, 2013. Licensee’s license is active.
3. The Board is the sole and exclusive administrative agency in the State of Kansas authorized to regulate the practice of the healing arts, specifically the practice of osteopathic medicine and surgery. K.S.A. 65-2801 *et seq.* and K.S.A. 65-2870.

4. This Consent Order and the filing of such document are in accordance with applicable law and the Board has jurisdiction to enter into the Consent Order as provided by K.S.A. 77-505 and 65-2838. Upon approval, these stipulations shall constitute the findings of the Board, and this Consent Order shall constitute the Board's Final Order.
5. The Kansas Healing Arts Act is constitutional on its face and as applied in the case. Licensee agrees that, in considering this matter, the Board is not acting beyond its jurisdiction as provided by law.
6. Licensee voluntarily and knowingly waives his right to a hearing. Licensee voluntarily and knowingly waives his right to present a defense by oral testimony and documentary evidence, to submit rebuttal evidence, and to conduct cross-examination of witnesses. Licensee voluntarily and knowingly agrees to waive all substantive and procedural motions and defenses that could be raised if an administrative hearing were held.
7. The terms and conditions of the Consent Order are entered into between the undersigned parties and are submitted for the purpose of allowing these terms and conditions to become an Order of the Board. This Consent Order shall not be binding on the Board until an authorized signature is affixed at the end of this document. Licensee specifically acknowledges that counsel for the Board is not authorized to sign this Consent Order on behalf of the Board.
8. The Board has received information and investigated the same, and has reason to believe that there may be grounds pursuant to: K.S.A. 65-2836(b); K.S.A. 65-2836(k); K.S.A. 65-2836(p); K.S.A. 65-2837(a)(1); K.S.A. 65-2837(a)(2); K.S.A.

65-2837(a)(3); K.S.A. 65-2837(b)(12); K.S.A. 65-2837(b)(23); K.S.A. 65-2837(b)(24); K.S.A. 65-2837(b)(25); and K.S.A. 65-2837(b)(27) to take action with respect to Applicant's license under the Kansas Healing Arts Act, K.S.A. 65-2801, *et seq.*

9. Licensee does not admit nor deny the allegations contained in this Consent Order. Licensee acknowledges that if formal hearing proceedings were conducted and Licensee presented no exhibits, witnesses or other evidence, the Board has sufficient evidence to prove that Licensee has violated the Kansas Healing Arts Act with respect to the above allegations contained in this Consent Order. Licensee further waives his right to dispute or otherwise contest the allegations contained in the above paragraphs in any further proceeding before this Board.

STATEMENT OF FACTS

PATIENT I

10. Licensee treated Patient 1, a female born on August 3, 1960, from on or about June 11, 2008 through July 20, 2010, for complaints of left knee pain, low back pain, and obesity.
11. Licensee noted in the medical records at the first appointment, June 11, 2008, that her former physician was no longer willing to prescribe Oxycontin to her. Patient 1 had also been fired by two other physicians due to medication overuse issues.
12. At Patient 1's first appointment, she had not taken Oxycodone for approximately one month. Licensee noted "we also recommended instead of trying Oxycontin to consider Ultram first, and then if she is not any better she can follow-up to try a

long-acting narcotic such as Oxycontin, rather than jumping back into the dependency situation that she has w/that.” Licensee did not document prescribing Oxycontin to Patient 1 on this date.

13. On or about June 11, 2008, Licensee performed horizontal therapy of Patient 1’s low back and left knee. Licensee also conducted laser therapy on the left knee.
14. On or about June 11, 2008, Licensee took an x-ray of Patient 1’s left knee. Licensee interpreted the x-ray as “minimal joint space narrowing with no evidence of bony fragment or fracture.”
15. Licensee failed to record in the medical record objective criteria for Patient 1’s pain, and due to Licensee’s failure to record objective criteria, the benefit of treatment for Patient 1’s low back pain or knee pain could not be objectively measured.
16. On or about June 18, 2008, Patient 1 presented to Licensee.. At that time, Licensee noted “she did try first Avinza for 1 dose and then went back to the Oxycontin 40 mg t.i.d. w/good improvement in her pain until the last 3 days.”
17. On or about June 30, 2008, Licensee noted that Patient 1 had self- increased her Oxycontin to 80 mg TID. On or about September 15, 2008, Patient 1 self-increased her Oxycontin to 80mg QID.
18. On or about November 6, 2008, Licensee documented in Patient 1’s medical record that he was prescribing Opana-ER 40mg 1 TID in addition to the Oxycontin he was prescribing.

19. On or about November 7, 2008, Patient 1 obtained an MRI of her left knee. The finding states “severe osteoarthritis” and “large atypical popliteal cyst tracking beneath the medial head of the gastrocnemius muscle.”
20. On or about December 8, 2008, Licensee documented in Patient 1’s medical record that “she is sticking to 80mg TID on the Oxycontin and gained benefit from the OxyIR.” The Opana is not documented. Licensee also noted, “she is actually over utilizing and is 4 days early, but she thinks she can keep it on an even keel. I told her we would need to increase the dosage of one or the other or try a new medicine, which we have tried many w/her, if she is unable to keep it on a monthly basis.”
21. As of the December 8, 2008 visit, Patient 1 was taking over 270mg of Oxycodone per day.
22. Approximately, five months later, in May of 2009, an orthopaedic consult was obtained. The orthopaedist recommended that Patient 1 have a left total knee arthroplasty. At that point, Patient 1 was on an extremely large dose of Oxycodone ER dose 480mg/day. Licensee’s medical record for Patient 1 does not contain any documentation or information that Patient 1 obtained the recommended arthroplasty.
23. Licensee failed to refer Patient 1 to a non-surgical spine specialist to obtain a diagnosis for Patient 1’s low back pain.
24. Licensee repeatedly engaged in experimental therapy without proper informed consent. Licensee administered vitamin infusions to Patient 1, but never

documented a vitamin deficiency in Patient 1, nor were any laboratory reports in Patient 1's medical record to support a diagnosis of vitamin deficiency.

25. On February 27, 2009, Licensee documented "patient with second degree burns on her back from laser last time." Licensee did not document any treatment provided to Patient 1 for her burns. At Patient 1's previous appointment, on or about January 28, 2009, Licensee failed to document conducting laser therapy.
26. On or about April 25, 2009, Patient 1 was hospitalized due to severe pain issues. On the second night of her admission, Patient 1 became unresponsive and was administered Narcan. Licensee advised the hospital to discharge Patient 1 and stated he would try to detox her utilizing Robaxin.
27. On or about April 30, 2009, Licensee documented "Patient 1 just spent 4 days in the hospital to which she went because of an allergic reaction to amoxicillin." Licensee continued Patient 1 on Oxycontin 80mg 2 pills TID.
28. On or about October 13, 2009, Patient 1 returned to Licensee after having been in Two Rivers Hospital for rehabilitation due to her Oxycontin and Neurontin abuse. Licensee noted "I told her we would entertain the thought of putting her back on a narcotic." Licensee further states, "She at no time abused or misused Oxycontin." However, the following day, October 14, 2009, Licensee noted that Patient 1 freely admitted to "crushing up and snorting Oxycontin for well over a year."
29. On or about October 14, 2009, Licensee instructed Patient 1 to continue Suboxone.

30. On or about October 28, 2009, Licensee noted in Patient 1's medical record "she has been on 40mg of Opana, so today I wrote her a prescription for #120 pills and she can titrate the Opana up."
31. On or about February 16, 2010, Licensee documented in Patient 1's medical record that she was taking "40mg 5 x/day of the Opana and 10mg of the IR #30 for breakthrough."
32. On or about March 5, 2010, Licensee documented in Patient 1's medical record "we refilled the Opana 40mg ER 2 t.i.d." Licensee did not document an explanation as to the reason or need for this increase.
33. On or about April 15, 2010, Licensee documented in Patient 1's medical record "she is doing quite well on Opana but wants to increase the middle dose to 2 and do away with the Opana IR. This will help with cost and give her a bit more medicine, an extra 40mg, and maybe would control pain better."
34. Throughout the course of Patient 1's treatment her urine drug screens tested positive for marijuana and other substances Licensee had not prescribed, and were negative for prescribed substances.

PATIENT II

35. Licensee treated Patient 2, a male born January 14, 1978, from on or about November 5, 2007 through June 29, 2010, for chief complaint of "spondylolisthesis chronic low back pain" and "intermittent radiculopathy."
36. On or about November 5, 2007, Patient 2 informed Licensee that he was fired from another physician's practice due to a problem with a date on his prescription

- for Oxycontin. Patient 2 also advised Licensee he had been informed he needed surgery to fuse his low back.
37. Licensee failed to request or obtain Patient 2's medical records from his previous treatment providers.
 38. On or about November 5, 2007, Licensee noted in Patient 2's medical record that "we will schedule an MRI for him when he has his next rain day." There is no documentation in Patient 2's medical record that the MRI was scheduled or completed.
 39. Licensee failed to properly document an adequate description of Patient 2's lower back pain, and failed to refer Patient 2 to a spine specialist to determine the pathology of Patient 2's pain.
 40. On or about November 5, 2007, Licensee prescribed Oxycontin to Patient 2. Licensee noted, "continue current meds w/ prescription given for Oxycontin, pending the response to the Ultram-ER at 400 mg. . ." Licensee further stated, "more than willing to try other long-acting narcotics." Additionally, Licensee allowed Patient 2 to determine how much and how often to take the narcotic medication when he documented, "I gave him more liberty to increase the Oxycontin to better fit his lifestyle and pain control."
 41. On or about November 5, 2007, Licensee failed to document the number, strength, or quantity of Oxycontin prescribed for Patient 2. Licensee documented no direction on how to take the medication other than "more liberty to increase."
 42. On or about November 26, 2007, Licensee wrote a prescription for Oxycontin 20 mg 2-3 tabs, 2-3 times a day, for Patient 2.

43. On or about December 22, 2007, Licensee documented in Patient 2's medical record "is doing fairly well w/ the Oxycontin at 20mg in a pattern of 2 in the morning 1 in the afternoon and 2 in the evening."
44. On or about January 10, 2008, Licensee noted, "Pt using more than 5/d (Oxycontin 20) because of cont [sic] severe elbow pain." Licensee increased Patient 2's dosage of Oxycontin to 40mg TID. He also documented that Patient 2's urinary drug screen ("UDS") was positive for fentanyl, which was not prescribed by Licensee.
45. On or about February 25, 2008, Licensee documented "[Patient 2] ... wants to continue w/ his plan of 20mg of Oxycontin using 3/2/3, w/ the hope that if the elbow pain does clear up that he can decrease back to his previous dosage."
46. Licensee further noted in Patient 2's medical record dated February 25, 2008, "I told him to use ice and adjust his Oxycontin prn. I did give him I believe #240 tablets for this next month."
47. Licensee documented a mostly illegible note including "try 60 1 BID oxycont vs oxycont 20 3/2/3." Fifteen days later on or about April 8, 2008, Licensee noted "Patient 2 comes in very stressed out because he lost a mixture of 60 and 20 mg Oxycontin, several of them that he just got 2 wks ago in a big pile of dirt." Licensee accepted this excuse and wrote a prescription for a 10 day supply #30 of 60mg Oxycontin.
48. Patient 2's next medical record is dated June 10, 2008. As per the last recorded visit, Patient 2 only received 10 days' worth of medication. However, Licensee documented "still using Oxycontin 60 3-4 x/d (he's 4 days early)." There is no

documentation contained in Licensee's medical record for Patient 2 for either late April or May 2008.

49. On or about July 9, 2008, Patient 2 came in for medication refills. Licensee documented, "Rx written for 3 months' worth of Oxycontin at 60mg 2 in the am and 1 b.i.d. and 1 prescription for OxyIR since he had plenty of pills left of that." Licensee increased Patient 2's dosage of Oxycontin without documenting a medical reason or necessity for the increase.
50. Patient 2 returned on or about August 27, 2008, for medication refills having utilized all three months' worth of medications prescribed on July 9, 2008. Although Patient 2 was 1.5 months early in his medication refill request, Licensee continued to prescribe "Oxycontin 80 2-3 x/d, (or 120 60 mg bid) + Actiq 800 1-2/ vs OxyIR (c 1 nt postdated Rx)."
51. On or about October 7, 2008, Patient 2 returned for medication refills 20 days early. At that visit, Licensee documented "Oxycontin #90 and also Actiq and OxyIR as described above." Licensee failed to mention Patient 2's index of pain for his low back and failed to note the dosage of the medications prescribed.
52. On or about October 24, 2008, Patient 2 returned for medication refills two weeks early reporting his Actiq and Oxycontin had been stolen. Licensee noted "In any event, we had talked about Patient 2 switching over to OxyIR anyway." Licensee prescribed Patient 2 "oxycontin 80mg #28 to continue to use 2 to 4 per day."
53. On or about October 31, 2008, Licensee wrote a prescription for "Oxycontin 80mg one in the am, one BID (to fill today), and OxyIR #60 to fill in two weeks."

54. On or about November 24, 2008, Licensee documented, Patient 2 “over utilized a bit on his Oxycontin in a transition over from Actiq.” Licensee noted, “we gave him Oxycontin 80 mg 2 q a.m. and 1 bid, and 60 OxyIR 30 mg.”
55. On or about December 23, 2008 Oxycontin and OxyIR were refilled.
56. On or about January 22, 2009, Licensee increased Patient 2’s OxyIR from 60 to 75 tablets per month “for when he has flair-ups.” However, “flair-ups” are not mentioned in the subjective statement and Licensee failed to note index pain, intensity or relief with opioids in subjective or objection statement.
57. On or about February 20, 2009, Licensee refilled Patient 2’s medications for Oxycontin and OxyIR.
58. On or about February 26, 2009, Licensee noted in the medical record for Patient 2 “Rx for Oxycontin 80 mg 2 qam then 1 bid and #75 OxyIR to use for breakthrough.”
59. On or about May 21, 2009, Licensee documented in Patient 2’s medical record “he is doing well, no complaints.” However, Licensee prescribed, “Oxycontin #120 80mg-tablets and I told him to take 2 consistently in the am and then use the OxyIR before and after the next Oxycontin dose. He was given #75 OxyIR. I told him we can go up to #80 or #90 next time if that is not adequate enough for breakthrough pain.”
60. On or about June 8, 2009, Licensee increased Patient 2’s dosage of Oxycontin as Patient 2 had significantly over utilized. Licensee also increased the number of OxyIR pills from 75 to 90 due to Patient 2’s over utilization.

61. On or about July 1, 2009, Licensee noted, "Patient 2 comes in for med refills. He wasn't able to get his Oxycontin 150 pills because of insurance restrictions until the 11th of June."
62. On or about July 17, 2009, Licensee noted, "Patient 2 comes in to tell me that he will be switching pharmacies because of the experience he had w/being shorted about 25 pills."
63. On or about July 29, 2009, Licensee noted, "Patient 2 continues to do well and he is in to get med refill. He is having excellent functionality without any excessive sedation or euphoria." However, Licensee without documenting medical necessity, increased Patient 2's medications to #120 OxyIR 30mg 5/da and #180 2/2/1 of the Oxycontin 80mg, a total daily dosage of 550mg.
64. On or about August 26, 2009, Patient 2 wanted to increase his Oxycontin 80 mg and decrease his breakthrough medicine. He wanted to take 2 pills tid on the Oxycontin 80mg. Licensee prescribed that and also OxyIR 30mg 1 to 2 per day #60
65. On or about December 16, 2009, Licensee noted in Patient 2's medical record "He is actually doing well but wants to try Opana which he states he has never had. I gave him 40mg (#90) of that in addition to the maximum amount of Oxycontin that he could get (#120)."
66. On or about January 13, 2010, Licensee noted in Patient 2's medical record, "He is out early because of a tough month. He wants to try to catch up with a few extra OxyIR and thinks he can maintain his current plan of 2 tid of the 80s." Licensee further noted, "He did try Opana and he did develop a rash with that and

would like to go back and use Opana in the future in the next 2 or 3 months possibly.” Licensee wrote prescriptions for Patient 2 for Oxycontin 80mg 2 t.i.d. #180 and OxyIR 30 mg increased from #60 to 75.

67. On or about May 7, 2010, Licensee noted in Patient 2’s medical record “He is going to go to Texas to work, so I did give him 2 months’ worth of the OxyIR and the Oxycontin at 80 mg 2 t.i.d. #180 and 75 mg on the OxyIR.” Licensee further noted in the plan statement, “The Oxycontin and OxyIR were written for 3 months, with 2 post-dated.”
68. On or about June 29, 2010, Licensee documented in Patient 2’s medical record that Patient 2 returned for the first time in 2.5 months. However, Patient 2 was last there on May 7, 2010, which was only 1.5 months prior. Licensee further noted, “The patient will continue the Oxycontin 80 mg 2 t.i.d., which is a very high dose” and “I gave him a prescription to get OxyIR increase from 75 pills to 90 pills since he has over utilized the IRs. But I gave him 2 Oxycontin 80 mg #180 each, post-dated one to get in a couple of weeks, and another to get in 5 or 6 weeks. I also gave him another OxyIR to get in 2 months, and he has the one at home that he can get in about 3 or 4 weeks.”

PATIENT III

69. Licensee treated Patient 3, a female born on March 29, 1975, from on or about April 26, 2007 until on or about September 30, 2011, for complaints of right shoulder pain.
70. On or about January 18, 2007, Patient 3 was seen by another physician in Licensee’s clinic. At that time, it was noted that Patient 3 wanted to “get off

methadone.” It is also noted that Patient 3 has been through treatment at the Kansas City Treatment Center and was put on methadone. Patient 3 stated she had a “very dependent personality.”

71. On or about April 25, 2007, Patient 3 returned to the clinic after having “been through a drug rehab program in Florida. She has been off methadone for 34 days.” At that time, no indication of pain was documented in Patient 3’s medical record. Patient 3 was referred to Licensee for “evaluation of pain management.”
72. On or about April 26, 2007, Licensee met with Patient 3 for the first time. At that time, Patient 3 was complaining of pain in her shoulder, back and abdomen. Licensee diagnosed Patient 3 with pelvic pain, right SI strain with pelvic dysfunction, right shoulder pain with crepitus, bilateral TMJ, mind racing rule out ADD, and hypoestrogenism. Licensee immediately began treating Patient 3 with psychotropic medications and noted he would “initiate Ultram.”. Licensee informed Patient 3 “she does not have addictive behavior except with cigarettes.”
73. Licensee, in his physical examination of Patient 3, failed to accurately and thoroughly describe her pain complaints. At Patient 3’s second visit with Licensee, Licensee listed multiple diagnoses including personality disorder consistent with ADD vs bipolar vs both. Patient 3 advised Licensee that she “had a long discussion w/ her husband last night and has agreed to go on Oxycontin at a low dose.” Licensee failed to document in Patient 3’s medical record what prescriptions he wrote for her.

74. Licensee failed to refer Patient 3 to a psychiatrist to properly address her diagnosis of “personality disorder consistent with ADD vs. bipolar vs. both,” and failed to refer Patient 3 to a gynecologist for a pelvic examination.
75. Licensee failed to immediately refer Patient 3 for an MRI to assist in diagnosing the cause of her shoulder pain.
76. On or about April 30, 2007, Licensee documented that “Oxycontin does not seem to be working all that well and she is using 2 pills qd.” He failed to note the dose or efficacy.
77. On or about April 30, 2007, Licensee increased Patient 3’s prescription for Oxycontin to “sometimes TID and up to 2-3 pills on the generic 10mg.”
78. Licensee continued to increase Patient 3’s narcotic use and dependence during the next three years by prescribing fentanyl, methadone, Oxycontin, OxyIR, and Actiq in ever changing dosages and quantities. At one point, he prescribed methadone and Oxycontin 80mg 2 TID.
79. On or about August 21, 2007, Licensee recognized that Patient 3 had an addiction problem and noted in her medical record “we will have to consult. . . an addiction specialist.” This never occurred and he kept prescribing highly addictive narcotics to Patient 3.
80. In addition to narcotics, Licensee offered prolotherapy, laser therapy and horizontal therapy to Patient 3, without any indication of pain relief. Licensee failed to obtain an informed consent for prolotherapy and horizontal therapy, which are both experimental in nature.

81. On or about February 26, 2008, Licensee prescribed Actiq 1600 mcg #90, i.e. TID, or 4800 mcg/day.
82. Licensee was constantly changing medications without medical indication, and changed medications when the evidence indicates the medications were working. Licensee explained these changes in medications as either required by the insurance company, pharmacy or at Patient 3's request.
83. Licensee failed to insist that Patient 3 obtain an MRI for her shoulder upon her presentation to him in April of 2007. Licensee finally sent Patient 3 to a surgeon for consultation in October of 2007, and Patient 3 put off surgery until June of 2008. When Patient 3 complained on or about November 17, 2008, that her shoulder pain "is worse after surgery," Licensee failed to have her follow up with her surgeon or another surgeon.
84. Licensee failed to refer Patient 3 to a spine specialist in order to diagnose the causation of the low back pain or obtain an MRI of the lower back. Licensee simply prescribed more narcotic medications.
85. Licensee on multiple occasions noted that there was no suspicion of diversion or misuse of narcotic medications by Patient 3. However, on numerous occasions, Patient 3 obtained early refills. Licensee wrote prescriptions and increased the dosages so that Patient 3 could get her medications since her insurance company would not allow an early refill. Licensee also noted that Patient 3 allowed her husband to use her medications. Patient 3 had multiple excuses as to why she needed early refills, such as her medications were stolen, the pharmacy shorted

her, or her husband threw her medications away. Licensee did not verify any of these excuses and wrote additional prescriptions for Patient 3.

PATIENT IV

86. Licensee treated Patient 4, a male born on March 31, 1952, from on or about February 8, 2008 through on or about October 12, 2011.
87. On or about October 24, 2010, an investigator with the Kansas State Board of Healing Arts issued a subpoena for medical records for Patient 4. The subpoena requested “ANY and ALL records in your possession and control or subject to your possession and control, regardless of source, including but not limited to radiology films and reports, pertaining to the following patients for 2007 to present date.”
88. Licensee failed to provide all documents legally requested by the Board for Patient 4.
89. On or about February 8, 2008, Licensee noted in Patient 4’s medical record, “he has been using 1-2 Percocet qd at 5mg and the Methadone #60 or #120 per month.” There is no mention in the medical record for Patient 4 dated February 8, 2008 indicating he was experiencing pain which required the use of narcotic medications. Licensee noted in the assessment portion of the note “chronic pain syndrome,” but failed to provide any subjective or objective criteria to support this diagnosis.
90. Licensee failed to conduct a proper physical examination of Patient 4.
91. Licensee failed to provide any pertinent and significant information concerning the patient’s pain complaint in the medical record for Patient 4.

92. During the time Licensee treated Patient 4, Licensee diagnosed Patient 4 with chronic neck pain, chronic back pain, severe wrist pain, chronic neck and headache pain, hand pain, shoulder pain, and upper back pain. Licensee failed to refer Patient 4 for an MRI of any of the diagnosed areas of pain or refer Patient 4 to a spine specialist to determine the pathology of Patient 4's pain.
93. Licensee failed to note, at any time, in Patient 4's medical record any objective findings of pain for Patient 4.
94. In the medical record obtained from Licensee for Patient 4 there are two separate notes for the date of April 21, 2011. The first note was dictated April 21, 2011 and transcribed on May 3, 2011. The second dictated on May 18, 2011, and transcribed on June 6, 2011. In the former note, the diagnosis of "bilateral SI and paralumbar" pain was noted, while in the second note "pain to palpation in the cervical and upper thoracic spine" was noted.
95. On or about October 1, 2008, Licensee noted in Patient 4's medical record "he got his methadone and 5 mg Percocet refilled for 2 months." On or about November 8, 2008, Licensee noted in Patient 4's medical record "he got his methadone and 5 mg Percocet refilled for 2 months." No information regarding dosage, quantity or manner in which the medication is to be taken is documented in either note.
96. On or about December 5, 2008, Licensee prescribed additional Percocet 5mg #30 and methadone #60 to Patient 4.
97. On or about March 20, 2009, Licensee noted in Patient 4's medical record, "his routine methadone which we will give him a 2 month prescription and increase the number from 60 to 75 plus he needs his Percocet #60 which lasts him 2

months usually.” However, on or about April 24, 2009, Licensee wrote a prescription for “Percocet 10/325 #60” for Patient 4.

PATIENT V

98. Licensee treated Patient 5, a female born on January 23, 1958, from on or about January 7, 2008 through on or about October 17, 2011.
99. Licensee failed to provide any pertinent and significant information concerning the Patient 5’s pain complaint in the medical record. On or about January 7, 2008, Licensee diagnosed Patient 5 with “chronic pain syndrome, now on long-acting narcotics, pending urine drug screen.” Chronic pain syndrome is not a recognized diagnosis that describes any pathology as a possible pain generator.
100. On or about January 7, 2008, Licensee treated Patient 5. It is unclear from Licensee’s medical record what medications Patient 5 had been prescribed. Licensee allowed Patient 5 to determine what dose of medication to take based on whether she was sleepy or sedated, rather than on medical necessity.
101. During the period Licensee treated Patient 5, he documented numerous pain diagnoses. Although Patient 5 had numerous pain complaints over her entire body, Licensee did not require Patient 5 to obtain any type of diagnostic testing such as an MRI nor did he refer her to a spine specialist to determine the pathology of her spinal pain.
102. During the period Licensee treated Patient 5, he treated her with experimental treatments. Licensee failed to obtain a proper informed consent from Patient 5 to engage in these experimental treatments.

103. On or about March 7, 2011, May 6, 2011, May 13, 2011, June 3, 2011, and June 6, 2011, Licensee treated Patient 5 with “vitamin infusions”. There is no evidence that Patient 5 suffered from a malabsorption disease or was malnourished.
104. Patient 5 failed her random UDS on numerous occasions. Patient 5 tested positive for marijuana on at least nine (9) occasions between September 27, 2010 and April 20, 2011; however, Licensee continued to prescribe highly abusable narcotic medications to Patient 5. Licensee even noted “last chance” on Patient 5’s drug screen of December 20, 2010. Even though Patient 5 continued to have positive drug screens for marijuana, he continued to prescribe to her.
105. Patient 5’s UDS tested positive for hydrocodone although it was not prescribed by Licensee on at least three (3) occasions, and Patient 5 failed to test positive for prescribed substances on at least two (2) occasions. Licensee failed to take any action.
106. On or about July 3, 2008, Licensee noted in Patient 5’s medical record “Opana has helped.” There is no previous documentation in the medical record for Patient 5 indicating Opana was prescribed.
107. On numerous occasions Licensee failed to document the dosage, quantity and/or instructions for Patient 5’s prescription medication. On or about June 1, 2009, Licensee noted in Patient 5’s medical record, “injected 0.5cc Lidoderm into the multiple triggers.” No information is contained as to what “triggers” he was referring to or where they were located. Lidoderm is not injectable, so it is unknown what solution was injected into Patient 5.

108. On or about April 7, 2010, Licensee did not document any prescriptions being written for Patient 5 in her medical record. However, pharmacy records show that Patient 5 filled prescriptions for both Oxycontin and OxyIR that day.
109. On or about April 29, 2011, Licensee noted in Patient 5's medical record "she did try 2 Oxycontin together one time, and it worked quite well, with a lasting pain relief effect. She is due to have Oxycontin refilled so I gave her 80mg tablets #90 to use 2 in the morning and 1 at night or vice versa." Patient 5 increased her narcotic medication use by 33% without the approval of Licensee. Licensee then enabled this behavior by writing a prescription for additional pills.

PATIENT VI

110. Licensee treated Patient 6, a female born on July 19, 1973, from on or about October 16, 2009 through August 18, 2011.
111. On or about October 16, 2009, Licensee documented in Patient 6's medical record "she is disabled from long history of metastatic disease." He further noted that she has been treated the entire time by Dr. Nadine Johnson. Further, Licensee noted "I do not have any records confirming that, so I asked her to bring back anything such as MRIs, echocardiograms, etc, that pertain to her chemotherapy." Patient 6 never provided the requested information. At no time did Licensee attempt to obtain Patient 6's medical records from Dr. Johnson or any other provider.
112. At Patient 6's first visit with Licensee, Licensee prescribed Percocet 10/325 mg ½ pill bid to tid, #90 and 5mg Opana ER #60.

113. On the next visit on or about November 13, 2009, the only item documented in the medical record was a Dexa scan to evaluate osteoporosis. There is no documentation indicating any additional narcotics were prescribed.
114. On or about December 16, 2009, Licensee noted in Patient 6's medical record "she did okay on the Opana but much better on 30mg of Embeda." No record of a prescription for Embeda for Patient 6 between October 16, 2009 and December 16, 2009, is contained in her medical record.
115. On or about October to November 2010, Licensee noted in Patient 6's medical record "she does not have metastatic cancer." Licensee changed Patient 6's working diagnosis from "history of left breast cancer with abdominal metastasis" to "musculoskeletal pains." However, Licensee prescribed Percocet, Opana IR, Opana ER, morphine, fentanyl, Dilaudid, methadone and Nucynta to Patient 6 in increasing dosages without evidence of benefit.
116. On or about November 14, 2010, Licensee noted in Patient 6's medical record "that, way we can avoid fentanyl to establish if she does not have metastatic cancer." Avoiding, or providing fentanyl does not establish or refute a diagnosis of metastatic cancer, or any other disease.
117. During the 20 months Licensee treated Patient 6, Licensee diagnosed Patient 6 with numerous diagnoses.
118. Licensee failed to provide any pertinent and significant information concerning Patient 6's pain complaint in her medical record. During that 20 month period, Licensee failed to refer Patient 6 to any other provider, such as a spine specialist,

psychiatrist nor did he ever obtain an MRI of the lumbar spine to aid in diagnosis of Patient 6's low back pain.

119. Patient 6 failed ten (10) UDS during the time Licensee treated her for pain complaints. At no time did Licensee confront Patient 6 about her failed UA's or take any action.
120. No drug screens are noted between the dates of August 18, 2010 and November 4, 2010. Additionally, Licensee did not insist his patient obtain the UA's as he ordered. For instance, Licensee noted in Patient 6's medical record on or about October 20, 2010 "she is unable to do a urine screen today, but will come back tomorrow." There is no evidence that Patient 6 returned on October 21, 2010 for the UDS.
121. On or about November 5, 2010, Licensee noted "Patient 6 comes in after just being seen yesterday when she told me that Nucynta was working telling me now that Nucynta really isn't working. . ." Licensee then prescribed Opana IR for breakthrough pain. Licensee failed to require Patient 6 to return the unused Nucynta (morphine + Naltrexone) pills.
122. Licensee's documentation as to what prescriptions were written for Patient 6 are unclear. For instance, on or about January 29, 2011, Licensee noted, "prescription written for Opana #180 10 mg tabs." No information was provided if that meant OpanaIR or OpanaER (immediate or extended release), or how Patient 6 was to take the Opana.
123. On or about January 31, 2011, Licensee noted in Patient 6's medical record, "we gave Patient 6 the Opana IR inadvertently, 10 mg #180." Licensee also noted

“This was done erroneously by Corner Pharmacy, because I did not put ER or IR on the prescription mistakenly.”

124. During the timeframe from February 2010 to February 2011, Licensee gave Patient 6 twenty-one vitamin infusions, without any evidence that Patient 6 had a vitamin deficiency.

PATIENT VII

125. Licensee treated Patient 7, a male born on July 30, 1970, from on or about January 14, 2008 through on or about September 8, 2011.
126. Licensee’s medical record for Patient 7 is deficient in regards to documenting medications prescribed, to include the name, quantity, dosage, and instructions on how to take the medication. Licensee failed, in the medical record for Patient 7, to provide any pertinent and significant information concerning the patient’s pain complaint
127. Licensee’s diagnosis of “chronic pain syndrome” is non-specific and provides no information as to the location, duration, intensity, or type of pain Patient 7 is experiencing.
128. Although Licensee diagnosed Patient 7 with “lumbosacral degenerative disc disease,” no MRI, CT, or plain film x-rays are contained in Patient 7’s medical record to support this diagnosis.
129. There is no evidence in the medical record for Patient 7, that Licensee ever referred Patient 7 to a spine specialist for a proper diagnosis.
130. Licensee also diagnosed Patient 7 with “radiculopathy in the right leg.” Licensee failed to note any neurological deficits to support this pathology. On or about

March 28, 2008, Licensee noted in Patient 7's medical record "he admits he did use 6-7 Oxycontin that he found." Licensee had not prescribed Oxycontin to Patient 7. Licensee continued to prescribe narcotic medications to Patient 7.

131. On or about April 8, 2008, Licensee noted in Patient 7's medical record, "Patient 7 is in to get 20 mg of his Opana. He is using 20 and a 40 b.i.d. He has some feelings that he may be getting in to an overutilization situation." Finally Licensee noted, "we are going to keep a close eye on him and also make the prescriptions every week."
132. On or about April 16, 2008, eight days later, Licensee noted in Patient 7's medical record "he also has been over utilizing Opana at 120 mg qd. He will probably not be able to get 40 mg #60 or 20 mg #60 until next week." Licensee then noted "I gave him #30 Oxy-IR 30 mg to use 1 b.i.d. or t.i.d. He has never snorted those but did get into snorting the Oxycontin at some point."
133. On or about April 21, 2008, Licensee noted in Patient 7's medical record "Patient 7 did not do well on Oxy-IR and is coming in to get his Opana on time, 40 mg #60." Licensee prescribed thirty days of Opana 40mg #60 to Patient 7 after having noted in the preceding two office visits that Patient 7 was abusing his medications. No instructions for taking the Opana are contained in the medical record.
134. On or about May 2, 2008, Licensee noted in Patient 7's medical record "he did admit to me after the last visit that he has been using Oxycontin and actually snorted some." Licensee did not refer Patient 7 to a pain specialist, psychiatrist, or for rehabilitation.

135. On or about June 19, 2008, in a mostly illegible note in Patient 7's medical record Licensee noted "MRI shows [?] arthritis." However, no MRI report from a radiologist or spine specialist is contained in the chart.
136. On or about November 8, 2008, Licensee noted in Patient 7's medical record "increased back pain" and "he actually tried splitting an Opana 20 mg in half." No pain index was included to determine the level of increased pain Patient 7 was experiencing.
137. On or about January 5, 2009, Licensee noted in Patient 7's medical record "patient in early due to increased low back pain." Licensee wrote prescriptions for "Opana ER 40 and 20 #60 (don't fill until 15 Jan 09)" and "IR Opana 10 #60." Since Patient 7 was early and could not refill the Opana 20mg and 40mg until the following week, Licensee writes a new prescription for Opana IR 10mg #60.
138. On or about March 4, 2009, Licensee noted in Patient 7's medical record "add Opana 10 ER #60 to Opana ER 40 and 20 to total 70 b.i.d."
139. On or about April 1, 2009, Licensee noted in Patient 7's medical record, "Patient 7 is doing fairly well at 70 mg bid on the Opana." Licensee then wrote prescriptions for #60 pills each of 10mg, 20mg, and 40mg Opana. Those prescriptions were enough to last one month.
140. On or about April 20, 2009, Licensee documented in Patient 7's medical record that "he has been using 3 10mg at a time and has run out of the 10mg Opana." Licensee did not take any action but instead wrote another prescription for #60 30mg Opana.

141. On or about April 29, 2009, Licensee documented in Patient 7's medical record "Patient 7 comes in to refill his 20mg and 40mg Opana as he has already about 2 weeks ago, started using 30mg and is doing well." Licensee noted "So he is using a total of 90 bid in essence." In less than one month Patient 7 self-increased his Opana from 140 mg daily to 180 mg daily.
142. On or about May 15, 2009, Licensee documented in Patient 7's medical record "Patient 7 is in to refill on the 30mg Opana. He is about 4 days early." Licensee then wrote the prescription for Opana 30mg as well as writing two post-dated prescriptions for Opana 20mg and 40mg.
143. On or about September 28, 2009, Licensee noted in Patient 7's medical record "Patient 7 is in about four days early on his Opana refill. He had been doing so well using one each of Opana 20, 30, and 40 for total of 90mg bid but now has over utilized because of his increased pain."
144. On or about December 4, 2009, Licensee noted in Patient 7's medical record "Patient 7 comes in to discuss the fact that he has been over utilizing his Opana still and not getting any significant relief." Licensee did not refer Patient 7 to a spine specialist or psychiatrist, but did prescribe Patient 7 Avinza (morphine extended release). Morphine had already been utilized and found to be non-effective.
145. On or about December 21, 2009, Patient returned to Licensee and informed Licensee that he had "given up on the Avinza as it was not helpful." Licensee documented in the medical record that prescriptions were written for "Opana 20

mg plus 40 mg, #90.” No instructions for taking the medication are noted in the chart.

146. On or about January 11, 2010, Licensee noted in Patient 7’s medical record “over utilized his medications.” Licensee further noted that because of insurance safeguards “he should not be able to get the medicine at this point and has another 10 days to wait. In the meantime, I will give him 30mg #120 to see if that should suffice 2 to 3 times per day.”
147. On or about February 8, 2010, Licensee noted in Patient 7’s medical record “Patient 7 comes in with 2 days left on his medications, using as much as 260mg Opana per day.” Patient 7 had self-increased his Opana from 180mg daily to 260mg daily. Licensee took no action and documented in the chart “We will now go ahead and try to use 30mg plus 40mg, #90 but we may have to go up to #120 of each now that we know that #120 will be covered and is using that much more anyway.”
148. On or about February 15, 2010, Licensee noted in Patient 7’s medical record “we actually decided to go ahead and give him 20mg and 40mg #90 so he could take a total of 90 mg tid at 270 mg per day to get control of his pain.” Licensee accepted Patient 7’s self-increase to 260 mg per day and further increased it one week later to 270mg per day without mentioning any medical necessity for such an increase.
149. On or about March 26, 2010, Licensee noted in Patient 7’s medical record “Patient 7 comes in to get his 30mg Opana. He is not due to get it until next week, as he has been over utilizing all of his medicines. . .” However, Licensee refused to acknowledge that Patient 7 had an abuse problem when he stated “no

misuse of medicine, except for the overuse as described.” In addition since Patient 7 was unable to refill his Opana 20mg and 30mg due to insurance safeguards, Licensee wrote a prescription for Opana IR 10 mg for Patient 7 “to plan to use that if his medicines run out or for the breakthrough if the Zipsor is not as effective as he hopes.”

150. On or about April 9, 2010, Licensee noted in Patient 7’s medical record “Patient 7 comes in because he has used up his 30’s and needs a prescription for 40’s and 20’s on the Opana ER.” However, Licensee had written on March 26, 2010, a prescription for Opana 20mg #90 “to be filled in a couple of weeks” and Opana 30mg “next Wednesday.”
151. Seventeen days later on or about April 26, 2010, Licensee noted in Patient 7’s medical record “Patient 7 is in for 1-month follow up (it’s only been seventeen days) and refill of his 30mg Opana ER. He also wanted to get post-dated for 10 days from now the prescription for 40mg and 20mg.”
152. On or about September 11, 2010, Licensee noted in Patient 7’s medical record “we were able to get the 30 mg Opana ER refilled which was last done on the 26th at 5 per day.” There is no documentation for August 26th contained in the medical record for Patient 7. However, Licensee wrote a prescription for Opana 30mg for Patient 7 on August 20th. Again, just fifteen (15) days after writing a prescription for Opana 30mg #90, Licensee increased the dosage to Opana 30mg #150. Licensee continued to enable Patient 7’s over utilization of medications by consistently writing for larger doses of medication without any documented medical necessity.

153. On or about October 14, 2010, Licensee noted in Patient 7's medical record "Patient 7 is not doing well." Licensee then wrote a prescription for Opana 30mg #150, without any instructions for taking the medication documented in the medical record.
154. On or about October 30, 2010, Licensee noted in Patient 7's medical record "Patient 7 comes in having had new musculoskeletal symptoms to include shoulder pain, numbness and pain in the distal fingers and hands." Licensee diagnosed Patient 7 with "myalgias" which is consistent with hyperalgesia and allodynia from chronic narcotic use. However, Licensee continued to prescribe narcotics to Patient 7.
155. On or about November 3, 2010, Licensee noted in Patient 7's medical record "Patient 7 was in last week [four days ago] and is using more than three 40 mg tabs as he is using 2, 3, and 2 which is a total of 7 pills per day or 280mg per day." Patient 7 was out of his Opana 40mg due to over use; Licensee wrote a prescription for Opana 20mg #150.
156. On or about November 22, 2010, Licensee noted in Patient 7's medical record "exquisite right shoulder pain with acute enthesopathy, rule out rotator cuff tear." Licensee further noted "we will see about getting an MRI if he is no better." However, Licensee did not order an MRI. Licensee then documented "he is to continue the Opana, either 40 mg or 20 mg or both, about t.i.d." Licensee allowed Patient 7 to determine how much and how often to take the narcotic medications, anywhere from 40mg (20mg b.i.d.) to 240mg (60 q.i.d.).

157. On or about January 3, 2011, Licensee noted in Patient 7's medical record "we are going to send him to Dr. Waitley and LaSalle to consider for epidural blocks and further diagnostic workup."
158. On or about January 24, 2011, Licensee documented in Patient 7's medical record "he saw Dr. LaSalle on Friday who did apparently facet blocks which did seem to help significantly for the back."
159. On or about March 25, 2011, Licensee diagnosed Patient 7 with "right shoulder pain, low back pain, chronic, upper lumbar spasm and gastroenteritis. Licensee failed to refer Patient 7 for an MRI of either his back or his right shoulder. Licensee failed to refer patient 7 to an orthopaedic surgeon.
160. On or about April 4, 2011, Licensee noted in Patient 7's medical record "he will also talk to his wife about switching back to OxyContin since he continues to require an excessive amount of Opana to manage his chronic low back pain." Again, Licensee considered prescribing Oxycontin to Patient 7 even though he knew Patient 7 had a well-known history of snorting Oxycontin.
161. On or about May 10, 2011, Licensee noted in Patient 7's medical record "Patient 7 has completely gone through the 20mg Opana 4 pills t.i.d. and actually has felt like some of his 30's came up missing." Licensee continued to write prescriptions for the maximum number of pills allowed by the insurance company.
162. On or about May 28, 2011, Licensee documented in Patient 7's medical record "he has used up all of his Opana in about 12 days." Again, Licensee documented marked abuse by Patient 7, but continued to prescribe narcotics when he wrote,

“we gave him a prescription for Opana 30mg #150, 3 in the morning and 2 at night, if it is possible to maintain that over 2-4 weeks.”

163. On or about July 29, 2011, Licensee documented, “Patient 7 is having significant problems with overuse still with the 30mg Opana.” Licensee wrote a prescription for Opana 20mg #150.

PATIENT VIII

164. Licensee treated Patient 8, a female born on July 23, 1944, from on or about January 25, 2008 through on or about September 30, 2011, for complaints of low back pain, arthritis and knee pain.
165. On or about January 25, 2008, Licensee documented in Patient 8’s medical record, “We also refilled her methadone. She can increase 1 or 2 pills qd for awhile [sic] but her girl will have to keep a close watch on this.” Licensee failed to document the number, dose and instructions for the methadone he prescribed. Licensee also documented “we gave her two months of the methadone and Adderall.”
166. Licensee repeatedly refilled Patient 8’s medications early and documented Patient 8 as over utilizing medications several times.
167. On at least two (2) occasions Licensee documented that Patient 8 obtained Xanax from others. On or about December 6, 2008, Licensee documented in Patient 8’s medical record “Patient was not seen.” However, in the objective portion of the medical record it states “BP checked and was normal.” Licensee further documented “Pt. was given Adderall 30 mg 1 tid and methadone 10 mg 2 pills tid. She will do a urine drug screen next time.”

168. On or about January 5, 2009, Licensee documented in Patient 8's medical record that Patient 8 stated she was addicted to methadone and Adderall. Licensee further noted, "Narcotic overutilization with possible diversion." Licensee continued to prescribe methadone and Adderall to Patient 8.
169. On or about July 7, 2009, Licensee documented in Patient 8's medical record "we asked her to do a urine drug screen and she did not do it. I called and left a message related to that situation as she has walked out in the last several times." Even though Patient 8 is being non-compliant with UDS, Licensee continued to write prescriptions for Patient 8. Licensee documented "she also needs Adderall 30 mg tid generic, for ADD and methadone 2 pills tid #180."
170. On or about November 30, 2009, Licensee noted in Patient 8's medical record "Patient 8 comes in for medication refills. She is on methadone 2 tid for her inflammatory arthritis and myalgia's." However, on or about May 28, 2010, Licensee states that Patient 8 is on the methadone for her "inflammatory arthritis and knee pain."
171. On or about July 21, 2010, Licensee noted in Patient 8's medical record "she also feels like she cannot back off to 2 bid on the methadone, so I wrote a prescription for 2 tid as we had been doing before." Licensee also documented, "remains stable on the Adderall, and no longer is taking Adipex which she tried one time." Licensee failed to document prescribing Adipex to Patient 8.
172. On or about February 10, 2011, Licensee documented in Patient 8's medical record "prescription written for the methadone 2 tid and Adderall 30 mg tid."

173. On or about June 8, 2011, Licensee documented in the medical record for Patient 8, “Patient has not done well with her idea to get off of her Tramadol.” Licensee failed to document prescribing Tramadol to Patient 8.
174. Licensee’s medical record for Patient 8 is deficient in regards to documenting medications prescribed, to include the name, quantity, dosage, and instructions on how to take the medication.
175. During the three and a half years Licensee treated Patient 8 he failed to refer Patient 8 to a spine specialist to determine the pathology of Patient 8’s low back pain; failed to obtain an imaging study (x-ray or CT scan) for Patient 8’s knee pain; failed to refer Patient 8 to any specialist to determine the pathology of her knee pain; failed to refer Patient 8 to a psychiatrist for her ADD; failed to conduct psychometric testing and did not document any improvement of Patient 8’s ADD symptoms with the use of Adderall; and failed to refer Patient 8 to a rheumatologist for a consultation or examination for inflammatory arthritis.
176. Licensee failed to obtain a proper informed consent regarding experimental therapy.

PATIENT IX

177. Licensee treated Patient 9, a female born on September 29, 1966, from on or about January 16, 2008 through on or about July 27, 2011 for complaints of chronic neck pain, chronic pain syndrome and chronic failed neck surgery.
178. On or about January 16, 2008, Licensee documented in Patient 9’s medical record “she is completely off methadone and it was ineffective for her”, Licensee further noted, “she is doing quite well on the plan of 2 Oxycontin q.i.d.”

179. On or about January 23, Licensee documented, "Patient wants to switch from Oxycontin 2 4x/d to methadone and Actiq." Licensee further noted "had MRI yesterday." However, no MRI report is contained in the medical record for Patient 9, nor did Licensee record the results of the MRI in the medical record for Patient 9. Licensee issued prescriptions for "Actiq 1600 #60 2-3x/d and methadone 2-3x/d."
180. Licensee did not require Patient 9 to return the unused Oxycontin pills that he prescribed just one week earlier. Patient 9 had seven weeks of unused Oxycontin pills which totaled 392 pills. The street value of Oxycontin pills is \$4 per mg. Each pill was 80mg. This equals \$125,400.
181. Only three UDS are contained in the medical record for Patient 9, dated, 8/6/10, 9/3/10, and 11/13/10. Although Patient 9 was prescribed Actiq during the time of all three drug screens, the three drug screens contain no evidence of fentanyl, or metabolites.
182. On or about February 21, 2008, Licensee documented in Patient 9's medical record "There is impingement so she knows she needs to see Dr. Amundson but she is still wanting the great desire to work and will go back to work and then make time to see Dr. Amundson sometime in the next few wks." No further documentation concerning a consult with Dr. Amundson is contained in the medical record for Patient 9.
183. Licensee failed to record in the medical record objective criteria for Patient 9's pain.

184. Licensee failed to insist that Patient 9 see an interventional spine pain specialist to determine the pathology of her neck pain. Licensee consistently wrote prescriptions for Actiq 1600mcg x4-5/day plus methadone which equals 480 Percocet tablets per day.
185. On or about January 10, 2011, Licensee documented in Patient 9's medical record a diagnosis of radiculopathy. However, Licensee failed to conduct an adequate neurological examination to support a diagnosis of radiculopathy.
186. Licensee failed to properly document an adequate description of Patient 9's thoracic and neck pain.
187. Licensee administered vitamin infusions to Patient 9 but never documented a vitamin deficiency in Patient 9, nor were there any laboratory reports in Patient 9's medical record to support a diagnosis of vitamin deficiency.
188. Licensee's medical record for Patient 9 is deficient in regards to documenting medications prescribed, to include the name, quantity, dosage, and instructions on how to take the medication.
189. Licensee documents numerous times in the medical record for Patient 9 that he is prescribing methadone for withdrawal symptoms. Patient 9 was taking large doses of fentanyl and would not be suffering withdrawal symptoms.

PATIENT X

190. Licensee treated Patient 10, a male born on April 4, 1965, from on or about December 22, 2007 through on or about June 10, 2011 for complaints of low back pain.

191. On or about December 22, 2007, Licensee documented in Patient 10's medical record "his pain seems to be well controlled on 6 Oxycontin per day." Licensee further noted "he wanted . . .to get methadone to help him taper down on the Oxycontin." Licensee wrote a prescription for "#90 methadone to use 1 t.i.d." No dosage was recorded.
192. On or about January 7, 2008, Licensee documented in Patient 10's medical record prescriptions for methadone 10 and Actiq #90. Licensee failed to document in the medical record any explanation or rationale to explain the need for a change in medication.
193. On or about January 15, 2008, Licensee documented in Patient 10's medical record "pt feels methadone not helping at current dose . . . he wants to go back to Oxycontin. Was using 8 Actiq/day."
194. On or about January 15, 2008, Licensee wrote a prescription for #270 Oxycontin 80mg 2-3 tid.
195. On or about March 27, 2008, Licensee documented in Patient 10's medical record "leaving for Afghanistan in 1 month for 1 to 1 ½ years." Further, Licensee documented he wrote prescriptions for three months of methadone and Actiq, enough to last until June 27, 2008.
196. On or about April 15, 2008, Licensee documented in Patient 10's medical record "patient comes in stating that he does not need methadone but is finding that Tussionex which he has been using for his cough also helps his intermittent back pain. He is to the point where he feels like he doesn't need the Actiq anymore."

Licensee further documented “he [Patient 10] is happy that he is completely off Oxycontin.”

197. However, on or about May 7, 2008, Licensee documented in Patient 10’s medical record “patient comes in for one last time before he goes to Afghanistan next week and he finds out that on Express Scripts he can get a 3 month refill prescription.” Licensee wrote prescriptions for three months of methadone and Actiq.
198. On or about May 16, 2008, Licensee documented in Patient 10’s medical record “methadone for the month and Actiq 1600 4x1d (plus 3 months to be mailed).”
199. On or about September 28, 2008, Licensee noted in Patient 10’s medical record “Pt. needing a refill on his methadone 10mg 2 tid #270 with no refills. Pt. is getting 3 rx.” However, on or about October 22, 2008, Patient 10’s wife (Patient 9), admitted to sending Patient 10 “30 Actiq and ¼ bottle of methadone.”
200. For over three years, Licensee treated Patient 10 for “low back pain.” Several times in the medical record Licensee documented the need for an MRI, but Patient 10 always had a reason why he could not have one taken. Licensee failed to refer Patient 10 to a spine specialist who could diagnose Patient 10’s pathology for his low back pain.
201. On several occasions, Licensee wrote prescriptions for methadone and Actiq which he gave to Patient 9 to fill for Patient 10 and mail overseas. Licensee continued to prescribe large quantities of narcotics to Patient 10 without examining Patient 10.

PATIENT XI

202. Licensee treated Patient 11, a female born on February 21, 1956, from on or about December 5, 2008, through on or about September 21, 2011, for complaints of chronic pain syndrome, chronic upper back and neck pain, fibromyalgia, and low back pain.
203. Patient 11 failed at least eleven (11) urine drug screens during the time Licensee treated her.
204. On or about December 5, 2008, Licensee documented in Patient 11's medical record "she wants to increase the Actiq just a bit, and we will go up to 60." Further, Licensee noted "Actiq 1200 to 1600 mcg now bid."
205. On or about February 6, 2009, Licensee documented in Patient 11's medical record that Patient 11 wanted to increase her medication again. Licensee noted "she has been using #200 methadone per month but wants to increase the Fentora to 800 mcg and she will still get #86 of them to use tid prn."
206. On or about March 28, 2009, Licensee documented in Patient 11's medical record "she either has misplaced some Adderall or over utilizing it. The other medicines are online except for the Fentora which she will have to wait to get probably."
207. On or about June 29, 2009, Licensee documented in Patient 11's medical record "Rx written for Lorazepam for anxiety #30, Adderall #120. Methadone and fentora #84." On or about August 7, 2009, Licensee documented in Patient 11's medical record "Patient . . . will try to cut back on the Methadone. I gave her #200 pills w/ an attempt to decrease if possible." Licensee prescribed the same number of Methadone pills he previously prescribed. Licensee also documented

“gave her only #60 Adderall XR this time, as we have been giving her #120 for 3 or 4 yrs now.”

208. However, on or about September 4, 2009, Licensee documented in Patient 11’s medical record “We also wrote for her ADD medicine, Adderall 2 bid #120 of the generic XR.” Licensee doubled the amount of Adderall given to Patient 11, without documenting a medical necessity which required the increase in medication.
209. On or about October 2, 2009, Licensee documented in Patient 11’s medical record “she is using Fentora 800mcg 84 per month and the methadone 200 per month.” Licensee further noted, “she is not over utilizing her medicine but does not want to decrease the methadone just yet.”
210. On or about December 1, 2009, Licensee documented in Patient 11’s medical record “she is a bit early because she is using 3 per day, and only gets #84 [Fentora] per month.” However, Licensee further documented “no signs of overuse at this time.”
211. On or about March 30, 2010, Licensee documented in Patient 11’s medical record “prescriptions written.” On or about April 19, 2010, Licensee documented in Patient 11’s medical record “[Patient] comes in a bit early today about 7 to 10 days. . . .” Licensee further documented “she has increased the amount of methadone, borrowing some from her husband.”
212. On or about May 18, 2010, Licensee documented in Patient 11’s medical record “[Patient] is due to refill her medications to include Adderall XL 30 mg 2 b.i.d., methadone 2 q.i.d. #250 for 1 more month and also Fentora 84.”

213. On or about June 17, 2010, Licensee documented in the subjective portion of Patient 11's medical record "medications: . . .Fentora 800 mg b.i.d. to t.i.d. . .methadone 10 mg 2 q.i.d. she is using 250. . . ." Later in the plan portion of the medical record Licensee documented, "prescription written for the methadone, Fentora. . . ."
214. On or about July 16, 2010, Licensee documented in Patient 11's medical record "she at first asked to be decreased on her methadone down to 200 mg and wanted to switch back to Demerol as she has been on Fentora or Actiq for a couple of years now." Further, Licensee documented "we decided to stick with the methadone at #240 pills per month and the Fentora 800 mcg #84, but next month we can consider going away from the Fentora and back to Demerol." Licensee also noted "we may consider getting consultation with a pain management expert."
215. On or about September 11, 2010, Licensee documented performing prolotherapy on Patient 11. Licensee documented only using hydrogen peroxide to cleanse the skin in the area of the injection. Licensee failed to document the areas of injection.
216. On or about November 24, 2010, Licensee documented in Patient 11's medical record "she got her medicines through her husband last month to include 200 methadone and 84 of the fentora." There is no documentation contained in Patient 11's medical record for the month of October 2010.

217. On or about December 17, 2010, Licensee documented in Patient 11's medical record "she was on methadone, and since she was seen in November has been ineffective, and she wants to go back to trying Kadian."
218. On or about January 15, 2011, Licensee documented in Patient 11's medical record "used the Kadian with good results, 2, sometimes 3, per day. She wants to go back to methadone." Licensee prescribed methadone to Patient 11. Licensee failed to document a medical reason for changing Patient 11 to methadone after documenting one month prior that she was receiving good results with the Kadian.
219. On or about June 16, 2011, Licensee documented in Patient 11's medical record "still with her usual neck pain, controlled with Fentora 800 mcg t.i.d. 84, and also the methadone 2 q.i.d. which has been her steady dose for the last several months."
220. On or about August 17, 2011, Licensee documented in Patient 11's medical record "did run out of her narcotic, methadone and Actiq 1200 mcg and she wants to increase to 1600 mcg since she was on the 800 mcg of Fentora." Licensee does not document any medical necessity for increasing the dosage of Actiq.
221. On or about September 21, 2011, Licensee documented in Patient 11's medical record "Patient wants to go back to 1200 as 1600 was too sedentary."
222. Licensee failed to refer Patient 11 for an MRI or to a spine specialist to assist in treatment and diagnosis for Patient 11. Licensee failed to record in the medical record objective criteria for Patient 11's pain.

PATIENT XII

223. Licensee treated Patient 12, a male born on October 14, 1966, from on or about April 20, 2009, through on or about September 21, 2011, for complaints of low back pain, knee pain and shoulder pain.
224. On or about December 7, 2009, Licensee documented in Patient 12's medical record "[Patient] comes in because of a severe right shoulder pain. He actually tried one of his wife's leftover Opana which did help." Licensee prescribed "pain medicine in the form of Ultram or Tramadol," Licensee did not specify which medication, Ultram or Tramadol he prescribed, amount, dosage, or instructions on usage.
225. On or about December 24, 2009, Licensee documented in Patient 12's medical record "[Patient] comes in still with severe shoulder pain and for about a week took his wife's Opana 40 mg 1 b.i.d." Licensee then "went ahead and gave him a prescription for 20 mg Opana ER today, 1 b.i.d. 60." Further, Licensee documented that a UDS was performed, but no report is contained in the medical record for that date.
226. On or about May 1, 2010, Licensee documented in Patient 12's medical record "he has developed left knee pain." Patient 12 denied any trauma to his left knee.
227. On or about May 25, 2010, Licensee documented "He has used extra Opana. He remains on Opana ER 20 mg #60 using up to 3 per day at times so he will try to get 60 and I gave him Opana IR 10mg #60.
228. On or about June 14, 2010, Licensee documented in Patient 12's medical record "he has been using the 20mg three times daily and would rather go up to 40mg

twice a day and get #60 of them since we know there is a limit on his insurance and how much he can get. On or about July 9, 2010, Licensee documented in Patient 12's medical record "we will see if we are able to get the Opana about 4 days early, ER, 40mg #90."

229. On or about October 7, 2010, Patient 12 submitted a UDS. The UDS was positive for Oxycodone even though Patient 12 had not been prescribed Oxycodone by Licensee.
230. On or about June 17, 2011, Licensee documented in Patient 12's medical record "he has had consistent drug screens and no evidence of diversion or misuse." However, the UDS conducted on May 20, 2011, was "negative" for opioids, even though Licensee had prescribed Opana, an opioid to Patient 12.
231. On nine (9) separate occasions Patient 12 submitted a UDS in which he failed the drug screen by not testing positive for the medications prescribed to him by Licensee. Licensee failed to take any action in regards to the failed drugs screens, and continued to write prescriptions for Opana, an opioid narcotic.
232. On several occasions Licensee documented the need for an MRI of Patient 12's shoulder and knee in Patient 12's medical record. However, over a period of two years, no MRI was obtained. Licensee failed to refer Patient 12 to an orthopaedic surgeon for a consult to determine the origin of the pain in Patient 12's shoulder and knee.
233. Licensee failed to properly document an adequate description of Patient 12's shoulder and knee pain.

PATIENT XIII

234. Licensee treated Patient 13, a male born on November 3, 1968, from on or about November 29, 2007, through on or about September 15, 2011 for low back pain.
235. On or about November 29, 2007, Licensee diagnosed Patient 13 with ADD (Attention Deficit Disorder) due to Patient 13 stating that he had “lost his wallet several times because he has ADD.” Licensee began prescribing amphetamines to Patient 13 for his ADD diagnosis. Licensee failed to request medical records from Patient 13’s previous providers in order to determine the accuracy of the information provided by Patient 13. During four years of treatment for ADD, Licensee did not conduct psychometric testing to determine if the treatment for ADD was effective for Patient 13.
236. Patient 13 failed his drug screens multiple times by either testing positive for medications not prescribed, not testing positive for medications prescribed or not testing positive to the levels expected from the dose prescribed. Although there were multiple problems with Patient 13’s UDS, Licensee failed to take any action and continued to prescribe narcotic medications to Patient 13.
237. Patient 13 consistently refilled his medications early and would, at some appointments, offer an explanation that his meds were stolen or taken by his nephew.
238. On or about May 27, 2008, Licensee documented in Patient 13’s medical record “Patient increased usage.” Licensee then increased the dosage of methadone from 240 pills per month to 270 pills per month.

239. On or about October 24, 2008, Licensee documented, "Pt comes in for med refill. He is using the methadone w/ decent results." Licensee documented "prescriptions written," no information is noted as to what medication, dose, number or instructions for use.
240. On or about December 17, 2008, Licensee documented in Patient 13's medical record "Pt using more methadone than 4 3x/d because of increased pain from cold weather." Licensee then prescribed "Opana 20 1-2 2-3xd."
241. On or about December 19, 2008, Licensee documented in Patient 13's medical record that he was abusing methadone; so he switched Patient 13 to Avinza and Kadian (morphine extended release).
242. On or about January 14, 2009, Licensee documented in Patient 13's medical record "Pt intolerant of Opana and Avinza; think he can stick with methadone (again) 3 3x/d."
243. On or about March 9, 2009, Licensee documented in Patient 13's medical record "he also is having increased pain and would like to go up to 4 pills tid as he was out of his medicine 3 or 4 days early because this was a short month." Licensee increased the methadone pills to #360 per month as per Patient 13's request.
244. On or about May 29, 2009, Licensee documented in Patient 13's medical record "[Patient] is here for med refills. He is doing fairly well, still using the high dose of methadone." Licensee prescribed "methadone at maximum dose 4 tid #360."
245. On or about July 24, 2009, Licensee documented in Patient 13's medical record "Pt comes back in for med refill. He is on maximum dose of methadone at 3 qid." Licensee further noted, "Rx written for 1 month's worth of the methadone."

246. On or about April 30, 2010, Licensee documented in Patient 13's medical record "He was counseled once again about diversion. We did post-date the methadone." On or about October 12, 2010, Licensee documented in Patient 13's medical record "[Patient] comes back in after just getting #120 methadone last visit. Patient states that he has also been out of his methadone about 5 to 7 days and has not gone through withdrawal."
247. On or about September 15, 2011, Licensee documented in Patient 13's medical record "he consistently comes in early." Licensee then documented "I flat out asked him if he is over-utilizing which he denies."

PATIENT XIV

248. Licensee treated Patient 14, a male born on November 30, 1985, from on or about March 11, 2008 through on or about September 29, 2010.
249. On or about March 11, 2008, Patient 14 presented to Licensee with complaints of Oxycontin withdrawal. Licensee documented that Patient 14 reported, "he has been taking 8 to 11 80-mg tabs of Oxycontin per day for approx. the last 1.5 yrs. Pt. states that he has been trying to wean himself off the Oxycontin and states he is currently down to 2 to 3 of the 80mg tabs qd." Licensee diagnosed Patient 14 with 1) Oxycontin dependence and withdrawal, 2) depression and anxiety, and 3) ADD.
250. Licensee failed to refer Patient 14 to a rehabilitation clinic, a psychiatrist or other mental health professional to assist with his drug use and mental health issues.
251. Licensee failed to properly document an adequate description of Patient 14's low back pain.

252. Patient 14 advised Licensee that “he has obtained Suboxone tablets from different acquaintances and that the Suboxone works but it is too expensive. Pt. also states that he has tried Methadone w/ some relief of his symptoms.” Patient 14 also admitted to using other controlled substances such as Ambien, Xanax, Lortab, and Vicodin, as well as alcohol and marijuana.
253. Licensee further documented in Patient 14’s medical record that “Pt. received a prescription for Suboxone 8mg.” Licensee failed to document the number of pills prescribed and the manner in which they were to be taken. Licensee instructed Patient 14 to return in a month.
254. On or about March 12, 2008, Licensee documented in Patient 14’s medical record “[Patient] was in yesterday. I am a little concerned that he is back today asking for the methadone.” However, Licensee prescribed “#180 methadone 2 pills t.i.d.” and noted “chronic low back pain” as the reason for prescribing the methadone. Licensee failed to conduct an objective physical examination of Patient 14. Licensee instructed Patient 14 to follow-up “either on Friday or in 2 wks to 4 wks depending on how well he does w/this plan.”
255. On or about March 24, 2008, Licensee documented in Patient 14’s medical record “[Patient] comes in doing fairly well on Methadone 7 per day.” Licensee then “gave him prescription for #210 methadone and he is to follow-up in 1 months’ time.”
256. On or about May 24, 2008, Patient 14 returned to see Licensee. Licensee documented “[Patient] says that he has been out of his methadone for 4 days and

he has been using the Lortab that he got from a dental appointment.” Licensee noted that he was concerned that Patient 14 bought the Lortab off the street.

257. On or about June 19, 2008, Licensee documented in Patient 14’s medical record “Pt. came out of forced rehab for DWI (for narcotics).” Licensee further noted, “he is using . . .methadone anywhere from 5 to 7 per day and he would like to go up to 200 pills per month.” Licensee then “gave him #200 [sic] methadone and probably should have limited it, but I am going away for 10 days, so he should have enough for at least 1 month.”

258. Patient 14 returned to Licensee’s office on or about July 19, 2008 for a medication refill, at that time Patient 14 is seen by a physician assistant (PA). The PA documented “I do not feel comfortable prescribing him the full 200 pills that he is requesting. I am going to give him #28 methadone and he is to follow-up on Tuesday with Licensee.”

259. On or about August 21, 2008, Licensee documented in Patient 14’s medical record “Pt has been using extra methadone. Did actually increase 9/d.” Licensee then wrote a prescription for methadone #240 pills.

260. On or about September 22, 2008, Licensee documented in Patient 14’s medical record “[Patient] comes in today stating that he has been using more than 8 methadone per day.” Licensee further noted, “we offered him rehab” and “we had an anonymous caller tell us that he was still selling methadone on the street.” Licensee then documented “I told him that if he did not go to rehab again, that we could no longer take care of him.”

261. On or about September 21, 2009, Patient 14 returned to see Licensee. Licensee noted “[Patient] is actively using narcotics.” Licensee further documented “he used Suboxone on the street and 3 or 4 of them per day have helped quell his narcotic addiction.” Licensee additionally noted, Patient “smokes cigarettes and marijuana and whatever else he can find on the street, especially his Oxycontin which he snorted that last night.” Again, Licensee failed to refer Patient 14 to a rehabilitation clinic and prescribed Suboxone #90. Licensee diagnosed Patient 14 with 1) narcotic addiction, 2) situational anxiety, and 3) chronic anxiety with depression and probably bipolar disorder. No mention was made in the medical record of low back pain.
262. On or about October 21, 2009, Licensee documented in Patient 14’s medical record “[Patient] came in to pick up Suboxone meds.” Licensee further noted, “he tested positive for marijuana, benzos and Oxycontin. Pt. stated his drug of choice was marijuana.” Licensee failed to refer Patient 14 for rehabilitation counseling or inpatient treatment.
263. On or about May 12, 2010, Licensee documented in Patient 14’s medical record “[Patient] comes in after 3 months stating that he used the Suboxone for 1 month and then went back on the street, buying Oxycontin 40 mg t.i.d.” Licensee further noted, “he may ultimately decide to switch back to methadone if he can remain substance free.”
264. Thirteen (13) UDS were conducted on Patient 14 during the period he was seen by Licensee. Of those thirteen (13) UDS, twelve (12) of them showed inconsistencies in the medications prescribed and the medications used. One

showed higher than expected levels of methadone in the urine, which indicates abuse.

265. On or about July 7, 2010, Licensee documented in Patient 14's medical record "Patient states that he has never bought or sold narcotics on the street, at least recently anywhere but Kansas City in the ghetto." On that same date, Licensee noted, "I probably made a mistake in giving him 3 months of Suboxone and asked him to bring back the 2nd 2 months within 1 week." There is no evidence in Patient 14's medical record that this occurred.

266. On or about September 29, 2010, Licensee documented in Patient 14's medical record "Patient states that his Suboxone effectively treats his withdrawal symptoms but still continues to use MS Contin which he gets from an unnamed source in Kansas City." Licensee noted, "the patient has also been warned that this is the last warning, and the next step will be termination." Licensee then refilled the Suboxone at 2.5 tablets per day, a six week supply.

FACTUAL CONCLUSIONS

267. Licensee failed to request medical records for Patients 1 through 14, from his or her previous providers.

268. Licensee's medical record for Patients 1, 6, 7, 10, 11, 12, 13, 14, is deficient in regards to documenting medications prescribed, to include the name, quantity, dosage, and instructions on how to take the medication.

269. Licensee failed to record in the medical record objective criteria for Patient 8's, 9's, 10's, 11's, 12's, and 13's pain.

270. Licensee failed to maintain an adequate medical record for Patients 1 through 14.

271. Licensee failed to conduct an adequate physical examination of Patients 1 through 14.
272. Licensee failed to adhere to the applicable standard of care to a degree constituting gross negligence in the treatment of Patients 1 through 14.
273. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence in the treatment of Patients 1 through 14.

CONCLUSIONS OF LAW

274. Pursuant to K.S.A. 65-2836, the Board may revoke, suspend, limit, censure or place under probationary conditions Licensee's license and pursuant to K.S.A. 65-2863a the Board has the authority to impose administrative fines for violations of the Kansas Healing Arts Act.
275. According to K.S.A. 65-2838(b) and K.S.A. 77-505, the Board has authority to enter into this Consent Order without the necessity of proceeding to a formal hearing.
276. Licensee acknowledges that the Board has sufficient evidence to prove that Licensee has violated the following provisions of the Kansas Healing Arts Act with respect to the above facts:
- a. K.S.A. 65-2836(b), in that Licensee committed an act of unprofessional or dishonorable conduct or professional incompetency, that if continued would reasonably be expected to constitute an inability to practice the healing arts with reasonable skill and safety to patients or unprofessional conduct as defined by K.S.A. 65-2837, and amendments thereto.

- b. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(1), in that Licensee committed one or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board.
- c. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(2), in that Licensee committed repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board.
- d. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(3), in that Licensee engaged in a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice the healing arts.
- e. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(23), in that Licensee prescribed, dispensed, administered or distributed 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 licensee's professional practice.
- f. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(24), in that Licensee engaged in repeated failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances.

- g. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(25), in that Licensee 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.
- h. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(27), in that Licensee used experimental forms of therapy without proper informed patient consent, without conforming to generally accepted criteria or standard protocols, without keeping detailed legible records or without having periodic analysis of the study and results reviewed by a committee or peers.
- i. K.S.A. 65-2836(k), in that Licensee 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, in that Licensee failed to maintain adequate medical records pursuant to K.A.R. 100-24-1.
- j. K.S.A. 65-2836(p), in that Licensee prescribed, sold, administered, distributed or gave a controlled substance to any person for other than medically accepted or lawful purposes.

277. According to K.S.A.65-2838(b) and K.S.A. 77-505, the Board has authority to enter into this Consent Order without the necessity of proceeding to a formal hearing.

278. All pending investigation materials in KSBHA Investigative Case Numbers 10-00147, 10-00314, 11-00136, 11-00363, and Docket Number 14-HA00014 regarding Licensee, were fully reviewed and considered by the Board members

who serve on the Board's Disciplinary Panel and/or their appointed member for this matter. Disciplinary Panel No. 27 authorized and directed Board counsel, through their appointed member for this matter, to seek settlement of this matter with the provisions contained in this Consent Order.

279. Licensee further understands and agrees that if the Board finds, after due written notice and an opportunity for a hearing, that Licensee has failed to comply with any of the terms of this Consent Order, the Board may immediately impose any sanction provided for by law, including but not limited to suspension or revocation of Licensee's license to practice osteopathic medicine and surgery in the State of Kansas. Licensee hereby expressly understands and agrees that, at any such hearing, the sole issue shall be whether or not Licensee has failed to comply with any of the terms or conditions set forth in this Consent Order. The Board acknowledges that at any such hearing, Licensee retains the right to confront and examine all witnesses, present evidence, testify on his own behalf, contest the allegations, present oral argument, appeal to the courts, and all other rights set forth in the Kansas Administrative Procedures Act, K.S.A. 77-501 *et seq.*, and the Kansas Healing Arts Act, K.S.A. 65-2801 *et seq.*

280. Nothing in this Consent Order shall be construed to deny the Board jurisdiction to investigate alleged violations of the Kansas Healing Arts Act, or to investigate complaints received under the Risk Management Law, K.S.A. 65-4921 *et seq.*, that are known or unknown and are not covered under this Consent Order, or to initiate formal proceedings based upon known or unknown allegations of violations of the Kansas Healing Arts Act.

281. Licensee hereby releases the Board, its individual members (in their official and personal capacity), attorneys, employees and agents, hereinafter collectively referred to as “Releasees”, from any and all claims, including but not limited to those alleged damages, actions, liabilities, both administrative and civil, including the Kansas Judicial Review Act, K.S.A. 77-601 *et seq.* arising out of the investigation and acts leading to the execution of this Consent Order. This release shall forever discharge the Releasees of any and all claims or demands of every kind and nature that Licensee has claimed to have had at the time of this release or might have had, either known or unknown, suspected or unsuspected, and Licensee shall not commence to prosecute, cause or permit to be prosecuted, any action or proceeding of any description against the Releasees.
282. Licensee further understands and agrees that upon signature by Licensee, this document shall be deemed a public record and shall be reported to any entities authorized to receive disclosure of the Consent Order.
283. This Consent Order, when signed by both parties, constitutes the entire agreement between the parties and may only be modified or amended by a subsequent document executed in the same manner by the parties.
284. Licensee agrees that all information maintained by the Board pertaining to the nature and result of any complaint and/or investigation may be fully disclosed to and considered by the Board in conjunction with the presentation of any offer of settlement, even if Licensee is not present. Licensee further acknowledges that the Board may conduct further inquiry as it deems necessary before the complete or partial acceptance or rejection of any offer of settlement.

285. Licensee, by signature to this document, waives any objection to the participation of the Board members, including the Disciplinary Panel and General Counsel, in the consideration of this offer of settlement and agrees not to seek the disqualification or recusal of any Board member or General Counsel in any future proceedings on the basis that the Board member or General Counsel has received investigative information from any source which otherwise may not be admissible or admitted as evidence.
286. Licensee acknowledges that he has read this Consent Order and fully understands the contents.
287. Licensee acknowledges that this Consent Order has been entered into freely and voluntarily.
288. The Board may consider all aspects of this Consent Order in any future matter regarding Licensee.
289. All correspondence or communication between Licensee and the Board relating to the Consent Order shall be by certified mail addressed to:
- Kansas State Board of Healing Arts
Attn: Compliance Coordinator
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612
290. Licensee shall obey all federal, state and local laws and rules governing the practice of osteopathic medicine and surgery in the State of Kansas that may be in place at the time of execution of the Consent Order or may become effective subsequent to the execution of this document.
291. Upon execution of this Consent Order by affixing a Board authorized signature below, the provisions of this Consent Order shall become a Final Order under

K.S.A. 65-2838. This Consent Order shall constitute the Board's Order when filed with the office of the Executive Director for the Board and no further Order is required.

292. Licensee shall immediately notify the Board or its designee of any citation, arrest or charge filed against him or of any conviction for any traffic or criminal offense.
293. Licensee shall at all times keep Board staff informed of all his current practice locations, addresses and telephone numbers. Licensee shall provide the above information in writing to the Board within ten (10) days of any such change.
294. This Consent Order constitutes disciplinary action.
295. Upon execution of this Consent Order by the Board, the Summary Order in Docket No. 14-HA00139 shall be dismissed by the Board.
296. In lieu of conducting a formal proceeding, Licensee, by signature affixed to this Consent Order, hereby voluntarily agrees to the following disciplinary action against his license to engage in the practice of osteopathic medicine and surgery:

SUSPENSION

297. Licensee's license shall be suspended for a period of not less than six (6) months from beginning June 19, 2014.
298. After the elapse of not less than six (6) months from the effective date of his suspension, Licensee agrees that a request to terminate the suspension of his license shall be in writing and will be considered in accordance with all applicable statutes, laws, rules and regulations regarding qualifications for licensure and reinstatement. Licensee may file his application for reinstatement with the Board prior to the expiration of the suspension period. Licensee's application for

reinstatement shall not request for early termination of the six (6) months suspension period, but allow for the consideration of the lifting of his suspension at the regularly scheduled December Board meeting, currently scheduled for December 12, 2014. Licensee agrees that in the event he requests termination of the suspension of his license, the allegations contained in this Consent Order will be considered findings of fact and conclusions of law.

299. All proceedings conducted on a request for termination of the suspension shall be in accordance with the provisions of the Kansas Administrative Procedure Act, K.S.A. 77-501, *et. seq.* and shall be reviewable in accordance with the Kansas Judicial Review Act, K.S.A. 77-601, *et. seq.*

LIMITATION

300. Licensee is prohibited from ordering, prescribing, dispensing, distributing and/or administering any controlled substance in Schedules II, III, and IV of the Controlled Substance Act.
301. Licensee may apply for the lifting of this prohibition from ordering, prescribing, dispensing, distributing and/or administering any controlled substance in Schedules II, III, and IV of the Controlled Substance Act after the expiration of three (3) years from the date of approval of this Consent Order. The burden of proof by clear and convincing evidence shall be on Licensee to show sufficient rehabilitation to justify reinstatement of his controlled substance privileges. If the Board determines Licensee's controlled substance privileges should not be reinstated, Licensee shall not be eligible to reapply for reinstatement of such

privileges for one (1) year from the effective date of the denial of all or part of any such request.

302. Licensee agrees that the Board may, at its discretion throughout the monitoring of this provision, request KTRACS reports to ensure Licensee's compliance with the above provision.
303. Licensee agrees to immediately surrender his license if he fails to comply with this aforementioned limitation of ordering, prescribing, dispensing, distributing and/or administering any controlled substance in Schedules II, III, and IV of the Controlled Substance Act in any manner.
304. All proceedings conducted on this limitation shall be in accordance with the provisions of the Kansas Administrative Procedure Act and shall be reviewable in accordance with the Kansas Judicial Review Act.
305. Such application for reinstatement of his controlled substance privileges shall be made in writing and addressed to:

Compliance Coordinator
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Ste. A
Topeka, Kansas 66612

SUPERVISION OF MID-LEVEL PRACTITIONERS

306. Licensee shall not supervise, direct, or monitor any mid-level practitioners effective upon approval of this Consent Order with the Board.
307. Licensee may apply for reinstatement of supervision authority over mid-level practitioners after the expiration of three (3) years from the date of approval of this Consent Order. The burden of proof by clear and convincing evidence shall be on Licensee to show sufficient rehabilitation to justify reinstatement of his

- supervision authority. If the Board determines his supervision authority should not be reinstated, Licensee shall not be eligible to reapply for reinstatement for one (1) year from the effective date of the denial of all or part of any such request.
308. Licensee agrees to immediately surrender his license if he fails to comply with this aforementioned limitation of supervision privileges in any manner.
309. All proceedings conducted on this limitation shall be in accordance with the provisions of the Kansas Administrative Procedure Act and shall be reviewable in accordance with the Kansas Judicial Review Act.
310. Such application for reinstatement of supervision authority shall be made in writing and addressed to:

Compliance Coordinator
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Ste. A
Topeka, Kansas 66612

EDUCATION

311. Licensee shall attend and successfully complete a competence assessment and educational intervention program assessment for physicians provided by the Center for Personalized Education for Physicians (“CPEP”).
312. Within ten (10) days of the approval of this Consent Order, Licensee shall contact CPEP located at 7351 Lowry Boulevard, Suite 100, Denver, Colorado 80230 - Phone: 303-577-3232 - Fax: 303-577-3241 to enroll in the aforementioned program. Licensee shall forward proof of enrollment in the above-mentioned course to the Compliance Coordinator immediately thereafter.

313. Licensee shall complete this course before August 31, 2014. Licensee shall provide proof of completion to the Compliance Coordinator within thirty (30) days of attending the program, but no later than September 30, 2014.
314. These hours shall be in addition to those hours required for renewal of licensure.
315. All foreseen and unforeseen expenses to complete the aforementioned program including travel, lodging, program fee, meals, etc. shall be at Licensee's own expense.
316. Upon his return to practice following his suspension, Licensee shall follow any and all recommendations made by CPEP.

FINE

317. Licensee agrees to pay a FINE in the amount of FIVE THOUSAND DOLLARS AND ZERO CENTS, (\$5,000.00).
318. Such fine shall be paid to the "Kansas State Board of Healing Arts" in full on or before August 30, 2014.
319. All monetary payments made to the Board relating to this Consent Order shall be mailed to the Board by certified mail addressed to:

Compliance Coordinator
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Ste. A
Topka, Kansas 66612

COSTS

320. The Board agrees to waive all incurred costs, known and unknown, up to and including the effective date of this Consent Order.
321. The Board does not agree to waive any future costs to defend and/or enforce this Consent Order.

IT IS THEREFORE ORDERED that the Consent Order and agreement of the parties contained herein is adopted by the Board as findings of fact, conclusions of law, and as a Final Order of the Board.

IT IS SO ORDERED on this 13 day of June, 2014.

**FOR THE KANSAS STATE
BOARD OF HEALING ARTS:**


Kathleen Selzler Lippert
Executive Director

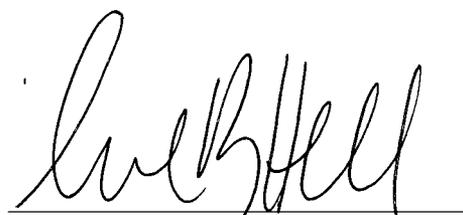
10/13/14
Date


Stewart Grote, D.O.
Licensee

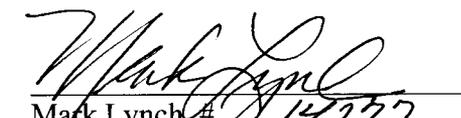
16 May 2014
Date

PREPARED AND APPROVED BY:


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mlynch@holbrookosborn.com

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that I served a true and correct copy of the Consent Order by United States mail, postage prepaid, on this 19th day of June, 2014, to the following:

Stewart Grote, D.O.
Licensee
Confidential
Lansing, Kansas, 66043

Mark Lynch
Attorney for Licensee
Holbrook & Osborn, P.A.
7400 W 110th St # 600
Overland Park, KS 66210

And the original was hand-filed with:

Kathleen Selzler Lippert
Executive Director
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

And a copy was hand-delivered to:

Seth K. Brackman, Associate Litigation Counsel
Anne B. Hall, Associate Litigation Counsel
Katy Lenahan, Licensing Administrator
Compliance Coordinator
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

General Counsel's Office
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612