Florida Board Of Medicine

PCP North
February 28, 2020

Meet-Me #: 1 (888) 585-9008
Participation Code: 432-162-565
Notice of Meeting/Workshop Hearing

DEPARTMENT OF HEALTH
Board of Medicine

The Board of Medicine - Probable Cause Panel North announces a public meeting to which all persons are invited.

DATE AND TIME: Friday, February 28, 2020, 2:30 p.m.

PLACE: Meet-Me #: 1 (888) 585-9008, Participation Code: 432-162-565

GENERAL SUBJECT MATTER TO BE CONSIDERED: To conduct a public meeting to reconsider disciplinary cases with prior findings of probable cause.

A copy of the agenda may be obtained by contacting: Jacoyia Reddick at (850) 558-9848 or email her at Jacoyia.Reddick@flhealth.gov.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Jacoyia Reddick at (850) 558-9848 or email her at Jacoyia.Reddick@flhealth.gov.

If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

If any person decides to appeal any decision made by the Board with respect to any matter considered at this meeting or hearing, he/she will need to ensure that a verbatim record of the proceeding is made, which record includes the testimony and evidence from which the appeal is to be issued.

For more information, you may contact: Jacoyia Reddick at (850) 558-9848 or email her at Jacoyia.Reddick@flhealth.gov.
NORTH PROBABLE CAUSE
BOARD OF MEDICINE AGENDA
SCHEDULED FOR FEBRUARY 28, 2020

RN-01  Reconsideration

The Probable Cause Panel meeting scheduled for February 28, 2020 will commence at 2:30 p.m., or thereafter, at the following location:

MEET – ME NUMBER
Toll Free Number - 1-888-585-9008

For this meeting, participants will need to call the number above for the public and non-public sections of the agenda.

After you dial in at the number above, please enter the following conference code number and then press #:

Public Code: 432-162-565#

PUBLIC PORTION
Call in Number: 1-888-585-9008
Public Conference Code: 432-162-565#

RECONSIDERATION

RN-01   John N. Mubang, M.D., 2010-07721
MEMORANDUM FOR RECONSIDERATION

TO: Probable Cause Panel
FROM: Corynn Alberto, Assistant General Counsel
RESPONDENT: John Nkolo Mubang, MD
CASE NO.: 2010-07721
DATE: January 10, 2020

This case was presented at the February 22, 2013, Probable Cause Panel meeting, at which time probable cause was found. Thereafter, a ten-count Administrative Complaint charging Respondent with violating sections 458.331(1)(m), 458.331(1)(t)1, and 458.331(1)(q), Florida Statutes, was filed against Respondent, related to his treatment of four patients.

Following the filing of the Administrative Complaint, Respondent’s Florida medical license was revoked by the Board in an unrelated case.

Based on the foregoing, the Department has brought this matter back before the Panel for reconsideration and requests that the case be dismissed.
NOTICE OF DISMISSAL/CLOSING ORDER RECONSIDERATION

THE COMPLAINT: The complaint alleges that Respondent violated section 458.331(1)(m), Florida Statutes, by failing to keep adequate medical records, section 458.331(1)(t)1., Florida Statutes, by practicing below the prevailing standard of care, and section 458.331(1)(q), Florida Statutes, by inappropriately and/or excessively prescribing controlled substances outside the scope of his professional practice.
THE FACTS: This case was predicated upon receipt of a Healthcare Practitioner Complaint Form alleging that Respondent was providing prescriptions for large amounts of controlled substances with minimal or no medical justification, while working at a pain management clinic. The complaint also alleged that Respondent conspired to operate a pill mill.

On or about March 5, 2013, the Department filed a ten-count Administrative Complaint was filed against Respondent, related to his treatment of four patients. The complaint alleged that Respondent violated sections 458.331(1)(m), 458.331(1)(t)1, and 458.331(1)(q), Florida Statutes.

On or about November 1, 2019, the Board issued a Final Order in an unrelated case against Respondent, revoking his medical license. Accordingly, because Respondent no longer holds a medical license in Florida, the Department recommends this case be dismissed.

THE LAW: Therefore, pursuant to section 456.073(2), Florida Statutes, the case is hereby DISMISSED.

It is, therefore ORDERED that this matter be, and same is hereby, dismissed.

DONE AND ORDERED this _______ day of ____________, 2020.

________________________
Chairperson, Probable Cause Panel
Board of Medicine

PCP Date: February 28, 2020

PCP Meeting:
STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 2010-12384
2013-12846
DOAH CASE NO.: 18-0528PL
18-0606PL
LICENSE NO.: ME0055171

JOHN NKOLO MUBANG, M.D.,

Respondent.

________________________________________

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) pursuant to Sections 120.569 and 120.57(1), Florida Statutes, on October 4, 2019, in Tampa, Florida, for the purpose of considering the Administrative Law Judge’s Recommended Order, Exceptions to the Recommended Order, and Response to Exceptions to the Recommended Order (copies of which are attached hereto as Exhibits A, B, and C, respectively) in the above-styled cause. Petitioner was represented by Chad Dunn, Assistant General Counsel. Respondent was present and was represented by Dale R. Sisco, Esquire.

Upon review of the Recommended Order, the argument of the parties, and after a review of the complete record in this case, the Board makes the following findings and conclusions.
RULING ON EXCEPTIONS

The Board reviewed and considered the Respondent’s Exceptions to the Recommended Order and ruled as follows:

1. Respondent’s exception to the Preliminary Statement of the Recommended Order is denied because there is competent substantial evidence in the record.

2. Respondent’s exception to Paragraph 17 of the Recommended Order is denied because Respondent failed to cite to any specific paragraph or page where the ALJ made such a finding and because there is competent substantial evidence in the record.

3. Respondent’s exception to Paragraphs 22 and 23 of the Recommended Order is denied because there is competent substantial evidence in the record and based upon the oral comments set forth by the Petitioner.

4. Respondent’s exception to Paragraphs 46 through 54 of the Recommended Order is denied there is competent substantial evidence in the record, the Board is without authority to reweigh the evidence in the record, and based upon the written and oral comments set forth by the Petitioner.

5. Respondent’s exception to Paragraph 69 of the Recommended Order is denied because there is competent substantial evidence in the record and based upon the written and oral comments set forth by the Petitioner.
6. Respondent’s exception to Paragraph 89 of the Recommended Order is denied because there is competent substantial evidence in the record and based upon the written and oral comments set forth by the Petitioner.

7. Respondent’s exception to Paragraphs 98, 99, 100, 119, 120, 130, 138, 139, 140, 150, 168, 169, 204, 205, and 227 of the Recommended Order is denied because there is competent substantial evidence in the record and based upon the written and oral comments set forth by the Petitioner.

8. Respondent’s exception regarding the patients who came to the Respondent’s practice is denied because Respondent failed to cite to any specific paragraph or page where the ALJ made such a finding.

9. Respondent’s exception to Paragraph 273(f) of the Recommended Order is denied because there is competent substantial evidence in the record and based upon the written and oral comments set forth by the Petitioner. To the extent Paragraph 273(f) is a conclusion of law, it is denied because Respondent has not provided any conclusion that would be as or more reasonable than the Administrative Law Judge’s.

10. Respondent’s exception to the findings of fact in Paragraphs 125, 153, 192, and 213 of the Recommended Order is denied because there is competent substantial evidence in the record. Respondent’s exception to the conclusions of law in
Paragraphs 266, 273(c,) and 274 is denied based upon the written and oral comments set forth by the Petitioner.

11. Respondent’s exception to findings of fact in Paragraphs 125, 153, 192, 213, 237, 238, 239, 240, 241, 242, and the conclusion of law in Paragraph 276 of the Recommended Order is denied because there is competent substantial evidence in the record and based upon the written and oral comments set forth by the Petitioner.

12. Respondent’s exception to Paragraph 275 of the Recommended Order is denied because Respondent has not provided any conclusion that would be as or more reasonable than the Administrative Law Judge’s and based upon the written and oral comments set forth by the Petitioner.

13. The Board takes exception to Paragraph 284 of the Recommended Order. Regarding malpractice, the Administrative Complaints specifically allege that Section 458.331(1)(t), F.S., subjects a licensee to discipline for committing medical malpractice as defined in Section 456.50, F.S. They further allege that Section 456.50(1)(g), F.S., states medical malpractice means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. The Administrative Complaints do not allege Dr. Mubang committed “repeated medical malpractice” a term which is specifically defined by Section
456.50(1)(h) as three or more incidents of medical malpractice found to have been committed by a medical doctor. In Section 456.50(1)(c), “found to have committed” means the malpractice has been found in a final judgment in a court of law, final administrative agency decision, or decision of binding arbitration. Because the Administrative Complaints allege medical malpractice rather than repeated medical malpractice and there have not been final administrative agency decisions, Paragraph 284 of the Recommended Order is reworded as follows:

Dr. Mubang committed “medical malpractice” as defined in section 456.50(1)(g) by departing from the standard of care on all six of the patients, who were the subject of the Administrative Complaints. Clear and convincing evidence supports the fact that Dr. Mubang overprescribed controlled substances to the six patients here; kept generally illegible and/or incomplete records; failed to refer the six patients to any or additional appropriate alternative modalities of treatment besides prescription drugs; and prescribed Adderall to one patient without a referral to the appropriate medical specialist to determine whether she suffered from ADD. In total, Dr. Mubang committed 23 separate violations, many of which include revocation as a possible penalty.

14. Respondent’s exception to the penalty recommended by the ALJ is denied because there is competent substantial evidence in the record.

FINDINGS OF FACT

1. The findings of fact set forth in the Recommended Order are approved and adopted and incorporated herein by reference.
2. There is competent substantial evidence to support the findings of fact.

CONCLUSIONS OF LAW

1. The Board has jurisdiction of this matter pursuant to Section 120.57(1), Florida Statutes, and Chapter 458, Florida Statutes.

2. The conclusions of law set forth in the Recommended Order are approved and adopted and incorporated herein by reference with the amendment set forth above in Paragraph 284 of the Recommended Order.

PENALTY

Respondent filed an exception to the penalty, which is addressed above.

Upon a complete review of the record in this case, the Board determines that the penalty recommended by the Administrative Law Judge be ACCEPTED. WHEREFORE, IT IS HEREBY ORDERED AND ADJUDGED: Respondent’s license to practice medicine in the State of Florida is hereby REVOKED.

RULING ON MOTION TO BIFURCATE COSTS

The Board reviewed the Petitioner’s Motion to Bifurcate Costs in this matter and the Board voted to bifurcate the issue of costs and retain jurisdiction to assess costs against Respondent.
(NOTE: SEE RULE 64B8-8.0011, FLORIDA ADMINISTRATIVE CODE. UNLESS OTHERWISE SPECIFIED BY FINAL ORDER, THE RULE SETS FORTH THE REQUIREMENTS FOR PERFORMANCE OF ALL PENALTIES CONTAINED IN THIS FINAL ORDER.)

DONE AND ORDERED this 31ST day of October, 2019.

BOARD OF MEDICINE

Claudia Kemp, J.D., Executive Director
For Steven Rosenberg, M.D., Chair

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW PURSUANT TO SECTION 120.68, FLORIDA STATUTES. REVIEW PROCEEDINGS ARE GOVERNED BY THE FLORIDA RULES OF APPELLATE PROCEDURE. SUCH PROCEEDINGS ARE COMMENCED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF THE DEPARTMENT OF HEALTH AND A SECOND COPY, ACCOMPANIED BY FILING FEES PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL, FIRST DISTRICT, OR WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE PARTY RESIDES. THE NOTICE OF APPEAL MUST BE FILED WITHIN THIRTY (30) DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by Certified Mail to JOHN NKOLO MUBANG, M.D., 741 Martin Luther King Boulevard West, Seffner, Florida 33584; to Dale R. Sisco, Esquire, Sisco Law, 1110 North Florida Avenue, Tampa, Florida 33602; to Robert S. Cohen, Administrative Law Judge, Division of Administrative
Hearings, The DeSoto Building, 1230 Apalachee Parkway, Tallahassee, Florida 32399-3060; by email to Louise Wilhite-St. Laurent, Deputy General Counsel, Department of Health, at Allison.Dudley@flhealth.gov; and by email to Edward A. Tellechea, Chief Assistant Attorney General, at Ed.Tellechea@myfloridalegal.com; and Donna C. McNulty, Special Counsel, at Donna.McNulty@myfloridalegal.com this 1st day of November, 2019.

[Signature]

Certified Article Number
9414 7266 9904 2140 1226 54

SENDER'S RECORD

John Nkolo Mubang, M.D.
741 Martin Luther King Boulevard West
Seffner, FL 33584
STATE OF FLORIDA  
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF  
MEDICINE,

Petitioner,

vs.  

Case Nos. 18-0528PL  
18-0606PL

JOHN NKOLO MUBANG, M.D.,

Respondent.

____________________________________/

RECOMMENDED ORDER

A final hearing was held in this matter before Robert S.  
Cohen, Administrative Law Judge with the Division of  
Administrative Hearings ("DOAH"), on December 18 and 19, 2018, in  
Tampa, Florida.

APPEARANCES

For Petitioner: Chad Wayne Dunn, Esquire  
Zachary Bell, Esquire  
Prosecution Services Unit  
Department of Health  
4052 Bald Cypress Way, Bin C-65  
Tallahassee, Florida 32399-3265

For Respondent: Dale R. Sisco, Esquire  
Sisco-Law  
1110 North Florida Avenue  
Tampa, Florida 33602

STATEMENT OF THE ISSUES

The issues to be decided are whether Respondent violated  
portions of chapter 458, Florida Statutes, as alleged in the  

Administrative Complaints; and, if so, what penalty should be imposed.

**PRELIMINARY STATEMENT**

On May 17, 2012, Petitioner, Department of Health, Board of Medicine ("Petitioner" or "DOH"), filed a 21-count Administrative Complaint against John Nkolo Mubang, M.D. ("Respondent" or "Dr. Mubang"), in DOH Case No. 2010-12384, which is DOAH Case No. 18-0606PL in this matter. The Administrative Complaint charged the doctor with five counts of violating section 458.331(1)(nn) by violating Florida Administrative Code Rule 64B8-9.013; five counts of violating section 458.331(1)(q) by prescribing controlled substances inappropriately or excessively; five counts of violating section 458.331(1)(t) by committing medical malpractice; five counts of violating section 458.331(1)(m) by failing to keep adequate, legible medical records; and one count of violating section 458.331(1)(cc) by prescribing a Schedule II amphetamine without a diagnosis supporting the prescription. Petitioner’s Administrative Complaint concerned five patients: A.M., B.B., C.C., W.B., and M.H. On June 7, 2012, Dr. Mubang disputed allegations of material fact contained in Petitioner’s Administrative Complaint and requested a formal hearing. On July 23, 2012, Petitioner forwarded the case to DOAH for assignment to an Administrative Law Judge ("ALJ"), and it was assigned DOAH Case No. 12-2517PL.
By Order entered January 31, 2013, the ALJ relinquished jurisdiction without prejudice so the parties could present a settlement agreement to the Board of Medicine. The settlement agreement was not approved. On September 19, 2017, Petitioner filed an Amended Administrative Complaint against Dr. Mubang in a separate case, DOH Case No. 2013-12846, which is DOAH Case No. 18-0528PL. The Amended Administrative Complaint charged the doctor with one count of violating section 458.331(1)(t) by committing medical malpractice and one count of violating section 458.331(1)(m) by failing to keep adequate, legible medical records, concerning his treatment of Patient B.D. On October 18, 2017, Dr. Mubang disputed allegations of material fact in Petitioner’s Amended Administrative Complaint and requested a formal hearing. On January 31, 2018, Petitioner forwarded both cases to DOAH for assignment to an ALJ. The cases were consolidated for hearing by Order dated February 14, 2018. By notice issued February 22, 2018, the consolidated cases were scheduled for hearing on June 11, 12, 14, and 15, 2018. The hearing was continued twice, once by joint request and once by Petitioner’s request. The hearing was rescheduled for December 18 and 19, 2018, at which time the hearing was commenced and concluded.

The parties filed a Joint Pre-hearing Stipulation on December 10, 2018. The Joint Pre-Hearing Stipulation included
facts for which the parties stipulated no evidence would be required at hearing. Where relevant, those facts have been incorporated into this Recommended Order. At hearing, Petitioner presented the testimony of DOH Investigator Victor Troupe. Petitioner also presented the testimony of Dr. Robert Guskiewicz via telephone at the hearing and via deposition in lieu of live testimony. Joint Exhibits 1 through 7 were admitted into evidence without objection. Petitioner offered Exhibits 1, 2, 3 (except for Bates-stamped page 78), 4, 5, and 6, all of which were admitted into evidence. Respondent testified on his own behalf and presented the testimony of Dr. Thomas Simopoulos via deposition in lieu of live testimony. Respondent offered Exhibits 1, 2, 4, 7, and 8, all of which were admitted into evidence without objection.

The Transcript of the hearing was filed with DOAH on January 17, 2019. Petitioner and Respondent’s Proposed Recommended Orders were timely filed on February 25, 2019, with a limit of 60 pages (by Order), and have been considered in the preparation of this Recommended Order.

References to statutes are to Florida Statutes (2005-2012), those in place at the time the alleged violations occurred, unless otherwise noted.
FINDINGS OF FACT

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

2. At all times material to this matter, Dr. Mubang was a licensed physician within the State of Florida, having been issued license number ME55171.

3. Respondent’s address of record is 741 Martin Luther King Boulevard West, Seffner, Florida 33584.

4. Since at least March 17, 2010, Dr. Mubang’s practice at 741 Martin Luther King Boulevard has been registered as a pain management clinic with Petitioner.

5. Dr. Mubang is board-certified in geriatric medicine and ambulatory medicine.

6. Dr. Mubang immigrated to the United States from Cameroon, West Africa, to obtain his college education at State University of New York—Buffalo (“SUNY-Buffalo”). Dr. Mubang received a bachelor of arts degree in biology from SUNY-Buffalo.

7. Dr. Mubang attended medical school at Southwestern University School of Medicine in the Philippines.

8. Upon completion of his medical education, Dr. Mubang attended the Medical College of Pennsylvania for clinical rotations. He performed his residency at State University of New York-Brooklyn and Hahnemann University.
9. Dr. Mubang's license was first issued June 14, 1989, and is valid through January 31, 2020. His license has not been the subject of prior discipline.

10. Dr. Mubang has maintained his Drug Enforcement Agency ("DEA") Certificate of Registration without revocation, suspension, or other sanction. He has additionally qualified for, and obtained, a separate DEA Certificate of Registration to dispense Suboxone and buprenorphine. This secondary DEA Certificate of Registration requires training in addiction medicine.

11. Dr. Mubang has continuously practiced as the primary care physician for many of his patients. He began his practice in Florida with CIGNA Health Group in one of its managed care clinics at University Mall in Tampa.

12. When CIGNA closed its clinics, Dr. Mubang became employed by Correctional Medical Services ("CMS"), initially at Lake Correctional Facility, and then as the medical director for the Hillsborough County Sheriff's Office. During his tenure with the Hillsborough County Sheriff's Office, Dr. Mubang was recognized as the "Medical Director of the Year" for CMS in 1998.

13. After leaving the Hillsborough County Sheriff's Office, Dr. Mubang joined a practice with Dr. Encarnacion in Seffner, Florida. When Dr. Encarnacion retired, Dr. Mubang acquired the practice.
14. In May 2009, Dr. Mubang received from the Board of Medicine and the Department of Health a publication entitled, “responsible opioid prescribing.”

15. Dr. Mubang learned through his participation in various continuing medical education seminars about certain forms recommended for the treatment of patients suffering from chronic pain. He did not use electronic medical records prior to the dates of treatment charged in these consolidated Administrative Complaints.

16. While in private practice, Dr. Mubang continued to treat patients committed to the State of Florida Juvenile Assessment Centers in Pasco, Pinellas, Sarasota, and Manatee counties.

17. Dr. Mubang’s practice was licensed as a pain management clinic in 2010, despite his having limited formal training or education in pain management. Since initial licensure, his pain management clinic has remained continuously in operation, and has consistently passed all inspections.

18. Pain Management Clinics are subject to annual inspections by DOH pursuant to section 458.3265(4)(a). Dr. Mubang’s Pain Management Clinic has never failed an inspection.
19. DOH Investigator Victor Troupe of the Investigative Services Unit performed inspections of Dr. Mubang’s clinic. The clinic passed inspection.

20. Dr. Mubang’s charged treatment of Patients A.M., B.B., C.C., W.B., and M.H., as alleged in the Administrative Complaint, occurred prior to October 17, 2010, the effective date of revised rule 64B8-9.013.

21. Both parties presented expert witnesses board-certified in pain management to testify as to the standard of care required in this matter.

22. Dr. Robert Guskiewicz testified as a medical expert for Petitioner. Dr. Guskiewicz is board-certified by the American Board of Anesthesiology in anesthesiology with a subspecialty in pain medicine. Dr. Guskiewicz practices as part of a large multispecialty practice in Gainesville, Florida, called Southeast Integrated Medical (“SIMED”). SIMED’s practice areas include neurology, neurosurgery, rheumatology, gynecology, psychology, urology, physiatry, allergy, family practice, and internal medicine. Dr. Guskiewicz is not now, and never has been, a primary care physician. About 40 percent of Dr. Guskiewicz’s practice is performing injections or interventions on patients. Most of the balance is patients on medication management seeking to achieve better functionality.
23. Dr. Guskiewicz defines the standard of care as “what a prudent physician would do with a particular patient in a particular situation at that particular time.”

24. In his practice, Dr. Guskiewicz prescribes 30 mg of oxycodone. Oxycodone is an effective pain medication. According to him, there is no maximum recommended dose for 30 mg of oxycodone.

25. For the purposes of his expert testimony, Dr. Guskiewicz has no knowledge or information regarding Dr. Mubang or his practice. He does not know how big the clinic is where Dr. Mubang practices, who owns it, how many patients are seen each day, how many employees work there, or the types of patients treated there.

26. Dr. Guskiewicz was paid an hourly fee for his expert testimony and preparation for deposition in this matter.

27. Dr. Guskiewicz testified that he did a page-by-page review of the medical records he initially reviewed and those provided for his deposition in lieu of live testimony.

28. Dr. Guskiewicz testified that the records were identical for Patients A.M., B.B., W.B., and M.H., but that the Bates numbers for the records for Patients C.C. and B.D. were not in sync.
29. For Patient B.B., it was apparent at the hearing that Dr. Guskiewicz was in possession of the requisite records, which Respondent argued, had not been reviewed.

30. For Patient M.H., Dr. Mubang argued that Joint Exhibit 6, covering records of treatment from 2010-2012, was not reviewed by Dr. Guskiewicz. Dr. Guskiewicz testified that the records for Patient M.H. were identical. In any event, the records subject to Respondent’s objection concern treatment after the treatment dates at issue in the Administrative Complaint. Only the records concerning the allegations contained in the Administrative Complaints will be considered for purposes of this Recommended Order.

31. Dr. Mubang also raised the issue that Dr. Guskiewicz was not a similarly situated practitioner to Respondent.

32. Dr. Mubang self-identified as practicing in pain management, and he owned and operated a clinic that was registered as a pain management clinic with DOH.

33. Each patient treated by Dr. Mubang signed an Attestation for Pain Management, along with an Agreement for Treatment with Controlled Substances Therapy for Pain.

34. Dr. Mubang acknowledged that if he gave a patient a pain management agreement, he was providing pain management to that patient.
35. If a health care provider is providing evaluation, treatment, or diagnosis for a condition that is not within his or her specialty, a specialist trained in the evaluation, treatment, or diagnosis for that condition shall be considered a similar health care provider, pursuant to section 766.102(8), Florida Statutes.

36. Because Respondent’s care at issue in this case is pain management, which is not specifically within his specialty, Dr. Guskiewicz is considered a similarly situated practitioner to Respondent.

37. Petitioner did not provide Dr. Guskiewicz with any deposition testimony in this action until after his deposition in lieu of live testimony on October 9, 2018. Consequently, the depositions were not considered at the time Dr. Guskiewicz prepared his reports in this action.

38. Dr. Guskiewicz never interviewed any of the patients at issue in this matter; never conducted any physical examination of the patients; and does not know where any of these patients are today. Further, he does not know what their current condition is; whether any of the patients are still receiving treatment for chronic pain; and whether any of the patients are still receiving opioid pain medications for the treatment of chronic pain.
39. During the time periods relevant to these consolidated actions, Florida did not have a prescription drug monitoring database or E-FORCSE.

40. At the time Dr. Guskiewicz authored his November 29, 2011, report, there was not a prescription drug monitoring database in Florida to permit practitioners to verify a patient’s representations about the medications they were taking and who had prescribed them.

41. Dr. Guskiewicz is not a primary care physician, and has never been called upon to cover for a primary care physician who is treating a patient and has an ongoing relationship with that patient.

42. Dr. Guskiewicz agrees that physicians in Florida have an obligation to consider their patients’ subjective complaints of pain and to treat them.

43. Dr. Guskiewicz defines pain management as “treating patients who have chronic pain and provide different modalities of care to increase the functionality and well-being within that patient.” The goal of pain management is to optimize the patient’s functionality, lifestyle, and well-being within his or her family and community.

44. Dr. Guskiewicz acknowledged that a patient coming to him for medical management of his or her pain is looking for an
increase in function so he or she can get back to work and participate in normal activities of daily living.

45. Dr. GusKiewicz defines intractable pain as “pain that perpetuates itself no matter what modalities are tried and will always be there. It’s now thought of being a more centralized pain that is basically within the brain itself.”

46. Dr. Thomas Simopoulos testified as a medical expert for Respondent. Dr. Simopoulos is board-certified by the American Board of Anesthesiology in anesthesiology with a subspecialty in pain medicine.

47. Dr. Simopoulos testifies as an expert for the defense more than 90 percent of the time. In the last five years, Respondent’s counsel has paid Dr. Simopoulos $30,000 to $50,000 in expert witness fees.

48. Dr. Simopoulos lives in and practices medicine in Massachusetts. Dr. Simopoulos is not licensed to practice medicine in any other state; and he has never practiced medicine in the State of Florida.

49. Dr. Simopoulos testified that the standard of care at the time material to this case was more regional than national.

50. Dr. Simopoulos educated himself about the regional standard of care in Florida through conversations with his students and through hearing from people at national meetings.
51. Dr. Simopoulos testified that patients have the right to reject a surgical recommendation: “Patients who are younger, in their more productive years, may not want to seek out surgery as a solution, particularly of the spine because it usually means that they’re at risk for having multiple surgeries. So and that even continues today, we try to manage younger folks with more conservative measure [sic], including medications to try to avoid surgery, because we know where that trajectory is going to go.”

52. Dr. Simopoulos admitted that there were no studies at the time material to this case that revealed the exact nature and course of practice in the State of Florida.

53. While Dr. Simopoulos is credited as an expert in anesthesiology and pain management, his reliance on the second-hand accounts from students and conferences he attended to form his opinions about the regional standard of care in Florida, are not as persuasive as the accounts of Dr. Guskiewicz, a physician practicing in the area of anesthesiology and pain management in Florida. Accordingly, Dr. Guskiewicz’s testimony is entitled to greater weight in this proceeding.

54. Dr. Simopoulos also opined that the standard of care can only be violated when a patient is harmed. DOH argued that his definition is inconsistent with the definition in Florida law as contained in section 766.102(1).
55. DOH Investigator Victor Troupe served a subpoena on September 2, 2010, for patient records to include: A.M., B.B., C.C., M.H., and W.B.

56. Investigator Troupe took possession of the original files on that date. He has no reason to believe those patient files had been altered in any way.

57. Investigator Troupe had performed numerous annual inspections of Dr. Mubang’s clinic, and neither found any violations or issued any citations.

58. Investigator Troupe never interviewed Patients A.M., B.B., C.C., M.H., W.B., or B.D. Further, Investigator Troupe has no knowledge or information regarding the present whereabouts of any of those individuals. Finally, he has no information about whether those patients are still receiving opioid analgesic pain medication, even though DOH has access to E-FORCSE for investigative purposes.

Drug Definitions

59. Oxycodone is commonly prescribed to treat pain. Roxicodone is a brand name for oxycodone. Oxycodone is a Schedule II controlled substance. Oxycodone will be used throughout this Order, even if the brand name Roxicodone was prescribed.

60. All Schedule II controlled substances have a high potential for abuse and have currently accepted, but severely
restricted, medical use in treatment in the United States. Abuse of Schedule II controlled substances may lead to severe psychological or physical dependence. § 893.03(2), Fla. Stat.

61. Fentanyl is a very strong opioid that is prescribed to treat pain and is listed as a Schedule II controlled substance. § 893.03(2)(b), Fla. Stat.

62. Hydromorphone is a Schedule II controlled substance that is commonly prescribed to treat pain. Hydromorphone is commonly prescribed under the brand name Dilaudid. § 893.03(2)(a), Fla. Stat.

63. Methadone is a synthetic opioid prescribed to treat pain. Methadone is a Schedule II controlled substance. § 893.03(2)(b), Fla. Stat.

64. Vicodin and Lortab are brand names for hydrocodone/APAP. Hydrocodone/APAP contains hydrocodone and acetaminophen and is prescribed to treat pain. Hydrocodone in the dosages found in Vicodin is a Schedule III controlled substance. § 893.03(3)(c)4., Fla. Stat.

65. All Schedule III controlled substances have a potential for abuse less than the substances in Schedules I and II. Abuse of Schedule III controlled substances may lead to moderate or low physical dependence or high psychological dependence. § 893.03(3), Fla. Stat.
66. Fiorinal with codeine is the brand name for a drug that contains butalbital and codeine and is commonly prescribed to treat migraine headaches. Butalbital is a Schedule III controlled substance. Codeine is commonly prescribed to treat pain. Codeine is a Schedule II controlled substance. § 893.03(3)(a) and (2)(a), Fla. Stat.

67. Ultram is a brand name for tramadol, an opioid-class narcotic medication prescribed to treat pain. At the time of the events of this case, tramadol was not a controlled substance. Tramadol is currently a Schedule IV controlled substance. § 893.03(4)(b), Fla. Stat. (2018).

68. All Schedule IV controlled substances have a low potential for abuse relative to the substances in Schedule III. Abuse of Schedule IV controlled substances may lead to limited physical or psychological dependence relative to the substances in Schedule III. § 893.03(4), Fla. Stat.

69. Soma is the brand name for carisoprodol. Carisoprodol is a muscle relaxant commonly prescribed to treat muscular pain. Carisoprodol is a Schedule IV controlled substance. § 893.03(4), Fla. Stat.

70. Adderall is the brand name for a drug that contains amphetamine. Adderall is commonly prescribed to treat attention deficit disorder (“ADD”). Adderall is a Schedule II controlled substance. § 893.03(2)(c), Fla. Stat.
71. Xanax is the brand name for alprazolam. Klonopin is the brand name for clonazepam. Valium is the brand name for diazepam. All three drugs are benzodiazepine-class drugs prescribed to treat anxiety, and all three drugs are Schedule IV controlled substances.

72. During the time Respondent treated the five patients, who are the subject of the DOH Case No. 2010-12384, Florida did not have a prescription drug monitoring database. Before E-FORCSE, practitioners had to rely upon a patient’s representation regarding his or her medication history and verify the information by calling identified pharmacies. This “trust but verify” policy was in place at Dr. Mubang’s practice.

73. During the time of Dr. Mubang’s treatment of these patients, he received a letter from Ana M. Viamonte Ros, M.D., the surgeon general for the State of Florida, and Fred Bearison, M.D., the chairman of the Florida Board of Medicine, dated May 13, 2009. That letter enclosed a copy of Responsible Opioid Prescribing, A Physician’s Guide, written by Scott M. Fishman, M.D. The letter advised Dr. Mubang, and others similarly situated, that Dr. Fishman’s book “is a practical guide to Florida’s current standards for the use of controlled substances for the treatment of pain,” based upon the Federation of State Medical Board’s Model Rule, “so it is right on point for Florida practicing doctors.”
74. The book also stated, at page 25:

Although Medicare and other institutions have defined what constitutes a physical examination for purposes of coding and reimbursement, exactly what comprises an appropriate or acceptable physical examination for pain is not well-defined, largely because it will differ from case to case. Regulators who expect to see a physical examination as part of the evaluation that leads to appropriate pain care involving controlled substances assume that a basic, if not focused, examination is warranted. The exact components of the examination are left to the judgment of the clinician who is expected to have performed an examination proportionate to the diagnosis that justifies a treatment.

75. Dr. Mubang testified at the hearing, "many point-of-care screens for 'opiates' do not reliably detect any opioid other than codeine and morphine, or may not report if levels are below a certain threshold. Therefore, they may give false negative results for semisynthetic and synthetic oil opioid analgesics."

76. Dr. Mubang received feedback from pharmacists and patients regarding limitations on prescribing imposed on distributors and pharmacies by the DEA, including during the fall of 2010.

77. During the time Dr. Mubang treated the six patients subject to these consolidated administrative actions, there was no upper limit recommended or identified regarding the maximum dosage for opioid analgesics.
78. New patients to Dr. Mubang’s practice have to fill out paperwork, including a patient history. Patients were also required to sign an opioid contract, which mandated patients to use only one pharmacy and required that the patient only obtain medication from Dr. Mubang.

79. Dr. Mubang obtained authorizations for release of medical information to acquire records of prior treating physicians. His office consistently obtained prior records, including MRIs and other diagnostic studies.

80. Dr. Mubang testified that he performed a physical examination of each patient on each office visit. The initial exam was broad, while follow-up examinations were focal. His physical examinations included a review of systems, from head to toe.

81. He stated that each physical examination included a review of the patient’s neurological status and notes whether the patient is oriented to person, time, and place. Dr. Mubang’s practice was to observe patients in his waiting room, and watch each patient as they come to the exam room. This observation is intended to identify things like gait abnormalities, guarding, and posture.

82. Pain patients in Dr. Mubang’s practice are required to complete a Brief Pain Inventory, which he reviews with each patient. Dr. Mubang also reviews past medications with each
patient to determine whether the medication has been effective in relieving pain and increasing activities of daily living. He reviews with each patient potential side effects of medication and the risks and benefits of using those medications.

83. Dr. Mubang prepares a progress note for each office visit with a patient. Additionally, he maintains copies of each prescription issued to a patient.

84. The identified treatment plan for each of these six patients was to improve the patient’s functional abilities, to allow them to return to work, and to participate in relationships.

85. Dr. Mubang periodically required patients to submit to a urine immunoassay. This is a presumptive screening test for illicit substances and some other controlled substances. As Dr. Fishman points out on page 61 in his book *Responsible Opioid Prescribing*, Dr. Mubang was aware that “point-of-care screens for opioids do not reliably detect any opiate other than codeine and morphine.”

86. During the 2010 timeframe, a physician who ordered a urine drug screen was not required to do anything with the results. Further, the requirements of rule 64B8-9.013(3)(d) to monitor patient compliance were not mandatory until after October 17, 2010.
87. Dr. Mubang is aware of the sedative effects of opioids taken with muscle relaxants like Soma. This combination of medication should be dispensed with caution, but if a patient has been taking it for a period of time with no problems, he believes the prescription is appropriate.

88. Dr. Mubang’s approach to changing pain medication, as explored more fully in the following discussion of the six patients subject to this proceeding is consistent, but deserves close scrutiny. He testified that:

If the vital signs are stable, you can do what you want, so long as it doesn't have consequences. If you see the visit after this, this patient did not come in with hypertension or they did not end up in the hospital or I was not called at 2:00 in the morning. So it tells you what you're doing is right. See? That's why we do these vital signs.

The Patients

89. Each of the patients in this cause completed a two-page questionnaire about his or her pain, titled “brief pain inventory,” during each visit after the initial visit. The pain inventory contained: an anatomical figure for the patient to mark painful areas, 12 questions with a one-to-ten scale for pain level and for activities of daily living, and spaces for the patient to describe the pain in writing. Dr. Mubang’s progress notes for each of the patients consisted of a printed form, containing a similar anatomical figure at the top of the page.
with most of the rest of the page containing a checklist for “assessment.”

**Patient A.M.**

90. From December 22, 2009, to October 20, 2010, Dr. Mubang provided pain management treatment to Patient A.M., a then 23-year-old female, for lower back pain related to a car accident that occurred several years earlier.

91. Dr. Mubang had first begun treating Patient A.M. while covering for Dr. Luis Azan at Plant City Polyclinic, where he prescribed her 240 30 mg tablets of oxycodone and 120 10 mg tablets of methadone.

92. Dr. Mubang noted that Patient A.M. had been a passenger in the back of the car and was wearing a seatbelt. He noted that Patient A.M. did not lose consciousness, and while she went to the emergency room, she did not have an in-patient stay.

93. On her initial evaluation questionnaire, Patient A.M. reported trying four alternative treatment methods for her pain out of 18 possible treatment options on Dr. Mubang’s checklist form: chiropractic treatment (no relief); muscle injections (no relief); massage (no relief); and pain relievers (some relief). By her own report, Patient A.M. had not tried physical therapy, nerve blocks, or surgery.

94. Patient A.M. had sequential MRI findings from November 7, 2007 (ordered by Dr. Murthy Ravipati), and March 23,
2010 (ordered by Dr. Mubang), which demonstrated a central focal
disc protrusion (herniated nucleus pulposus) at L5-S1.

95. On her first visit at his office, Dr. Mubang increased
Patient A.M.’s oxycodone from 240 to 270 30 mg tablets per month.
He failed to document a rationale for the 30-pill increase.

96. Dr. Mubang’s medical records included Patient A.M.’s
medical history and physical examination; diagnostic,
therapeutic, and laboratory results; evaluations and
consultations; objectives identified; risks and benefits of the
treatment ordered; treatments and medications ordered and
documented; and instructions and agreements regarding pain
management.

97. Dr. Mubang made referrals to consulting physicians,
including Dr. Goldsmith (orthopedic) and physical therapy (Select
Physical Therapy).

98. From December 22, 2009, to August 27, 2010, Dr. Mubang
prescribed 270 30 mg tablets of oxycodone in combination with
120 10 mg tablets of methadone to Patient A.M. monthly. In
ten months, Patient A.M. received 3,870 pain pills from
Dr. Mubang.

99. In order to take the pain medication as prescribed,
Patient A.M. would have to take 13 pain pills per day.

100. By comparison, Dr. Mubang’s expert, Dr. Simopoulos,
testified that in his practice the most 30 mg of oxycodone that
he ever prescribed was six tablets per day, or 180-200 tablets per month. Petitioner’s expert, Dr. Guskiewicz, testified that in his practice the most 30 mg of oxycodone that he ever prescribed was five per day, or 150 tablets.

101. In addition to the pain medication, Dr. Mubang prescribed 90 350 mg tablets of Soma to Patient A.M. per month.

102. On August 2, 2010, Dr. Mubang ordered a urine drug screen for Patient A.M. The drug screen was positive for benzodiazepines and negative for methadone.

103. If a patient tests negative for a prescribed medication, the physician should consider the possibility that the patient is not taking the drug and, instead, is diverting it.

104. Given Patient A.M.’s negative test for methadone, Dr. Mubang should not have continued to prescribe methadone to her, or at least should have questioned her about her usage of the prescribed drug.

105. Despite the aberrant test result, Dr. Mubang continued to prescribe potentially lethal doses of oxycodone, methadone, and Soma to Patient A.M.

106. Further, from December 22, 2009, through August 27, 2010, Dr. Mubang did not perform nor did he document performing a complete and adequate physical examination or medical history to justify his prescribing of potentially lethal doses of methadone, oxycodone, and Soma to Patient A.M.
107. From December 22, 2009, through August 27, 2010, Dr. Mubang did not diagnose Patient A.M. with intractable pain prior to prescribing potentially lethal doses of methadone, oxycodone, and Soma to Patient A.M.

108. To meet the standard of care, Dr. Mubang should have immediately reduced the amount of medication that he prescribed to Patient A.M. Additionally, he should have tried to determine the root cause of Patient A.M.'s pain. Dr. Mubang should have followed up on his ordering of alternative treatment modalities, such as physical therapy, and if Patient A.M. refused to follow his instructions, he should have discharged Patient A.M.

109. While Dr. Mubang’s records are at times difficult to read, some were legible enough for review by the two experts who offered opinions in this matter. On the whole, however, the medical records for Patient A.M. were inadequate (and some of them were actually illegible) to provide complete information to either Dr. Mubang or another reviewing physician or investigator.

Patient B.B.


111. Patient B.B. initially visited Dr. Mubang on March 25, 2010, with a history of cervical spinal fusion in 2003 following a motor vehicle accident.
112. Dr. Mubang’s Initial Evaluation documented a thorough review of systems, including skin; HEENT (head, eyes, ears, nose, and throat); neurological; and musculoskeletal. Simultaneously, Dr. Mubang and the patient completed a Pain Questionnaire documenting the location and severity of Patient B.B.’s pain and other treatment modalities, which had been tried, but failed (surgery, braces, chiropractic, physical therapy, TENS, and massage).

113. On her initial visit with Dr. Mubang, Patient B.B. reported having neck, shoulder, and upper back pain.

114. Dr. Mubang noted on his initial range of motion assessment that Patient B.B. had no thoraco-lumbar spine pain.

115. Patient B.B. never indicated on her brief pain inventories that she had pain radiating down the leg. Instead, she consistently marked pain in the neck, radiating down the right arm, and pain in the middle back.

116. After the initial visit, Dr. Mubang recorded that Patient B.B. had lower back pain by noting “LBP & radiculopathy” with a line drawn down the leg of the anatomical figure.

117. Dr. Mubang’s explanation for the discrepancy between his notation on the anatomical figure and Patient B.B.’s notation was that the patient was noting pain, but that he was noting tenderness. He did not explain the difference.
118. As discussed below, this same inconsistency appears frequently in many of the patients’ records. Dr. Mubang’s offered explanation for the discrepancy between his records and the patient-generated records is not credible.

119. From March 25, 2010, to August 23, 2010, Dr. Mubang prescribed 240 30 mg tablets of oxycodone in combination with 60 2 mg tablets of Xanax to Patient B.B. monthly.

120. From March 25, 2010, to May 20, 2010, Dr. Mubang also prescribed 120 350 mg tablets of Soma to Patient B.B., in addition to the oxycodone and Xanax each month.

121. To justify the amount of Xanax he prescribed to Patient B.B., Dr. Mubang relied on an anxiety checklist questionnaire completed by Patient B.B.

122. In his practice, if a patient marked five to six of the criteria on his anxiety checklist, Dr. Mubang would prescribe the patient Xanax.

123. For Patient B.B., on three of his five progress notes, Dr. Mubang checked the box for anxiety. Other than that, there is no annotation or documentation by Dr. Mubang concerning Patient B.B.’s anxiety.

124. From March 25, 2010, through August 23, 2010, based on Patient B.B.’s history and physical findings, Dr. Mubang prescribed potentially lethal doses of oxycodone, Xanax, and Soma
to Patient B.B. in excessive quantities and without sufficient justification.

125. From March 25, 2010, through August 23, 2010, Dr. Mubang neither performed nor documented performing a complete and adequate physical examination or medical history to justify his prescribing of potentially lethal doses of oxycodone, Xanax, and Soma to Patient B.B.

126. From March 25, 2010, through August 23, 2010, Dr. Mubang failed to diagnose Patient B.B. with an anxiety disorder, which would have supported his prescribing of Xanax to Patient B.B.

127. From March 25, 2010, through August 23, 2010, Dr. Mubang did not diagnose Patient B.B. with intractable pain prior to prescribing potentially lethal doses of oxycodone, Xanax, and Soma to Patient B.B.

128. To meet the standard of care, Dr. Mubang should have done more to treat Patient B.B.'s underlying source of pain through referrals for physical therapy or orthopedics. Depending on the particular findings, he should have tried intervention care to relieve Patient B.B.'s pain instead of relying solely on medication management, particularly, excessive amounts of oxycodone. Patient B.B., as a relatively young patient, would have benefited from more aggressive physical therapy, massage
therapy, and other treatment modalities to keep her off of addictive pain medication as much as possible.

129. Dr. Mubang attempted, in part, to justify his excessive amounts of medications, based upon The Super Saver pharmacy profile for Patient B.B., which confirms that this patient was receiving the same quantities and combination of medications from the prior physician, Ibem R. Borges, M.D.

130. He also cites rule 64B8-9.013 (2003) to support the heavy prescribing of medications, which indicates the Board of Medicine will not judge the validity of prescribing, "based upon the quantity and chronicity," and that a "physician's conduct will be evaluated to a great extent by treatment outcome." He argues that Petitioner failed to introduce any evidence to establish Patient B.B. suffered any adverse effect from Dr. Mubang's treatment.

**Patient C.C.**

131. From April 29, 2010, to May 28, 2012, Dr. Mubang provided pain management treatment to Patient C.C., a then 32-year-old female.

132. At her initial evaluation, Patient C.C. reported having lower back pain and left knee pain.

133. On her subsequent brief pain inventories, Patient C.C. consistently marked pain at the middle of the lower back and pain at the left knee.
134. Almost identical to Patient B.B., Dr. Mubang’s progress notes for Patient C.C. note “LBP & radiculopathy” with a line drawn down the leg of an anatomical figure indicating pain radiating down the leg.

135. Contained in Respondent’s records were notes from two prior treating providers, Drs. David Herson and Marc Weinstein.

136. On a note dated February 27, 2007, Dr. Herson noted that Patient C.C.’s cervical and lumbar range of motion was within normal limits, and he noted no tenderness to palpation of the lumbar spine. Dr. Herson recommended epidural injections to Patient C.C. for the left knee pain. Dr. Herson prescribed Patient C.C. 30 tablets of Ultram for her pain.

137. On a note dated March 1, 2007, Dr. Weinstein noted that “MRI scans of her cervical and lumbar spine and left knee were performed and show no significant abnormalities that would require surgery.”

138. From April 29, 2010, to August 19, 2010, Dr. Mubang prescribed 290 30 mg tablets of oxycodone in combination with 180 10 mg tablets of methadone to Patient C.C. monthly. In a period of four months, Patient C.C. received 2,350 pain pills from Dr. Mubang, which equates to a daily prescription of 15.5 pills.

139. In addition to addictive pain medication, Dr. Mubang also prescribed 60 2 mg tablets of Xanax to Patient C.C. per
month. Opioids and benzodiazepines in combination increase the risk of respiratory depression, which can be fatal.

140. On April 29, 2010, and May 27, 2010, Dr. Mubang added 90 350 mg tablets of Soma to the potentially lethal cocktail of medications he prescribed to Patient C.C.

141. Dr. Mubang failed to document his rationale for starting and stopping Soma.

142. On April 29, 2010, as part of her initial evaluation with Dr. Mubang, Patient C.C. reported to him that her current medications were oxycodone, methadone, Xanax, and Soma.

143. On April 29, 2010, Dr. Mubang ordered a urine drug screen for Patient C.C. The drug screen was positive for opiates, oxycodone, and benzodiazepines, but was negative for methadone.

144. Opiates and opioids are discernibly different categories of drugs. Opiates are morphine derivatives. Opioids are synthetic opiates. No medications Patient C.C. reported taking were opiates.

145. The standard of care required Dr. Mubang to inquire as to the reasons behind the aberrant drug test result and adjust Patient C.C.’s medications accordingly.

146. In his 2012 deposition, Dr. Mubang speculated that he may have consulted Patient C.C. about the drug test and that maybe she ran out of medication. He could not tell from his
records if he discussed the results with Patient C.C. or the reason for the aberrant test result because his records lacked any such information.

147. At the final hearing in this matter, Dr. Mubang raised for the first time the defense that the urine drug screen he used at that time was incapable of testing for methadone. He also argued that if a patient is taking oxycodone and methadone together, then either one, both, or neither may show up positive on a urine drug screen due to “tolerance” and methadone’s interaction with oxycodone and with the NMDA (the amino acid neuro receptor that increases the tolerance of oxycodone by interacting with methadone). This was a clear misunderstanding by Dr. Mubang of his expert’s testimony regarding the use of methadone in pain management.

148. Dr. Mubang testified many times at hearing that methadone has a tolerance effect on oxycodone, which causes a physician to increase the dose of oxycodone.

149. Respondent’s testimony was incongruent with the description given by his expert witness. Dr. Simopoulos explained that methadone can antagonize NMDA receptors, which can help some patients who have a tolerance to oxycodone. However, Dr. Simopoulos’s testimony regarding NMDA did not relate to the ability to detect methadone in a urine drug screen.
150. Despite the negative test result for methadone, during the same visit, Dr. Mubang prescribed 180 10 mg tablets of methadone to Patient C.C. No questions of whether Patient C.C. may have diverted her methadone or notations of such were in the doctor’s notes.

151. Dr. Mubang failed to order a second urine drug screen for Patient C.C. until ten months later on February 2, 2011. The second test was also negative for the prescribed medication methadone.

152. From April 29, 2010, through August 19, 2010, based on Patient C.C.’s presentation, Dr. Mubang prescribed potentially lethal doses of oxycodone, methadone, Xanax, and Soma to Patient C.C. inappropriately, in excessive quantities, and without justification.

153. From April 29, 2010, through August 19, 2010, Dr. Mubang neither performed nor documented performing a complete and adequate physical examination or medical history to justify his prescribing potentially lethal doses of oxycodone, methadone, Xanax, and Soma to Patient C.C.

154. Dr. Mubang did not diagnose Patient C.C. with intractable pain prior to prescribing to the patient the potentially lethal doses of oxycodone, methadone, Xanax, and Soma.
155. To meet the standard of care, Dr. Mubang should not have prescribed such large amounts of pain medication to Patient C.C., a patient who did not have a significant pathology for pain. Instead, he should have pursued other treatment modalities, such as injections and physical therapy.

Patient W.B.

156. From December 13, 2008, to February 18, 2011, Dr. Mubang provided pain management treatment to Patient W.B., a then 52-year-old male.

157. On or about April 20, 2008, prior to visiting Dr. Mubang, Patient W.B. presented to the emergency room at Sarasota Memorial Hospital after being hit by a “slow moving vehicle,” while riding his bicycle.

158. The emergency room physician diagnosed Patient W.B. with a bruise of the left knee and left hip and prescribed an unknown quantity of 7.5 mg Lortab to Patient W.B.

159. Patient W.B. then visited Physician’s Group, LLC, in Sarasota for follow-up care on April 20, May 28, November 11, and December 2, 2008.

160. On May 28, 2008, Patient W.B. reported to a provider at Physician’s Group, LLC, that he had taken Dilaudid from a friend.

161. On November 11, 2008, Patient W.B. saw Dr. Frederic Sonstein. Dr. Sonstein noted that Patient W.B. missed a
scheduled appointment because he was incarcerated. While incarcerated, Patient W.B. was treated with Flexeril and Ultram.

162. Dr. Sonstein recommended referral to a pain management specialist and prescribed Vicodin for pain control.

163. A November 24, 2008, MRI report of Patient W.B.’s lumbar spine was unremarkable.

164. On December 13, 2008, Patient W.B. came to Dr. Mubang and reported having pain in his neck and shoulders, with pain radiating down both arms.

165. In contrast to Patient W.B.’s report, on his initial range of motion evaluation, Dr. Mubang did not document any findings under cervical spine. Instead, he noted lumbar spine pain with radiculopathy.

166. On his initial evaluation questionnaire, Patient W.B. reported only having tried one alternative treatment method for his pain, “braces or cast.” By his own report, Patient W.B. had not tried any of the other alternative treatment options on Dr. Mubang’s checklist form, such as physical therapy, chiropractic, muscle injections, or surgery.

167. Despite the minimal objective findings in Patient W.B.’s history, Dr. Mubang began to prescribe escalating amounts of oxycodone to Patient W.B.

168. On December 13, 2008, Dr. Mubang prescribed 120 30 mg tablets of oxycodone to Patient W.B. Then, he increased the
amount of oxycodone he prescribed to Patient W.B. over the following monthly visits as follows: 150, 180, 210, 210, 240, 240, and ultimately settling at 270 30 mg tablets of oxycodone per month.


170. On July 11, 2009, in addition to oxycodone and Soma, Dr. Mubang added Xanax and Fiorinal with codeine to Patient W.B.’s monthly prescription regimen.

171. Like with Patient B.B., Dr. Mubang prescribed Xanax to Patient W.B. based on Patient W.B.’s answers to his checklist anxiety questionnaire.

172. On July 11, 2009, Dr. Mubang saw Patient W.B. and renewed his medication. He scheduled Patient W.B. to return on August 9, 2009; however, Patient W.B. missed the appointment.

173. Patient W.B. next visited Dr. Mubang two months later, on October 13, 2009.

174. Dr. Mubang failed to document the reason for Patient W.B.’s three-month absence. He failed to document if Patient W.B. continued to receive pain medication from another source. He did not note whether Patient W.B. experienced withdrawal symptoms without his oxycodone for two months or how Patient W.B. managed his pain without oxycodone for two months.
175. Dr. Mubang admitted during the hearing that, “[i]t is important to me to know why he misses visits. And you're right. Your point is well-taken.”

176. Dr. Mubang’s own controlled substance agreement, which was executed by Patient W.B., explicitly stated that renewals are contingent on keeping scheduled appointments.

177. Despite the unexplained absence, on October 13, 2009, he renewed Patient W.B.’s prescriptions for 270 tablets oxycodone, 30 tablets Soma, 60 tablets Xanax, and 90 tablets of Fiorinal with codeine.

178. Dr. Mubang should not have restarted Patient W.B. at the same high dosage of oxycodone that he had previously prescribed, as it was potentially fatal.

179. On November 10, 2009, Dr. Mubang ordered a urine drug screen for Patient W.B. The drug screen was positive for cocaine and hydromorphone. The drug screen was negative for the prescribed medications Soma (carisoprodol) and Xanax (alprazolam).

180. Based upon the November 10, 2009, drug screen result, the standard of care required Dr. Mubang to refer Patient W.B. to a drug treatment center.

181. When questioned about the positive cocaine result, Dr. Mubang’s expert, Dr. Simopoulos, testified, “That’s the part where this patient has a substance abuse disorder, obviously.”
Dr. Simopoulos opined that, "if you are going to continue prescribing in this case, because the patient has duel diagnoses, you would want the input of a psychiatrist for this case."

182. Patient W.B. next visited Dr. Mubang approximately three months later on February 9, 2010. Again, Dr. Mubang failed to document the reason for the absence.

183. At the February 9, 2010, visit, Dr. Mubang ordered a urine drug screen for Patient W.B., which returned completely negative results.

184. After a multi-month absence and with a completely negative urine drug screen, Patient W.B. would have been opioid negative.

185. In his 2012 deposition, Dr. Mubang theorized that the completely negative result may have been because Patient W.B. drove himself to his appointment and Dr. Mubang instructed his patients not to drive while on medication. This made little sense.

186. Despite the completely negative result and unexplained absence, Respondent prescribed Patient W.B. 270 tablets of oxycodone, 30 tablets of Soma, 60 tablets of Xanax, and 90 tablets of Fiorinal with codeine.

187. Again, Dr. Mubang should not have restarted Patient W.B. at the same high dosage of oxycodone that he had previously prescribed, as it was potentially fatal.
188. Despite prescribing 270 tablets of oxycodone per month to Patient W.B., or nine pills per day, Dr. Mubang testified at hearing that, "[i]f I give them what they call 'breakthrough medications,' like oxycodone, all these, they'll tell you some days they take it, some days they don't take it."

189. Dr. Mubang was aware that Patient W.B. did not require nine oxycodone tablets per day and that the amount of oxycodone he prescribed to Patient W.B. was not justified.

190. The foregoing pattern of unexplained absence and completely negative urine drug screen result, followed by Dr. Mubang renewing prescriptions, was repeated in November 2010.

191. From December 13, 2008, through November 10, 2010, Dr. Mubang prescribed potentially lethal doses of oxycodone, Soma, Xanax, and Fiorinal with codeine to Patient W.B. inappropriately, in excessive quantities, and without justification.

192. From December 13, 2008, through November 10, 2010, Dr. Mubang neither performed nor did he document performing a complete and adequate physical examination or medical history to justify his prescribing of the potentially lethal doses of oxycodone, Soma, Xanax, and Fiorinal with codeine to Patient W.B.

193. From December 13, 2008, through August 24, 2010, Respondent did not diagnose Patient W.B. with intractable pain
prior to prescribing potentially lethal doses of oxycodone, Soma, Xanax, and Fiorinal with codeine to Patient W.B.

194. To meet the standard of care, Dr. Mubang should have discontinued prescribing the amount of medication that he prescribed to Patient W.B. based on the minimal findings in Patient W.B.'s history and the minimal changes on examination. In addition, Dr. Mubang should have referred Patient W.B. to a drug treatment center.

Patient M.H.


196. Prior to seeing Dr. Mubang, on March 24, 2004, Patient M.H. visited Dr. Edward Jacobson. Dr. Jacobson noted that Patient M.H. had been in a car accident on February 21, 2004, and that Patient M.H. was complaining of headaches. He prescribed 15 tablets of Vicodin to her.

197. On January 10, 2005, Patient M.H.'s first visit with Dr. Mubang, he prescribed her 60 tablets of Vicodin.

198. On January 21, 2005, Dr. Mubang added clonazepam and Adderall to Patient M.H.'s medication regimen.

199. Dr. Mubang's note for the January 21, 2005, visit does not make any mention of Patient M.H. suffering from an anxiety disorder or ADD that would justify his use of clonazepam or
Adderall, save for a simple “ADD” noted in the assessment/plan portion of the form. Dr. Mubang should have referred Patient M.H. to a psychiatrist for diagnostic confirmation of ADD before automatically prescribing (or refilling) the Adderall prescription.


201. Dr. Mubang neglected to document a justification for prescribing Patient M.H. benzodiazepine-class drugs, or for prescribing her a combination of two different benzodiazepine-class drugs, or for the changes he made to the benzodiazepines he prescribed.

202. On January 6, 2009, Patient M.H. reported having lower back pain from a car accident in 2003. Dr. Mubang noted that Patient M.H. was the driver of a car that was rear-ended. He also noted that Patient M.H. did not lose consciousness during the accident and did not go to the emergency room.

203. At the January 6, 2009, visit, Patient M.H. reported trying three alternative treatment methods for her pain. By her own report, Patient M.H. had not tried any of the other 18 alternative treatment options on Dr. Mubang’s checklist form, such as physical therapy, muscle injections, or surgery.
204. In 2009, for unexplained reasons, Dr. Mubang began significantly increasing Patient M.H.’s opioid pain medication. In January 2009, he increased Patient M.H.’s Vicodin from 60 to 90 tablets per month, then in July 2009 from 90 to 120 tablets per month. On October 19, 2009, Dr. Mubang prescribed Patient M.H. ten 50 mcg patches of fentanyl in combination with 120 tablets of Vicodin. A 50 mcg fentanyl patch is intended to last for 72 hours; so, a prescription of ten patches is intended to last one month. Fentanyl is a very strong opioid. Based on Patient M.H.’s experience with opioids, Dr. Mubang’s prescribing fentanyl to Patient M.H. was potentially lethal.

205. On November 16, 2009, Dr. Mubang discontinued fentanyl and started Patient M.H. on 90 15 mg tablets of oxycodone, which he increased to 120 tablets the next month. Dr. Mubang prescribed the oxycodone in combination with 120 tablets of Vicodin.

206. At hearing, Dr. Mubang could not tell from his notes and was, therefore, unable to explain his rationale as to why he prescribed fentanyl to Patient M.H., or why he discontinued the fentanyl and started Patient M.H. on oxycodone. The limited documentation that was included in Dr. Mubang’s records contradicted his course of treatment, as he routinely documented that Patient M.H.’s pain was a two out of ten with medication.
207. From March 8, 2010, to June 28, 2010, Dr. Mubang added and then discontinued prescribing Soma to Patient M.H. His records do not contain any justification for starting Patient M.H. on Soma or for stopping Soma.

208. On May 3, 2010, Dr. Mubang ordered a urine drug screen for Patient M.H. The urine drug screen result was negative for the prescribed medication oxycodone.

209. The standard of care required Dr. Mubang to ask about the reason for the aberrant result to determine whether she was taking the medications or diverting them. Depending upon Patient M.H.’s answer, he should have ordered a repeat urine drug screen at the following visit.

210. Despite the negative test, Dr. Mubang continued to prescribe potentially lethal doses of oxycodone and Vicodin to Patient M.H.

211. From January 10, 2005, through August 23, 2010, Dr. Mubang prescribed potentially lethal doses of Vicodin, Xanax, Adderall, Soma, Valium, clonazepam, fentanyl, or oxycodone to Patient M.H. inappropriately, in excessive quantities, and without justification.

212. From January 10, 2005, through August 23, 2010, Dr. Mubang did not diagnose Patient M.H. with ADD or any other clinical indication to support his prescribing Adderall to Patient M.H.
213. From January 10, 2005, through August 23, 2010, Dr. Mubang neither performed nor documented performing a complete and adequate physical examination or medical history to justify his prescribing of the potentially lethal doses of Vicodin, Xanax, Adderall, Soma, Valium, clonazepam, fentanyl, or oxycodone to Patient M.H.

214. Dr. Mubang did not diagnose Patient M.H. with intractable pain prior to prescribing to the patient the potentially lethal doses of Vicodin, Xanax, Adderall, Soma, Valium, clonazepam, fentanyl, or oxycodone.

215. To meet the standard of care in his treatment of Patient M.H., Dr. Mubang should not have prescribed fentanyl to Patient M.H. without sufficient medical justification, as doing so was life threatening. Respondent should have referred Patient M.H. to specialists, such as orthopedics, physical therapy, and psychiatry. To the extent Dr. Mubang documented referrals to specialists, he should have followed up on his ordering of referrals to minimize the amount of medications he provided to Patient M.H., instead of escalating the amounts of pain medicine he prescribed.

Patient B.D.

216. From November 11, 2010, to November 8, 2012, Dr. Mubang provided pain management treatment to Patient B.D., a then 24- to 26-year-old female.
217. In addition to lower back pain, Patient B.D. was also diagnosed with fibromyalgia.

218. Dr. Mubang’s medical records for Patient B.D. contain a note from Dr. Indira Koshy, a prior treating provider, for a visit on August 24, 2010, in New York.

219. Dr. Koshy noted that Patient B.D. was “entering rehab” and that Patient B.D. has seizures when she does not take her medications.

220. Dr. Koshy’s note indicates potential for doctor shopping.

221. At no point during his treatment of Patient B.D. did Dr. Mubang address the note from Dr. Koshy, specifically; Patient B.D.’s entry into rehabilitation; Patient B.D.’s seizures when she did not take her medications; or Patient B.D.’s potential for doctor shopping.

222. Dr. Mubang previously treated Patient B.D. at Care Point Medical Center as a covering physician. He testified that when covering as a physician he provided “continuation of care” and that his practice was not to change a patient’s medication. Despite his testimony, when covering at Care Point Medical Center, Dr. Mubang increased Patient B.D.’s oxycodone from 210 tablets per month to 240 tablets per month.

223. Then, on November 11, 2010, when Patient B.D. visited his practice, Dr. Mubang decreased her oxycodone from 240 to
180 tablets. As discussed below, this decrease came after he received notice of Petitioner’s investigation.

224. From November 11, 2010, until May 24, 2012, Dr. Mubang prescribed Patient B.D. 180 30 mg tablets of oxycodone, 30 or 60 10 mg tablets of methadone, 60 350 mg tablets of Soma, and 30 0.5 mg to 2 mg tablets of Xanax monthly.

225. On June 21, 2012, Dr. Mubang changed Patient B.D.’s prescribed muscle relaxant from Soma to baclofen; and on July 19, 2012, he changed Patient B.D.’s prescribed anxiolytic medication from 60 0.5 mg tablets of Xanax to 60 2 mg tablets of clonazepam.

226. Dr. Mubang did not document any justification for the foregoing medication changes.

227. From September 13, 2012, until November 8, 2012, Dr. Mubang prescribed 112 8 mg tablets of Dilaudid, 28 10 mg tablets of methadone, and 60 tablets of clonazepam to Patient B.D. monthly.

228. On June 23, 2011, Dr. Mubang performed a urine drug screen on Patient B.D. The drug screen was negative for benzodiazepines, even though he prescribed Xanax to Patient B.D. The urine drug screen was positive for methadone, despite Dr. Mubang’s testimony that his urine drug screen could not detect methadone.
229. On December 8, 2011, and June 21, 2012, Dr. Mubang performed urine drug screens on Patient B.D. Both drug screens were negative for the prescribed medication methadone.

230. The standard of care required a reasonably prudent physician to question the patient about the aberrant urine drug screens results and cease prescribing methadone to a patient whose urine drug screen was negative for the drug.

231. Despite the negative test results, Dr. Mubang continued to prescribe methadone to Patient B.D.

232. From November 11, 2010, through November 8, 2012, Dr. Mubang neither performed nor documented performing an adequate history or physical examination to justify his prescribing of the potentially lethal controlled substances to Patient B.D.

233. From November 11, 2010, through November 8, 2012, based on Patient B.D.’s history and physical findings, Dr. Mubang’s prescribing of the controlled substances to Patient B.D. was excessive and without justification.


235. To meet the standard of care in his treatment of Patient B.D., Dr. Mubang should not have prescribed the quantity and combination of drugs he prescribed to Patient B.D. He should
have referred Patient B.D. for a rheumatology consult to confirm or rule out fibromyalgia and other diseases. He should have offered more physical therapy, and other, non-opioid modalities of care, and he should have routinely followed up with Patient B.D. to ensure that she was complying with his orders.

236. Dr. Mubang testified that Soma was part of the “holy trinity,” which is a slang drug term used to refer to the prescription combination of oxycodone, a benzodiazepine, and Soma. He prescribed the “holy trinity” to five of the six patients in this cause.

Dr. Mubang’s Medical Records

237. Dr. Mubang’s medical records for the six patients, who are the subjects of the Administrative Complaints, were generally lacking in specificity to justify the level of his prescribing.

238. Some examples common to the patients at issue illustrate these shortcomings. For each visit for each of the patients, Dr. Mubang noted that the patient had straight leg raise pain at 30 degrees, even though he testified that a patient can have straight leg raise pain at 15, 20, 30, or 45 degrees. Maybe this was a coincidence, but more credibly it is a pattern of sloppiness or autofill by the doctor. Also, for each patient, Dr. Mubang routinely drew a line down one leg of the anatomical figure on his progress notes indicating radiculopathy, regardless of where the patient reported pain.
239. At hearing, on multiple occasions, Dr. Mubang could not determine his rationale for changing a patient’s medication regimen, based on his progress notes. His own expert, Dr. Simopoulos, testified that, “there’s not much rationale on the plans in--in Dr. Mubang’s notes in general.”

240. Dr. Mubang tried to justify the lack of documented rationale by explaining that if a subsequent treating physician needed to know why he made medication changes, the physician would just call him and ask. While this should be true in an ideal world, his attempted justification is contrary to the purpose of medical records, which is continuity of care. No doctor, regardless of his education and experience, can be expected to remember every detail about every patient when he only sees the patient periodically. The medical record and doctor’s notes comprise his guide to ensuring the patient receives continuous, appropriate care.

241. In addition to lacking in rationale, both experts were unable to read some of Dr. Mubang’s handwritten notes due to legibility. His own expert testified that, “The hardest part about these records is, obviously, how legible they are. I wish they were more legible.”

242. Dr. Mubang’s medical records were inadequate for all six of the patients at issue here.
Dr. Mubang’s Defenses

243. Dr. Mubang passionately testified at hearing that he practices addiction medicine, that he prescribes Suboxone, and that his goal is to titrate patients’ medication. However, Dr. Mubang’s interest in addiction medicine and Suboxone is a recent phenomenon. In his 2012 deposition, he did not mention practicing addiction medicine, and the word Suboxone does not even appear in that deposition.

244. Dr. Mubang titrated the medication he prescribed for four of the six patients in this cause. His reasoning for titrating the patients’ medication changed from his deposition testimony to his hearing testimony. In his 2018 deposition, he testified that he reduced the patients’ pain medication because the patients’ conditions were improving, and his goal was to titrate the medication. At hearing, he asserted the theory that he changed his prescribing practices because pharmacies contacted him and told him that they would no longer fill prescriptions written for such large quantities. The first of these is based upon a consideration of quality of care, while the second is based upon the practical reality of changing pharmacy practices as the dangers of over-prescribing opiates started to become more prevalent in the eyes of health professionals and regulators.

245. On September 2, 2010, Investigator Victor Troupe personally served Dr. Mubang with a notice of investigation and a
subpoena for medical records for Patients A.M., B.B., C.C., W.B., and M.H., among others. Following receipt of the notice of investigation, the doctor radically changed his prescribing practice for the patients in this case.

246. For ten months, Dr. Mubang prescribed Patient A.M. 270 tablets of oxycodone. Then on September 24, 2010, three weeks after being served by Petitioner, Respondent reduced Patient A.M.’s prescription of oxycodone from 270 tablets to 210, and then from 210 tablets to 180.

247. For five months, Dr. Mubang prescribed Patient C.C. 290 tablets oxycodone. Then on September 9, 2010, Respondent reduced Patient C.C.’s prescription of oxycodone from 290 tablets to 210. At the patient’s next visit on January 5, 2011, Dr. Mubang reduced the patient’s prescription of oxycodone from 210 tablets to 180.

248. Dr. Mubang also reduced Patient C.C.’s methadone. For five months, he prescribed 180 10 mg tablets of methadone to Patient C.C., but he reduced that number first to 60 tablets, then to 30, then discontinued the prescription. Further, in a matter of three visits, the doctor went from prescribing Patient C.C. 470 pain pills per month to 180 tablets.

249. For ten months, Dr. Mubang prescribed Patient W.B. 270 tablets of oxycodone. Then on November 6, 2010, Patient W.B.’s first visit after the doctor received notice of
the investigation, he reduced Patient W.B.’s prescription of oxycodone to 240 tablets, then to 210 on the next visit.

250. For five months, Dr. Mubang prescribed Patient B.D. 240 tablets of oxycodone. Then on November 11, 2010, Patient B.D.’s first visit with the doctor after he had received notice of the investigation, he reduced Patient B.D.’s prescription of oxycodone to 180 tablets.

251. The logical explanation for Dr. Mubang’s sudden reduction in amounts of pain medication prescribed is that the Petitioner’s notice of investigation triggered him to change his prescribing practice. The notice of investigation might have been his “eureka” moment or it might have served as a wake-up call to him concerning his prior over-prescribing practices.

252. The evidence clearly and convincingly demonstrates that Dr. Mubang used little critical medical judgment when prescribing dangerous controlled substances to the patients in this matter. His diagnoses were based solely on patient report, and his primary tool for treating these patients was the prescription of controlled substances without first exhausting less harmful treatment modalities or combining lower doses of controlled substances with his patients seeking other treatment modalities.
CONCLUSIONS OF LAW

253. DOAH has jurisdiction of the subject matter and the parties to this action pursuant to sections 120.569 and 120.57(1), Florida Statutes (2018).

254. Petitioner is the state agency charged with regulating the practice of medicine. See § 20.43 and chs. 456 and 458, Fla. Stat.

255. A proceeding, such as this one, to suspend, revoke, or impose other discipline upon a license is penal in nature. State ex rel. Vining v. Fla. Real Estate Comm’n, 281 So. 2d 487, 491 (Fla. 1973). Accordingly, to impose such discipline, Petitioner must prove the allegations in the Administrative Complaints by clear and convincing evidence. Dep’t of Banking & Fin., Div. of Sec. & Investor Prot. v. Osborne Stern & Co., 670 So. 2d 932, 933-34 (Fla. 1996) (citing Ferris v. Turlington, 510 So. 2d 292, 294-95 (Fla. 1987)); Nair v. Dep’t of Bus. & Prof’l Reg., Bd. of Med., 654 So. 2d 205, 207 (Fla. 1st DCA 1995).

256. What constitutes clear and convincing evidence was described in Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1989) as follows:

[C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such
weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

257. The Florida Supreme Court later adopted the Slomowitz court’s description of clear and convincing evidence. See In re Davey, 645 So. 2d 398, 404 (Fla. 1994). The First District Court of Appeal also followed the Slomowitz test, adding the interpretive comment that “[a]lthough this standard of proof may be met where the evidence is in conflict . . . it seems to preclude evidence that is ambiguous.” Westinghouse Elec. Corp. v. Shuler Bros., 590 So. 2d 986, 988 (1991) (citations omitted), rev. denied, 599 So. 2d 1279 (Fla. 1992).

258. Disciplinary statutes and rules “must be construed strictly, in favor of the one against whom the penalty would be imposed.” Munch v. Dep’t of Prof’l Reg., Div. of Real Estate, 592 So. 2d 1136, 1143 (Fla. 1st DCA 1992); see Camejo v. Dep’t of Bus. & Prof’l Reg., 812 So. 2d 583, 583-84 (Fla. 3d DCA 2002); McClung v. Crim. Just. stds. & Training Comm’n, 458 So. 2d 887, 888 (Fla. 5th DCA 1984) (“[W]here a statute provides for revocation of a license the grounds must be strictly construed because the statute is penal in nature. No conduct is to be regarded as included within a penal statute that is not reasonably proscribed by it; if there are any ambiguities
included, they must be construed in favor of the licensee.”
(citing State v. Pattishall, 126 So. 147 (Fla. 1930)).

259. The grounds proven in support of Petitioner’s assertion that Dr. Mubang’s license should be disciplined must be those specifically alleged in the Administrative Complaints. See, e.g., Trevisani v. Dep’t of Health, 908 So. 2d 1108 (Fla. 1st DCA 2005); Cottrill v. Dep’t of Ins., 685 So. 2d 1371 (Fla. 1st DCA 1996); Kinney v. Dep’t of State, 501 So. 2d 129 (Fla. 5th DCA 1987); and Hunter v. Dep’t of Prof’l Reg., 458 So. 2d 842 (Fla. 2d DCA 1984). Due process prohibits Petitioner from taking disciplinary action against a licensee based on matters not specifically alleged in the charging instrument, unless those matters have been tried by consent. See Shore Vill. Prop. Owners’ Ass’n v. Dep’t of Envtl. Prot., 824 So. 2d 208, 210 (Fla. 4th DCA 2002); and Delk v. Dep’t of Prof’l Reg., 595 So. 2d 966, 967 (Fla. 5th DCA 1992).

260. Section 458.331(1) provides, in pertinent part, as follows:

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

*   *   *

(m) Failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and
professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

* * *

(q) Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician’s professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician’s professional practice, without regard to his or her intent.

* * *

(t) Notwithstanding s. 456.072(2) but as specified in s. 456.50(2):
1. Committing medical malpractice as defined in s. 456.50. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. Medical malpractice shall not be construed to require more than one instance, event, or act.
2. Committing gross medical malpractice.
3. Committing repeated medical malpractice as defined in s. 456.50. A person found by the board to have committed repeated medical malpractice based on s. 456.50 may not be licensed or continue to be licensed by this state to provide health care services as a medical doctor in this state.
(cc) Prescribing, ordering, dispensing, administering, supplying, selling, or giving any drug which is a Schedule II amphetamine or a Schedule II sympathomimetic amine drug or any compound thereof, pursuant to chapter 893, to or for any person except for:
1. The treatment of narcolepsy; hyperkinesis; behavioral syndrome characterized by the developmentally inappropriate symptoms of moderate to severe distractability, short attention span, hyperactivity, emotional lability, and impulsivity; or drug-induced brain dysfunction;
2. The differential diagnostic psychiatric evaluation of depression or the treatment of depression shown to be refractory to other therapeutic modalities; or
3. The clinical investigation of the effects of such drugs or compounds when an investigative protocol therefor is submitted to, reviewed, and approved by the board before such investigation is begun.

* * *

(nn) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

261. Section 456.50 states in relevant part:

(e) "Level of care, skill, and treatment recognized in general law related to health care licensure" means the standard of care specified in s. 766.102.
(f) "Medical doctor" means a physician licensed pursuant to chapter 458 or chapter 459.
(g) "Medical malpractice" means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. Only for the purpose of finding repeated medical malpractice pursuant
to this section, any similar wrongful act, neglect, or default committed in another state or country which, if committed in this state, would have been considered medical malpractice as defined in this paragraph, shall be considered medical malpractice if the standard of care and burden of proof applied in the other state or country equaled or exceeded that used in this state.

(h) "Repeated medical malpractice" means three or more incidents of medical malpractice found to have been committed by a medical doctor. Only an incident occurring on or after November 2, 2004, shall be considered an incident for purposes of finding repeated medical malpractice under this section.

262. Section 766.102 defines the prevailing professional standard of care as "that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers."

263. As in effect at the times material to this matter, rule 64B8-9.003 provided:

(2) A licensed physician shall maintain patient medical records in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.
(3) The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or
reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

264. At all times material to this matter, the Florida Board of Medicine had promulgated rule 64B8-9.013, titled "Standards for the Use of Controlled Substances for the Treatment of Pain." As in effect from October 19, 2003, to October 17, 2010, rule 64B8-9.013 provided in relevant part:

(3) Standards. The Board has adopted the following standards for the use of controlled substances for pain control:
(a) Evaluation of the Patient. A complete medical history and physical examination must be conducted and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.
(b) Treatment Plan. The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.
(c) Informed Consent and Agreement for Treatment. The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient, or with the patient’s surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician should employ the use of a written agreement between physician and patient outlining patient responsibilities, including, but not limited to:
1. Urine/serum medication levels screening when requested;
2. Number and frequency of all prescription refills; and
3. Reasons for which drug therapy may be discontinued (i.e., violation of agreement).
(d) Periodic Review. At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician’s evaluation of the patient’s progress. If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.
(e) Consultation. The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder
requires extra care, monitoring, and documentation, and may require consultation with or referral to an expert in the management of such patients.

(f) Medical Records. The physician is required to keep accurate and complete records to include, but not be limited to:
1. The medical history and physical examination, including history of drug abuse or dependence, as appropriate;
2. Diagnostic, therapeutic, and laboratory results;
3. Evaluations and consultations;
4. Treatment objectives;
5. Discussion [sic] of risks and benefits;
6. Treatments;
7. Medications (including date, type, dosage, and quantity prescribed);
8. Instructions and agreements; and
9. Periodic reviews. Records must remain current and be maintained in an accessible manner and readily available for review. Records must remain current and be maintained in an accessible manner and readily available for review.

265. The Board of Medicine amended rule 64B8-9.013 on October 17, 2010, to change the use of “should” in paragraph three to “shall.”

266. The previous use of the word “should” does not alter the identification of the standard of care in this cause. See Dep’t of Health v. Sabates, M.D., Case No. 10-9430, RO at 73 (Fla. DOAH June 23, 2011; Fla. DOH Aug. 29, 2011).

267. In DOH Case No. 2010-12384, Petitioner alleged that Dr. Mubang violated section 458.331(1)(nn) by violating rule 64B8-9.013 with respect to Patients A.M., B.B., C.C., W.B., and M.H.:
a. By failing to diagnose the patient with intractable pain prior to prescribing controlled substances;
b. By failing to perform complete or adequate physical examinations prior to prescribing controlled substances; and/or
c. By failing to obtain a complete medical history prior to prescribing controlled substances.

268. Therefore, Petitioner proved, by clear and convincing evidence, that Dr. Mubang violated section 458.331(1)(nn) by violating rule 64B8-9.013 for all five patients in DOH Case No. 2010-12384.

269. In DOH Case No. 2010-12384, Petitioner alleged that Dr. Mubang violated section 458.331(1)(q) by prescribing controlled substances to Patients A.M., B.B., C.C., W.B., and M.H. inappropriately or in excessive or inappropriate quantities.

270. As detailed in the Findings of Fact, Dr. Mubang’s prescribing of controlled substances to all five patients was excessive, given the patients’ presentation. Because the amount of medication he prescribed far exceeded what should have been prescribed, his prescribing is legally presumed to have been not in the patients’ best interest and is legally presumed to have been not done in the course of Dr. Mubang’s professional practice, without regard to his intent. See Scheininger v. Dep’t of Prof’l Reg., 443 So. 2d 387 (Fla. 1st DCA 1983); and Waters v. Dep’t of Health, 962 So. 2d 1011 (Fla. 3d DCA 2007) (upholding Petitioner’s position that section 458.331(1)(t) and (q) are not
mutually exclusive grounds for discipline). See also Dep’t of Health v. Christensen, M.D., Case No. 11-5163 (Fla. DOAH Mar. 16, 2012), rejected in part, Case No. 11-11153 (Fla. DOH June 14, 2012), per curiam aff’d, Christensen v. Dep’t of Health, 123 So. 3d 577 (2013).

271. Petitioner proved, by clear and convincing evidence, that Dr. Mubang’s prescribing of controlled substances to all five patients in DOH Case No. 2010-12384 was excessive, and, therefore, constituted a violation of section 458.331(1)(q).

272. In DOH Case No. 2010-12384, Petitioner alleged that Dr. Mubang violated section 458.331(1)(cc) by prescribing Adderall to Patient M.H. without sufficient findings or diagnosis. As discussed in the Findings of Fact, the doctor failed to document his rationale for prescribing controlled substances in general. The same holds true for his prescribing Adderall to Patient M.H. He also failed to refer Patient M.H. to a psychiatrist or other appropriate health care professional for diagnostic confirmation of ADD, despite having prescribed Adderall to Patient M.H. for seven years. Petitioner proved, by clear and convincing evidence, that Dr. Mubang’s prescribing Adderall to Patient M.H. constituted a violation of section 458.331(1)(cc).

273. In both cases, Petitioner alleged that Dr. Mubang violated section 458.331(1)(t) by failing to meet the standard of
care in his treatment of Patients A.M., B.B., C.C., W.B., M.H., and B.D. in one or more of the following ways:

   a. By failing to diagnose the patient with intractable pain prior to prescribing controlled substances;
   b. By prescribing controlled substances without justification;
   c. By failing to perform an adequate physical examination prior to prescribing controlled substances;
   d. By failing to obtain a complete medical history prior to prescribing controlled substances;
   e. By failing to diagnose an anxiety disorder or any other clinical indication to support prescribing Xanax to Patient B.B.; and/or
   f. By failing to address aberrant urine drug screen results for Patients A.M., W.B., and B.D.

274. As detailed in the Findings of Fact, Petitioner proved, by clear and convincing evidence, Dr. Mubang failed to perform adequate physical examinations and failed to obtain complete histories for all six patients that justified his prescribing of controlled substances. Petitioner also proved that the doctor failed to diagnose the patients with intractable pain.

275. In addition, Petitioner proved that Dr. Mubang’s prescribing of controlled substances to all six patients was excessive and not medically justified based on the patients’ presentations. Dr. Mubang’s prescribing Xanax to Patient B.B. based solely on a patient-completed questionnaire was not
medically justified. For Patients A.M., W.B., and B.D., Petitioner proved that Dr. Mubang failed to address significant aberrant urine drug screen results. For those reasons, Petitioner proved, by clear and convincing evidence, that the doctor violated section 458.331(1)(t) by committing medical malpractice in his treatment of all six patients.

276. In both cases, Petitioner alleged that Dr. Mubang violated section 458.331(1)(m) by failing to keep legible medical records that justified his course of treatment for all six patients. As detailed in the Findings of Fact, the doctor’s medical records for all six patients were inadequate in varying degrees and frequently illegible. Therefore, Petitioner has proved, by clear and convincing evidence, that he violated section 458.331(1)(m), for all six patients.

277. In a licensure disciplinary action, Petitioner can take action to protect the public from negligent medical practice that has the potential for harm, even if by happenstance the patient avoids actual injury. Britt v. Dep't of Prof'l Reg., 492 So. 2d 697, 698-99 (Fla. 1st DCA 1986), disapproved on other grounds by Dep't of Prof'l Reg. v. Bernal, 531 So. 2d 967 (Fla. 1988); see also Major v. Dep't of Prof'l Reg., Bd. of Med., 531 So. 2d 411, 413 (Fla. 3rd DCA 1988)(noting “[t]he fact that no patient harm occurred was fortuitous.”). In this cause, evidence was not offered by either party to show the outcome of
Dr. Mubang's treatment of the six patients that are the subject of the two Administrative Complaints. Regardless, the over-prescribing of controlled substances, poor record-keeping, lack of thorough intake for the subject patients, and failure to diagnose intractable pain created a substantial likelihood of harm or addiction occurring to each of the patients over time. Moreover, based on the multiple, negative drug screen results for medications Respondent prescribed in this cause, some of the lack of patient harm can be attributed to the patients not even taking the medications as prescribed, but perhaps diverting the medications to others.

278. Pursuant to section 456.079, the Board of Medicine has adopted Florida Administrative Code Rule 64B8—8.001 (effective August 29, 2006, as amended from time to time, through January 1, 2015). The rule provides notice of the disciplinary penalties typically imposed for violations of sections 456.072 and 458.331.

279. At all times material to these proceedings, the penalties authorized for a violation of section 458.331(1)(m), ranged from a reprimand, to denial of licensure or two years' suspension followed by probation, to 50 to 100 hours of community service (community service can no longer be ordered by Petitioner due to subsequent rule amendments), and an administrative fine from $1,000 to $10,000.
280. At all times material to these proceedings, the penalties authorized for a violation of section 458.331(1)(t) ranged from one year of probation, to 50 to 100 hours of community service (no longer applicable), to revocation or denial and an administrative fine from $1,000 to $10,000.

281. At all times material to these proceedings, the penalties authorized for a violation of section 458.331(1)(q) ranged from one year of probation to revocation or denial of licensure and 50 to 100 hours of community service (no longer applicable); and an administrative fine from $1,000 to 10,000.

282. At all times material to these proceedings, the penalties authorized for a violation of section 458.331(1)(cc) ranged from probation to 50 hours of community service (no longer applicable); to denial of licensure or two years' suspension followed by probation; 100 hours of community service (no longer applicable); and an administrative fine from $1,000 to $10,000.

283. At all times material to these proceedings, the penalties authorized for a violation of section 458.331(1)(nn), ranged from a reprimand to 50 to 200 hours of community service (no longer applicable); to revocation or denial of licensure; and an administrative fine from $1,000 to $10,000.

284. Dr. Mubang committed "repeated medical malpractice," as defined in section 456.50(1)(h) by departing from the standard of care on all six of the patients, who were the subject of the
Administrative Complaints. Clear and convincing evidence supports the fact that Dr. Mubang overprescribed controlled substances to the six patients here; kept generally illegible and/or incomplete records; failed to refer the six patients to any or additional appropriate alternative modalities of treatment besides prescription drugs; and prescribed Adderall to one patient without a referral to the appropriate medical specialist to determine whether she suffered from ADD. In total, Dr. Mubang has been found to have committed 23 separate violations, many of which include revocation as a possible penalty.

285. The one troubling aspect of this case is the length of time Dr. Mubang was permitted to continue in the practice of medicine unrestricted since the occurrence of the last date of violation, November 8, 2012. This matter was not ripened for adjudication at DOAH until January 2018, more than five years following the last date of violation. No explanation was given by either party as to why no additional charges were brought. This matter is built upon evidence and none was submitted to show Dr. Mubang has lived a model life as a physician since the time of the violations. The undersigned is bound to follow the law and apply the evidence, which is produced at hearing, to the applicable statutes and rules. If Dr. Mubang changed his medical practice to conform with the prevailing standard of care, perhaps a suspension followed by probation with continuing medical
education in the areas of prescribing controlled substances and appropriate, complete medical charting of new and existing patients would allow a long-practicing physician, such as Dr. Mubang, to provide some good in the medical field. However, the evidence before me was too compelling for me to make such a recommendation here. Too many patients receiving too many controlled substances without the benefit of alternative modalities of treatment leaves the undersigned with no discretion in determining the outcome of this matter. Accordingly, there is no alternative penalty for the undersigned to recommend than a revocation of Dr. Mubang’s license to practice medicine.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Board of Medicine enter a final order:

1) finding that Respondent, John Nkolo Mubang, M.D., violated sections 458.331(1)(nn), 458.331(1)(q), 458.331(1)(t), 458.331(1)(m), and 458.331(1)(cc), Florida Statutes, as charged in Petitioner’s Administrative Complaints; and

2) revoking Dr. Mubang’s Florida medical license.
DONE AND ENTERED this 25th day of June, 2019, in Tallahassee, Leon County, Florida.

[Signature]

ROBERT S. COHEN
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the Division of Administrative Hearings this 25th day of June, 2019.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.
STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH,

          Petitioner,

DOAH CASE NOS.: 18-0528PL
18-0600PL

vs.

DOH CASE NOS.: 2010-12384
2013-12846

JOHN NKOLO MUBANG, M.D.,

          Respondent,

          ________________/

RESPONDENT’S EXCEPTIONS TO RECOMMENDED ORDER¹

The Respondent, JOHN NKOLO MUBANG, M.D., by and through his undersigned counsel, and pursuant to Section §120.57 (Florida Statues), and Florida Administrative Code Rule 28-106.217, hereby files the following Exceptions to the Administrative Law Judge’s (ALJ’s) Recommended Order filed June 25, 2019, in the above-referenced matter. For the reasons stated below, the ALJ’s findings of fact and conclusions of law, as well as the recommendation of the Recommended Order should be rejected. As grounds therefore, Respondent states:

¹ On June 25, 2019 counsel for Respondent file a Notice of Unavailability. Subsequently, on June 27, 2019, Respondent’s counsel filed a Motion for Extension of Time to File Exceptions. Despite the prompt filing of this motion, as of the filing of this document no ruling has been issued on the motion. Respondent requests the opportunity to amend or supplement these exceptions consistent with the filed and pending motion.
Preliminary Statement

Respondent takes exception to the Preliminary Statement to the extent it suggests that Respondent was responsible in any way for the more than five and a half year delay in prosecution of this action. Respondent was presented with a Settlement Agreement in 2012. That Settlement Agreement, executed by Respondent, was never presented to the Board of Medicine by the Department of Health.

It should be noted that these consolidated disciplinary licensure actions relate to medical treatment provided to six (6) patients by Respondent, John Nkolo Mubang, M.D. between May 30, 2006 and November 8, 2012. These cases languished with the Department of Health for years until referred for hearing in January 2018, more than five (5) years after the last charged treatment of patient BD and seven and one-half (7.5) years after the charged treatment of the remaining five (5) patients.

As the ALJ notes in Paragraph 285 of the Recommended Order, he was troubled by this delay. However he was apparently troubled for the wrong reason. First, if the Department of Health believed that Respondent’s continued practice of medicine endangered public health and safety, an Immediate Suspension Order could have been issued. It was not. Second, without evidence of any continuing violation after November 8, 2012, the ALJ ignores the fact that the Department of
Health took no action to advance this case for more than five (5) years. The ALJ recognized (Recommended Order ¶9) that Dr. Mubang’s license has never been subject to discipline.

In this action the Department of Health had the burden of proof. The Department failed to offer any evidence to suggest that Dr. Mubang’s practice of medicine since the last date of treatment in these consolidated cases was deficient in any way. Conversely, and as noted by the ALJ, Respondent did offer evidence regarding Dr. Mubang’s addiction medicine training and certification. [Trans. 88:23-89:14 and 90:18-91:8]; confirming that Dr. Mubang’s clinic passed all Department annual inspections required by F.S. §458.3265(4)(a); Dr. Mubang’s ongoing and continuous DEA Certificate of Registration in Schedules II-V without revocation, suspension or other sanction (Recommended Order ¶9); and Dr. Mubang’s subsequently acquired DEA Certificate of Registration for the Suboxone and Buprenorphine.

Paragraph 58 of the Recommended Order demonstrates the shoddy and incomplete investigation conducted in this action by the Department of Health. The sole Investigator offered at the hearing was unaware of the present health of these patients and whether those patients continue to receive opioid analgesic pain medication, even though DOH has access to E-FORCSE for investigative purposes.
Findings of Fact

1. Respondent takes exception to RO ¶17 to the extent that it suggests Dr. Mubang's training in pain management was insufficient. Dr. Mubang met and maintained the statutorily created training requirements for operation of a pain management clinic.

2. Respondent takes exception to RO ¶22 and 23. Dr. Guskiewicz's clinical practice related to medication management of pain is limited. Further, during the time period relevant to the present claims, Dr. Guskiewicz did not write, teach or otherwise train pain management practitioners. He was unable to identify the appropriate standard of care (RO ¶23 and Pet. Ex. 1, 18:9-13).

3. Respondent takes exception to RO ¶46 through ¶54. The conclusion that Dr. Guskiewicz's testimony is entitled to greater weight than that of Dr. Simopoulos lacks merit.

The Recommended Order fails to acknowledge that Dr. Simopoulos is the Director of the Pain Program at Beth Israel Deaconess Medical Center under Harvard Medical Faculty Physicians [Resp. Ex. 1, 156:14-18]. His curriculum vitae admitted into evidence demonstrates significant, ongoing writing, teaching, research and lecturing on pain management issues nationwide. Dr. Simopoulos is an award winning Professor at Harvard Medical School (see Respondent's Ex. ___, pages 159-160); In contrast, Dr. Guskiewicz's CV demonstrates a dearth of writing, current
teaching or research endeavors. [See Pet. Ex. 1]

It is interesting to note the ALJ made specific reference to fees paid to Dr. Simopoulos when previously retained by Respondent’s counsel, but inexplicably failed to consider the significant fees charged by Dr. Guskiewicz. At his deposition in lieu of live testimony, Dr. Guskiewicz testified that he had been paid over $4,000 by the Department prior to his deposition, that he had significant unbilled time; that he was charging Respondent $1,000 per hour for his deposition testimony; and that he expected to charge the Department $8,000 for his hearing testimony. [Pet. Ex. 2, 91:7 – 93:2]

Dr. Simopoulos confirmed that patients have the right to reject a surgical recommendation. He testified, “Patients who are younger, in their more productive years, may not want to seek out surgery as a solution, particularly of the spine because it usually means that they’re at risk for having multiple surgeries. So and that even continues today, we try to manage younger folks with more conservative measure, including medications to try to avoid surgery, because we know where that trajectory is going to go.” [Resp. Ex. 2, 190:18-191:2].

At RO ¶ 54 the ALJ appears to accept Petitioner’s argument that Dr. Simopoulos applied the incorrect standard of care. At his deposition, which was admitted into evidence in this case, Dr. Simopoulos acknowledged the standard of care is “that level of care, skill and treatment which, in light of all relevant,
surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar healthcare providers". [Resp. Ex. 2, 164:10-165:10]. Dr. Simopoulos further testified that his opinions have never before been excluded and that he has testified in State and Federal courts in Florida.

Dr. Guskiewicz’s opinions were reached without the benefit of reading any deposition testimony. Both his written reports and his deposition testimony in lieu of live appearance were offered without having the benefit of available, relevant testimony (cf. RO ¶ 37). Further, Dr. Guskiewicz’s review of records was tainted by Abbason & Associates, the expert witness broker used by the Department of Health. When Dr. Guskiewicz received the records, the expert broker had placed Post-It notes on records which it believed would be important to his review. This does not represent a true independent and thorough review of the available information.

4. Significantly, Dr. Guskiewicz was not familiar with Responsible Opioid Prescribing, A Physician’s Guide, written by Dr. Scott Fishman and distributed to Florida pain management practitioners, including Respondent, with a letter from Ana M. Viamonte Ros, M.D., the Surgeon General for the State of Florida and Fred Bearison, M.D., the Chairman of the Florida Board of Medicine dated May 13, 2009. That letter enclosed Dr. Fishman’s book and advised Dr. Mubang and others similarly situated, Dr. Fishman’s book “is a practical guide to Florida’s
current standards for the use of controlled substances for the treatment of pain”, based upon the Federation of State Medical Board’s Model Rule, “so it is right on point for Florida practicing doctors.” [Resp. Ex. 6].

5. The most telling indication that Dr. Guskiewicz failed to perform the “page-by-page” review of the medical records described by the ALJ in RO ¶ 27 is that he offered opinions that Respondent failed to document office visits corresponding to prescriptions in the records produced to him by Petitioner. At his deposition in lieu of live testimony Dr. Guskiewicz was confronted with those records (which were in his possession) and admitted he had not considered them.

Drug Definitions

6. Respondent takes exception to RO ¶69 which suggests carisoprodol (Soma) is a Schedule IV controlled substance. Prior to Monday, January 11, 2012, carisoprodol was not a controlled substance. It was placed in Schedule IV by the DEA Administrator in DEA Docket No, DEA-333 and published at Federal Register Volume 76, Number 238 (Monday, December 12, 2011).

The Patients

Quantity and Chronicity of Prescribing

7. Respondent takes exception to RO ¶89 to the extent the ALJ fails to acknowledge that each of these patients had attempted alternative treatment modalities. There is no obligation on the patient or the physician to exhaust all
possible treatment modalities before medication management of pain. In fact, physicians have a statutory obligation to treat their patient’s subjective complaints of pain. Further, Florida Patient Bill of Rights requires patients to provide truthful information to their physicians. That Bill of Rights also specifically provides the patient the opportunity to accept or reject recommended forms of treatment.

8. Respondent takes exception to RO ¶¶ 98, 99, 100, 119, 120, 130, 138, 139, 140, 150, 168, 169, 204, 205, 227. Each of these paragraphs ignore F.A.C. 64B8-9.013 wherein physicians, including Dr. Mubang, are advised the Board will not judge the validity of prescribing “based upon the quantity and chronicity” and that “a physician’s conduct will be evaluated to a great extent by treatment outcome.” The Petitioner failed to introduce any evidence to establish any named patient suffered any adverse effect from Dr. Mubang’s treatment. Where the regulation guiding physicians says a “physician’s conduct will be evaluated to a great extent by treatment outcome”, the Petitioner’s fail to submit any evidence of treatment outcome is curious and represents a failure to establish their burden of proof by clear and convincing evidence.

9. Each of the enumerated patients came to Respondent’s practice with a lengthy history of medication management of pain conditions. Respondent did not initiate any of the subject patients to opioid analgesics.
During the time Dr. Mubang treated the six patients subject to these consolidated administrative actions, there was no upper limit recommended or identified regarding the maximum dosage for opioid analgesics. [Trans. 117:4-9].

Dr. Mubang is aware of the sedative effects of opioids and muscle relaxants like Soma. This combination of medication should be dispensed with caution, but if a patient has been taking it for a period of time with no problems, the prescription is appropriate. [Trans. 142:14-143:2].

**Urine Drug Screening**

10. Respondent takes exception to RO ¶ 273f because it is inconsistent with the findings of fact identified in RO ¶¶ 75, 85, 86, and 147. The conclusion in RO ¶ 273f also ignores the unrebutted testimony of Dr. Simopoulos about the standard of care related to the use of urine drug screen (UDS) results.

Dr. Simopoulos testified that the standard of care is not a static concept. It changes with developments in research and changes in the law. At the time Respondent treated the subject patients, his handling of urine drug screens was within the applicable standard of care. [See Resp. Ex. 2, 195:18-196:21 and 61:4-65:23].

Interestingly, Dr. Guskiewicz testified on cross-examination [Pet. Ex. 2, 131-132] that although there can be legitimate and illegitimate explanations for aberrant urine drug screens, “most are legitimate”.
As Dr. Mubang testified at the hearing, “many point-of-care screens for “opiates” do not reliably detect any opioid other than codeine and morphine, or may not report if levels are below a certain threshold. Therefore, they may give false negative results for semisynthetic and synthetic oil opioid analgesics.” [Resp. Ex. 6, page 61]

Dr. Mubang ordered urine drugs screens for Patient WB on only two dates during the charged time period. The first, on November 10, 2009 [J4, WB:000158-000159] was not the typical presumptive immunoassay used in Dr. Mubang’s clinic. Rather, it was run by HPLC-MS/MS (liquid chromatography–mass spectrometry) at American Clinical Solutions. Collateral documentation [J4, WB:000043] by Missy Alexander demonstrates WB left Dr. Mubang’s office on November 10, 2009 after his urine sample was collected. The American Clinical Solutions report shows the sample was collected by “MA” and submitted to the lab for testing. It tested “positive” for cocaine, however it is unclear if this report was communicated to Dr. Mubang prior to the next visit. Missy Alexander’s note for November 17, 2009 [J4, WB:000043] shows WB returned to the clinic for treatment. He was seen by Dr. Mubang [J4, WB:000060] confirms WB was seen in the office, but no prescriptions were issued to him.
The second relevant UDS was obtained when WB returned to the clinic on February 9, 2010. This presumptive immunoassay demonstrated no illicit substances.

**Physical Examination**

11. Respondent takes exception with RO ¶ 125, 153, 192, 213, 266, 273c and 274 which conclude Respondent failed to obtain sufficient medical histories and perform adequate physical examinations before prescribing controlled substances. This conclusion ignores the unrebutted testimony of Respondent, as well as the medical records and other evidence in the case. Specifically, RO ¶ 74, 80, 81, and 96 recognize that "what constitutes a physical examination for pain is not well-defined . . . The exact components of the examination are left to the judgment of the clinician who is expected to have performed an examination proportionate to the diagnosis that justifies a treatment."

Dr. Mubang testified that he performed a physical examination of each patient on each office visit. The initial examination was broad, while the follow-up examinations were focal (RO ¶ 80). Each physical examination included a review of the patient’s neurological status and Dr. Mubang further testified that his practice was to observe patients in his waiting room, and watch each patient as they came into the examination room to identify gait abnormalities, guarding and posture (RO ¶ 81). Like many physicians, Respondent used a templated form to document his
patient encounters. These forms demonstrated and confirmed Respondent’s hearing testimony that he performed a physical examination at each office visit.

**Record Keeping**

12. Respondent takes exception to the conclusions that his records were not sufficient (RO ¶¶ 125, 153, 192, 213, 237, 238, 239, 240, 241 242 and 276. Even Petitioner’s expert admitted that, while he is anal compulsive, the standard for record keeping does not require a physician to be anal compulsive. Dr. Guskiewicz testified that some things do not need to be documented in the medical record “because they’re intuitive”. [Pet. Ex. 2 108:5-15].

**Patient A.M.**

Patient AM had previously been treated at Plant City Polyclinic [J1, AM:000104-000107] and her prescription drug profile from Northdale Pharmacy [J1, AM:000113-000114] demonstrated she was not opiate-naive.

Dr. Mubang’s medical records included Patient AM’s medical history and physical examination; diagnostic, therapeutic and laboratory results; evaluations and consultations; identified the treatment objective; evidenced discussion of the risks and benefits of the treatment ordered; documented the treatments and medications ordered; and included instructions and agreements regarding pain management.

Dr. Mubang made referrals to consulting physicians including Dr. Goldsmith (orthopedic) and physical therapy (Select Physical Therapy). [J1, AM:000121]
Dr. Mubang obtained a prescription history from Fast and Friendly Pharmacy which confirmed patient AM filled a prescription for 240 oxycodone 30 mg tablets on November 27, 2009, the month before she first came to Dr. Mubang’s office. [Trans. 151:10-17]. Dr. Mubang also obtained a pharmacy prescription profile for Patient AM from Northdale Pharmacy which further established Patient AM was not opiate naïve. [Cf. AC ¶18].

Dr. Mubang’s prescribing for Patient AM was not inappropriate or excessive given her prior treatment regimen. Dr. Mubang documented his justification for the course of treatment in his testimony and progress notes.

At each follow-up visit Patient AM completed a Brief Pain Inventory which described her pain symptoms since the last visit. Additionally, Patient AM completed an anxiety assessment form on each visit. Dr. Mubang completed on each visit a progress note containing his own assessment of pain/tenderness on the form’s Visual Analog Scale. Each of those forms identifies a treatment plan to restore normal range of motion; documents discussions with the patient regarding the medications prescribed and confirms no evidence of diversion, addiction, abuse or allergy. [J1, AM:000141, for example; and Trans. 167:19-24].
Patient B.B.

Patient BB presented to Dr. Mubang with a history of cervical spinal fusion with a bone graft from her left posterior iliac crest. She complained of marked lumbar pain with radiculopathy.

Dr. Mubang’s Initial Evaluation of Patient B.B. [J2, BB:000066-000069] documents a thorough review of systems including skin, HEENT (head, eyes, ears, nose and throat), neurological, and musculoskeletal. Simultaneously, Dr. Mubang and the patient completed a Pain Questionnaire [J2, BB:000070-000075] which documented the location and severity of B.B.’s pain and other treatment modalities which had been tried, but failed (surgery, braces, chiropractic, physical therapy, TENS and massage).

Dr. Mubang made referrals to consulting physicians including an orthopedic consult to evaluate and treat low back pain issued March 25, 2010 [J2, BB:000024] and a referral for physical therapy to evaluate and treat low back pain on the same date. [J2, BB:000025]. Dr. Mubang provided this patient with exercises to stretch her back [J2, BB:000026-000029]. Patient BB was terminated from Respondent’s practice when she failed to comply with his request for an updated MRI.

Dr. Mubang’s medical records included Patient BB’s medical history and physical examination; diagnostic, therapeutic and laboratory results; evaluations and consultations; identified the treatment objective; evidenced discussion of the risks
and benefits of the treatment ordered; documented the treatments and medications ordered; and included instructions and agreements regarding pain management.

The February 18, 2009 MRI documented complaints of cervical spine and right arm pain with tingling in hands and headaches status post motor vehicle accident. BB had a prior cervical fusion at C4-5 and C5-6 in 2003. [J2, BB:000052-000053]

The Super Saver pharmacy profile [J2, BB:000037-000038] confirm this patient was receiving in the same quantities and combination of medications from prior physician Ibem R. Borges M.D.

Dr. Mubang’s prescribing for Patient BB was not inappropriate or excessive given her prior treatment regimen. Dr. Mubang documented his justification for the course of treatment in his testimony and progress notes.

At each follow-up visit Patient BB completed a Brief Pain Inventory which described her pain symptoms since the last visit. Additionally, Patient BB completed an anxiety assessment form on each visit. Dr. Mubang completed on each visit a progress note containing his own assessment of pain/tenderness on the form’s visual Analog Scale. Each of those forms identifies the treatment plan to restore normal range of motion; discussions with the patient regarding the medications prescribed and confirms no evidence of diversion, addiction, abuse or allergy.
Patient C.C.

CC was a disabled, white female formerly employed by USAA insurance. [J3, CC:000072]. Upon her initial presentation to Dr. Mubang's practice on April 29, 2010, she received an orthopedic referral related to low back pain with radiculopathy [J3, CC:000077], a referral to physical therapy for low back pain with radiculopathy [J3, CC:000078] and an exercise regimen for lower back pain [J3, CC:000079-000082].

On April 29, 2010, patient CC completed a Patient Consent Form For Opioid Use [J3, CC:000007], Treatment Attestation for Pain Management [J3, CC:000008], a Controlled Substances Agreement [J3, CC:000009-00011], and confirmation that patient understood the potential side effects of Soma [J3, CC:000014] and Xanax [J3, CC:000013].

Dr. Mubang's Initial Evaluation on April 29, 2010 documents a patient history of motor vehicle accident resulting in L5-S1 spinal stenosis and disc bulging at L4-5 and L5-S1. [J3, CC:000151-000154]. A Pain Questionnaire [J3, CC:000154-000162] documents constant stabbing and throbbing pain characterized as "4" (at best) and "9" (at worst). Numerous treatment modalities were ineffective, including nerve blocks, casts or braces, physical therapy and home exercises.
Dr. Mubang’s records include a pharmacy profile from Fast and Friendly Pharmacy for the six months prior to CC’s initial presentation to Dr. Mubang’s office on April 29, 2010 [J3, CC:0000111].

MRI reports from Rose Radiology, both within and outside of the charged time period, are reported to show disc desiccation with central broad-based disc protrusion at L5-S1 effacing the thecal sac [J3, CC:000130-000145]. The findings of Rose Radiology were independently reviewed and confirmed by F. Reed Murtaugh, M.D. [J3, CC:000147-000148].

Dr. Mubang’s medical records included Patient CC’s medical history and physical examination; diagnostic, therapeutic and laboratory results; evaluations and consultations; identified the treatment objective; evidenced discussion of the risks and benefits of the treatment ordered; documented the treatments and medications ordered; and included instructions and agreements regarding pain management.

Patient CC consistently presented with complaints of low back pain with radiculopathy [J3, CC:000320-000324]. As early as March 2007 patient CC was advised by Marc Weinstein, MD, that she needed pain management and referred her to Dr. Sidhom [J3, CC:000261-000262].

**Patient W.B.**

Patient WB was a 52-year-old male complaining of back and shoulder pain related to having been hit by a car while riding his bicycle [J4, WB:000027 and
WB:000191]. WB reported excruciating pain [J4, WB:000038]. He initially presented to Dr. Mubang on December 13, 2008.

Dr. Mubang performed an Initial Evaluation which demonstrated results consistent with the records from Physician’s Health Group. WB had positive results at 30 degrees on straight leg raising; limped on his right foot; and limited range of motion [J4, WB:000027-000030]. Along with the Initial Evaluation, Dr. Mubang and the patient completed a Pain Questionnaire [J4, WB:000031-000036] which documented a pain score of “7” (at best) and “10” (at worst); the pain was characterized as constant, throbbing, shooting and aching.

Dr. Mubang timely obtained prior treatment records from Physicians Health Group [J4, WB:000174-000190]. Dr. Mubang made referrals to a neurologist [J4, WB:000173], a CT scan of brain without contrast [J4, WB:000168], orthopedics and physical therapy [J4, WB:000144].

The MRIs confirmed broad-based disc protrusions at C3-4 and C5-6. [J4, WB:000140]. Dr. Mubang consistently diagnosed WB with cervical pain secondary to broad disc bulging; cervical disc protrusion at C3-4; cervical radiculopathy; and anxiety disorder [J4, WB:000193-WB:000209].

At each follow-up visit Patient WB completed a Brief Pain Inventory which described his pain symptoms since the last visit. Additionally, Patient WB completed an anxiety assessment form on each visit. Dr. Mubang completed on each visit a
progress note containing his own assessment of pain/tenderness on the form’s Visual Analog Scale. Each of those forms identifies a treatment plan to restore normal range of motion; discussions with the patient regarding the medications prescribed and confirms no evidence of diversion, addiction, abuse or allergy. [J4, WB:000138-WB:000139 for example].

Dr. Mubang’s medical records included Patient WB’s medical history and physical examination; diagnostic, therapeutic and laboratory results; evaluations and consultations; identified the treatment objective; evidenced discussion of the risks and benefits of the treatment ordered; documented the treatments and medications ordered; and included instructions and agreements regarding pain management.

Patient M.H.

Patient MH was a 29-year-old female who initially presented to Dr. Mubang January 10, 2005 status post motor vehicle accident with a lumbar disc herniation at L4-5 [J5, MH:000323]. Patient MH treated consistently with Dr. Mubang through August 23, 2010 [J5 MH: 000255]. Dr. Mubang obtained records from MH’s prior treating physicians. Dr. Mubang referred the patient for consultation with a neuropsychiatrist, called that physician to make the appointment which was confirmed for April 18, 2005. Patient MH was also referred by Dr. Mubang to an orthopedic physician on May 18, 2009. Dr. Mubang requested numerous diagnostic
studies including a CT scan of her head and a lumbar MRI July 26, 2004. Dr. Mubang referred her for physical therapy 9/21/2009.

Patient MH had an MRI read by William Foxworthy, M.D., which reported “Central and left paracentral disc herniation at L4-5 causing mass effect on the thecal sac.” [J5, MH:000206-000207].

Dr. Mubang issued patient MH an orthopedic referral to evaluate patients lumbosacral pain with radiculopathy [J5, MH:000225 and MH:000210], and based on an incidental finding referred patient MH for evaluation of a left upper outer quadrant mass of the breast [J5, MH:000230]. See also [J5, MH:000233-000236].

Dr. Mubang did an Initial Evaluation of MH on January 6, 2009 [J5, MH:000075-000078] documenting his physical examination, diagnoses and the patient’s reported pain level. Patient MH’s Pain Questionnaire from January 6, 2009 simultaneously reflects she is in pain continuously, which she rated between “5” (at best) and “9” (at worst) [J5, MH:00079]. Chiropractic care, massage and home exercise were ineffective in the relief of her pain.

Dr. Mubang’s medical records include Patient MH’s medical history and physical examination; diagnostic, therapeutic and laboratory results; evaluations and consultations; identified the treatment objective; evidenced discussion of the risks and benefits of the treatment ordered; documented the treatments and medications ordered; and included instructions and agreements regarding pain management.
Patient B.D.

Patient BD presented to Dr. Mubang’s practice on November 11, 2010 with a history of cervical and lumbar pain. Dr. Mubang obtained BD’s prior treatment records, including an MRI which demonstrated, among other things, an L5-S1 disc protrusion. [J7, BD:000076]. The records also demonstrated a longstanding treatment history following a motor vehicle accident in 2006.

Dr. Mubang had some exposure to Patient BD at another clinic. Her treatment records demonstrate she had been treated with opioid analgesics for many years and she was far from opiate-naïve. The Trinity Pharmacy prescription profile [J7, BD:0000340] establishes BD was prescribed by other physicians the equivalent of 200 oxycodone 30mg doses per month as early as September 2007 and continued for at least a year.

Dr. Mubang changed BD’s medication regimen and introduced low dose methadone. This, according to Dr. Simopoulos, was a reasonable and appropriate response to building oxycodone tolerance. Dr. Mubang also reduced the amount of oxycodone from 210 30mg doses per month to 180 doses. Eventually, Dr. Mubang changed BD’s prescription from oxycodone to dilaudid (120 doses 8mg) [J7, Additional BD: 000023].

Only one page of records in BD’s chart refers to a diagnosis of fibromyalgia [J&, BD:000082], a single page form a multi-page report (from an unidentified.
physician) dated May 29, 2007. Contrary to Dr. Guskiewicz’s opinion, Dr. Mubang was not treating BD for fibromyalgia [Pet. Ex. 2, 49:24-50:2]. The records clearly establish Dr. Mubang’s diagnosis was L5-S1 disc protrusion with myofascial pain and spasm [J7, BD:000094].

Based upon BD’s unremarkable multi-year drug treatment regimen (including a combination of benzodiazepines with opiates), the risk of respiratory depression was significantly reduced. [Resp. Ex. 1, 186:13-187:21]

Dr. Mubang’s medical records include Patient BD’s medical history and physical examination; diagnostic, therapeutic and laboratory results; evaluations and consultations; identified the treatment objective; evidenced discussion of the risks and benefits of the treatment ordered; documented the treatments and medications ordered; and included instructions and agreements regarding pain management.

**Conclusions of Law**

13. Respondent takes exception to RO ¶ 275 finding Petitioner proved by clear and convincing evidence that Respondent violated section 458.331(1)(t) by committing medical malpractice in his treatment of all six patients.

"[T]he revocation of a professional license is of sufficient gravity and magnitude to warrant a standard of proof greater than a mere preponderance of the evidence. ... In case where the proceedings implicate the loss of livelihood, an elevated standard is necessary to protect the rights and interests of the

Fears of investigation or sanction by federal, state, and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Physicians should not fear disciplinary action from the Board or other state regulatory or enforcement agencies for prescribing, dispensing, or administering controlled substances including opioid analgesics, for a legitimate medical purpose and that is supported by appropriate documentation establishing a valid medical need and treatment plan. *64B8-9.013(1)(b)* (2003)

Each case of prescribing for pain will be evaluated on an individual basis. The Board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these standards, if good cause is shown for such deviation. The physician’s conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient’s individual needs including any improvement in functioning, and recognizing that some types of pain cannot be completely relieved. *64B8-9.013(1)(f)* (2003)

The Board will judge the validity of prescribing based on the physician’s treatment of the patient and on available documentation, rather than on the quantity
and chronicity of prescribing. The goal is to control the patient’s pain for its duration while effectively addressing other aspects of the patient’s functioning, including physical, psychological, social, and work-related factors. 64B8-9.013(1)(g) (2003)

In this case the evidence presented by Petitioner was insufficient to support a finding of repeated medical malpractice.

**Recommendation**

14. Respondent takes exception with the recommendation for revocation of his license. Dr. Mubang has practiced medicine for 30 years without sanction. For the reasons stated in the foregoing exceptions, Respondent urges the Board to reject the ALJ’s recommendation and impose a period of probation with reasonable conditions of continued practice.

Respectfully Submitted,

SISCO-LAW

[Signature]

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by electronic mail to the following recipients on July 10, 2019.

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[Signature]
Attorney
DEPARTMENT OF HEALTH,

Petitioner,

v.

DOAH CASE NOS.: 18-0528PL
18-0606PL

DOH CASE NOS.: 2013-12846
2010-12384

JOHN NKOLO MUBANG, M.D.,

Respondent.

PETITIONER’S RESPONSE TO RESPONDENT’S EXCEPTIONS TO THE RECOMMENDED ORDER

Petitioner, Department of Health ("Department"), pursuant to Rule 28-106.217(3), Florida Administrative Code, hereby files this Response to Respondent’s Exceptions to the Recommended Order. In support thereof, Petitioner states the following:

I. BACKGROUND

1. Respondent, John Nkolo Mubang, M.D., is a licensed physician in the state of Florida, having been issued license number ME 55171.

2. A formal administrative hearing of the instant matter was held December 18 and 19, 2018, in Tampa, Florida.
3. The administrative hearing was held to determine whether Respondent violated portions of chapter 458, Florida Statutes, as alleged in the Administrative Complaints filed by Petitioner against Respondent.

4. On June 25, 2019, the presiding Administrative Law Judge ("ALJ") entered his Recommended Order. The ALJ found that Petitioner proved by clear and convincing evidence that Respondent violated sections 458.331(1)(nn), 458.331(1)(q), 458.331(1)(t), 458.331(1)(m), and 458.331(1)(cc), Florida Statutes, as charged in the Administrative Complaints. The ALJ recommended that the Board of Medicine ("Board") enter a final order revoking Respondent’s medical license.

5. On June 27, 2019, Respondent filed a motion with the Board requesting an extension of time to file exceptions to the Recommended Order. Petitioner filed a response in opposition to Respondent’s motion. The Board did not rule on Respondent’s motion.

6. On July 10, 2019, Respondent filed exceptions to the Recommended Order with the Board.

II. APPLICABLE STANDARD OF REVIEW

7. The ALJ and the Board have distinct roles in formal administrative hearings. It is the function of the ALJ to consider all of the
evidence presented, resolve conflicts in the evidence, assess the credibility of witnesses, draw permissible inferences from the evidence, and complete a recommended order consisting of findings of fact, conclusions of law, and a recommended penalty. See, e.g., § 120.57(1)(k), Fla. Stat (2019); Heifetz v. Dep't. of Bus. Regulation, 475 So. 2d 1277, 1281 (Fla. 1st DCA 1985) (citing State Beverage Dep't v. Ernal, Inc., 115 So. 2d 566 (Fla. 3d DCA 1959)); Goss v. District Sch. Bd. of St. John's Cty., 601 So. 2d 1232, 1234 (Fla. 5th DCA 1992); and Bejarano v. Dep't of Educ., Div. of Vocational Rehab., 901 So. 2d 891, 892 (Fla. 4th DCA 2005). If the evidence presented supports two inconsistent findings, it is the ALJ's role to decide the issue one way or the other. Heifetz, 475 So. 2d at 1281.

8. Parties may file exceptions to findings of fact and conclusions of law contained within the ALJ's recommended order. § 120.57(1)(k), Fla. Stat. (2019). Exceptions shall identify the disputed portion of the recommended order by page number or paragraph, shall identify the legal basis for the exception, and shall include any appropriate and specific citations to the record. § 120.57(1)(k); Fla. Admin. Code R. 28-106.217(1) (2019).

9. The Board cannot reject or modify the ALJ's findings of fact unless it first determines from a review of the entire record, and states with
particularity in the order, that the findings of fact were not based on competent substantial evidence or that the proceedings on which the findings were based did not comply with essential requirements of law. § 120.57(1)(l), Fla. Stat. (2019).

10. Competent evidence is evidence sufficiently relevant and material to the ultimate determination “that a reasonable mind would accept it as adequate to support the conclusion reached.” City of Hialeah Gardens v. Miami Dade Charter Found., 857 So. 2d 202, 204 (Fla. 3rd DCA 2003) (citing DeGroot v. Sheffield, 95 So. 2d 912, 916 (Fla. 1957)). Substantial evidence is evidence that provides a factual basis from which a fact at issue may reasonably be inferred. Id.

11. The Board may only reject or modify an ALJ’s conclusions of law and interpretations of administrative rules if the Board has substantive jurisdiction. See, e.g., § 120.57(1)(l), Fla. Stat. (2019); Barfield v. Dep’t of Health, 805 So. 2d 1008 (Fla. 1st DCA 2001); Deep Lagoon Boat Club, Ltd. v. Sheridan, 784 So. 2d 1140 (Fla. 2nd DCA 2001). “Jurisdiction” has been interpreted to mean “administrative authority” or “substantive expertise.” See Deep Lagoon Boat Club, Ltd., 784 So. 2d at 1142.
12. While the ALJ recommends interpretations of law and/or administrative rules, the Board has ultimate discretion over matters of substantive jurisdiction. However, the Board may only reject or modify the ALJ’s conclusions of law if the Board:

   a. states with particularity its reasons for rejecting or modifying such conclusions of law or interpretation of administrative rule; and

   b. makes a finding that the substituted conclusions of law or interpretation of administrative rule is as reasonable or more reasonable than that which was rejected.

§ 120.57(1)(l), Fla. Stat: (2019); Barfield, 805 So: 2d at 1011.

III. PETITIONER’S RESPONSE TO RESPONDENT’S EXCEPTIONS

First Exception: Preliminary Statement

13. Respondent takes exception to the ALJ’s preliminary statement “to the extent it suggests that Respondent was responsible in any way for the more than five and a half year delay in prosecution of this action.”

14. Respondent failed to cite any specific paragraph or page where the ALJ made such a finding.

15. The preliminary statement is simply a recitation of the procedural history of this case.

17. Should the Board consider the preliminary statement to be a finding of fact, the docket in this matter speaks for itself and is competent substantial evidence to support the preliminary statement.

18. Petitioner respectfully requests that the Board deny Respondent’s exception to the preliminary statement for failing to comply with rule 28-106.217(1), and/or because there is competent substantial evidence to support the ALJ’s preliminary statement.

Second Exception: Paragraph 17

19. Respondent takes exception to paragraph 17 of the Recommended Order “to the extent that it suggests Dr. Mubang’s training in pain management was insufficient.”

20. Respondent failed to comply with rule 28-106.217(1), by failing to include any citations to the record to support his exception.

21. The Recommended Order at paragraph 17 states that Respondent had “limited formal training or education in pain management.”
22. The finding is supported by competent substantial evidence. Respondent's deposition testimony regarding his training in pain management supports the finding in paragraph 17. P. Exh. 5, pp. 13-17.

23. Petitioner respectfully requests that the Board deny Respondent's exception to paragraph 17 for failing to comply with rule 28-106.217(1), and/or because there is competent substantial evidence to support the finding.

Third Exception: Paragraphs 22 and 23

24. Respondent takes exception to paragraphs 22 and 23 of the Recommended Order related to Petitioner's expert witness Dr. Robert Guskievicz's qualifications and Dr. Guskievicz's definition of the standard of care.

25. The findings of fact in paragraph 22 regarding Dr. Guskievicz's qualifications are supported by Dr. Guskievicz's testimony and curriculum vitae. P. Exh. 1, p. 7-9, 16-17, 93; P. Exh. 2.

26. The finding of fact in paragraph 23 regarding Dr. Guskievicz's definition of the standard of care comes directly from Dr. Guskievicz's testimony. P. Exh. 1, p. 17.
27. Petitioner respectfully requests that the Board deny Respondent’s exception to paragraphs 22 and 23 because there is competent substantial evidence to support the findings.

**Fourth Exception: Paragraphs 46-54**

28. Respondent takes exception to paragraphs 46 through 54 of the Recommended Order related to the ALJ’s finding that Petitioner’s expert Dr. Guskiewicz’s testimony was entitled to greater weight than Respondent’s expert witness Dr. Thomas Simopoulos’s testimony.

29. The findings of fact in paragraphs 46-52 and 54 come directly from Dr. Simopoulos’s testimony and are, thus, supported by competent substantial evidence. R. Exh. 1, pp. 7, 10-11, 15, 17-18, 44-47, 156-157, 190-191.

30. In paragraph 53, the ALJ determined that Dr. Guskiewicz’s testimony was entitled greater weight in this proceeding than Dr. Simopoulos’s testimony due to the information Dr. Simopoulos, a physician in Massachusetts, relied on in forming his opinion about the regional standard of care in Florida.
31. It is the role of the ALJ, not the Board, to consider all of the evidence presented, resolve conflicts in the evidence, and assess the credibility of witnesses. *Heifetz*, 475 So. 2d at 1281.

32. The Board is not permitted to reweigh the evidence. *Rogers v. Dep't of Health*, 920 So. 2d 27, 30 (Fla. 1st DCA 2005) (citing to *Aldrete v. Dep't of Health, Bd. of Med.*, 879 So. 2d 1244, 1246 (Fla. 1st DCA 2004)).

33. Respondent’s exception to paragraphs 46 through 54 asks the Board to reweigh the testimony of the expert witnesses.

34. Petitioner respectfully requests that the Board deny Respondent’s exception to paragraphs 46 through 54, because the standard of review does not permit the Board to determine the weight of evidence, and/or because there is competent substantial evidence to support the ALJ’s findings of fact.

**Fifth Exception: Paragraph 69**

35. Respondent takes exception to paragraph 69 of the Recommended Order which states that carisoprodol, brand name Soma, is a Schedule IV controlled substance.

36. Respondent failed to comply with rule 28-106.217(1), by failing to include any citations to the record to support his exception.
37. Respondent cites the Federal Register as evidence that carisoprodol was not a controlled substance until January 11, 2012.

38. Respondent failed to consider that carisoprodol was listed as a controlled substance under Florida law prior to being a federally controlled substance.

39. As noted in Petitioner's Proposed Recommended Order, Carisoprodol has been listed as a Schedule IV controlled substance in section 893.03, Florida Statues, since 2005. See, Petitioner's Proposed Recommended Order, p. 11.

40. Petitioner respectfully requests that the Board deny Respondent's exception to paragraph 69 because Respondent failed to comply with rule 28-106.217(1), and/or because there is competent substantial evidence to support the finding.

**Sixth Exception: Paragraph 89**

41. Respondent takes exception to paragraph 89 of the Recommended Order "to the extent the ALJ fails to acknowledge that each of these patients had attempted alternative treatment modalities."

42. Respondent failed to comply with rule 28-106.217(1), by failing to include any citations to the record to support his exception.
43. Paragraph 89 describes the format of Respondent's medical records in general and makes no findings regarding alternative treatment modalities attempted or not attempted by any patient.

44. The description of Respondent's records in paragraph 89 is supported by Respondent's medical records entered into evidence. See, e.g., J. Exh. 2, pp. 79, 82, 88, 121-125.

45. Petitioner respectfully requests that the Board deny Respondent's exception to paragraph 89 for failing to comply with rule 28-106.217(1), and/or because there is competent substantial evidence to support the finding.

Seventh Exception: Paragraphs 98, 99, 100, 119, 120, 130, 138, 139, 140, 150, 168, 169, 204, 205, and 227

46. Respondent takes exception to paragraphs 98, 99, 100, 119, 120, 130, 138, 139, 140, 150, 168, 169, 204, 205, and 227 on the basis that the paragraphs do not consider rule 64B8-9.013; titled "Standards for the Use of Controlled Substances for the Treatment of Pain" and do not consider select testimony from Respondent.

47. Paragraphs 98, 99, 119, 120, 138, 139, 140, 168, 169, 204, 205, and 227 purely provide a factual account of Respondent's prescribing of
controlled substances to the patients in this matter. The paragraphs do not make any judgments or conclusion as to the appropriateness of Respondent's prescribing. For example, paragraphs 98 and 99 state:

98. From December 22, 2009, to August 27, 2010, Dr. Mubang prescribed 270 30 mg tablets of oxycodone in combination with 120 10 mg tablets of methadone to Patient A.M. monthly. In ten months, Patient A.M. received 3,870 pain pills from Dr. Mubang.

99. In order to take the pain medication as prescribed, Patient A.M. would have to take 13 pain pills per day.

Recommended Order, p. 24.

48. The ALJ's factual presentation of Respondent's prescribing is supported by the evidence received. Tr., p. 402; P. Exh. 1, p. 29, 76; J. Exh. 3, pp. 109-110, 324; J. Exh. 5, p. 25; R. Exh. 1, pp. 27-28; R. Exh. 7 for A.M., B.B., C.C., W.B., M.H., and B.D.

49. Paragraph 100 identifies the highest amount of 30 mg oxycodone prescribed by the two experts in this case. That fact is supported by the experts' testimony. R. Exh. 1, pp. 27-28; P. Exh. 1, p. 29.

50. In paragraph 130, the ALJ summarizes Respondent's argument regarding rule 64B8-9.013. This paragraph demonstrates that the ALJ considered Respondent's argument when crafting his opinion. The finding
that Respondent made the argument is supported by Respondent's Proposed Recommended Order at pages 12-14 and 24.

51. Paragraph 150 concerns a drug test result for Patient C.C. in addition to medication prescribed. Paragraph 150 is supported by Respondent's medical records. J. Exh. 3, pp. 109-110, 324; R. Exh. 7 for C.C.

52. Petitioner respectfully requests that the Board deny Respondent's exceptions to the findings of fact in paragraphs 98, 99, 119, 120, 138, 139, 140, 168, 169, 204, 205, and 227, because each are supported by competent substantial evidence.

**Eighth Exception: Paragraph 273(f)**

53. Respondent takes exception to the conclusion of law in paragraph 273(f); but Respondent does so as if he was taking exception to a finding of fact. Specifically, Respondent argues that the conclusion of law in paragraph 273(f), is inconsistent with the findings of fact in paragraphs 75, 85, 86, and 147. Respondent cites testimony from his expert as to the standard of care for the use of urine drug screens as the basis for the exception.
54. Paragraph 273 is merely a summary of the medical malpractice allegations in the Administrative Complaints filed against Respondent. Paragraph 273 exists to give context to the other conclusions of law.

55. Paragraph 273(f), specifically, states that Petitioner alleged that Respondent violated section 458.331(1)(t) by failing to meet the standard of care by failing to address aberrant urine drug screen results for Patients A.M., W.B., and B.D.

56. To the extent that the summary in paragraph 273(f) is a finding of fact and not a conclusion of law, Petitioner respectfully requests that the Board deny Respondent’s exception because paragraph 273(f) is supported by competent substantial evidence, i.e., the Administrative Complaints filed in this matter. Administrative Complaint, case no. 2010-12384 at pp. 24-26, 43-45; Administrative Complaint, case no. 2013-12846 at pp. 5-6.

57. To the extent that paragraph 273(f) is a conclusion of law, Petitioner respectfully requests that the Board deny Respondent’s exception to paragraph 273(f) because Respondent has not provided any conclusion that would be as or more reasonable than the ALJ’s.
Ninth Exception: Paragraphs 125, 153, 192, 213, 266, 273(c), and 274

58. Respondent takes exception to the findings of fact in paragraphs 125, 153, 192, and 213 and to the conclusions of law in paragraphs 266, 273(c), and 274, which find and conclude that Respondent failed to obtain adequate medical histories and perform adequate physical examinations to justify his prescribing of controlled substances in this matter.

59. The findings of fact in paragraphs 125, 153, 192, and 213 are supported by the competent, substantial testimony of Petitioner's expert. P. Exh. 1, pp. 46-47, 65-66, 68, 70-71, 82.

60. Because the findings of fact in paragraphs 125, 153, 192, and 213 are supported by competent substantial evidence, Petitioner urges the Board to deny Respondent's exception to those paragraphs.

61. Paragraph 266 cites a prior Division of Administrative Hearings decision for the proposition that the Board's use of the word "should" in rule 64B8-9.013 prior to October 17, 2010, does not alter the identification of the standard of care in this matter.

62. Respondent provided no alternative conclusion of law that would be as or more reasonable than the ALJ's in paragraph 266.
63. Paragraph 273 is a summary of the medical malpractice allegations in the Administrative Complaints. The summary in paragraph 273(c) is supported by the Administrative Complaints in this matter. Administrative Complaint, case no. 2010-12384 at pp. 24-27, 31-33, 37-39, 43-46, 51-53; Administrative Complaint, case no. 2013-12846 at pp. 5-6.

64. Respondent provided no alternative conclusion of law that would be as or more reasonable than the ALJ’s in paragraph 273(c).

65. The conclusion of law in paragraph 274 flows from the findings of fact. Paragraph 274 states:

274. As detailed in the Findings of Fact, Petitioner proved, by clear and convincing evidence, Dr. Mubang failed to perform adequate physical examinations and failed to obtain complete histories for all six patients that justified his prescribing of controlled substances. Petitioner also proved that the doctor failed to diagnose the patients with intractable pain.

Recommended Order, p. 65.

66. Respondent appears to offer the alternative conclusion that Respondent performed adequate physical examinations.

67. To reach Respondent’s proposed conclusion, the Board would have to reweigh the evidence that supports the findings of fact in paragraphs 125, 153, 192, and 213.
68. The Board is not permitted to reweigh evidence, as such, based on the findings of fact, Respondent’s alternative conclusion is not as or more reasonable.

69. Petitioner respectfully requests that the Board deny Respondent’s exceptions to paragraph 266, 273(c), and 274 because Respondent has not provided any conclusion that would be as or more reasonable than the ALJ’s.

Tenth Exception: Paragraphs 125, 153, 192, 213, 237-242, and 276

70. Respondent takes exception to the findings of fact in paragraphs 125, 153, 192, 213, and 237-242 and to the conclusions of law in paragraph 276, which find and conclude that Respondent failed to keep legible medical records that justified his prescribing of controlled substances in this matter.

71. The findings of fact in paragraphs 125, 153, 192, 213, and 237-242 are supported by competent substantial evidence:

72. Respondent’s records were devoid of rationale for his prescribing. Notably, Respondent’s own expert testified “there's not much rationale on the plans in -- in Dr. Mubang's notes in general.” R. Exh. 1, p. 147.

74. Because the findings of fact in paragraphs 125, 153, 192, and 213 are supported by competent substantial evidence, Petitioner urges the Board to deny Respondent's exception to those paragraphs.

75. The conclusion of law in paragraph 276 is the logical culmination of the findings of fact. Paragraph 276 states:

276. In both cases, Petitioner alleged that Dr. Mubang violated section 458.331(1)(m) by failing to keep legible medical records that justified his course of treatment for all six patients. As detailed in the Findings of Fact, the doctor's medical records for all six patients were inadequate in varying degrees and frequently illegible. Therefore, Petitioner has proved, by clear and convincing evidence, that he violated section 458.331(1)(m), for all six patients.

Recommended Order, p. 66.
76. Respondent appears to offer the alternative conclusion that Respondent's medical records were adequate.

77. To reach Respondent's proposed conclusion, the Board would have to reweigh the evidence that supported the findings of fact in paragraphs 125, 153, 192, 213, and 237-242.

78. The Board is not permitted to reweigh evidence. Given the ALJ's findings of fact, Respondent's alternative conclusion is not as or more reasonable.

79. Petitioner respectfully requests that the Board deny Respondent's exception to paragraph 276; because Respondent has not provided any conclusion that would be as or more reasonable than the ALJ's.

Eleventh Exception: Paragraph 275

80. Respondent takes exception to paragraph 275 of the Recommended Order wherein the ALJ found that, "Petitioner proved, by clear and convincing evidence, that the doctor violated section 458.331(1)(t) by committing medical malpractice in his treatment of all six patients."

81. In support of his exception, Respondent largely cites rule 64B8-9.013. Respondent argues that the evidence in this case was insufficient to support a finding of repeated medical malpractice.
82. As stated previously, the ALJ considered Respondent's argument regarding rule 64B8-9.013 in paragraph 130 of the Recommended Order. Based on his findings and recommendation, the ALJ did not find Respondent's argument persuasive.

83. Respondent's argument regarding rule 64B8-9.013 is flawed because in a licensure disciplinary action, Petitioner can take action to protect the public from negligent medical practice that has the potential for harm, even if by happenstance the patient(s) avoid actual injury. Britt v. Dep't of Prof'l Regulation, 492 So. 2d 697, 698-99 (Fla. 1st DCA 1986), disapproved on other grounds by Dep't of Prof'l Regulation v. Bernal, 531 So. 2d 967 (Fla. 1988); see also, Major v. Dep't of Prof'l Regulation, Bd. Of Med., 531 So. 2d 411, 413 (Fla. 3rd DCA 1988) (noting "[t]he fact that no patient harm occurred was fortuitous.").

84. The Board should not interpret rule 64B8-9.013 to condone the excessive prescribing detailed in the findings of facts of this case, simply because Respondent's patients avoided actual injury by happenstance, or because evidence of actual harm was not uncovered.

85. As the ALJ concluded in paragraph 277:

In this case, evidence was not offered by either party to show the outcome of [Respondent's] treatment of the six patients that
are the subject of the two Administrative Complaints. Regardless, the over-prescribing of controlled substances, poor record-keeping, lack of thorough intake for the subject patients, and failure to diagnose intractable pain created a substantial likelihood of harm or addiction occurring to each of the patients over time. Moreover, based on the multiple, negative drug screen results for medications Respondent prescribed in this cause, some of the lack of patient harm can be attributed to the patients not even taking the medications as prescribed, but perhaps diverting the medications to others.

Recommended Order, p. 66-67.

86. Based on the foregoing, Petitioner respectfully requests that the Board deny Respondent’s exception to paragraph 275 because Respondent has not provided any conclusion that would be as or more reasonable than the ALJ’s.

Twelfth Exception: Recommendation

87. Respondent takes exception to the ALJ’s recommendation of revocation.

88. The state of Florida cannot continue to license a physician who commits repeated medical malpractice. Art. X, § 26, Fla. Const.

89. In paragraph 284, the ALJ made a specific finding that Respondent committed “repeated medical malpractice,” as defined in section 456.50(1)(h), Florida Statutes.
90. Pursuant to Article X, section 26 of the Florida Constitution and section 458.331(1)(t)3., Florida Statutes, the Board must revoke Respondent’s license to practice medicine.

91. Based on the foregoing, Petitioner respectfully requests the Board deny Respondent’s exception to the ALJ’s recommendation.

IV. CONCLUSION

For the foregoing reasons, Petitioner respectfully requests that the Board deny each of Respondent’s Exceptions.

Respectfully submitted this 16th day of July, 2019.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true copy of the foregoing has been provided via e-mail this 16th day of July 2019, to Respondent’s counsel, Dale Sisco, Esq., 1110 N. Florida Ave., Tampa, FL 33602, at dsisco@sisco-law.com.

Chad Dunn
Chad Dunn
Assistant General Counsel
DEPARTMENT OF HEALTH,

PETITIONER,

v. 

JOHN NKOLO MUBANG, M.D.,

RESPONDENT.

CASE NO. 2010-12384

ADMINISTRATIVE COMPLAINT

Petitioner, Department of Health, by and through its undersigned counsel, files this Administrative Complaint before the Board of Medicine against Respondent, John Nkolo Mubang, M.D., and in support thereof alleges:

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

2. At all times material to this complaint, Respondent was a licensed physician within the State of Florida, having been issued license number 55171.

3. Respondent's address of record is 741 Martin Luther King Boulevard West, Seffner, Florida 33584.
4. During the period May 30, 2006 through August 23, 2010, Respondent treated five patients for intractable pain, they are referred to throughout by their initials, AM, BB, CC, WB and MH; during this time, Respondent prescribed to each of these patients one or more of the following controlled substances as more particularly set out below.

5. Oxycodone is commonly prescribed to treat pain. According to Section 893.03(2), Florida Statutes, oxycodone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of oxycodone may lead to severe psychological or physical dependence.

6. Methadone is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, methadone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of methadone may lead to severe psychological or physical dependence.

7. Roxicodone® is the brand name for oxycodone hydrochloride. According to Section 893.03(2), Florida Statutes, oxycodone is a Schedule
II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States. Abuse of oxycodone may lead to severe psychological or physical dependence.

8. Adderall® is the brand name for a drug that contains amphetamine, commonly prescribed to treat attention deficit disorder. According to Section 893.03(2), Florida Statutes, amphetamine is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States. Abuse of amphetamine may lead to severe psychological or physical dependence.

9. Fentanyl is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, Fentanyl is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States. Abuse of Fentanyl may lead to severe psychological or physical dependence.

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

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

12. Fiorinal® with codeine is the brand name for a drug that contains butalbital and codeine and is commonly prescribed to treat migraine headaches. According to Section 893.03(3), Florida Statutes, butalbital is a Schedule III controlled substance that has a potential for abuse less than the substances in Schedules I and II and has a currently accepted medical use in treatment in the United States. Abuse of butalbital
may lead to moderate or low physical dependence or high psychological
dependence.

13. Codeine is commonly prescribed to treat pain. According to
Section 893.03(2), Florida Statutes, codeine is a Schedule II controlled
substance that has a high potential for abuse and has a currently accepted
but severely restricted medical use in treatment in the United States.
Abuse of codeine may lead to severe psychological or physical dependence.

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

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

16. Soma® is the brand name for carisoprodol, a muscle relaxant commonly prescribed to treat muscular pain. According to Section 893.03(4), Florida Statutes, carisoprodol is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States. Abuse of carisoprodol may lead to limited physical or psychological dependence relative to the substances in Schedule III.


Section 458.326 titled Intractable Pain; Authorized Treatment, provides in part:

(1) For the purposes of this section, the term "intractable pain" means pain for which, in the generally accepted course of medical practice, the cause cannot be removed and otherwise treated.
(2) Intractable pain must be diagnosed by a physician licensed under this chapter and qualified by experience to render such diagnosis.
(3) Notwithstanding any other provision of law, a physician may prescribe or administer any controlled substance under Schedules II-V, as provided for in s.
893.03, to a person for the treatment of intractable pain, provided the physician does so in accordance with that level of care, skill, and treatment recognized by a reasonably prudent physician under similar conditions and circumstances.

Rule 64B8-9.013(3), Florida Administrative Code, provides in pertinent part:

The Board has adopted the following standards for the use of controlled substances for pain control:

(a) Evaluation of the Patient. A complete medical history and physical examination must be conducted and documented in the medical record.

**Facts Specific to AM**

18. Patient AM was a 22 year-old female with a past history of a motor vehicle accident on July 27, 2007 initially presenting with complaints of low back pain, Respondent prescribed methadone, Roxicodone®, and Soma®, for AM, on the dates and in the strengths and quantities described in the following table:

<table>
<thead>
<tr>
<th>Methadone 10 mg.</th>
<th>Roxicodone® 30 mg.</th>
<th>Soma® 350 mg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/22/2009 10 mg. 90 pills</td>
<td>12/22/2009 30 mg. 270 pills</td>
<td>12/22/2009 350 mg. 90 pills</td>
</tr>
<tr>
<td>1/19/2010 10 mg. 90 pills</td>
<td>1/19/2010 30 mg. 270 pills</td>
<td>1/19/2010 350 mg. 90 pills</td>
</tr>
<tr>
<td>2/16/2010 10 mg. 120 pills</td>
<td>2/16/2010 30 mg. 270 pills</td>
<td>2/16/2010 350 mg. 90 pills</td>
</tr>
<tr>
<td>Date</td>
<td>Quantity</td>
<td>Date</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------</td>
<td>------------</td>
</tr>
<tr>
<td>3/16/2010</td>
<td>10 mg, 120 pills</td>
<td>3/16/2010</td>
</tr>
<tr>
<td>4/12/2010</td>
<td>10 mg, 120 pills</td>
<td>4/12/2010</td>
</tr>
<tr>
<td>5/10/2010</td>
<td>10 mg, 120 pills</td>
<td>5/10/2010</td>
</tr>
<tr>
<td>5/24/2010</td>
<td>10 mg, 120 pills</td>
<td>5/24/2010</td>
</tr>
<tr>
<td>7/5/2010</td>
<td>10 mg, 120 pills</td>
<td>7/5/2010</td>
</tr>
<tr>
<td>8/3/2010</td>
<td>10 mg, 120 pills</td>
<td>8/3/2010</td>
</tr>
<tr>
<td>8/27/2010</td>
<td>10 mg, 120 pills</td>
<td>8/27/2010</td>
</tr>
</tbody>
</table>

19. From about December 22, 2009, through about August 27, 2010, Respondent prescribed potentially lethal doses of methadone, Roxicodone®, or Soma®, for AM inappropriately or in excessive or inappropriate quantities without justification and or without documenting justification for the course of treatment.

20. From about August 2, 2010, Respondent did not use the results of the urine screens appropriately or did not appropriately interpret the results, when he failed to address the positive drug result for benzodiazepines, which had not been prescribed, with AM, and continued to prescribe potentially lethal doses of methadone, Roxicodone®, or Soma®, for AM.
21. From about August 2, 2010, Respondent did not use the results of the urine screens appropriately or did not appropriately interpret the results, when he failed to address the negative drug result for methadone, which had been prescribed, with AM, and continued to prescribe potentially lethal doses of methadone, Roxicodone®, or Soma®, for AM.

22. From about December 22, 2009, through about August 27, 2010, Respondent did not perform or did not document a complete or adequate physical examination prior to prescribing potentially lethal doses of methadone, Roxicodone®, or Soma®, for AM.

23. From about December 22, 2009, through about August 27, 2010, Respondent did not obtain or did not document a complete medical history prior to prescribing potentially lethal doses of methadone, Roxicodone®, or Soma®, for AM.

24. From about December 22, 2009, through about August 27, 2010, Respondent did not diagnose AM with intractable pain prior to prescribing potentially lethal doses of methadone, Roxicodone®, or Soma®, for AM.
Facts Specific to BB

25. Patient BB, a 24 year-old female, presented with complaints of pain in her neck, mid back and right knee, subsequent to two motor vehicle accidents and a cervical fusion, a fall precipitated her pain and her initial visit to the Respondent who prescribed Xanax®, oxycodone, and Soma®, for BB, on the dates and in the strengths and quantities described in the following table:

<table>
<thead>
<tr>
<th>Xanax® 2 mg.</th>
<th>Oxycodone 30 mg.</th>
<th>Soma® 350 mg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 mg.</td>
<td>30 mg.</td>
<td>350 mg.</td>
</tr>
<tr>
<td>60 pills</td>
<td>240 pills</td>
<td>120 pills</td>
</tr>
<tr>
<td>2 mg.</td>
<td>30 mg.</td>
<td>350 mg.</td>
</tr>
<tr>
<td>60 pills</td>
<td>240 pills</td>
<td>120 pills</td>
</tr>
<tr>
<td>2 mg.</td>
<td>30 mg.</td>
<td>350 mg.</td>
</tr>
<tr>
<td>60 pills</td>
<td>240 pills</td>
<td>120 pills</td>
</tr>
<tr>
<td>6/22/2010</td>
<td>6/22/2010</td>
<td></td>
</tr>
<tr>
<td>2 mg.</td>
<td>30 mg.</td>
<td></td>
</tr>
<tr>
<td>60 pills</td>
<td>240 pills</td>
<td></td>
</tr>
<tr>
<td>7/19/2010</td>
<td>7/19/2010</td>
<td></td>
</tr>
<tr>
<td>2 mg.</td>
<td>30 mg.</td>
<td></td>
</tr>
<tr>
<td>60 pills</td>
<td>240 pills</td>
<td></td>
</tr>
<tr>
<td>2 mg.</td>
<td>30 mg.</td>
<td></td>
</tr>
<tr>
<td>60 pills</td>
<td>240 pills</td>
<td></td>
</tr>
</tbody>
</table>

26. From about March 25, 2010, through about August 23, 2010, Respondent prescribed potentially lethal doses of Xanax®, oxycodone, or Soma®, for BB inappropriately or in excessive or inappropriate quantities.
without justification and or without documenting justification for the course of treatment.

27. From about March 25, 2010, through about August 23, 2010, Respondent did not diagnose BB with an anxiety disorder or any other clinical indication to support prescribing potentially lethal doses of Xanax® to BB.

28. From about March 25, 2010, through about August 23, 2010, Respondent did not perform or did not document a complete or adequate physical examination on BB prior to prescribing potentially lethal doses of Xanax®, oxycodone, or Soma®, for Patient BB.

29. From about March 25, 2010, through about August 23, 2010, Respondent did not obtain or did not document a complete or adequate medical history for BB prior to prescribing potentially lethal doses of Xanax®, oxycodone, or Soma®, for BB.

30. From about March 25, 2010, through about August 23, 2010, Respondent did not diagnose BB with intractable pain prior to prescribing potentially lethal doses of Xanax®, oxycodone, or Soma®, for BB.
**Facts Specific to CC**

31. Patient CC, a 32-year-old female, first presented to Respondent on April 29, 2010, and Respondent’s primary diagnosis was lumbosacral sprain secondary to L5S1 stenosis, right knee pain ulceration and abrasion and anxiety. Respondent prescribed Xanax®, Soma®, methadone, and oxycodone, for CC on the dates and in the strengths and quantities described in the following table:

<table>
<thead>
<tr>
<th>Methadone  10 mg.</th>
<th>Oxycodone 30 mg.</th>
<th>Xanax® 2 mg.</th>
<th>Soma® 350 mg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/22/2010 10 mg. 180 pills</td>
<td>7/22/2010 30 mg. 290 pills</td>
<td>7/22/2010 2 mg. 60 pills</td>
<td>7/22/2010 350 mg. 90 pills</td>
</tr>
<tr>
<td>8/19/2010 10 mg. 180 pills</td>
<td>8/19/2010 30 mg. 290 pills</td>
<td>8/19/2010 2 mg. 60 pills</td>
<td>8/19/2010 350 mg. 90 pills</td>
</tr>
</tbody>
</table>

32. From about April 29, 2010, through about August 19, 2010, Respondent prescribed potentially lethal doses of Xanax®, Soma®, methadone, or oxycodone, inappropriately or in excessive or inappropriate quantities without justification and or without documenting justification for the course of treatment.
33. From about April 29, 2010, through about August 19, 2010, Respondent did not perform or did not document a complete or adequate physical examination on CC prior to prescribing potentially lethal doses of Xanax®, Soma®, methadone, or oxycodone to CC.

34. From about April 29, 2010, through about August 19, 2010, Respondent did not obtain or did not document a complete or adequate medical history on CC prior to prescribing potentially lethal doses of Xanax®, Soma®, methadone, or oxycodone to CC.

35. Respondent did not diagnose patient CC with intractable pain prior to prescribing potentially lethal doses of Xanax®, Soma®, methadone, or oxycodone to CC.

**Facts Specific to WB**

36. Patient WB a 51 year-old male first presented on December 13, 2008. Respondent’s primary diagnosis was with complaints of neck, pain, low back pain and right knee pain and Respondent prescribed Roxicodone®, Soma®, Xanax®, and Fiorinal® with codeine, to WB on the dates and in the strengths and quantities described in the following table:
<table>
<thead>
<tr>
<th>Roxicodone® 30 mg.</th>
<th>Soma® 350 mg.</th>
<th>Xanax® 1 mg.</th>
<th>Florinal® w/Codeine</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/13/2008 30 mg.</td>
<td>12/13/2008 350 mg.</td>
<td>12/13/2008 30 pills</td>
<td></td>
</tr>
<tr>
<td>1/10/2009 30 mg.</td>
<td>1/10/2009 350 mg.</td>
<td>1/10/2009 30 pills</td>
<td></td>
</tr>
<tr>
<td>2/6/2009 30 mg.</td>
<td>2/6/2009 350 mg.</td>
<td>2/6/2009 30 pills</td>
<td></td>
</tr>
<tr>
<td>3/7/2009 30 mg.</td>
<td>3/7/2009 350 mg.</td>
<td>3/7/2009 30 pills</td>
<td></td>
</tr>
<tr>
<td>4/14/2009 30 mg.</td>
<td>4/14/2009 350 mg.</td>
<td>4/14/2009 30 pills</td>
<td></td>
</tr>
<tr>
<td>4/6/2010 30 mg.</td>
<td>4/6/2010 350 mg.</td>
<td>4/6/2010 1 mg.</td>
<td>4/6/2010 90 pills</td>
</tr>
<tr>
<td>5/22/2010 30 mg.</td>
<td>5/22/2010 350 mg.</td>
<td>5/22/2010 1 mg.</td>
<td>5/22/2010 90 pills</td>
</tr>
<tr>
<td>6/19/2010 30 mg.</td>
<td>6/19/2010 350 mg.</td>
<td>6/19/2010 1 mg.</td>
<td>6/19/2010 90 pills</td>
</tr>
<tr>
<td>7/17/2010 30 mg.</td>
<td>7/17/2010 350 mg.</td>
<td>7/17/2010 1 mg.</td>
<td>7/17/2010 90 pills</td>
</tr>
<tr>
<td>Roxicodone®</td>
<td>Soma®</td>
<td>Xanax®</td>
<td>Fiorinal® w/Codeine</td>
</tr>
<tr>
<td>------------</td>
<td>-------</td>
<td>--------</td>
<td>---------------------</td>
</tr>
<tr>
<td>30 mg.</td>
<td>350 mg.</td>
<td>1 mg.</td>
<td>8/24/2010 30 pills</td>
</tr>
<tr>
<td>8/24/2010 30 mg. 90 pills</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

37. From about December 13, 2008, through about August 24, 2010, Respondent prescribed potentially lethal doses of Roxicodone®, Soma®, Xanax®, or Fiorinal® with codeine, to WB inappropriately or in excessive or inappropriate quantities without justification and or without documenting justification for the course of treatment.

38. From about November 10, 2009, Respondent did not use the results of the urine screens appropriately or did not appropriately interpret the results, when he failed to address the positive drug results for cocaine, an illegal drug and hydromorphone, which had not been prescribed to WB, and continued to prescribe potentially lethal doses of Roxicodone®, Soma®, Xanax®, or Fiorinal® with codeine, to WB.

39. From about November 10, 2009, Respondent did not use the results of the urine screen appropriately or did not appropriately interpret the results, when he failed to address the negative drug result for Soma®, and Xanax®, which had been prescribed to WB, and continued to prescribe
potentially lethal doses of Roxicodone®, Soma®, Xanax®, or Fiorinal® with codeine, for Patient WB.

40. From about February 9, 2010, Respondent did not use the results of the urine screen appropriately or did not appropriately interpret the results, when he failed to address the fact that the urine test was negative for all controlled substances which had been prescribed to WB, and continued to prescribe potentially lethal doses of Roxicodone®, Soma®, Xanax®, or Fiorinal® with codeine, for Patient WB.

41. From about December 13, 2008, through about August 24, 2010, Respondent did not perform or did not document a complete or adequate physical examination on Patient WB prior to prescribing potentially lethal doses of Roxicodone®, Soma®, Xanax®, or Fiorinal® with codeine, to WB.

42. From about December 13, 2008, through about August 24, 2010, Respondent did not obtain or did not document a complete or adequate medical history on Patient WB prior to prescribing potentially lethal doses of Roxicodone®, Soma®, Xanax®, or Fiorinal® with codeine, to WB.
43. From about December 13, 2008, through about August 24, 2010, Respondent did not diagnose WB with intractable pain prior to prescribing potentially lethal doses of Roxicodone®, Soma®, Xanax®, or Fiorinal® with codeine to WB.

**Facts Specific to MH**

44. Patient MH a 30 year-old female initially presented with complaints of insomnia, anxiety and attention deficit disorder. Respondent prescribed Vicodin®, Xanax®, Adderall®, Soma®, Valium®, clonazepam, fentanyl, and oxycodone, to MH on the dates and in the strengths and quantities described in the following table:

<table>
<thead>
<tr>
<th></th>
<th>Clonazepam .5 Mg. &amp; 2 Mg.</th>
<th>Adderall 20 Mg.</th>
<th>Adderall CR 30 Mg.</th>
<th>Valium 5mg &amp; 10 Mg</th>
<th>Xanax 2 Mg.</th>
<th>Fentanyl Patch 50 Mg.</th>
<th>Oxycodone 15 Mg.</th>
<th>Soma 350 Mg.</th>
</tr>
</thead>
</table>

---

45. Thereafter, Respondent prescribed Vicodin® and Xanax® to WB on the dates and in the strengths and quantities described in the following table:

<table>
<thead>
<tr>
<th></th>
<th>Clonazepam .5 Mg.</th>
<th>Adderall 20 Mg.</th>
<th>Adderall CR 30 Mg.</th>
<th>Valium 5mg &amp; 10 Mg</th>
<th>Xanax 2 Mg.</th>
<th>Fentanyl Patch 50 Mg.</th>
<th>Oxycodone 15 Mg.</th>
<th>Soma 350 Mg.</th>
</tr>
</thead>
</table>

---

46. Respondent prescribed Vicodin® and Xanax® to WB on the dates and in the strengths and quantities described in the following table:
<table>
<thead>
<tr>
<th>Vicodin ES 750 Mg.</th>
<th>Clonazepam .5 Mg. &amp; 2 Mg.</th>
<th>Adderall 20 Mg.</th>
<th>Adderall CR 30 Mg.</th>
<th>Valium 5mg &amp; 10 Mg.</th>
<th>Xanax 2 Mg.</th>
<th>Fentanyl Patch 50 Mg.</th>
<th>Oxycodone 15 Mg.</th>
<th>Soma 350 Mg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/31/2005 750 Mg. 90 Tablets</td>
<td>8/31/2005 2 Mg. 45 Tablets</td>
<td>8/31/2005</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/21/2005 750 Mg. 90 Tablets</td>
<td>12/21/2005 2 Mg. 45 Tablets</td>
<td>12/21/2005 20 Mg. 60 Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3/16/2006 750 Mg. 60 Tablets</td>
<td>3/16/2006 2 Mg. 30 Tablets</td>
<td>3/16/2006 20 Mg. 60 Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/30/2006 750 Mg. 60 Tablets</td>
<td>5/30/2006 2 Mg. 60 Tablets</td>
<td>5/30/2006 20 Mg. 60 Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8/2/2006 750 Mg. 60 Tablets</td>
<td>8/2/2006 2 Mg. 60 Tablets</td>
<td>8/2/2006 20 Mg. 60 Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8/30/2006 750 Mg. 60 Tablets</td>
<td>8/30/2006 2 Mg. 60 Tablets</td>
<td>8/30/2006 20 Mg. 60 Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/1/2006 750 Mg. 60 Tablets</td>
<td>11/1/2006 2 Mg. 30 Tablets</td>
<td>11/1/2006 20 Mg. 60 Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/13/2006 750 Mg. 60 Tablets</td>
<td>12/13/2006 2 Mg. 30 Tablets</td>
<td>12/13/2006 20 Mg. 60 Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3/7/2007 750 Mg. 60 Tablets</td>
<td>3/7/2007 2 Mg. 30 Tablets</td>
<td>3/7/2007 20 Mg. 60 Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4/12/2007 750 Mg. 60 Tablets</td>
<td>4/12/2007 2 Mg. 30 Tablets</td>
<td>4/12/2007 20 Mg. 60 Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/10/2007 750 Mg. 60 Tablets</td>
<td>5/10/2007 2 Mg. 30 Tablets</td>
<td>5/10/2007 20 Mg. 60 Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7/5/2007 750 Mg. 60 Tablets</td>
<td>7/5/2007 2 Mg. 30 Tablets</td>
<td>7/5/2007 20 Mg. 60 Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8/9/2007 750 Mg. 60 Tablets</td>
<td>8/9/2007 2 Mg. 30 Tablets</td>
<td>8/9/2007 20 Mg. 60 Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9/13/2007 750 Mg. 60 Tablets</td>
<td>9/13/2007 2 Mg. 30 Tablets</td>
<td>9/13/2007 20 Mg. 60 Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/5/2007 750 Mg. 60 Tablets</td>
<td>11/5/2007 2 Mg. 30 Tablets</td>
<td>11/5/2007 30 Mg. 30 Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Clonazepam 0.5mg &amp; 2mg</td>
<td>Adderall 20mg</td>
<td>Adderall CR 30mg</td>
<td>Valium 5mg &amp; 10mg</td>
<td>Xanax 2mg</td>
<td>Fentanyl Patch 50mg</td>
<td>Oxycodone 15mg</td>
<td>Soma 350mg</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------</td>
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<td>------------------</td>
<td>-----------</td>
<td>---------------------</td>
<td>----------------</td>
<td>-----------</td>
</tr>
<tr>
<td>1/22/2008</td>
<td>750mg 60Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/31/2008</td>
<td>1/31/2008 2mg 30Tablets</td>
<td>1/31/2008</td>
<td></td>
<td></td>
<td>1/31/2008</td>
<td>10mg 60Tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/6/2008</td>
<td>2mg 30Tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3/10/2008</td>
<td>3mg 30Tablets</td>
<td></td>
<td></td>
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<td>1/6/2009 0.5mg 30Tablets</td>
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<td>8/20/2009</td>
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<td>10/19/2009 30mg 60Tablets</td>
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<td>Vicodin ES 750 Mg.</td>
<td>Clonazepam 5 mg. &amp; 2 Mg.</td>
<td>Adderall CR 20 Mg.</td>
<td>Adderall 5 mg. &amp; 10 Mg</td>
<td>Valium 2 Mg.</td>
<td>Fentanyl Patch 50 Mg.</td>
<td>Oxycodone 15 Mg.</td>
<td>Soma 350 Mg.</td>
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<td>12/14/2009 2 Mg. 120 Tablets</td>
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<td>8/23/2010 750 Mg. 120 Tablets</td>
<td>8/23/2010 30 Mg. 60 Tablets</td>
<td>8/23/2010 2 Mg. 120 Tablets</td>
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45. From about January 10, 2005, through about August 23, 2010, Respondent prescribed potentially lethal doses of Vicodin®, Xanax®, Adderall®, Soma®, Valium®, clonazepam, fentanyl, or oxycodone, to MH
inappropriately or in excessive or inappropriate quantities without justification and or without documenting justification for the course of treatment.

46. From about January 10, 2005, through about August 23, 2010, Respondent did not diagnose Patient MH with attention deficit disorder (ADD), or any other clinical indication to support prescribing Adderall®, to MH.

47. From about January 10, 2005, through about August 23, 2010, Respondent did not perform or did not document a complete or adequate physical examination of MH prior to prescribing potentially lethal doses of Vicodin®, Xanax®, Adderall®, Soma®, Valium®, clonazepam, fentanyl, or oxycodone to Patient MH.

48. From about January 10, 2005, through about August 23, 2010, Respondent did not obtain or did not document a complete or adequate medical history of MH prior to prescribing potentially lethal doses of Vicodin®, Xanax®, Adderall®, Soma®, Valium®, clonazepam, fentanyl, or oxycodone to Patient MH.
49. Respondent did not diagnose MH with intractable pain prior to prescribing potentially lethal doses of Vicodin®, Xanax®, Adderall®, Soma®, Valium®, clonazepam, fentanyl, or oxycodone to Patient MH.

**COUNT ONE**

50. Petitioner re-alleges paragraphs 1 through 23 as if fully set forth herein.

51. Section 458.331(1)(nn), Florida Statutes (2009-2010), subjects a doctor to discipline for violating any provision of chapter 458 or chapter 456, or any rules adopted pursuant thereto.

52. Respondent violated Section 458.331(1)(nn) when he violated Section 458.326 Florida Statutes (2009-2010) and or Rule 64B8-9.013(3), Florida Administrative Code with regard to AM, in one or more of the following ways:

a. By failing to diagnose Patient AM with intractable pain prior to prescribing methadone, Roxicodone®, or Soma®, for Patient AM, from about December 22, 2009, through about August 27, 2010;

b. By failing to perform a complete or adequate physical examination prior to prescribing potentially
lethal doses of methadone, Roxicodone®, or Soma®, for Patient AM, from about December 22, 2009, through about August 27, 2010;
c. By failing to obtain a complete medical history on Patient AM prior to prescribing potentially lethal doses of methadone, Roxicodone®, or Soma®.

53. Based on the foregoing, Respondent has violated Section 458.331(1)(nn), Florida Statutes, by violating Section 458.326 Florida Statutes.

**COUNT TWO**

54. Petitioner re-alleges paragraphs 1 through 23 as if fully set forth herein.

55. Section 458.331(1)(q), Florida Statutes (2009-2010), subjects a licensee to discipline, including suspension, for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician’s professional practice. For purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately
or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician’s professional practice, without regard to his intent.

56. Respondent prescribed controlled substances inappropriately or in excessive or inappropriate quantities, with regard to AM, as more particularly set out above.

57. Based on the forgoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2009-2010).

COUNT THREE

58. Petitioner re-alleges paragraphs 1 through 23 as if fully set forth herein.

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

60. Level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care specified in
Section 766.102. Section 766.102(1), Florida Statutes, defines the standard of care to mean "... The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers. . . ."

61. Respondent failed to meet the required standard of care, with regard to AM, in one or more of the following ways:

a. By failing to diagnose AM with intractable pain prior to prescribing potentially lethal doses of methadone, Roxicodone®, or Soma®, for Patient AM, from about December 22, 2009, through about August 27, 2010;

b. By prescribing potentially lethal doses of methadone, Roxicodone®, or Soma®, for Patient AM without justification, from about December 22, 2009, through about August 27, 2010;

c. By failing to use the results of the urine screens appropriately or failing to appropriately interpret the results, when Respondent failed to address the
positive drug result for benzodiazepines, which had not been prescribed, with AM, and continuing to prescribe potentially lethal doses of methadone, Roxicodone®, or Soma®, for AM, about August 2, 2010;

d. By failing to use the results of the urine screens appropriately or failing to appropriately interpret the results, when he failed to address the negative drug result for methadone, which had been prescribed, with Patient AM, and continuing to prescribe potentially lethal doses of methadone, Roxicodone®, or Soma®, for AM, about August 2, 2010;

e. By failing to perform a complete or adequate physical examination prior to prescribing potentially lethal doses of methadone, Roxicodone®, or Soma®, for Patient AM, from about December 22, 2009, through about August 27, 2010;
f. By failing to obtain a complete medical history on AM prior to prescribing potentially lethal doses of methadone, Roxicodone®, or Soma®.

62. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes, (2009-2010).

COUNT FOUR

63. Petitioner re-alleges paragraphs 1 through 23 as if fully set forth herein.

64. Section 458.331(1)(m), Florida Statutes (2009-2010), provides that failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations, constitutes grounds for disciplinary action by the Board of Medicine.

65. Respondent failed to keep legible medical records justifying the course of treatment for AM in one or more of the following ways:

a. By prescribing potentially lethal doses of methadone, Roxicodone®, or Soma®, for AM without documenting justification, from about
December 22, 2009, through about August 27, 2010;

b. By failing to document a complete or adequate physical examination prior to prescribing potentially lethal doses of methadone, Roxicodone®, or Soma®, for AM, from about December 22, 2009, through about August 27, 2010;

c. By failing to document a complete medical history on AM prior to prescribing potentially lethal doses of methadone, Roxicodone®, or Soma®.

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

**COUNT FIVE**

67. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 24 through 29, as if fully set forth herein.

68. Section 458.331(1)(nn), Florida Statutes (2009-2010), subjects a doctor to discipline for violating any provision chapter 458 or chapter 456, or any rules adopted pursuant thereto.

69. Respondent violated Section 458.331(1)(nn), Florida Statutes when he violated Section 458.326 Florida Statutes and or Rule 64B8-
9.013(3), Florida Administrative Code with regard to BB, in one or more of the following ways:

a. By failing to diagnose BB with intractable pain prior to prescribing potentially lethal doses of oxycodone, or Soma®, for BB, from about March 25, 2010, through about August 23, 2010;

b. By failing to perform a complete or adequate physical examination on BB prior to prescribing potentially lethal doses of oxycodone, or Soma®, for Patient BB, from about March 25, 2010, through about August 23, 2010;

c. By failing to obtain a complete or adequate medical history for BB prior to prescribing potentially lethal doses of oxycodone, or Soma®, for BB, from about March 25, 2010, through about August 23, 2010.

70. Based on the foregoing, Respondent has violated Section 458.331(1)(nn), Florida Statutes, (2009-2010) by violating Section 458.326 Florida Statutes (2009-2010).
COUNT SIX

71. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 24 through 29, as if fully set forth herein.

72. Section 458.331(1)(q), Florida Statutes (2009-2010), subjects a licensee to discipline, including suspension, for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician’s professional practice. For purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician’s professional practice, without regard to his intent.

73. Respondent prescribed controlled substances inappropriately or in excessive or inappropriate quantities, with regard to BB, as more particularly set out above.

74. Based on the forgoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2009-2010).
COUNT SEVEN

75. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 24 through 29, as if fully set forth herein.

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

77. Level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care specified in Section 766.102. Section 766.102(1), Florida Statutes, defines the standard of care to mean “... The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers. ...”

78. Respondent failed to meet the required standard of care with regard to Patient BB in one or more of the following ways:
a. By failing to diagnose BB with intractable pain prior to prescribing potentially lethal doses of Xanax®, oxycodone, or Soma®, for BB, from about March 25, 2010, through about August 23, 2010;

b. By prescribing potentially lethal doses of Xanax®, oxycodone, or Soma®, for BB without justification, from about March 25, 2010, through about August 23, 2010;

c. By failing to diagnose anxiety disorder or any other clinical indication to support prescribing Xanax®, to BB, from about March 25, 2010, through about August 23, 2010;

d. By failing to perform a complete or adequate physical examination on BB prior to prescribing potentially lethal doses of oxycodone, or Soma®, for Patient BB, from about March 25, 2010, through about August 23, 2010;

e. By failing to obtain a complete or adequate medical history for BB prior to prescribing potentially lethal
doses of oxycodone, or Soma®, for BB, from about March 25, 2010, through about August 23, 2010.

79. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes, (2009-2010).

**COUNT EIGHT**

80. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 24 through 29 as if fully set forth herein.

81. Section 458.331(1)(m), Florida Statutes (2009-2010), provides that failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations, constitutes grounds for disciplinary action by the Board of Medicine.

82. Respondent failed to keep legible medical records justifying the course of treatment for BB in one or more of the following ways:

a. By prescribing potentially lethal doses of oxycodone, or Soma®, for BB without documenting justification, from about March 25, 2010, through about August 23, 2010;
b. By failing to document a complete or adequate physical examination on BB prior to prescribing potentially lethal doses of oxycodone, or Soma®, for Patient BB, from about March 25, 2010, through about August 23, 2010;

c. By failing to document a complete or adequate medical history for BB prior to prescribing potentially lethal doses of oxycodone, or Soma®, for Patient BB, from about March 25, 2010, through about August 23, 2010.

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

**COUNT NINE**

84. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 30 through 34, as if fully set forth herein.

85. Section 458.331(1)(nn), Florida Statutes (2009-2010), subjects a doctor to discipline for violating any provision chapter 458 or chapter 456, or any rules adopted pursuant thereto.
86. Respondent violated Section 458.331(1)(nn) Florida Statutes when he violated Section 458.326 Florida Statutes and or Rule 64B8-9.013(3), Florida Administrative Code with regard to CC, in one or more of the following ways:

a. By failing to diagnose CC with intractable pain prior to prescribing potentially lethal doses of Soma®, methadone, or oxycodone to CC, from about April 29, 2010, through about August 19;

b. By prescribing potentially lethal doses of Soma®, methadone, or oxycodone, without justification, from about April 29, 2010, through about August 19;

c. By failing to perform a complete or adequate physical examination on CC prior to prescribing potentially lethal doses of Soma®, methadone, or oxycodone to CC, from about April 29, 2010, through about August 19;

d. By failing to obtain a complete or adequate medical history on CC prior to prescribing potentially lethal
doses of Soma®, methadone, or oxycodone to CC, from about April 29, 2010, through about August 19.

87. Based on the foregoing, Respondent has violated Section 458.331(1)(nn), Florida Statutes, (2009-2010) by violating Section 458.326 Florida Statutes (2009-2010).

**COUNT TEN**

88. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 30 through 34 as if fully set forth herein.

89. Section 458.331(1)(q), Florida Statutes (2009-2010), subjects a licensee to discipline, including suspension, for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his intent.
90. Respondent prescribed controlled substances inappropriately or in excessive or inappropriate quantities, with regard to Patient CC as more particularly set out above.

91. Based on the forgoing, Respondent violated Section 458.331(1)(q), Florida Statutes, (2009-2010).

**COUNT ELEVEN**

92. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 30 through 34 as if fully set forth herein.

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

94. Level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care specified in Section 766.102. Section 766.102(1), Florida Statutes, defines the standard of care to mean "... The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and
treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers. . . .”

95. Respondent failed to meet the required standard of care with regard to CC, in one or more of the following ways:

a. By failing to diagnose patient CC with intractable pain prior to prescribing potentially lethal doses of Xanax®, Soma®, methadone, or oxycodone to CC, from about April 29, 2010, through about August 19;

b. By prescribing potentially lethal doses of Xanax®, Soma®, methadone, or oxycodone, without justification, from about April 29, 2010, through about August 19;

c. By failing to perform a complete or adequate physical examination on CC prior to prescribing potentially lethal doses of Xanax®, Soma®, methadone, or oxycodone to CC, from about April 29, 2010, through about August 19;
d. By failing to obtain a complete or adequate medical history on CC prior to prescribing potentially lethal doses of Xanax®, Soma®, methadone, or oxycodone to CC, from about April 29, 2010, through about August 19.

96. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes, by committing medical malpractice.

**COUNT TWELVE**

97. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 30 through 34 as if fully set forth herein.

98. Section 458.331(1)(m), Florida Statutes (2009-2010), provides that failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations, constitutes grounds for disciplinary action by the Board of Medicine.

99. Respondent failed to keep legible medical records justifying the course of treatment for CC in one or more of the following ways:
a. By prescribing potentially lethal doses of Xanax®, Soma®, methadone, or oxycodone, to CC, without documenting justification, from about April 29, 2010, through about August 19;

b. By failing to document a complete or adequate physical examination on CC prior to prescribing potentially lethal doses of Xanax®, Soma®, methadone, or oxycodone to CC, from about April 29, 2010, through about August 19;

c. By failing to document a complete or adequate medical history on CC prior to prescribing potentially lethal doses of Xanax®, Soma®, methadone, or oxycodone to CC, from about April 29, 2010, through about August 19.

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

COUNT THIRTEEN

101. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 35 through 42, as if fully set forth herein.
102. Section 458.331(1)(nn), Florida Statutes (2008-2010), subjects a doctor to discipline for violating any provision chapter 458 or chapter 456, or any rules adopted pursuant thereto.

103. Respondent violated Section 458.331(1)(nn) Florida Statutes when he violated Section 458.326 Florida Statutes and or Rule 64B8-9.013(3), Florida Administrative Code with regard to WB, in one or more of the following ways:

a. By failing to diagnose WB with intractable pain prior to prescribing potentially lethal doses of Roxicodone® and Soma® or Fiorinal® with codeine, to WB, from about December 13, 2008, through about August 24, 2010;

b. By failing to perform a complete or adequate physical examination on WB prior to prescribing potentially lethal doses of Roxicodone®, Soma®, or Fiorinal® with codeine, to WB, from about December 13, 2008, through about August 24, 2010;
c. By failing to obtain a complete or adequate medical history on Patient WB prior to prescribing potentially lethal doses of Roxicodone®, Soma or Fiorinal® with codeine, to WB, from about December 13, 2008, through about August 24, 2010.

104. Based on the foregoing, Respondent has violated Section 458.331(1)(nn), Florida Statutes, (2008-2010).

**COUNT FOURTEEN**

105. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 35 through 42 as if fully set forth herein.

106. Section 458.331(1)(q), Florida Statutes (2008-2010), subjects a licensee to discipline, including suspension, for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician’s professional practice. For purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the
patient and is not in the course of the physician’s professional practice, without regard to his intent.

107. Respondent prescribed controlled substances to WB inappropriately or in excessive or inappropriate quantities as more particularly set out above.

108. Based on the forgoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2008-2010).

**COUNT FIFTEEN**

109. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 35 through 42 as if fully set forth herein.

110. Section 458.331(1)(t), Florida Statutes (2008-2010), subjects a doctor to discipline for committing medical malpractice as defined in Section 456.50. Section 456.50, Florida Statutes (2008-2010), defines medical malpractice as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

111. Level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care specified in Section 766.102. Section 766.102(1), (2008-2010) Florida Statutes,
defines the standard of care to mean "... The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers. . . ."

112. Respondent failed to meet the required standard of care with regard to WB in one or more of the following ways:

a. By failing to diagnose WB with intractable pain prior to prescribing potentially lethal doses of Roxicodone®, Soma®, or Fiorinal® with codeine, to WB, from about December 13, 2008, through about August 24, 2010;

b. By prescribing potentially lethal doses of Roxicodone®, Soma®, Xanax®, or Fiorinal® with codeine, to WB without justification, from about December 13, 2008, through about August 24, 2010;

c. By failing to use the results of the urine screens appropriately or failing to appropriately interpret the
results, when he failed to address the positive drug results for cocaine, an illegal drug and hydromorphone, which had not been prescribed to WB, and continued to prescribe potentially lethal doses of Roxicodone®, Soma®, Xanax®, or Fiorinal® with codeine, to WB, about November 10, 2009;

d. By failing to use the results of the urine screen appropriately or failing to appropriately interpret the results, when he failed to address the negative drug result for Soma®, and Xanax®, which had been prescribed to WB, and continued to prescribe potentially lethal doses of Roxicodone®, Soma®, Xanax®, or Fiorinal® for WB, about November 10, 2009;

e. By failing to use the results of the urine screen appropriately or did not appropriately interpret the results, when he failed to address the fact that the urine test was negative for all controlled substances
which had been prescribed to WB, and continued to prescribe potentially lethal doses of Roxicodone®, Soma®, Xanax®, or Fiorinal® for WB, about February 9, 2010;

f. By failing to perform a complete or adequate physical examination on WB prior to prescribing potentially lethal doses of Roxicodone®, Soma®, or Fiorinal® with codeine to WB from about December 13, 2008, through about August 24, 2010;

g. By failing to obtain a complete or adequate medical history on WB prior to prescribing potentially lethal doses of Roxicodone®, Soma®, or Fiorinal® with codeine, to WB, from about December 13, 2008, through about August 24, 2010.

113. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes, (2008-2010).

COUNT SIXTEEN
114. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 35 through 42 as if fully set forth herein.

115. Section 458.331(1)(m), Florida Statutes (2008-2010), provides that failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations, constitutes grounds for disciplinary action by the Board of Medicine.

116. Respondent failed to keep legible medical records justifying the course of treatment for WB in one or more of the following ways:

a. By prescribing potentially lethal doses of Roxicodone®, Soma®, Xanax®, or Fiorinal® with codeine, to WB without documenting justification for the course of treatment from about December 13, 2008, through about August 24, 2010;

b. By failing to document a complete or adequate physical examination on WB prior to prescribing potentially lethal doses of Roxicodone®, Soma®, or Fiorinal® with codeine, to WB, from about
December 13, 2008, through about August 24, 2010;

c. By failing to document a complete or adequate medical history on WB prior to prescribing potentially lethal doses of Roxicodone®, Soma®, or Fiorinal® with codeine, to WB, from about December 13, 2008, through about August 24, 2010.

117. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, (2008-2010).

**COUNT SEVENTEEN**

118. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 43 through 48, as if fully set forth herein.

119. Section 458.331(1)(nn), Florida Statutes (2005-2010), subjects a doctor to discipline for violating any provision chapter 458 or chapter 456, or any rules adopted pursuant thereto.

120. Respondent violated Section 458.331(1)(nn), Florida Statutes (2005-2010) when he violated Section 458.326 Florida Statutes and or Rule
64B8-9.013(3), Florida Administrative Code with regard to MH, in one or more of the following ways:

a. By failing to diagnose MH with intractable pain prior to prescribing potentially lethal doses of Vicodin®, Soma®, fentanyl, or oxycodone to MH, from about May 30, 2006 through about August 23, 2010;

b. By failing to perform a complete or adequate physical examination of MH prior to prescribing potentially lethal doses of Vicodin®, Soma®, Valium®, fentanyl, or oxycodone to MH, from about May 30, 2006 through about August 23, 2010;

c. By failing to obtain a complete or adequate medical history of MH prior to prescribing potentially lethal doses of Vicodin®, Xanax®, Adderall®, Soma®, Valium®, clonazepam, fentanyl, or oxycodone to MH.

121. Based on the foregoing, Respondent has violated Section 458.331(1)(nn), Florida Statutes, by violating Section 458.326 Florida Statutes, (2005-2010).
COUNT EIGHTEEN

122. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 43 through 48 as if fully set forth herein.

123. Section 458.331(1)(q), Florida Statutes (2005-2010), subjects a licensee to discipline, including suspension, for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician’s professional practice. For purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician’s professional practice, without regard to his intent.

124. Respondent prescribed controlled substances inappropriately or in excessive or inappropriate quantities to MH as more particularly set out above.

125. Based on the forgoing, Respondent violated Section 458.331(1)(q), Florida Statutes, (2005-2010).

COUNT NINETEEN
126. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 43 through 48 as if fully set forth herein.

127. Section 458.331(1)(t), Florida Statutes (2005-2010), subjects a doctor to discipline for committing medical malpractice as defined in Section 456.50. Section 456.50, Florida Statutes (2005-2010), defines medical malpractice as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

128. Level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care specified in Section 766.102. Section 766.102(1), Florida Statutes, defines the standard of care to mean “...The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers...”

129. Respondent failed to meet the required standard of care in one or more of the following ways:
a. By failing to diagnose MH with intractable pain prior to prescribing potentially lethal doses of Vicodin®, Soma®, fentanyl, or oxycodone to MH, from about May 30, 2006 through about August 23, 2010;

b. By prescribing potentially lethal doses of Vicodin®, Xanax®, Adderall®, Soma®, Valium®, clonazepam, fentanyl, or oxycodone, to MH without justification, from about May 30, 2006 through about August 23, 2010;

c. By failing to make a diagnosis or a finding to support a diagnosis of attention deficit disorder (ADD) or any other clinical indication to support prescribing Adderall®, to MH, from about January 10, 2005, through about August 23, 2010;

d. By failing to perform a complete or adequate physical examination of MH prior to prescribing potentially lethal doses of Vicodin®, Soma®, fentanyl, or oxycodone to MH, from about January 10, 2005, through about August 23, 2010;
e. By failing to obtain a complete or adequate medical history of MH prior to prescribing potentially lethal doses of Vicodin®, Soma®, fentanyl, or oxycodone to Patient MH.

130. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes, (2005-2010).

COUNT TWENTY

131. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 43 through 48 as if fully set forth herein.

132. Section 458.331(1)(cc), Florida Statutes (2005-2010), provides that prescribing, ordering, dispensing, administering, supplying, selling, or giving any drug which is a Schedule II amphetamine or a Schedule II sympathomimetic amine drug or any compound thereof, pursuant to chapter 893, to or for any person except for:

1. The treatment of narcolepsy; hyperkinesis; behavioral syndrome characterized by the developmentally inappropriate symptoms of moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity; or drug-induced brain dysfunction;

2. The differential diagnostic psychiatric evaluation of depression the treatment of depression shown to be refractory to other therapeutic modalities; or
3. The clinical investigation of the effects of such drugs or compounds when an investigative protocol therefore is submitted to, reviewed, and approved by the board before such investigation is begun.

constitutes grounds for disciplinary action by the Board of Medicine.

133. Respondent violated Section 458.331(1)(cc) with regard to MH, by failing to make a diagnosis or a finding to support prescribing Adderall®, to MH, from about May 30, 2006 through about August 23, 2010.

134. Based on the foregoing, Respondent violated Section 458.331(1)(cc), Florida Statutes,(2005-2010).

COUNT TWENTY ONE

135. Petitioner re-alleges paragraphs 1 through 16 and paragraphs 43 through 48 as if fully set forth herein.

136. Section 458.331(1)(m), Florida Statutes (2005-2010), provides that failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations, constitutes grounds for disciplinary action by the Board of Medicine.
137. Respondent failed to keep legible medical records justifying the course of treatment for MH in one or more of the following ways:

a. By prescribing potentially lethal doses of Vicodin®, Xanax®, Adderall®, Soma®, Valium®, clonazepam, fentanyl, or oxycodone, to MH without documenting justification, from about May 30, 2006 through about August 23, 2010;

b. By failing to document a complete or adequate physical examination of MH prior to prescribing potentially lethal doses of Vicodin®, Soma®, fentanyl, or oxycodone to Patient MH, from about January 10, 2005, through about August 23, 2010;

c. By failing to document a complete or adequate medical history of MH prior to prescribing potentially lethal doses of Vicodin®, Soma®, fentanyl, or oxycodone to Patient MH.

138. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, (2005-2010).
WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent’s license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of
fees billed or collected, remedial education any other relief that the Board
deems appropriate.

SIGNED this 17th day of May, 2012.

STEVEN L. HARRIS, M.D., M.Sc.
Interim State Surgeon General
Florida Department of Health

Jennifer A. Tschetter
Interim General Counsel
Florida Department of Health

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RJM/jb

PCP: 4/20/2012
PCP Members: Avila, Thomas & Levine
NOTICE OF RIGHTS

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

NOTICE REGARDING ASSESSMENT OF COSTS

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

PETITIONER,

v.

JOHN NKOLO MUBANG, M.D.,

RESPONDENT.

/________________________________________/

AMENDED ADMINISTRATIVE COMPLAINT

Petitioner, Department of Health, hereby files this Amended Administrative Complaint before the Board of Medicine against Respondent, John Nkolo Mubang, M.D., and in support thereof alleges:

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

2. At all times material to this complaint, Respondent was a licensed physician within the State of Florida, having been issued license number 55171.

3. Respondent's address of record is 741 Martin Luther King Boulevard West, Seffner, Florida 33584.
4. Beginning on or about November 11, 2010, until on or about November 8, 2012, Patient BD, a then twenty-four to twenty-six year-old female, presented to Respondent at his office located in Seffner, Florida, approximately monthly for treatment of lower-back pain.

5. From on or about November 11, 2010, until on or about May 24, 2012, Respondent prescribed in combination 180 tablets of oxycodone\(^1\) 30 mg, 30 or 60 tablets of methadone\(^2\) 10 mg, 60 tablets of Soma\(^3\) 350 mg, and a benzodiazepine\(^4\) to Patient DB approximately monthly.

6. On or about September 13, 2012, Respondent discontinued the prescribing of oxycodone and Soma and began prescribing Dilaudid\(^5\) in combination with methadone and a benzodiazepine to Patient BD.

---

\(^1\) Oxycodone is commonly prescribed to treat pain. According to Section 893.03(2), Florida Statutes, oxycodone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of oxycodone may lead to severe psychological or physical dependence.

\(^2\) Methadone is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, methadone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of methadone may lead to severe psychological or physical dependence.

\(^3\) Carisoprodol, commonly known by the brand name Soma, is a muscle relaxant prescribed to treat muscular pain. According to Section 893.03(4), Florida Statutes, carisoprodol is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States. Abuse of carisoprodol may lead to limited physical or psychological dependence relative to the substances in Schedule III.

\(^4\) Respondent prescribed either Xanax or Klonopin to Patient BD. Xanax is the brand name for alprazolam. Klonopin is a brand name for clonazepam. Both are commonly prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, alprazolam and clonazepam are Schedule IV controlled substances that have a low potential for abuse relative to the substances in Schedule III and have a currently accepted medical use in treatment in the United States, and abuse of alprazolam or clonazepam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

\(^5\) Dilaudid is the brand name for hydromorphone and is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, hydromorphone is a Schedule II controlled substance that has a high...
7. From on or about September 13, 2012, until on or about November 8, 2012, Respondent prescribed in combination 112 tablets of Dilaudid 8 mg, 28 tablets of methadone 10 mg, and a benzodiazepine to Patient DB, approximately monthly.

8. The combination of medications prescribed by Respondent to Patient BD approximately monthly from on or about November 11, 2010, until on or about November 8, 2012, was dangerous.

9. Based on the minimal pathology found in Patient BD’s history and physical examinations, the combination of medications prescribed by Respondent to Patient BD approximately monthly from on or about November 11, 2010, until on or about November 8, 2012, were not medically justified.

10. On or about June 23, 2011, Respondent performed a urine drug screen on Patient BD, which was negative for the prescribed medication Xanax (a benzodiazepine).

11. On or about December 8, 2011, Respondent performed a urine drug screen on Patient BD, which was negative for the prescribed medication methadone.

potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of hydromorphone may lead to severe psychological or physical dependence.
12. On or about June 21, 2012, Respondent performed a urine drug screen on Patient BD, which was negative for the prescribed medication methadone.

13. At no point during his treatment of Patient BD did Respondent address the results of the foregoing abhorrent urine drug screens.

14. Respondent routinely used a prepared evaluation form to document his treatment of Patient BD; however, Respondent's handwritten notes are illegible on one or more of the prepared forms.

15. At all times material to this complaint, the prevailing standard of care for a physician treating a patient like Patient BD required the physician to:

   a. perform an adequate history and physical examination prior to prescribing controlled substances;

   b. only prescribe controlled substances when medically justified; and

   c. adequately address abhorrent urine drug screen results.

   **Count I**
   
   **Section 458.331(1)(t)**

16. Petitioner realleges and incorporates paragraphs one (1) through fifteen (15) as if fully set forth herein.
17. Section 458.331(1)(t), Florida Statutes (2010-2012), subjects a licensee to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes. Section 456.50(1)(g), Florida Statutes (2010-2012), states medical malpractice means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. Section 766.102, Florida Statutes (2010-2012), provides that the prevailing standard of care for a given healthcare provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

18. Respondent fell below the standard of care in his treatment of Patient BD in one or more of the following ways:

a. By failing to perform an adequate history and physical examination of Patient BD prior to prescribing controlled substances to Patient BD on one or more occasions from on or about November 11, 2010, until on or about November 8, 2012;
b. By prescribing controlled substances to Patient BD without medical justification on one or more occasions from on or about November 11, 2010, until on or about November 8, 2012; and/or
c. By failing to address Patient BD’s abhorrent urine drug screens results on one or more occasions from on or about June 23, 2011, until on or about November 8, 2012.


Count II
Section 458.331(1)(m)

20. Petitioner realleges and incorporates paragraphs one (1) through fifteen (15) as if fully set forth herein.

21. Section 458.331(1)(m), Florida Statutes (2010-2012), subjects a licensee to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of
drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

22. Rule 64B8-9.003, Florida Administrative Code, provides that:

(2) A licensed physician shall maintain patient medical records in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.
(3) The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

23. Respondent failed to create or maintain records that justified his treatment of Patient BD in one or more of the following ways:

a. By failing to create or maintain legible copies of his handwritten notes on one or more occasions from on or about November 11, 2010, until on or about November 8, 2012; and/or
b. In the alternative to paragraph 18(a) above, by failing to document an adequate history and physical examination of Patient BD prior to prescribing controlled substances on one or more
occasions from on or about November 11, 2010, until on or about November 8, 2012.

24. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2010-2012).

WHEREFORE, Petitioner respectfully requests that the Board of medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent’s license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

[Signature appears on the following page.]
SIGNED this 14\textsuperscript{th} day of September, 2017.

Celeste Philip, MD, MPH
Surgeon General and Secretary

Chad Dunn
Assistant General Counsel
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Amended PCP Date: September 14, 2017
PCP Members: Robert London, M.D. and Mr. Donald Mullins

Original PCP Date: November 7, 2014
PCP Members: Dr. Avila, Dr. Ginzburg, and Ms. Pardue
NOTICE OF RIGHTS

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

A request or petition for an administrative hearing must be in writing and must be received by the Department within 21 days from the day Respondent received the Administrative Complaint, pursuant to Rule 28-106.111(2), Florida Administrative Code. If Respondent fails to request a hearing within 21 days of receipt of this Administrative Complaint, Respondent waives the right to request a hearing on the facts alleged in this Administrative Complaint pursuant to Rule 28-106.111(4), Florida Administrative Code. Any request for an administrative proceeding to challenge or contest the material facts or charges contained in the Administrative Complaint must conform to Rule 28-106.2015(5), Florida Administrative Code.

Mediation under Section 120.573, Florida Statutes, is not available to resolve this Administrative Complaint.

NOTICE REGARDING ASSESSMENT OF COSTS

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

DEPARTMENT OF HEALTH,

PETITIONER,

v. CASE NO. 2010-07721

JOHN NKOLO MUBANG, M.D.,

RESPONDENT.

______________________________/

ADMINISTRATIVE COMPLAINT

Petitioner, Department of Health hereby files this Administrative Complaint before the Board of Medicine against Respondent, John Nkolo Mubang, M.D., and in support thereof alleges:

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

2. At all times material to this complaint, Respondent was a licensed physician within the State of Florida, having been issued license number 55171.

3. Respondent’s address of record is 741 Martin Luther King Boulevard West, Seffner, Florida 33584.
4. During the period May 2009 through April 2010, Respondent treated four patients with complaints of chronic pain. These patients are referred to throughout by their initials, RB, AS, KP and DC.

5. Oxycodone is commonly prescribed to treat pain. According to Section 893.03(2), Florida Statutes, oxycodone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of oxycodone may lead to severe psychological or physical dependence.

6. Methadone is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, methadone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of methadone may lead to severe psychological or physical dependence.

7. Roxicodone and Oxycontin are brand name for drugs containing oxycodone.

8. Ultram is the brand name for tramadol hydrochloride, a centrally acting synthetic analgesic, commonly prescribed to treat moderate
to severe pain. The drug has a wide range of applications, including treatment of rheumatoid arthritis, restless legs syndrome, motor neuron disease and fibromyalgia. Ultram is not a controlled substance but is a legend drug, and a mood altering substance that can cause dependence.

9. Flexeril is a brand name for cyclobenzaprine and is a muscle relaxant. Flexeril is a legend drug but not a controlled substance.

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

11. Percocet is a brand name for a drug containing oxycodone and acetaminophen and is prescribed to treat pain.

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

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

14. Soma is a brand name for carisoprodol, a muscle relaxant commonly prescribed to treat muscular pain. According to Section 893.03(4), Florida Statutes, carisoprodol is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States. Abuse of carisoprodol may lead to limited physical or psychological dependence relative to the substances in Schedule III.
Facts Specific to RB

15. Patient RB, a 56 year-old male, presented to Respondent in July 2009 as a new patient with a complaint of chronic pain from an auto accident many years in the past.

16. Respondent treated RB on three occasions from July through September 2009.

17. Respondent prescribed Ultram and Flexeril to RB during this first visit.

18. On the following monthly visits in August and September 2009, Respondent prescribed oxycodone to RB inappropriately or in excessive or inappropriate quantities without justification and/or without documenting justification for the course of treatment without any dosage titration.

19. Respondent failed to undertake any form of monitoring for patient compliance with dosage instructions and/or prevention of diversion.

20. Respondent failed to perform and/or failed to document a complete and adequate physical examination of RB.

21. During the period from July 2009 and September 2009, Respondent failed to obtain and/or failed to document a complete and adequate medical history of RB.
COUNT ONE

22. Petitioner re-alleges paragraphs 1 through 21 above as if fully set forth herein.

23. Section 458.331(1)(q), Florida Statutes (2008-2009), subjects a licensee to discipline, including suspension, for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician’s professional practice. For purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician’s professional practice, without regard to his intent.

24. Respondent prescribed controlled substances to RB inappropriately or in excessive or inappropriate quantities, in one or more of the following ways:

   a. by prescribing controlled substances to RB inappropriately or in excessive or inappropriate
quantities without justification for the course of treatment;

b. by prescribing controlled substances to RB without any dosage titration;

c. by failing to undertake any form of monitoring of RB for compliance with dosage instructions and/or prevention of diversion;

d. by failing to perform a complete and adequate physical examination of RB; and

e. by failing to obtain a complete and adequate medical history of RB.

25. Based on the forgoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2008-2009).

COUNT TWO

26. Petitioner re-alleges paragraphs 1 through 21 above as if fully set forth herein.

27. Section 458.331(1)(t), Florida Statutes (2008-2009), subjects a doctor to discipline for committing medical malpractice as defined in Section 456.50. Section 456.50, Florida Statutes (2008-2009), defines
medical malpractice as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. The level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care specified in Section 766.102. Section 766.102(1), Florida Statutes, defines the standard of care to mean “... The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers. ...”

28. Respondent failed to meet the required standard of care, in the treatment of RB in one or more of the following ways:

a. by prescribing controlled substances to RB inappropriately or in excessive or inappropriate quantities without justification;

b. by prescribing controlled substances to RB without any dosage titration;

c. by failing to undertake any form of monitoring of RB for compliance with dosage instructions and/or prevention of diversion; and
d. by failing to perform a complete and adequate physical examination of RB; and

e. by failing to obtain a complete and adequate physical examination of RB.

29. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes, and (2008-2009).

COUNT THREE

30. Petitioner re-alleges paragraphs 1 through 21 above as if fully set forth herein.

31. Section 458.331(1)(m), Florida Statutes (2008-2009), provides that failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations, constitutes grounds for disciplinary action by the Board of Medicine.

32. Respondent failed to keep legible medical records justifying the course of treatment for RB in one or more of the following ways:
33. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, and (2008-2009).

**Facts Specific to AS**

34. Patient AS, a 51 year-old male, presented to Respondent with complaints of chronic pain in May 2009.


36. On his initial visit the Respondent prescribed alprazolam, oxycodone and Percocet AS without appropriate workup and after obtaining only an extremely limited and inadequate medical history and performing a limited and inadequate physical examination.

37. Respondent prescribed alprazolam, oxycodone and Percocet inappropriately or in excessive or inappropriate quantities without
justification and/or without documenting adequate justification for the course of treatment.

38. Respondent failed to diagnose AS with an anxiety disorder or any other clinical indication to support prescribing high doses of alprazolam.

39. Respondent also failed to refer the patient to a board-certified psychiatrist, or other mental health professional, in light of the high doses of alprazolam being prescribed for appropriate management of a chronic anxiety disorder.

40. Respondent failed to perform and/or document a complete or adequate physical examination or obtain a complete and adequate medical history on AS prior to prescribing controlled substances to him.

41. Respondent failed to employ any drug compliance monitoring of AS despite the fact that Respondent was prescribing him high doses of opioids concurrently with high doses of alprazolam, both of which are highly divertible and subject to abuse.
COUNT FOUR

42. Petitioner re-alleges paragraphs 1 through 14 and 34 through 41 above as if fully set forth herein.

43. Section 458.331(1)(q), Florida Statutes (2008-2009), subjects a licensee to discipline, including suspension, for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician’s professional practice. For purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician’s professional practice, without regard to his intent.

44. Respondent prescribed controlled substances to RB inappropriately or in excessive or inappropriate quantities, in one or more of the following ways:

a. by prescribing controlled substances to AS inappropriately or in excessive or inappropriate
quantities without justification for the course of
treatment;
b. by prescribing controlled substances to AS without
any dosage titration;
c. by failing to employ any drug compliance monitoring
of AS despite the fact that Respondent was
prescribing him high doses of opioids concurrently
with high doses of alprazolam, both of which are
highly divertible and subject to abuse;
d. by prescribing controlled substances to AS without
performing a complete and adequate physical
examination;
e. by failing to diagnose AS with an anxiety disorder or
any other clinical indication to support prescribing
high doses of alprazolam; and
f. by failing to refer AS patient to a board-certified
psychiatrist, or other mental health professional in
light of the high doses of alprazolam being
prescribed for appropriate management of a chronic anxiety disorder.

45. Based on the forgoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2008-2009).

COUNT FIVE

46. Petitioner re-alleges paragraphs 1 through 14 and 34 through 41 above as if fully set forth herein.

47. Section 458.331(1)(t), Florida Statutes (2008-2009), subjects a doctor to discipline for committing medical malpractice as defined in Section 456.50. Section 456.50, Florida Statutes (2008-2009), defines medical malpractice as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. The level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care specified in Section 766.102. Section 766.102(1), Florida Statutes, defines the standard of care to mean "... The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is
recognized as acceptable and appropriate by reasonably prudent similar health care providers. . . ."

48. Respondent failed to meet the required standard of care, in the treatment of these four patients in one or more of the following ways:

a. by prescribing controlled substances to AS inappropriately or in excessive or inappropriate quantities without justification;

b. by prescribing controlled substances to AS without any dosage titration;

c. by failing to employ any drug compliance monitoring of AS despite the fact that Respondent was prescribing him high doses of opioids concurrently with high doses of alprazolam, both of which are highly divertible and subject to abuse.

d. by prescribing controlled substances to AS without performing and documenting a complete and adequate physical examination;
e. by failing to diagnose AS with an anxiety disorder or any other clinical indication to support prescribing high doses of alprazolam; and

f. by failing to refer AS patient to a board-certified psychiatrist, or other mental health professional in light of the high doses of alprazolam being prescribed for appropriate management of a chronic anxiety disorder;

49. Based on the foregoing, Respondent has violated Section 458.331(1) (t), Florida Statutes, and (2008-2009).

COUNT SIX

50. Petitioner re-alleges paragraphs 1 through 15 and 34 through 40 above as if fully set forth herein.

51. Section 458.331(1)(m), Florida Statutes (2008-2009), provides that failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations, constitutes grounds for disciplinary action by the Board of Medicine.
52. Respondent failed to keep legible medical records justifying the course of treatment for AS in one or more of the following ways:

a. by controlled substances to AS without documenting adequate justification for the course of treatment;

d. by failing to document a complete and adequate physical examination prior to prescribing controlled substances to AS; and

c. by failing to document a complete and adequate medical history on AS prior to prescribing controlled substances to him.

53. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, and (2008-2009).

**Facts Specific to KP**

54. Patient KP, a 41 year-old male, first presented to Respondent in May 2009 complaining of low back pain.


57. In October 2009, Respondent added carisoprodol to KP's monthly prescription list.

58. Respondent prescribed controlled substances to KP inappropriately or in excessive or inappropriate quantities, without justification and or without documenting in the medical record adequate justification for the course of treatment.

59. Respondent did not perform and/or did not document a complete and adequate physical examination on KP.

60. Respondent did not obtain and/or did not document a complete and adequate medical history of KP.

61. Respondent failed to refer KP to a pain management specialist, or other medical professional to explore other treatment modalities, or to further assess his degree of physical and psychological functioning.

62. During the treatment period, Respondent failed to monitor KP for compliance with his treatment protocol or diversion of controlled substances being prescribed despite the fact that the drugs were highly divertible and subject to abuse.
COUNT SEVEN

63. Petitioner re-alleges paragraphs 1 through 14 and 54 through 62 above as if fully set forth herein.

64. Section 458.331(1)(q), Florida Statutes (2008-2009), subjects a licensee to discipline, including suspension, for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his intent.

65. Respondent prescribed controlled substances to RB inappropriately or in excessive or inappropriate quantities, in one or more of the following ways:

   a. by prescribing controlled substances to KP inappropriately or in excessive or inappropriate
quantities without justification for the course of treatment.

b. by prescribing controlled substances to KP without performing a complete and adequate physical examination;

c. by prescribing controlled substances to KP without obtaining a complete and adequate medical history;

d. by failing to refer KP to a board-certified pain specialist, or other medical professional to explore other non-medication means of treating pain as well as to further assess the degree of physical and psychological functioning.

e. by failing to undertake any form of monitoring of KP RB for compliance with dosage instructions and/or diversion despite the fact that the drugs were highly divertible and subject to abuse.

66. Based on the forgoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2008-2009).
COUNT EIGHT

67. Petitioner re-alleges paragraphs 1 through 15 and 55 through 63 above as if fully set forth herein.

68. Section 458.331(1)(t), Florida Statutes (2008-2009), subjects a doctor to discipline for committing medical malpractice as defined in Section 456.50. Section 456.50, Florida Statutes (2008-2009), defines medical malpractice as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. The level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care specified in Section 766.102. Section 766.102(1), Florida Statutes, defines the standard of care to mean "... The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers. . . ."

69. Respondent failed to meet the required standard of care, in the treatment of KP in one or more of the following ways:
a. by prescribing controlled substances to KP inappropriately or in excessive or inappropriate quantities without justification;

b. by failing to undertake any form of monitoring of RB for compliance with oxycodone dosage and/or prevention of diversion; and

c. by failing to perform a complete and adequate physical examination or history prior to prescribing controlled substances to KP;

d. by failing to obtain a complete and adequate medical history prior to prescribing controlled substances to KP;

e. by failing to refer KP to a board-certified pain specialist, or other medical professional, to explore other non-medication means of treating pain as well as to further assess the degree of physical and psychological functioning.

f. by failing to undertake any form of monitoring of KP for compliance with dosage instructions and/or
diversion despite the fact that the drugs were highly divertible and subject to abuse.

70. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes, and (2008-2009).

**COUNT NINE**

71. Petitioner re-alleges paragraphs 1 through 14 and 54 through 62 above as if fully set forth herein.

72. Section 458.331(1)(m), Florida Statutes (2008-2009), provides that failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations, constitutes grounds for disciplinary action by the Board of Medicine.

73. Respondent failed to keep legible medical records justifying the course of treatment for KP in one or more of the following ways:

   a. by prescribing controlled substances to KP without documenting adequate justification for the course of treatment;
b. by failing to document a complete and adequate physical examination prior to prescribing controlled substances to KP; and

c. by failing to document a complete and adequate medical history prior to prescribing controlled substances to KP;

74. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2008-2009).

Facts Specific to DC

75. Patient DC, a 42 year-old male, first presented to Respondent in October 2009 with complaints of chronic pain.

76. Respondent treated DC on approximately 5 occasions between October 2009 and February 2010.

77. Respondent prescribed potentially lethal doses of carisoprodol, oxycodone, clonazepam and methadone, in excessive or inappropriate quantities without justification and or without documenting justification for the course of treatment.

78. During the treatment period, Respondent failed to monitor DC for compliance with his treatment protocol or diversion of controlled substances being prescribed despite the fact
79. Respondent failed to perform and/or not document a complete and adequate physical examination on DC prior to prescribing controlled substances to him.

80. Respondent failed to obtain and/or not document a complete and adequate medical history of DC prior to prescribing controlled substances to him.

COUNT TEN

81. Petitioner re-alleges paragraphs 1 through 15 and 75 through 80 above as if fully set forth herein.

82. Section 458.331(1)(q), Florida Statutes (2008-2009), subjects a licensee to discipline, including suspension, for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his intent.
83. Respondent prescribed controlled substances to DC inappropriately or in excessive or inappropriate quantities, in one or more of the following ways:

a. by prescribing controlled substances to DC inappropriately or in excessive or inappropriate quantities without justification for the course of treatment;

b. by prescribing controlled substances to DC without performing a complete and adequate physical examination;

c. by prescribing controlled substances to DC without obtaining a complete and adequate medical history;

d. by failing to undertake any form of monitoring of DC for compliance with dosage instructions and/or diversion despite the fact that the drugs were highly divertible and subject to abuse.

84. Based on the forgoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2008-2009).
COUNT ELEVEN

85. Petitioner re-alleges paragraphs 1 through 14 and 75 through 80 above as if fully set forth herein.

86. Section 458.331(1)(t), Florida Statutes (2008-2009), subjects a doctor to discipline for committing medical malpractice as defined in Section 456.50. Section 456.50, Florida Statutes (2008-2009), defines medical malpractice as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. The level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care specified in Section 766.102. Section 766.102(1), Florida Statutes, defines the standard of care to mean "... The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers. . . ."

87. Respondent failed to meet the required standard of care, in the treatment of DC in one or more of the following ways:
a. by prescribing controlled substances to DC inappropriately or in excessive or inappropriate quantities without justification;

b. by failing to undertake any form of monitoring of DC for compliance with dosage instructions and/or prevention of diversion despite the fact that the drugs were highly divertible and subject to abuse;

c. by failing to perform a complete and adequate physical examination prior to prescribing controlled substances to DC;

d. by failing to obtain a complete and adequate medical history prior to prescribing controlled substances to DC;

88. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes, and (2008-2009).

COUNT TWELVE

89. Petitioner re-alleges paragraphs 1 through 15 and 76 through 81 above as if fully set forth herein.

90. Section 458.331(1)(m), Florida Statutes (2008-2009), provides that failing to keep legible medical records that justify the course of
treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations, constitutes grounds for disciplinary action by the Board of Medicine.

91. Respondent failed to keep legible medical records justifying the course of treatment for KP in one or more of the following ways:

a. by prescribing controlled substances to DC without documenting adequate justification for the course of treatment;

b. by failing to document a complete and adequate physical examination prior to prescribing controlled substances to DC; and

c. by failing to document a complete and adequate medical history prior to prescribing controlled substances to KP;

92. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2008-2009).

WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of
practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education any other relief that the Board deems appropriate.

SIGNED this 25th day of February, 2013.

John H. Armstrong, MD, FACS
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Florida Department of Health

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(850) 245-4684 (fax)

PCP Date: February 22, 2013
PCP Members: Dr. Miguel, Dr. Sugarman and Mr. Levine
NOTICE OF RIGHTS

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

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.
SOME OR ALL PAGES IN THIS DOCUMENT ARE PATIENT RECORDS AND/OR DOCUMENTS THAT IDENTIFY THE PATIENT BY NAME AND ARE EXEMPT FROM PUBLIC RECORDS LAWS.

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10)(a) All patient records obtained by the department and any other documents maintained by the department which identify the patient by name are confidential and exempt from s. 119.07(1) and shall be used solely for the purpose of the department and the appropriate regulatory board in its investigation, prosecution, and appeal of disciplinary proceedings. The records shall not be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department or the appropriate board.
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