



UNITED STATES DEPARTMENT OF JUSTICE

Drug Enforcement Administration

Docket No. 13-37

Samuel Mintlow, M.D.

Decision and Order

On July 2, 2013, the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration, issued an Order to Show Cause to Samuel Mintlow, M.D. (hereinafter, Respondent), of Conyers, Georgia. ALJ Ex. 1. The Show Cause Order proposed the revocation of Respondent's DEA Certificate of Registration BM0288983, which authorizes him to dispense controlled substances in schedules II through V, and the denial of any pending applications to renew or modify his registration, on the ground that his "registration is inconsistent with the public interest." *Id.* (citing 21 U.S.C. 823(f) and 824(a)(4)).

The Show Cause Order specifically alleged that around January 2011, one Charles Thomas Laing, a resident of Tennessee, and one Mark Del Percio, a resident of South Florida, neither of whom is a licensed medical professional, decided to open a pain management clinic which was named Liberty Wellness Center (hereinafter, Liberty or LWC) in Norcross, Georgia. *Id.* at 2. The Order alleged that in January 2011, Respondent was hired to treat Liberty's patients and to distribute controlled substances, and that through April 2012, Liberty "unlawfully distributed controlled substances through prescriptions issued under [Respondent's] registration for no legitimate medical purpose" including highly abused drugs such as oxycodone, hydrocodone, alprazolam, and carisoprodol. *Id.*

The Order further alleged that the majority of Liberty's patients (687) were from Tennessee (while 54 were from Georgia), and that 50 of the Tennessee patients lived in the same

town (Rogersville) as Charles Laing (with sixteen living on the same road), and that this town was located 254 miles from Liberty. Id. The Show Cause Order then alleged that between January and June 2011, “Laing recruited approximately 20-25 [persons] to travel to [Liberty] and obtain” prescriptions for oxycodone 30mg from Respondent, and that they provided the oxycodone to Laing who then sold the drugs. Id. The Order alleged that Laing subsequently pled guilty in federal district court to conspiracy to distribute and possess with the intent to distribute oxycodone, in violation of 21 U.S.C. 846 and 841(b)(1)(c). Id. at 3.

Next, the Show Cause Order alleged that “between February 2011 and April 2012, [Respondent] unlawfully distributed approximately 1,950 oxycodone” 30mg tablets, “by issuing prescriptions” to one Terrance Q. Williams, an alleged associate of Laing, who also sponsored various other individuals from Greenville, Tennessee. Id. The Order alleged that Williams would pay the costs of a sponsored person’s trip, including the amount charged by Liberty and by the pharmacy which filled the prescriptions, and that the latter would provide a percentage of the oxycodone to Williams, who sold the drugs to persons including Del Percio. Id. The Order then alleged that while Williams and the persons he sponsored complained of pain, Respondent did little or nothing to verify their complaints and that Respondent “repeatedly and deliberately ignored red flags that could or did indicate likely paths of diversion while prescribing controlled substances to Williams.” Id. The Order also alleged that on February 8, 2013, Williams pled guilty in federal district court to one count of conspiracy to distribute and possess with the intent to distribute oxycodone, in violation of 21 U.S.C. 846 and 841(b)(1)(c). Id.

The Show Cause Order next alleged that “[b]etween March 2011 and April 2012, [Respondent] unlawfully distributed 1,560 oxycodone [30mg] tablets by issuing prescriptions to Jessica R. Bernard,” who resided in Rogersville, Tennessee and was an acquaintance of Williams

and Laing. Id. The Show Cause Order alleged that Bernard also sponsored persons from Tennessee, and that she would “bring groups of people” to Liberty, “sometimes two to three times a week to obtain prescriptions for oxycodone and other controlled substances” from Respondent, which she would then distribute in Tennessee, and that Respondent “repeatedly and deliberately ignored red flags that could or did indicate likely paths of diversion while prescribing controlled substances to Bernard.” Id. The Show Cause Order then alleged that “on August 28, 2012,” Bernard pled guilty in federal district court to one count of conspiracy to distribute and possess with the intent to distribute oxycodone, in violation of 21 U.S.C. 846 and 841(b)(1)(c). Id. at 3-4.

Finally, the Show Cause Order alleged that between August 2 and December 1, 2011, DEA conducted seven undercover visits, during which Respondent issued controlled substance prescriptions to three undercover officers (UC), “for other than a legitimate medical purpose or outside the usual course of professional practice.” Id. at 4 (citing 21 CFR 1306.04(a); Ga. Code Ann. 16-13-41(f)). The Show Cause Order also alleged that Respondent “violated Georgia medical practice standards” by failing “to maintain appropriate patient records that supported the prescribing of controlled substances and” by failing “to conduct an appropriate physical examination or maintain substantial supporting documentation to support large doses of narcotic medication.” Id. (citing Ga. Comp. R. & Regs. 360-3-.02(7) and 360-3-.02(14)). Id.¹ Finally, with respect to UC3, the Show Cause Order alleged that Respondent further violated Agency regulations by prescribing oxycodone to him knowing that he was dependent on narcotics. Id. at 6 (citing 21 CFR 1306.04(c) and 1306.07).

On August 5, 2013, Respondent requested an extension of time to respond to the Order to Show Cause. ALJ Ex. 2. Therein, Respondent stated that he received the Order to Show Cause

¹ The Order then set forth various factual allegations related to each of the seven undercover visits. ALJ Ex. 4-6.

on July 23, 2013. Id. The case was then placed on the docket of the Office of Administrative Law Judges and assigned to ALJ Christopher B. McNeil. The next day, the ALJ found that Respondent's request "should be treated as a request for a hearing," and issued an Order for Prehearing Statements and Setting the Matter for Hearing. ALJ Ex. 3.

Following pre-hearing procedures, the ALJ conducted an evidentiary hearing in Atlanta, Georgia on October 8-9, 2013, at which both parties called witnesses to testify and submitted various exhibits for the record. Following the hearing, both parties submitted briefs containing their proposed findings of fact, conclusions of law, and argument.

On December 18, 2013, the ALJ issued his recommended decision (hereinafter, R.D.). Therein, the ALJ found that "the Government has established its prima facie case by at least a preponderance of the evidence, and [that] Respondent had failed to rebut that case through a demonstration of sufficient remediation." R.D. 108. The ALJ thus recommended that Respondent's registration be revoked and that any pending application be denied. Id.

Most significantly, the ALJ found that "between January 2011 and April 2012 . . . Respondent issued prescriptions . . . for controlled substances, including oxycodone and Xanax to [ten patients] and to [three] undercover DEA agents . . . under conditions that were inconsistent with the usual course of professional practice for [a] physician in Georgia and that were not for a legitimate medical purpose." R.D. at 102 (Finding of Fact Number 4).² As support for his conclusion, the ALJ found that Respondent prescribed controlled substances "based on a diagnosis of pain, without obtaining and sufficiently verifying the patient's medical history including his or her history of prescription medications," and "without first conducting a

² But see R.D. at 107 (Conclusion of Law Number Seven) (stating that "between December 2011 and April 2012 the Respondent issued prescriptions . . . for controlled substances that were not for a legitimate medical need and were not issued in the ordinary course of a professional medical practice"). The Recommended Decision contains no explanation for this inconsistency.

physical examination sufficient to determine the necessity of opioid treatment.” R.D. at 103. The ALJ also relied on his findings that Respondent “fail[ed] to use medication and other modalities of treatment based on generally accepted or approved indications with proper precautions to avoid adverse physical reactions, habituation, or addiction”; that he prescribed controlled substances “under conditions where the medical records fail to contain sufficient indicia to support diagnoses warranting narcotic pain therapy”; and that he “prescrib[ed] controlled substances to patients who without demonstrating legitimate medical reasons travelled from out of state and from long distances.” Id. The ALJ thus concluded that the evidence supported a finding that Respondent’s continued registration “is inconsistent with the public interest” and supported the revocation of his registration.” Id. at 107.

The ALJ further found that “Respondent has failed to affirmatively acknowledge specific acts of improper prescribing . . . and failed to establish by . . . substantial evidence effective steps taken in remediation.” Id. at 108. The ALJ thus concluded that “the Government has established cause to revoke Respondent’s . . . registration and to deny all pending applications,” and recommended that I revoke Respondent’s registration and deny any pending application to renew or modify his registration. Id.

Both parties filed exceptions to the ALJ’s recommended decision. Thereafter, the record was forwarded to me for final agency action. Having considered the entire record, including the parties’ exceptions, I adopt the ALJ’s ultimate conclusions that the Government has met its prima facie burden of showing that Respondent’s continued registration is inconsistent with the public interest and that Respondent has not produced sufficient evidence to rebut the Government’s case. Accordingly, I will order that Respondent’s registration be revoked and that any pending application be denied. I make the following findings.

FINDINGS

Respondent's Registration Status

Respondent is a medical doctor who is apparently licensed by the Georgia Composite State Board of Medical Examiners. Tr. 330. Respondent also holds DEA Certificate of Registration BM0288983, which authorizes him to dispense controlled substances in schedules II through V as a practitioner, at a registered address in Conyers, Georgia. GX 1. Respondent's registration was due to expire on January 31, 2013. Id. However, on January 30, 2013, Respondent submitted a renewal application. GX 2, at 1. While Respondent's application has not been approved and remains pending until the resolution of this proceeding, because the application was timely filed, Respondent's registration remains in effect. 5 U.S.C. 558(c).

The Investigation of Respondent

In either October or November 2010, Respondent answered a newspaper advertisement, which apparently sought a physician for a pain management clinic. Tr. 279; GX 34, at 3. Thereafter, Respondent met one Mark Del Percio at a restaurant; Del Percio told Respondent that he was opening Liberty and that while he had interviewed another doctor, "he wanted somebody closer to his age." Id. at 280. Del Percio offered the job to Respondent, who began working at Liberty in January 2011. Id. Liberty was located in Norcross, Georgia, a suburb of Atlanta. GX 9, at 2; Tr. 238, 282.

Respondent admitted that Del Percio told him "that he had a partner named Charles," and "that Charles would be working out of one of the rooms in the office," but "Charles never showed up." Tr. 280. Respondent further testified that he "never met Charles," "never talked to

[him] on the phone,” and “didn’t even know his last name.” Id. Charles’ last name was Laing. Id. at 282.

Respondent admitted that he knew Del Percio was from Florida and that he did not have a background in pain management. Tr. 349. He also testified that he did not ask Del Percio why he wanted to open a pain clinic when Del Percio had no background in pain management. Id. at 348. Respondent nonetheless claimed that he did not find this unusual. Id. at 349. Nor did Respondent ask Del Percio why he wanted to open a pain clinic in Georgia, even though he acknowledged having read about the pill mills in Florida and further testified that he knew “they were prescribing an excessive amount of oxycodone . . . 120 -- 240 of the 30s, and 120 of the 15s.” Id. at 350. Respondent further testified that he did not ask Del Percio about his background and did not “do a criminal check on him.” Id. at 349.

According to Respondent, during his first month, he saw “maybe ten people.” Id. at 281. Because the business was slow, Del Percio hired “a marketing person”; “[t]he following month, more patients began to come in, and the following month, even more patients began to come in,” with “quite a few” of the patients coming “from Tennessee.” Id.

Indeed, according to a Task Force Officer, Investigators executed a search warrant at Liberty pursuant to which they seized 881 patient files. Tr. 84, 226-7; GX 3, at 19. Upon reviewing the patient files, the Investigators determined that 690 patients (or 78.3%) of Liberty’s patients came from Tennessee; by contrast, only 54 patients lived in Georgia.³ GX 4, at 1. Moreover, the Investigators determined that 27 of the patients lived on Beech Creek Road in Tennessee (including Charles Laing’s mother) and in at least nine instances, two or three patients lived at the same address.

³ The Investigators found that the other Liberty patients came from the following States in the following amounts: South Carolina (21); Virginia (37); Kentucky (41); North Carolina (19), Florida (11), West Virginia (7), and Arkansas (1). GX 4, at 1.

Based on their review of the 881 patient files, the Investigators determined that 875 patients received oxycodone, while six patients did not. GX 3, at 19. However, of the six patients, four of them received Percocet 10/325, a combination drug which contains ten (10) milligrams of oxycodone.⁴ See id. at 4 (Pt. S.A.), 11 (Pt. J.I.), 12 (Pt. J.L.), and 16 (Pt. J.S.). Thus, nearly every patient Respondent saw received oxycodone, which according to a Task Force Officer, is “the drug of choice among pill seekers and diverters.” Tr. 260.

In June 2011, Respondent came to the attention of DEA after the Hawkins County, Tennessee Sheriff’s Office (HCSO) executed a search warrant at the home of Charles Laing in Rogersville, based on information it obtained that Laing was involved in trafficking oxycodone obtained by persons from Liberty. GX 40, at 2. According to a DEA Task Force Officer, the HCSO seized oxycodone, Xanax and Suboxone totaling approximately 300 tablets, as well as appointment cards for Liberty. Id. at 2. The Investigators also determined that Laing co-owned Liberty with Del Percio, and that Respondent was Liberty’s prescribing physician. Id.

Thereafter, DEA and the Norcross, Georgia Police Department conducted surveillance operations at Liberty. According to several Investigators, Liberty did not have any signage or other markings outside the building in which it was located, Tr. 76, and when the Investigators first went to the clinic, “there was no way to know if [they] were at the right location.” Id. at 77. It was not until the next morning when the Investigators returned and observed an “abundance of” cars with “Tennessee tags parked in front of the” clinic that they knew that they were at the right location. Id.

During their surveillance of the clinic, the Investigators observed numerous cars arriving at the clinic that had out-of-state license plates, including cars from Tennessee, Kentucky, North

⁴ Of the remaining two patients, one (E.P.) received Lortab 10/500mg (a combination drug containing hydrocodone) and one (J.P.) was never seen by Respondent. GX 3, at 1-2.

Carolina, and Florida. GX 40, at 2. They also observed that in some instances, the cars had multiple passengers who would then enter the clinic. Id. at 2-3. Finding their observations to be consistent with drug diversion, the Investigators decided to conduct undercover visits at the clinic to determine if Respondent was issuing unlawful prescriptions. Id. at 3. Between August and December 2011, three TFOs conducted a total of seven visits.⁵

The Visits of TFO Vickery

In his role as L.C., Officer Vickery made four visits to Liberty Wellness Center, the first of which occurred on August 22, 2011. Tr. 158. Vickery explained that “[m]ostly every time I was there, every chair was full, so that [there] would probably be 30, 35 people sitting there, all younger crowds . . . the majority of [the patients were] under 40.” Id. at 207. Vickery also testified that while in the waiting room, he “could overhear [the patients] talking back and forth about what they’re getting from different doctors, where they’re filling at, what pharmacy charges what. You would see that a lot of the patients would travel in groups.” Id. at 207-208.

Officer Vickery further testified during the time he spent in the waiting room, he was able to identify persons acting as “sponsors.” Id. at 208. He described a sponsor as someone who “takes care of everything as far as financial, getting their MRIs, their prescriptions filled,” and the sponsor “would deal with the owner of the clinic, up until the point to where . . . the patient finally went back to see the doctor.” Id.

Officer Vickery testified that he observed that only two people worked at the clinic, Del Percio and Respondent. Del Percio was “actually controlling everything that [was] going on out in the front area.” Id. at 209-212. According to Vickery, once a patient entered the waiting room, Del Percio would not allow the patient to go outside to smoke or go to the parking lot, such that if the patient had to leave the waiting room before seeing the doctor, he or she would

⁵ Having reviewed the entire record, I deem it unnecessary to make findings regarding the single visit of TFO Jones.

have to leave the area. Id. at 210. Del Percio's duties included answering the phones, arranging appointments, providing the patients with the intake forms and receiving them back, collecting the patients' payment, answering their questions, taking their blood pressure, and directing them to provide urine samples. Id. at 212-14. Only after the initial intake was completed would patients be escorted back to Respondent's office.

Officer Vickery also stated that each time he received treatment at Liberty Wellness Center he paid \$300 in cash. Id. at 167. He testified that the clinic required cash payments, that it "didn't do insurance," and was told, "well, we're in the process of getting our insurance accepted, but we haven't been approved for anything so everything's got to be cash at the moment." Id. at 210-211.

According to Vickery, Respondent's office had a massage table that served as the examination table. Id. at 215. Vickery testified that while the table was used during the examination done by Respondent at his first visit, he remained fully clothed. Id. Vickery further testified that during his three subsequent visits, he remained seated in an office chair for the entirety of each visit. Id. at 216.

Officer Vickery explained that he had obtained an MRI for another investigation and that he presented the MRI to Del Percio, along with a false Georgia driver's license showing a Newnan, Georgia address, which was located approximately 60 miles from the clinic. Id. at 160-161. Vickery testified that he brought the MRI to the August 22, 2011 visit because he had been to the clinic twice before and that during those visits, Del Percio told him he needed an MRI before he could be seen by Respondent. Id. at 163, 165. Vickery also testified that the MRI was of the lumbar spine, based on a complaint of "LBP" or lower back pain. Id. at 164; GX 27, at 4.

The MRI Report states that “[t]here is no significant disc disease at L1 through L3.” GX 27, at 4. However, at L3-L4, it states that “[a] left far posterolateral asymmetrical disc protrusion with annular tear is noted” and that “[d]isc material effaces the exiting left L3 nerve root.” Id. At L4-L5, it notes a “posterior disc bulging effacing the thecal sac without nerve root impingement,” and that at L5-S1, “[t]here is low-grade disc bulging without significant mass effect.” Id. The report then states that “[t]here is no extruded disc herniation identified. No central canal or neuroforaminal canal stenosis is identified.” Id.

However, on his medical intake form, Vickery listed his chief complaint as shoulder pain, and reported that “with medication” his pain level was a “0” (this “being no pain”), and “without medication” a “5.” Id. at 5. He explained that he did this “basically to see if I could get into the clinic without an MRI, like I was told I needed, on an ailment or an injury different than what I gave them.” Tr. 165. However, on the third page of the intake form, which listed a large number of medical conditions, Vickery placed an “x” in the blanks corresponding to both his back and shoulders.⁶ GX 27, at 7.

There are video recordings of Officer Vickery’s office visits with Respondent, and three computer disc files containing recordings of brief exchanges between Vickery and Del Percio during the first visit. RX G, Disc N-29.

During the time Officer Vickery spent with Respondent, the two discussed Vickery’s physical condition and the likely reasons for his pain. Respondent made no mention of the distance between Liberty and Vickery’s home address, nor did he ask why Vickery had come to

⁶ As part of the intake process, Vickery (as were the other undercover officers) was required to review and sign a Pain Management Agreement. GX 27, at 9-10. The Agreement contained twenty-two paragraphs, including one which states that “I will not share, sell, or trade my medications with anyone.” Id. at 10. Moreover, at his subsequent visits, Vickery was required to complete a Patient Comfort Assessment Guide, which included the statement and question: “To sell or divert and [sic] of my medication is illegal. Do you give permission to this clinic to report any illegal incident?” Id. at 22. The same form also include the question: “Do you understand this clinic has reported a number of individuals to authorities for illegal behavior?” Id.

Liberty. When Respondent asked Vickery if he had a history of back injuries, Vickery said no, but that he worked in construction and home improvement, and that his age was “starting to catch up to” him. GX 28, at 2; RX G, Disc N-29.

Vickery explained that he had tried ibuprofen but that “it just didn’t,” and that he had got a few “oxys” and they worked.⁷ GX 28, at 2. He then explained that he had seen a Dr. Chapman in Cartersville, who treated him with Dilaudid and Xanax and “sometimes Oxy 30s, sometimes . . . Oxy 15s. It was just whatever I needed for the break through.” Id. at 2-3. Vickery further stated that his previous doctor had written prescriptions for 100 Dilaudid 4mg (but did not keep him on the drug for “very long”), 120 oxy 30s, 90 oxy 15s for the breakthrough, and 60 Xanax 2mg. Id.

When Respondent asked “where are you hurting now,” Officer Vickery did not deny having pain, but replied: “Well, sometimes it’s the shoulder, sometimes the lower back. It just comes in spurts.” Id. at 3. Respondent then asked him how bad his lower back pain was; Vickery replied, “Like today, it’s not bad, because . . . I hadn’t been working because construction has been slow.” Id. at 4. Respondent then stated: “when you’re not working, you don’t have much pain is what you told me.” Id. Vickery agreed with this characterization, stating that he “just kept going,” adding that Dr. Chapman told him to do so. Id. Vickery then told Respondent that he was returning to work the next week, and he wanted “to get on track so I . . . won’t miss work next time.” Id. at 4-5.

When Respondent asked him about his pain levels, Officer Vickery said that without medication, his pain was “probably around a five” on a ten-point scale, but with medication, it

⁷ Officer Vickery also testified that when trying to obtain oxycodone from Respondent, he referred to them as “30s” “because it’s basically street lingo, drug lingo, and that’s what most of the addicts, drug dealers, whatever, refer to the oxycodone as . . . by their milligrams.” Tr. 173-74.

was “almost down to zero.” Id. at 5. Respondent then asked whether Vickery had ever had any treatment other than pain killers, including epidural injections, chiropractic service, physical therapy or surgery. Id. He also engaged in a lengthy discussion with Vickery about his consumption of caffeine, learning that Vickery was drinking about four 24-ounce cups of coffee a day. Id. at 6-8. After Vickery told him that he drank very little water each day, Respondent stated “we’re in trouble,” adding “what if I told you, you were on your way for a dialysis soon?” Id. at 8. Respondent recommended that Vickery cut back on his caffeine consumption and increase his daily water intake, explaining that caffeine can damage the kidneys and contribute to back pain. Id. at 9.

At this point, Respondent referred to a model of a spine, showing those areas when the discs lose water and explaining that this can cause pain. See RX G, Disc N-29. Respondent then reviewed Vickery’s MRI report, and explained that the MRI showed that he had bulging discs, one effacing the thecal sac; one with material affecting the spinal nerve roots; and still another, which had an annular tear resulting in a bulge pressing on a nerve end. GX 28, at 10-11. Respondent warned Vickery that drinking caffeinated coffee and not that much water would cause more pain. Id. at 11. He then stated that “the first thing we need to do is work on these – getting rid of a lot of this caffeine and get you up to maybe half a gallon of water. I think that’s going to make a big difference in your pain. It may get rid of all your pain.” Id.

Respondent had Vickery sit on the exam table and then lie on his back, at which point, he directed Vickery to lift his legs, one at a time, “straight up,” and asked if this “bothered [him] at all”; Vickery answered “no.” Id. Respondent then directed Vickery to turn over onto his stomach, palpated Vickery’s back in several areas, asking if it bothered him. Id. at 12. In response to the first palpation, Vickery replied that “It’s a little tender right there, yeah.” Id.

The next three times, Vickery denied any pain. Id. However, the fifth time, Vickery replied “Well, it’s a little sore to me because I spent [yesterday] washing my car.” Id.

Respondent then asked Vickery if he had tried anti-inflammatories; Vickery answered that he had quit taking them because they didn’t do anything for him and added that the only drug that worked for him were the drugs he was getting from Chapman – the 30s and the “15s every now and then.” Id. at 12-13. Respondent then asked if he had taken Percocet, Vicodin, or Lortab; Vickery replied that he had tried Lortab but that it didn’t work for him. Id. at 13.

Respondent stated that Vickery’s “main thing” was to get away from the caffeine and that he also needed to use the anti-inflammatories for three to four months for them to work. Id. Respondent also asked Vickery if he had tried muscle relaxants such as Flexeril or Robaxin; Vickery said that he had tried them but they “just never worked.” Id. at 13-14.

After Respondent told Vickery he was going to place him on an anti-inflammatory, he asked Vickery when he had last taken oxycodone. Id. at 14. While this visit took place on a Monday, Vickery said that he had probably taken three tablets late Thursday or early Friday morning. Id. Respondent then asked Vickery if he took the oxycodone because he was hurting or just to take them; Vickery did not answer directly, replying that “I could feel something coming on.” Id.

Respondent suggested that this was because of Vickery’s coffee consumption and “not having enough water in your system.” Id. at 15. While he then told Vickery that his “x-rays do show that you have a problem, but your exam is not showing a whole lot at all,” Respondent said: “I’ll try you on maybe two or three times a day and see how that works for you.” Id. He added, however:

I’m not even sure you need that much, because, I mean, your x-ray – your x-ray shows that your nerves are being pinched on, but [unintelligible] I

just don't feel a whole lot. Okay. And what that suggests to me is that if you get away from the caffeine and drink more water, you're probably not going to have any pain at all.

Id.

Vickery then asked if could get some Xanax for "the night." Id. While Respondent told Vickery that Xanax and Oxycodone is not a real good mixture, and that they both "suppress your lungs" and that he "may not wake up," he agreed to prescribe 30 tablets of Xanax 1mg to him. Id. at 15. Vickery asked if he could get 60 tablets, explaining that "my wife kind of uses them, too"; Respondent stated, "No. She can't use your medicine." Id. at 16. When Vickery persisted, saying that "she takes them every now and then, and it's like, come on," Respondent repeated his earlier answer, stating "she's got to get her own medicine," and "[y]ou've got to hide your stuff, [s]he can't . . . take your medicine." Id. After a further discussion of the Vickery's caffeine use, the visit ended.

Officer Vickery paid \$300 cash to Del Percio for the visit. Tr. 167. Respondent issued Vickery prescriptions for 90 tablets of oxycodone 30mg, a schedule II narcotic; 30 tablets of Xanax 1mg, a schedule IV benzodiazepine; and 60 tablets Naproxen, a non-controlled drug. GX 27, at 2.

Officer Vickery testified that he not been taking oxycodone, notwithstanding his representation during the visit. Tr. 171. He also testified that contrary to what he wrote in his medical history, he was not being treated by Dr. Chapman, and had not been prescribed Xanax or Dilaudid. Id. at 172-73. Moreover, he had not been taking oxycodone or any other prescription drugs. Id. at 171, 173. Vickery testified that while he was required to provide a urine sample prior to his visit with Respondent, he did not know what the test results were and they were not discussed with him. Id. at 170.

On cross-examination, Officer Vickery testified that he believed Dr. Chapman's medical office had been closed before his initial visit to Liberty. Id. at 201. Respondent subsequently testified that while he was working at Liberty, he "had heard the word 'pill mill.' Dr. Chapman's office was shut down and they called it a pill mill." Id. at 346. However, Respondent otherwise denied knowing why Dr. Chapman's office was shut down. Id. While the closure of Chapman's clinic may have resulted in Respondent being unable to obtain medical records from it, according to Officer Vickery, Respondent never attempted to obtain his purported medical records from Chapman. Id. at 172.

On September 22, 2011, Officer Vickery returned to see Respondent. Tr. 179; GX 27, at 20. Recordings were made of this visit,⁸ which were also transcribed. See RX G, Disc N-42; GX 29. Prior to seeing Respondent, Vickery completed a form entitled "Patient Comfort Assessment Guide" on which he wrote that he had back pain and circled the words "aching," "sharp," "nagging," "unbearable" and "continuous." GX 27, at 22. Asked by the form to rate his pain in the last month "with medication," he indicated that it was a "6" "at its worst," a "2" "at its least, and a "5" on "average." Id. He also noted that "right now," his pain was a "3." Id. Finally, he noted that oxycodone 30 provided a level of relief of "3," where 0 was "no relief" and 10 was "complete relief." Id.

Officer Vickery's visit with Respondent lasted just under six minutes. See generally RX G, Disc N-42. As was the case with the initial visit, Vickery was required to provide a urine sample for drug screening; however, Respondent did not discuss the results of either the previous test or this test. Tr. 187. Nor did Respondent discuss with Vickery his records from any prior treating physician. Id.

⁸ There are seven video files on the disc, six of which depict people sitting in the clinic's waiting room or Officer Vickery's actions before or after the office visit, and have no probative value. RX G, Disc N-42.

Upon being seated in Respondent's office, Officer Vickery commented on the number of patients yet to be seen in the waiting room while Respondent, who was seated at his desk, made notes on one of about a dozen medical folders before him. GX 29, at 1. Twenty-two seconds into the recording, Respondent rose from his chair and moved to where Vickery was seated. Respondent asked Vickery to lean forward, and after six seconds or so, during which time no one spoke, returned to the chair behind his desk. RX G, Disc N-42, clip 7.

Officer Vickery testified that Respondent "walked over to where I was at, took his hand, r[a]n it down my back; then went back and sat down at his desk." Tr. 181. Vickery stated that in running his hands down his back, Respondent was "kind of just like pushing down, as you're going down from the top of your neck, down towards your body with the tip of your fingers." Id.

At no time during this visit did Respondent inquire of Officer Vickery's pain level, nor did Vickery raise the subject. See GX 29; RX G, Disc N-42, clip 7. Nonetheless, in the Physical Exam section of the Progress Notes for this visit, Respondent wrote "Lumbar – severe tenderness over paravertebral muscle with [two up arrows] muscle tone." GX 27, at 20. Nothing in the recording, however, suggests that Officer Vickery indicated either by word or physical response that he was experiencing severe tenderness in any part of his body. See GX 29; RX G, Disc N-42, clip 7.

Similarly, the progress note describes Officer Vickery's chief complaint as "pain is 5 with medication." GX 27, at 20. While on the "Patient Comfort Assessment" form for this visit, Vickery circled "5" as his average pain "in the last month with medication," he also circled "3" as his pain "right now." Id. at 22. Moreover, at no point in the various recordings of the visit, did Vickery assert to either Del Percio or Respondent that his current pain level was a 5, or even suggest that he was then in pain. See GX 29; RX G, Disc N-42, clip 7.

Upon Respondent's returning to his desk, he asked Vickery how the medicine was working for him. GX 29, at 1. While Vickery said "It's fine," he then added that someone had told him that he was taking Opana (oxymorphone) and that it "was working out better for them." Id. at 2. Vickery then said that "you gave me the 30's, but I . . . think I still need some of those 15's during the in between the times." Id. Respondent then asked Vickery if he was taking the anti-inflammatory; the latter replied that he took some of them but "I just don't like it." Id.

After a discussion of Vickery's consumption of both coffee and water, Vickery told Respondent that "it just seems like in between my 30's, I need something in between there." Id. at 3. When Respondent suggested that "that's where the Naproxen comes in," Vickery replied "that it just didn't do anything." Id. Respondent told Vickery that while the Naproxen "feel[s] like it's not doing anything, . . . it's working for you." Id. Vickery took issue with Respondent, explaining that "[b]ut then I'm having to . . . put some beers on top of it to kind of go through all that stuff." Id.

After asking Vickery if he was "taking 90 of the Oxycodone" and Vickery asked if he could "up them," Respondent agreed and added, "[w]e'll take you up to 120" and "[s]ee if that works better for you." Id. Vickery then asked Respondent if he thought that Opana was "worth anything"; Respondent answered that different drugs work differently on different persons and offered to prescribe Opana, while rejecting Vickery's request to try Opana with the Oxy 30s. Id. at 3-4. Respondent then told Vickery that he could "go with just the plain Opana by itself, or you can go with the Oxycodone." Id. at 4.

Officer Vickery then asked if he got the Opana, could he also "get some of the 15's just in case." Id. When Respondent said "no," Vickery replied: "Doc, you killing me, man. Even if I float you a little bit extra on the side, maybe a couple hundred bucks on the side to." Id.

Respondent again said “no,” and then explained that Opana came in 10, 20 and 40 milligram dosage units. Id. Vickery asked if he could “get the 40’s”; Respondent replied: “I would try it three times a day” and asked Vickery if he “want[ed] to try that?” Id. Vickery agreed, notwithstanding that Respondent told him that Opana was “pretty expensive,” but then asked for some Lortabs for “in between them,” adding that the Naproxen “just doesn’t work.” Id. at 4-5. Respondent insisted that the Naproxen would work with time. Id. at 5.

Apparently upon reviewing the prescriptions, Officer Vickery complained that Respondent had decreased the amount of his Xanax prescription. Id. When Respondent explained that he had gotten 30 last time, Vickery complained that “they didn’t last me all month. . . . They didn’t last at all. You being stingy, Doc.” Id. Vickery’s visit with Respondent then ended.

Respondent gave Vickery three prescriptions: one for 90 Opana ER 40mg, a schedule II controlled substance, one for 30 Xanax 1mg, and one for 60 Naproxen. GX 27, at 21. Moreover, Respondent did not document in the medical record Vickery’s attempt to buy extra drugs from him. Id. at 20.

Officer Vickery testified that his goal in this visit was to determine whether he could get more Opana (oxymorphone) or oxycodone, and he was “just kind of bargaining to see what I could get . . . prescribed to me, just by asking for whatever.” Tr. 182-183. As Vickery put it, the exchange recorded during this visit would best be described as one between a “drug dealer and a supplier.” Id. at 184.

On October 24, 2011, Officer Vickery made a third office visit with Respondent. GX 30, at 26. A video recording and transcript of the visit were entered into evidence. One video file

captures the office visit from start to finish and provides a fairly steady view of Respondent from across his office desk. RX G, Disc N-49, Clip 4.

As with the first and second visits, Del Percio had Officer Vickery produce a urine sample for drug screening, but neither he nor Respondent discussed the results of this screening with Vickery. Tr. 187. Thus, there was no discussion of any possible inconsistency between what Vickery told Respondent about his current use of narcotics and the results of his urine screen – although Vickery testified that he was not taking any medications at the time of this office visit. Id. at 188.

Once again, Vickery completed a Patient Comfort Assessment form, in which he complained of back pain that was “aching,” “exhausting,” “nagging,” and “continuous.” GX 27, at 28. Rating his various pain levels “in the last month with medication,” Vickery circled “O” for the “worst” his pain was, the “least” it was, and his “average” level. Id. However, he then circled “3” for his pain level “right now.” Moreover, while he then wrote that “meds” made his pain better, he also wrote that Opana 40mg provided no relief, oxycodone 30 provided relief at a level of 1 (where 0 was “no relief” and 10 “complete relief”), and that Xanax 1mg provided no relief. Id. at 28-29.

The entire office visit with Respondent took approximately seven minutes. RX G, Disc N-49, Clip 4. About two minutes elapsed at the beginning of the visit, during which Respondent remained seated behind his desk, apparently making notes in Vickery’s medical record. Id. During this time the dialogue between Respondent and Officer Vickery focused almost exclusively on the medications that were prescribed, with Respondent asking “how’s the medicine working for you,” and Vickery reporting that “[i]t’s good,” but that he would “like to get something for” break-through. GX 30, at 2. Respondent then asked Vickery if he had “taken

Lortabs”; Vickery replied that “I may have before,” and added that he thought “the Percocets do better than the Lortab.” Id., See generally RX G, Disc N-49, Clip 4.

Vickery then explained that the Opanas “went pretty quickly,” asked Respondent if he could “raise some of them or may be up the Percocet,” and added that “the Oxy 15’s worked perfect for me in between . . . everything.” Id. Notwithstanding that he had not previously prescribed Percocet to Vickery, Respondent asked: “you’re taking the Percocet also?” Id. Vickery answered that he had “taken them before with the Oxy,” at which point Respondent left his chair and asked if he could press on Vickery’s back. Id.

The entire exam lasted less than thirteen seconds, and while the video does not show what it involved, Officer Vickery testified that this exam involved his “just lean[ing] over in the chair. [Respondent] would take his hands, both rub from the top to the bottom. . . .” Tr. 189. As this occurred, Vickery stated that he “was always the getting the 30’s . . . and then I’d take the 15’s in between” and that Chapman “was giving me 180 of the 30’s” and “90 or 120 of the 15’s in between, something like that . . . [a]nd those seemed to get me through the whole 28-day cycle.” GX 30, at 2-3. After Respondent said that Liberty used a 30-day cycle and that Vickery was “here a little early,” Vickery maintained that “this is the appointment he gave me” and Respondent conceded that it was not Vickery’s fault. Id. at 3.

Vickery explained that he had a hard “time getting a ride up here” and that he had been dropped off by his buddy. Id. Vickery then told Respondent that his buddy liked Xanax and had asked him to give Respondent “200 bucks and see if he” would write a prescription for Xanax. Id. Respondent laughed; Vickery showed him the cash and said: “I don’t know if you can do that and put it in my name for an extra – or up my Xanax some.” Id. at 3-4. Respondent replied: “No, we can’t do.” Id. at 4. Vickery asked: “Can we do that?”; Respondent answered “no.” Id.

Vickery then asked if he was getting 40 Percocet; Respondent said “right.” Id. Vickery then complained that Respondent was “stingy,” explained that he “was used to what [he] was getting,” and asked if he could up the Xanax prescription because the 30 tablets “didn’t get me through two, three weeks.” Id. When Vickery further asserted that he had been getting 60 of the two milligram Xanax, Respondent stated that he had been “doing 45.” Id. Respondent then suggested that if Vickery’s friend had a problem with anxiety and needed Xanax, he could go to a walk-in clinic. Id. Vickery then asked: “so you can’t do nothing?”; Respondent said “No.” Id.

Respondent gave Vickery prescriptions for 90 tablets of Opana 40mg, 45 tablets of Xanax (an increase from 30), and 40 tablets of Percocet 10/325, which was an additional prescription.⁹ GX 27, at 27. On each of the controlled substance prescriptions, Respondent wrote: “an emergency exists for Rx.” Id.

Here again, Respondent did not document Vickery’s attempt to purchase additional controlled substances from him. See id. at 27. Instead, he wrote that Vickery was “having more problems [with] anxiety.” Id.

Officer Vickery returned for a fourth visit to Liberty Wellness Center on December 1, 2011. GX 31; GX 27, at 32-37; RX G, Disc N-54. Vickery testified that he was intentionally one week late for his appointment so that “I would have been out of my medication for over seven days.” Tr. 194. Before meeting Respondent, Officer Vickery was required to produce a urine sample and complete another Patient Comfort Assessment form. Tr. 191; GX 27.

On the form, Vickery noted that he had back pain which was aching, exhausting, and tiring, but was only occasional. GX 27, at 34. Rating his worst, least, and average pain level in the last month with medication, Vickery circled 0, indicating no pain, for all three levels. Id. However, he then claimed that his pain was a “3” “right now.” Id. While he also wrote that

⁹ He also wrote him a prescription for Naproxen.

“meds” made his pain better, he then indicated that each of the three drugs (Opana 40, Percocet 10/325, and Xanax 1mg) provided “0” relief. Id. at 34-35.

Upon meeting, Vickery told Respondent that the Opana was “doing good” and was “unbelievable,” but that he had been “talking to some people” who said he could get “25 milligram caplets” instead of the oxy 30 pills. Id. at 3-4. Respondent asked Vickery where he would get “those filled”; Vickery replied that someone told him he could go to a pharmacy (Stacy’s) that did compounding. Id. at 4. After Vickery said that he had heard in the lobby “that the pills are getting scarce,” Respondent replied: “yeah, yeah, yeah.” Id. Respondent then advised Vickery that he may want to check with the pharmacy “to see if there’s any available because sometimes they have it and sometime they don’t.” Id.

After some small talk about Thanksgiving, Respondent asked Vickery to rate his pain on the one to ten scale; Vickery replied that it was “[a]round 3,4” but that “it comes and goes.” Id. at 5. Respondent then asked Vickery to rate his pain when he was “on the medicine”; Vickery replied that it was “down around almost nothing really on the medicine.” Id.

Respondent then got up and asked Vickery to let him “press on [his] back a little bit”; Vickery agreed. Respondent asked Vickery to lean forward, pressed on Vickery’s back and asked, “[d]oes that bother you?” Id. While Vickery’s answer is unintelligible, Respondent then asked, “[b]ut not a lot of pain?” Id. at 5-6. Vickery replied: “I guess today I’m having kind of a good day . . . but then again, I didn’t work today.” Id. at 6.

Respondent said “[t]hat a good thing” and added that “I don’t even think you need those 25’s,” a point which he then reiterated. Id. Vickery stated that “I really do, Doc. I need the 25’s, especially since I been taking all that other stuff. I been taking the Opanas, and I had Percocets.” Id.

Respondent then observed that Vickery was “a week late” and was “still not having much pain.” Id. Vickery replied, “Okay, well, I’m having a lot of pain Doc,” to which Respondent said “no” and started laughing. Id. Vickery insisted that he was “in a lot of pain” and that “Doc [your] kill [sic] me.” Id. After Respondent replied, “no, no,” Vickery asked him for “something to hold me” because “it’s going to be a mess” when he resumed working. Id.

At this point, Respondent, for the first and only time during Vickery’s four visits, discussed his urine test results, noting that “you’re doing good. I mean, your urine doesn’t show any medicine in your system. You’re not having much pain. I mean, you’re actually doing pretty good.” Id. After Vickery said “okay,” Respondent added: “I’m not sure if you need much of anything.” Id. Vickery then asserted that he needed “at least my oxy’s . . . and my Xanax,” prompting laughter from Respondent, who after an unintelligible comment by Vickery, asked: “What, the anxiety’s bothering you a bit.” Id. at 6-7. Vickery asserted that he knew “I’ll have to have it because . . . it may not be going on right now, but . . . it will.” Id. at 7. Respondent then told Vickery that “you may not need anything but the Xanax and the Naproxen. Id.

After Vickery explained that he didn’t take the Naproxen and did not “even like it,” Respondent again asked Vickery “so how much pain are you having today?” Id. Vickery said, “well, I guess now I’m having . . . up in the five, six, seven,” and Respondent observed, “That’s not what you told me when you came in.” Id. Vickery then stated, “I’ll say around four, okay”; Respondent said: “But that’s not what you told me.” Id. After Vickery stated that “I said three or four,” Respondent acknowledged that he “did write down three.” Id. However, Respondent then stated that “when I pressed, you’re not having much tender[ness],” noted that there was “no medicine in [Vickery’s] system,” and added “you don’t need much of anything.” Id. Vickery

asserted that he was “going to have to have something,” and that he would find a different doctor “to go to next month,” prompting more laughter from Respondent. Id. at 7-8.

Vickery then explained that the Opanas “were good” but expensive; Respondent reiterated that there was no medicine in his urine. Id. at 8. Vickery stated that he didn’t know why, suggested that “maybe the urine screen is wrong,” and added that he had taken “one a couple days ago.” Id. Respondent subsequently asked Vickery how much pain he felt when his back was pressed on; Vickery did not answer directly, stating that he “hadn’t done anything today” and that he worked “for the last couple of days” and hadn’t done anything “to aggravate” it, but that he was going back to work the next day and that if his “appointment had been tomorrow . . . it would probably be[] a whole different story.” Id. at 8-9.

Respondent said “okay,” and added: “I think you can probably get away with using maybe either some Percocet or some oxy 15’s.” Id. at 9. Vickery then said that he would “really like to get some of the 25’s, noting that there was “not that much difference” between the 15’s and the 25’s. Id. Respondent agreed, Vickery asked “why can’t we do the 25’s, and I can get the caplets,” Respondent said “okay,” and Vickery asked for “some Percocets in between.” Id.

Respondent then asked Vickery if he would check the pharmacy “and see if they have any 25’s?” Id. Vickery replied that he did not “have a number for them,” and added that he was “sure they can make them” and “can get the stuff.” Id. Vickery added that “they can fill my . . . Xanax to hold me till they can make . . . the other stuff.” Id. He then complained that Respondent was “getting hard to work with.” Id.

Respondent replied, “No. I’m easy, but . . . I don’t need you taking anything if you’re not having any problem because that’s not good for you. And that’s where the problem is.” Id. at 10. Respondent then observed that Vickery had almost no pain when he was on medication and that

his pain level was only a three when he was not taking medication.¹⁰ Id. Vickery then insisted that his “3 may be somebody else’s 7, 8,” to which Respondent replied “that’s a good thing” and “that means you don’t need as much medicine,” and laughed. Id. Vickery then said: “yes I do, yes I do, Doc. Yes, I do.” Id.

Respondent reiterated that it was “a good thing” that Vickery did not “feel as much pain as someone else” and did not “need as much medicine” as other persons. Id. Vickery then stated: “I like what I take, Doc, so – I been – used to taking it[,] kind of where I’m at.” Id. Respondent replied that if “you’re used to taking it, then we’re talking about somewhat of a dependency here, okay,” and laughed. After an unintelligible remark from Vickery, Respondent stated that he was going to “try and wean” Vickery “down some,” because he did not “need as much as . . . what you’ve been taking.” Id.

When Vickery asked what this involved, Respondent explained that: “I can’t just cold turkey you, either, because then you have some withdrawal problems. But you haven’t taken it in seven days, so I doubt you would have that.” Id. at 11. Respondent then laughed, and added, “[t]here none in your system,” and again laughed. Id.

Vickery complained that Respondent was being stingy; Respondent replied that he was “trying to keep [him] out of trouble,” noting that “everything suggests to me that you don’t need as much as you had before.” Id.

Vickery then asked “how many 25’s” he could get”; Respondent stated that he “was on 90” and if he “got the 25 a couple of times a day,” that would keep Vickery “out of trouble.” Id. When Vickery then sought some Percocets for “in between,” Respondent said “no” and that “[y]ou’re not hurting in between.” Id. Vickery replied, “Okay, my pain is higher now. Now

¹⁰ Having compared the transcript with the video recording, I conclude that Respondent actually said: “when you’re not taking any, your pain level is only at a 3.” RX G Disc N-54.

since I sat here and talked to you, my pain is higher.” Id. Respondent laughed, and Vickery stated: “You really got to be a pain in my back Doc. Now, I’m getting higher.” Id.

Respondent laughed, and said that he would prescribe the 25’s “maybe twice a day and see how that works for you.” Id. Vickery then sought more drugs for “in between” and asked if he could get Lortab. Id. at 12. While Respondent initially agreed to prescribe “maybe one Lortab a day,” Vickery then complained that he was only getting 60 oxycodone 25’s, and asked if he could get 90. Id.

Respondent then asked if Vickery “was on 90 of the Opanas,” and after Vickery confirmed this, Respondent agreed to prescribe 90 oxycodone 25s but not the Lortabs. Id. Vickery said “that’s fine” and asked “What about Somas in between? What would those do?” Id. Respondent said that it was “a muscle relaxer” and agreed to prescribe the drug, telling Vickery that he could take them at bedtime and not at work. Id. Vickery said “okay,” and Respondent said that he “did feel some tight muscles back there,” to which Vickery replied, “[s]ee, they’ve gotten tighter since I’m talking to you.” Id. Respondent laughed. Id. at 12-13.

Vickery then said he would have to ask Del Percio for the pharmacy’s phone number; Respondent said there were other places that made compounds. Id. at 13. Respondent then reiterated his statement that Vickery was “doing better” and that “the medicine is working for you,” adding that “you probably don’t need as much as what you’re taking” as he had not had medication for a whole week and was not “bending over in pain or anything.” Id. at 13-14. Respondent then gave Vickery the prescriptions, after which Vickery said: “I’ll be in more pain next time.” Id. at 14. Respondent replied: “No, no, no, no no,” and Vickery said: “I know what you’re saying. I’m just messing with you.” Id. Following an exchange of pleasantries, Vickery left Respondent’s office. Id.

Vickery then saw Del Percio and asked him about the name of the pharmacy that did the caplets (oxy 25). Id. at 15. Del Percio told Vickery that he could not “get those today” and asked “why’d he give you those.” Id. Vickery explained that he could not afford the Opana and that he had been told “that there were no pills around.” Id. Del Percio told Vickery that Stacy’s Pharmacy did not have any caplets available today and that Vickery was to call him the next morning and that he (Del Percio) would then call the pharmacy to check on whether the caplets would be available. Id. Vickery agreed to “do that,” and Del Percio explained, “that’s how it works over there.” Id. Vickery then left Liberty. Id.

Consistent with the recording and the transcript, Respondent provided Vickery with prescriptions for three drugs. GX 27, at 33. The prescriptions were for 90 oxycodone 25mg, 30 Xanax 1mg, and 30 Soma (carisoprodol). Id.

As the ALJ found, this visit “can only be described as a negotiation over the quantity of narcotics Respondent would prescribe for Officer Vickery.” R.D. at 44. Officer Vickery summarized this office visit in these terms: “It appeared to me, because it was almost like it was starting out, he didn’t want to give me anything. And then the further we went along and the more I kept changing my story here and there, he just decided, well, okay, we’ll just go with it.” Tr. 196.

The Visits of TFO Lawson

In his role as C.F., TFO Lawson made two office visits to Liberty, the first on August 2, 2011, the second on September 2, 2011. Tr. 78; GX 40 at 3. He stated that his objective was to investigate “the general activity of the clinic” and “to obtain prescriptions for controlled substances for no legitimate purpose.” Tr. 81; GX 40, at 3. To do this, he “was to make as

minimal complaint as possible, provide as few indications of pain as [he] reasonably could, and to try to show that [he] was involved in diversion.” Tr. 81.

TFO Lawson testified that Del Percio conducted the initial intake on August 2, 2011. On intake, Del Percio asked Lawson if he had an appointment (Lawson saying “yeah”), where his MRI was (with Lawson saying that “it should have been faxed to you” and “when I called I thought you had it”), and if all he was then taking was Endocet. GX 23, at 1. Lawson replied that this was the drug he got at an urgent care center he went to and that his pain clinic (which he later identified as Atlanta Medical Group in Cartersville) had been “shut down.” Id. at 1-3. Del Percio then asked Lawson again about his MRI and if he had gotten it done at Greater Georgia Imaging, with Lawson answering “yeah.” After searching through various documents for the MRI, Del Percio told Lawson that he would “have them fax over a copy” and not to “worry about it.” Id. at 2. See generally RX G, Disc N-13.

Next, Del Percio asked Lawson for his last name and date of birth and had him sign and date a form, after which he gave him paperwork to complete and asked him to clip his ID to the forms when he was done. GX 23, at 2-3. Included in the forms was one which solicited general health information; on the form, Lawson listed his “chief complaint” as his back, wrote that the pain started “3 years ago,” and that it was the result of an “accident in military.” He also indicated that his pain was a 5 without medication and a 2 with medication on a scale of 0 to 10, with “0 being no pain and 10 being the worst pain possible.” GX 22, at 5.

Del Percio asked Lawson where he had previously gone and how he had heard about Liberty; Lawson replied that a buddy had told him and that “everybody else was giving me the runaround because my place was shut down.” Id. at 3. Del Percio then gave Lawson an

additional form to complete, again asked him to clip his ID to it when he was done, and told Lawson that he would need to provide a urine sample.

After completing the interview, Del Percio collected \$300 in cash from Officer Lawson and brought him into Respondent's office, where after exchanging pleasantries, Respondent stated that Lawson's x-rays¹¹ showed that he had "a little bulging disc" and asked if he had "any injuries at all to [his] back." GX 23, at 4. Lawson said that "ten years ago," while he was "in the military," he was in a Humvee that "went off the road." Id. Respondent asked Lawson where he was now hurting; Lawson said, "about mid-back." Id.

Respondent then asked, "[d]oes the pain go anywhere?" Lawson said that it depended on what he was doing and that he hadn't "been at work today." Id. at 4-5. He then explained that on a normal day, "it's usually all in the same place." Id. at 5. However, Lawson denied having "any numbness or tingling in [his] legs." Id. Respondent then asked Lawson to rate his usual pain level on a scale of one to ten; Lawson said "five." Id.

Next, Respondent asked if anyone had recommended that Lawson receive injections or surgery and if he had seen either an orthopedic surgeon or neurosurgeon. Id. Lawson answered "no" to both questions. Id. Respondent also asked if this had been "looked at in the military," Lawson said that "was so long ago," and after he "got out," he "went to the VA," but "they patch you up and send you on." Id. Respondent then asked Lawson if he would want to undergo surgery; Lawson answered "[n]ot necessarily." Id.

¹¹ Lawson's undercover patient file included an MRI report which is dated July 22, 2011 and which lists the referring physician as "LIBERTY." GX 22, at 3. The report notes "no significant disc disease at L1-L2, L2-L3, and L3-4." Id. At L4-L5, the report notes that "[t]here is broad based low grade disc bulging abutting the ventral thecal sac without significant mass effect or nerve root impingement," and at L5-S1, it notes that "[t]here is posterior low grade disc bulging without significant mass effect identified." Id. The report further notes that "[t]here is no extruded disc herniation identified at any level" and that "[t]here is no central canal or neural foraminal canal stenosis see." Id.

Respondent asked Lawson about his fluid consumption. Id. Lawson said that he usually drank three cans of Mountain Dew a day, a glass of tea at both lunch and dinner, four bottles of water, and alcohol on the weekends. Id. at 6-7.

Next, Respondent asked Lawson what medicines he had taken that had helped. Id. at 7. Lawson stated that when he “was going to Atlanta Medical Group,” he was taking oxycodone, Soma, and “Xanax to help with the jitters.” Id. Lawson further stated that he was taking the thirty milligram oxycodone, “at most . . . 3 a day”; that he thought he was supposed to take one Soma a day but that the clinic had “been shut down for two months”; and that he took the Xanax two milligram tablets. Id. Respondent then noted that Lawson been “taking something in the past month”; Lawson explained that he had gone “to an urgent care place” after his “clinic got shut down,” where he got “two weeks” of Percocet, which “hardly” worked for him. Id.

Respondent then asked if Lawson had ever been prescribed the oxycodone 15’s; Lawson replied that it had “been so long when they did this,” but “at one point” they gave him “a few of the 15’s to try to cut down on taking the three 30’s a day.” Id. Lawson then denied that the 15’s had been prescribed in the place of the 30’s, and when Respondent suggested that they had been given to him “for breakthrough,” he agreed. Id. at 8-9.

Respondent then told Lawson that he was drinking a half gallon of caffeine a day, plus alcoholic beverages on the weekend, and that this was causing his body to lose water, and that “the less water you have in your system, the more pain you’re going to have.” Id. at 9. Continuing, Respondent stated that a muscle that is not “well hydrated goes into spasms” and causes pain. Id. He also told Lawson that his caffeine consumption was “going to mess up [his] kidneys” and that he was surprised that Lawson was “even sleeping at night drinking that much caffeine.” Id.

Respondent then showed Lawson a model of the spine and explained that his discs lost “water throughout the day” and because he was drinking lots of caffeine, the discs were not filling back up with water at night while he was sleeping. Id. Respondent explained his “x-ray” showed he had a bulging disc, pointed to where the disc was on his spine model, and explained that he actually had two bulging discs, one “between L4 and L5,” that was “actually coming near or pressing on the spinal cord a little bit,” and one at “L5-S1, where it’s just back here bulging.” Id. at 9-10. Respondent then reiterated his earlier advice that Lawson needed to reduce his caffeine consumption to one can of Mountain Dew per day and to increase his water consumption to six bottles per day. Id.

Respondent then asked Lawson to sit on the exam table and performed a physical examination. Id. The video shows that the exam consisted of Respondent testing Lawson’s left and right patellar reflexes with a hammer; having Lawson lie on his back and raise each leg and asking whether each movement hurt, with Lawson saying no¹²; having Lawson turn over on his stomach and asking him whether this movement “bother[ed]” him, with Lawson saying “um, a bit”; followed by Respondent palpating Lawson in several areas and asking “[r]ight in here,” with Lawson answering “[r]ight in there”; upon which Respondent concluded that Lawson had muscle spasms which he asserted were caused by Lawson’s caffeine consumption. See generally RX G, Disc N-13; see also GX 23, at 10-11.¹³

¹² In the progress note, Respondent noted that each straight leg lift was “unremarkable.” GX 22, at 1. He also wrote that he found moderate tenderness in the paravertebral muscles and muscle spasms in both Lawson’s thoracic and lumbar regions. Id.

¹³ Regarding the physical examination, Respondent testified that the deep tendon reflex he observed in performing the patellar examination was normal and the leg lifts were unremarkable for both legs, suggesting that there was no nerve impingement in the area of Lawson’s lumbar spine. Tr. 321. According to Respondent, the MRI presented by Officer Lawson “was abnormal,” and there was “moderate tenderness of [the] paravertebral muscles . . . with increased muscle tone.” Id.

Respondent then told Lawson that he needed to do back exercises (although Liberty was out of back-stretching sheets) and asked if he had ever taken anti-inflammatories such as Naproxen or Motrin. Id. at 11. Lawson replied that he had gotten Naproxen “along with the other medicines.” Id. Respondent then asked Lawson if he had ever taken Flexeril; Lawson replied that he believed he did. Id. Respondent told Lawson that it was a muscle relaxer and asked how it worked for him; Lawson replied that he “really couldn’t say.” Id. at 11-12. Respondent then asked Lawson if “the Soma work[ed] better for you; Lawson said “yeah.” Id. at 12.

Respondent then asked whether the Percocet had helped him; Lawson replied that “it didn’t seem like it was doing anything . . . it just didn’t touch.” Id. Respondent then said he was going to try Lawson on “the oxycodone, the 15’s . . . maybe four times a day” and “we’ll see how well that works with you”; Lawson said “all right.” Id. Respondent then stated that he thought that “a lot of the problems we’re seeing is just these tight muscles” and “you got some pain in the lower back, where you showed the disc problem, but I think a lot of it’s just the muscle spasm.” Id. Continuing, Respondent explained that “then we’re talking about stretching the muscles, take the muscle relaxer, and then the anti-inflammatory, something for pain, then stretching those muscles. But if you . . . don’t decrease your caffeine, they’re going to stay tight. And they’re going to continue to bother your body.” Id. Respondent reiterated his earlier advice on fluid intake, provided Lawson with prescriptions for 120 oxycodone 15mg and 30 Soma 350mg, (as well as Naproxen), told him he would see him in a month, and the visit ended. Id.; GX 22, at 2.

On September 2, 2011, TFO Lawson returned to Liberty. GX 22, at 21; GX 24. Prior to seeing Respondent, Lawson completed a form entitled “Patient Comfort Assessment Guide,” on

which he identified his pain as being in his “lower back” and circled that it was “aching,” “sharp” and “continuous.” GX 22, at 23. He also rated his “worst” pain in the last month as a “9,” his “least” pain as a “6,” his “average” pain as a “7,” and his pain “right now” as an “8.” Id. He also noted that “medication” made his pain better, but then indicated that oxycodone 15 provided “No Relief.” Id. at 23-24. Lawson’s visit with Respondent lasted under six minutes, with the physical exam lasting approximately fifteen seconds. See generally RXG, Disc N-34.

Upon meeting, Respondent and Lawson exchanged pleasantries, and Respondent asked Lawson how the medicine was working for him. GX 24, at 1-2. Lawson replied: “Well, the clinic I was going to before — I was taking 30 milligram and the 15’s aren’t as affective [sic] as the 30’s were.” Id. at 2. Respondent then asked Lawson to rate his pain on a one to ten scale; Lawson replied: “it has gotten worse than last time. It was — it’s about an eight or a nine.” Id. Respondent said “okay” and asked: “and with the 30’s you were — where were you running?” Id. Lawson then stated that “on the medicine,” he was “[u]nder five.” Id.

Respondent replied: “Okay. So we need you under five,” and asked if Lawson was “taking the anti-inflammatories?” Id. Lawson asked “is that what the Naproxen is,” and after Respondent confirmed this, Lawson said: “Yeah. You gave me that.” Id. Respondent then asked, “[w]hat about those Mountain Dews?”; Lawson answered that it was “harder to give up” caffeine than smoking, but added that he had been “drinking more water though.” Id. After Lawson promised to do better, Respondent asked how many Mountain Dews he was drinking a day; Lawson answered: “maybe three. Is that still too much?” Id. at 3. Respondent said it was “too much” and that if Lawson would “give up the Mountain Dews, [he] probably wouldn’t have that much pain now” and that he needed him “on like one Mountain Dew a day.” Id.

Respondent then asked Lawson if he was “taking the 30’s three times a day before?”; Lawson answered “correct.” Id. Respondent then asked Lawson to lean forward in his chair, palpated his back, and noted that “you’ve got all these muscles spasms here” and “[w]ith that caffeine they’re not going anywhere.” Id. at 3-4. Respondent and Lawson engaged in further discussion of the latter’s caffeine consumption, followed by a discussion of Lawson’s fortuitousness in arriving at the clinic before it closed for the weekend. Id. at 4-5.

Respondent provided Lawson with prescriptions for 90 oxycodone 30mg, 30 Soma 350mg, and Naproxen. Id. at 5; GX 22, at 22. The visit then ended. GX 24, at 5.¹⁴

Regarding the visits, TFO Lawson testified that at no time did Respondent ask why he traveled from Thomaston to Norcross, a distance of 84 miles (GX 40, at 3), in order to receive treatment. Tr. 91-92. He also testified that Respondent never asked the names of his prior treating physicians, and although he did require Lawson to produce a urine sample, he never discussed the results of the sample, even though Lawson testified that to his knowledge he had no drugs in his system at the time this sample was taken. Id. at 92. TFO Lawson added that at the start of the initial office visit at Liberty, he told Del Percio that he was currently taking Endocet, a drug combining oxycodone and acetaminophen. Id. at 93. While Lawson told Respondent he had also been treated at a Veterans Administration hospital and at a clinic in Cartersville, to the best of his knowledge Respondent never attempted to confirm any of these statements. Id. at 94-96.

Respondent testified that when TFO Lawson reported his medical history, the latter told him that he was using an existing prescription for oxycodone 30 mg, which Respondent noted on

¹⁴ At the hearing, Respondent contended that various portions of the transcripts were inconsistent with the recordings. See Tr. 314-16. The ALJ carefully reviewed the recordings in light of Respondent’s testimony and found that the transcripts were “substantially accurate reports of what the parties said during these visits.” R.D. at 8-9. The staff of this Office has also watched the videos and agrees with the ALJ’s conclusion that the transcriptions are substantially accurate and notes that any errors are not material.

the progress note. Tr. 323; GX 22, at 1. However, the recording and the transcript establish that Lawson said that the pain clinic he had previously gone to had been shut down two months earlier and that he had since gone to an urgent care center from which he received only Percocet. GX 23, at 1, 8; RX G, Disc N-13.

Respondent further testified that he would normally take steps to confirm a prior prescription, but acknowledged that he did not do so in this case and offered no explanation for failing to do so. Tr. 325. While Respondent also testified that the clinic Lawson identified as his prior treating source had closed, and then asserted that this was why he would not be able to obtain records from it, he gave no explanation for why he could not obtain the same information by contacting Lawson's pharmacy. Id. at 325-326. Nor did he explain why he did not contact the urgent care clinic which Lawson claimed he had recently gone to. Id.

The Visit of TFO Manning

On or about October 24, 2011, a fourth TFO also went to Liberty in an attempt to see Respondent. According to the video recording, the TFO did not have an MRI report and instead provided Del Percio with a letter from a doctor. See RX G, Disc N-51. On reviewing the letter, Del Percio observed that "if you read his comments there's nothing on there. This is like his examination. Where is the MRI report? . . . if you read his comments, there's nothing there. This is his review" [and it says there] is "no evidence of lumbar disk herniation, no nothing, MRI was unremarkable." Id. Del Percio then reiterated that he needed an MRI report and not the films because the doctor's letter did not show him anything and told the TFO to have the report faxed. Id.

A short while later, the TFO placed a phone call to Del Percio, in which he stated that he was going to New York the next day and that he hoped to get his prescription filled. Id. Del

Percio explained that he could not use the letter the TFO had provided and that “the doctor would laugh at me if I tried to hand that” to him. Id. The TFO then told the Del Percio if he could get in to see Respondent, he would “get another one while” he was in New York and that he would “take care of” Del Percio. Id. Del Percio replied that “[i]t’s not about that man, we cannot do that. We cannot risk anything like that . . . the Dr. is not going to risk his license. He’s just not going to [] He can’t see a patient without one.” Id. After the TFO again promised that he would “take care” of Del Percio, the latter stated that “he couldn’t do it” and “that he had to have something to show because otherwise any person could walk in off the street and say Oh hey, I got pain.” Id. The TFO then stated that there were a lot places that do that, to which Del Percio replied that they were shut down. Id.

Regarding TFO Manning’s attempt to see him, Respondent testified that “there’s only one agent that really came into the office for no legitimate medical reason” for a prescription. Tr. 292-93. Continuing, Respondent testified that “[i]f you come in and you complain of pain, you have a positive MRI, you have findings on your exam, it suggests that your pain is real and your MRI is real. Whether you are a good actor or a bad actor, that suggestion is still there.” Id. at 293-94.

The Expert Testimony

Both the Government and Respondent elicited testimony from an expert witness, the Government calling Thomas E. Hurd, M.D., and Respondent calling Carol Anastasia Warfield, M.D. GX 37; RX F2. Dr. Hurd holds a doctor of medicine degree from Northwestern University Medical School, held a fellowship in critical care medicine at the Department of Anesthesia, University of Florida, and is a diplomate of the American Board of Anesthesiology, the American Board of Pain Medicine, and the American Board of Interventional Pain

Physicians. GX 37, at 1; Tr. 434. He further testified that in 2005, he did a Fellowship in Interventional Pain Practice and is certified by the World Institute of Pain. Tr. 434.

Dr. Hurd is licensed in four States, including Georgia, and has been president of Pain Solutions Treatment Centers, a multi-clinic interventional pain practice located in Georgia. GX 37, at 1-2. He has testified as an expert in pain management and chronic regional pain syndrome in other proceedings. Tr. 440. Dr. Hurd further testified that he currently practices only interventional pain medicine and that fifty to seventy percent of his practice involves treating chronic pain patients. Id. at 449.

Dr. Warfield holds a Doctor of Medicine degree from Tufts University Medical School, did a fellowship in anesthesia, and is a diplomate of the American Board of Anesthesiology and a Fellow of the American Board of Pain Medicine. RX F2, at 1. Between 1980 and 1986, she was an Instructor in Anesthesia at Harvard Medical School, after which she became a Professor of Anesthesia at Harvard Medical School. Id. at 2. Between 1980 and 2000, she was the Director of the Pain Management Center, at Beth Israel Hospital in Boston, Mass., and between 2000 and 2007, she was the Chairman, Department of Anesthesia, Critical Care and Pain Medicine. Id. She has also served on the editorial boards of various professional journals. Id. at 6.

Dr. Hurd testified that he had reviewed the Georgia statutes governing controlled substance prescriptions, the Georgia Board of Medical Examiners' regulation defining unprofessional conduct,¹⁵ the Board's guidelines for using controlled substances to treat pain,

¹⁵ Dr. Hurd specifically identified that he had reviewed the provisions defining "unprofessional conduct" to include "failing to maintain appropriate patient records whenever" controlled substances are prescribed, "failing to use such means as history, physical examination, laboratory, or radiographic studies, when applicable, to diagnose a medical problem," and "failing to use medication and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation, or addiction." Tr. 438-39 (discussing Ga. Comp. R. & Regs. R. 3603.02(5), (14), & (15)).

and the Board's "recommendations and guidelines" for identifying pill mills and drug-seeking patients. Tr. 435-36. Dr. Hurd testified that at the initial visit, the patient's history must be obtained from both the patient orally and by obtaining documentation from other sources who treated the patient, after which a physical exam is performed based on the history to arrive at a preliminary diagnosis and a treatment plan is then begun. Id. at 441. While Dr. Hurd acknowledged the role of opioids in giving pain relief, he further explained that it "is incumbent upon the physician to go ahead and engage in other more conservative measures and make sure those have been taken out, such as physical therapy, maybe injection therapy, [and] different kinds of medication modalities." Id. at 442.

Asked to describe what information he needed to establish a diagnosis of chronic pain, Dr. Hurd stated that he would first perform a physical examination. Id. at 450. Second, he would want to see if the patient had any records from other physicians because he did not "want to repeat failed treatments," and if the patient claimed he was on opioids, he would "want to know that another physician has treated them already" so that he would not be "giving the patient a medicine that they're not taking." Id. at 450-51. Later, Dr. Hurd explained that "if a patient is telling you that they took a bunch of medications for legitimate reasons, you'd like to see [that physician's] reasoning, because otherwise, you're basing your entire treatment plan [on] the patient's statement, and . . . not everybody always tells the truth." Id. at 468-69.

Dr. Hurd then added that "almost every patient within the first two visits is going to have an MRI." Id. at 451. Dr. Hurd explained, however, that half of the patients whose MRIs show an abnormality do not "have any pain." Id. Dr. Hurd then testified that an MRI alone "is not sufficient" to form a diagnosis of chronic pain and the MRI's findings must be correlated to the patient's pain complaint "by doing a physical exam . . . that's usually a neurological physical

exam,” and that during the exam, the patient’s motor function, sensory function and reflexes are checked. Tr. 452; see also id. at 484-86 (discussing use of sensory testing to correlate MRI findings with patient’s pain complaint and how different nerve roots correspond to various areas of the body). Dr. Hurd also discussed the importance of testing the strength of a patient’s muscles. Id. at 484.

Dr. Hurd testified that “[t]here are several classes of pain medication,” which vary from lower-risk drugs which include anti-inflammatories, anti-depressants, and “nerve medications,” to higher-risk drugs including opioids and benzodiazepines. Id. at 453-54. He also testified that “[t]here are many” non-drug therapies for chronic pain, including physical therapy, aqua therapy, stretching or exercise programs, trigger point injections, and spinal injections. Id. at 455. When then asked by the Government whether, aside from an emergency or acute situation, there was any situation in which he would prescribe opioids at a patient’s first visit without having obtained the patient’s records from his previous treating physician, Dr. Hurd testified that if he

judge[d] their pain to be severe enough that I would think they needed some help, if I could find on physical exam, their history that they were clearly weak or impaired, I would consider using that as a modality. However, I would also consider using other drugs as a modality as well. Now – and the ones I just talked about: anti-inflammatory medications, antidepressant medications, et cetera.

. . . I’ll give you an example. Suppose somebody just had an acute fall. They saw me two weeks later. They were not getting better. Then I might consider a low dose of opioid therapy, in addition to the other things I’ve already mentioned.

Id. at 456. Later, Dr. Hurd testified that where he had determined that it was appropriate to treat a patient with opioids, he would not normally start a patient on oxycodone 30mg. Id. at 558.

Rather, he would usually start a patient on a combination of oxycodone and Tylenol (acetaminophen), such as Percocet 5/325 or 7.5/325. Id.

Dr. Hurd then explained that he would “absolutely try[] to seek prior treatment records of any other physician that’s treated this patient” and that while “I don’t want to say that a physician doesn’t have latitude to ever use a narcotic . . . it would be a lower dose narcotic, if you thought that . . . there was some reason that the patient couldn’t take or tolerate a different medication,” such as an anti-inflammatory because of “kidney problems.” Id. at 457.

As for how he would address the situation where a patient’s prior practice had closed and the patient’s records were not available, Dr. Hurd testified that he would determine where the patient filled their prescriptions and obtain a pharmacy record. Id. at 458. Dr. Hurd noted, however, that under Georgia law, “[e]very legitimate practice is required . . . to maintain records,” and every physician who retires from practice is required to notify their patients and must keep patient records so that they can be retrieved. Id. at 458-59.

Next, Dr. Hurd testified as to the use of urine drug screens in monitoring pain patients. Dr. Hurd explained that the tests serve two purposes: 1) determining if the patient has been taking the drugs that were prescribed to him, and 2) determining if the patient is taking illegal drugs. Id. at 459-60. He further testified that the use of these tests is “imperative” at a patient’s first visit if a patient has already been on opioids or is asking for them, id. at 461; he also explained that if a patient tests negative for a prescribed medication, “then that means they didn’t take the medicine” and “that usually means [they] don’t need it.” Id. at 462.¹⁶

¹⁶ Dr. Hurd also testified regarding the Georgia’s Board January 2011 Newsletter (GX 39), which contained a two page discussion of the characteristics of “pill mills,” or illegitimate pain management practices, as well as various “red flags” associated with drug-seeking patients. Tr. 463-69. Of relevance here, the Newsletter identified the following red-flags: “[t]he patient is from another state,” “[t]he patient requests a specific drug,” “[t]he patient states that an alternative drug does not work,” “[t]he patient states that their[sic] previous physician closed their practice,” “[p]rior treatment records cannot be obtained,” “[t]he patient presents to an appointment with an MRI,” “[t]he patient(s) carpool,” “[t]he patient’s pain level remains the same,” “[t]he patient is non-compliant with the physician’s treatment plan.” GX 39, at 7.

Regarding the large number of out-of-state patients who obtained drugs from Respondent, Dr. Hurd testified that this “just seems unusual and unwarranted.” Id. at 513.

While not denying that patients might travel out of state to see a specialist, Dr. Hurd observed that:

[t]here is nothing about the ultimate prescription . . . of 30 milligrams of oxycodone several times a day, repeated over and over again, in case after case that is anything unique, except perhaps in the willingness of the physician to prescribe it. So . . . there’s no reason for somebody to pass 120 pain doctors on the road from Tennessee to Georgia to select the one who will write that medicine, except for a non-legitimate purpose.

Id.

Dr. Hurd also testified that in his chart review, he noted that “over and over again,” the patients were given an order from Liberty for an MRI “without a previous exam.” Id. at 514.

Dr. Hurd explained that “[t]here is no reason to order an MRI . . . in the absence of an emergency, without examining a patient.” Id. While Dr. Hurd acknowledged that he “get[s] patients all the time with MRIs . . . they’ve been ordered by a referring physician.” Id. at 514-15.

Dr. Warfield took issue with much of Dr. Hurd’s testimony. She testified that she had reviewed the reports of the investigation, the videos of the undercover visits, Dr. Hurd’s report, and a number of patient files. Id. at 570. She disputed Dr. Hurd’s testimony regarding the use of urine drug screens, explaining that “there are lots of pain centers that don’t use a lot of urine drug testing, because the people who want to obviate the urine drug test know how to do it. . . . So many folks feel that they’re not particularly useful.” Id. at 573. She also testified that while “Dr. Hurd was saying . . . that this is the way he does it . . . I’ve been on many . . . national boards

The Newsletter also made a variety of suggestions to prescribers, including that they “[r]equire patients to submit treatment records from previous providers,” and verify the authenticity of MRIs and prior treatment records. Id.

across the country. This isn't the way everybody does it, and by no means does everybody have to do it the way he does it." Id. at 573-74.

Dr. Warfield also took issue with Dr. Hurd's testimony regarding the need to obtain a patient's medical records. Tr. 590-91. She testified: "[w]e don't do that in our practice. I think it's a rare medical practice that does that." Id. at 591. Dr. Warfield then testified that:

[t]ypically . . . when you go to a physician, you walk in the door without any medical records. You see the physician. They ask you questions. You tell them about your medical history, and they take what you say as the truth. There has to be a certain amount of trust between the patient and the physician, so if the patient says to me, I had back surgery in 1995, and they removed my L5 disc, I believe the patient. I don't say . . . I'm going to need the medical records from that hospital where you say you had that surgery.

Id. at 591. She then asserted that "[m]ost physicians do not ask for old medical records." Id. at 591-92.

The ALJ then asked Dr. Warfield what verification process she recommended her students use when a patient presents with no records, but has an MRI showing some degenerative disc disease or other disease impacting the spine, and tells the student that he has an existing prescription for oxycodone. Id. at 592. Dr. Warfield answered: "what we teach our residents is if a patient comes in, you do a history and you do a physical exam, and you make up your own mind as to what the diagnosis is and what the treatment is for that particular diagnosis." Id. at 593. While Dr. Warfield testified that there are a variety of situations which would prompt further investigation of a patient's story (i.e., slurred speech, being very sleepy, changing their story, erratic behavior, shaking hands, track marks on physical exam, id. at 595), she then explained:

But I think a patient who comes in and tells me they have pain, and their pain is consistent with what I know from my experience is a real medical condition – in other words, someone comes in and says, you know, I was in an accident; I hurt my right lower back, and I subsequently have pain going down my leg, and it goes into my toes, and I

know that's consistent with a real medical entity, and I look at their MRI and they have findings that are consistent with that, and their physical examination is consistent with that, I don't go and get old medical records or further verify what they have.

Id. at 595-96.¹⁷ See also id. at 628 (Dr. Warfield's testimony: "occasionally there are patients who it's very obvious that they don't need the drug. Their physical exam is inconsistent with their MRI.").

The ALJ then asked Dr. Warfield whether "she would expect a Georgia doctor to be mindful" of the Guidelines published in the Georgia's Board January 2011 newsletter "when evaluating patients who present [with] chronic pain?" Id. at 597. She answered:

Yes. I mean, I would expect the physician to be mindful of it, but I would expect a physician to individually decide which of those is appropriate for their particular patient and which are not. I don't see guidelines as being laws. They're -- you know, certainly everybody should have a history; certainly a physical examination should be done. And, you, I think the way those things are done and how they're documented in the record and how extensive a physical examination is and such is really up to the individual physician to decide for an individual patient.

Id. Dr. Warfield then asserted that while she gives lectures on opiate prescribing "around the country," the guidelines have not been well publicized and most physicians "don't even know they exist." Id. at 598. And on follow-up questioning by the ALJ, Dr. Warfield agreed that physicians "should make themselves familiar with those guidelines" but then maintained that "most reasonable physicians in the same situation don't know about those state guidelines." Id. at 599-600.¹⁸

¹⁷ See also id. at 594 (asserting that if a patient with high blood pressure came to see her and said she was on a particular medication, she doesn't "do verification . . . we make our own mind up as to whether that's the appropriate drug . . . or should they be on a different drug or a different treatment"). Id.

¹⁸ Asked by the ALJ what she would instruct her students to do if they were presented with an employment opportunity at a clinic which was "run on a cash-only basis; where patients drive long distances, often from other states; and where all the patient MRIs come from the same imaging facility," Dr. Warfield testified that "taking each of those individually, I don't think any of these things would make me tell my particular doctors to sway one or the other." Tr. 610-11. She then explained that "none of those things are illegal per se," and that there are "very outstanding, legitimate pain centers that take only cash" because they don't want to deal with insurance companies. Id. at 611. As for patients travelling a long distance, she asserted that there are states where legitimate pain patients

Dr. Warfield further asserted that there are “no national guidelines” and “no standards in terms of exactly how one needs to treat a particular patient with pain when dealing with opiates,” and that she had “seen time and again with these kind of cases” that experts testify as to the “best possible practice, that in the perfect world, this is the way we should practice when we deal with these opiate patients.” Id. at 621. While Dr. Warfield testified that she “would agree with that,” she maintained that people do not practice that way. Id. She then explained:

And unfortunately, I see a lot of experts who come forward and say that, you know, this is he [sic] best possible practice, and this is the way I do it. Therefore, anybody who doesn't do this is practicing below the standard of care. And I think that's what we're really talking about here. We're talking about the fact that . . . we all agree that there probably is a best possible practice out there, but the fact that someone is not practicing the best possible practice or not practicing the way a particular individual thinks is the law or standard doesn't mean that they're not practicing legitimate medicine.

Id. at 622.

On questioning by Respondent, Dr. Warfield then testified that she had reviewed “in detail” the charts for patients she identified by the initials of V.S., L.C., T.W., C.P., A.C., L.L., S.G., J.L., A.B., H.W., and J.B. and that she did not “see . . . any evidence . . . that this was not a legitimate medical practice or that these drugs were not prescribed . . . in the usual course of practice or were not appropriate.” Id. at 623-24. While these initials apparently correspond to the patients other than the undercover officers whose medical records were reviewed by Dr.

cannot get medication because “doctors are just unwilling to prescribe these drugs” and “don't care what the patient has,” “[s]o there is some legitimacy to patients coming from other states to states where they can get these drugs.” Id. at 611-12. As for the MRIs coming from the same place, Dr. Warfield testified that if “you're in a small town, there may be one place where patients get their MRIs.” Id. at 613.

When then asked what she would advise her students if all three of these issues were present, Dr. Warfield testified that “if you're in a practice like that . . . you better make darn sure that you're treating your patients in an appropriate way, that you are . . . seeing your patients, treating them individually, doing histories, doing physical exams, doing, you know, an appropriate medical practice, is what I might tell them.” Tr. 614-15.

Hurd,¹⁹ Respondent also introduced a letter which Dr. Warfield had written on his behalf, apparently in connection with a criminal proceeding. RX F2. Therein, Dr. Warfield noted that she had reviewed various items of evidence related to the visits of the three undercover officers.

Id. at 1. She then wrote:

I do not see any evidence that the medications prescribed by [Respondent] were not prescribed in the usual course of care in a legitimate medical practice. Histories and physical examinations were conducted, a diagnosis was made and a plan was formulated. The patients underwent urine drug screens and follow-up visits with a review of the drug effects. And while I agree that the examinations were brief, I do not believe that this in any way indicated that the practice was not legitimate.

Id. at 3.

Dr. Warfield further suggested that Respondent had been deceived by the undercover officers who, in her view, “were clearly very good actors” who “knew what to say and how to argue their case for needing pain medicine.” Id. at 4. She then suggested “[t]here is no way any physician can ever be correct all the time about who is fooling them and who is not. They can only try to treat these patients in the best way they can without denying other patients the pain-relieving drugs they need and deserve.” Id.

Finally, Dr. Warfield pointed to the two “occasions when [Respondent] was specifically offered cash for a prescriptions,” noting that “he quickly and adamantly refuse[d].” Id. Dr. Warfield maintained that “[t]his clearly demonstrates that this is not a cash for drugs business but rather a legitimate medical practice intent on providing relief to patients with chronic pain.” Id. Dr. Warfield then concluded that it was her belief that Respondent’s “treatment of these patients was part of a legitimate medical practice and that the drugs that were prescribed were done so in the course of usual medical practice.” Id.

¹⁹ The initials of two of these individuals T.W. and J.B. correspond with those of Terrance Williams and Jessica Bernard, both of whom were eventually criminally charged and pled guilty to violations of 21 U.S.C. §§ 846 and 841(b)(1)(C). See GXs 10 & 12.

On questioning by the ALJ as to whether she would document a patient's attempt to bribe her to obtain additional drugs, Dr. Warfield offered a lengthy and evasive answer. She stated:

I may or may not make a note of that. . . . I would certainly . . . you know, if I'm the only doctor seeing that patient, I may or may not write that down. What I would do is I would keep it in mind. . . . [Y]ou're asking me what I would say to a doctor in training. I would say, you know. This is . . . someone who has some suspicious activity here, so you have to keep this in mind when you - - you know, when you subsequently see the patient.

Tr. 583-84. After then explaining that the appropriate thing is "to not take the bribe and know that this patient . . . possibly has been involved in some suspicious activity," Dr. Warfield contended that just because the patient "might be involved in some suspicious act or asking you to do something that isn't legal doesn't mean that the person does not have pain." Id. at 584.

Continuing with her answer, Dr. Warfield testified:

I mean, you can believe that patient, that they still have pain and that they were honestly trying to get medication for a friend of theirs. You could discharge that patient. . . . You could send that patient off for a consultation with someone, or you could continue to treat the patient. I think all of those, depending on the situation, are reasonable at one time or another.

I don't think there are any guidelines or anything that says that if a patient comes in and offers you money to get a prescription for their sister and you refuse to do that, that you should automatically discharge that patient.

Id. at 585. When asked a further time by the ALJ what a physician should note in the patient's record regarding an "offer to bribe," Dr. Warfield asserted:

Again, I don't think there are any guidelines that say you should write that . . . in the record. I mean, would I argue if somebody wrote it in the record? No. Would I think that if somebody didn't write it in the record, they didn't have a legitimate medical practice? No. . . .

We don't write down everything that the patient tells us and says to us every time we see them in an office, and the fact that somebody doesn't write down something that the patient says . . . I don't think indicates that it's below the standard of care or not a legitimate medical practice. It's just in a busy practice, one can never, you know, write down everything the patient tells you. I think that if that's a patient you're going to be seeing again and again, that you keep that in mind when you're seeing the patient.

Id. at 586-87. However, unexplained by Dr. Warfield is how a doctor in a busy practice, such as Respondent's which had nearly 900 patients, would be able to remember which of his patients had attempted to buy extra drugs if he only kept a mental note of the incidents.

Dr. Hurd came to the exact opposite conclusion as to the lawfulness of the controlled substances prescriptions Respondent issued to both the undercover officers and multiple other patients whose charts he reviewed, including those persons who pled guilty to conspiring to unlawfully distribute controlled substances. In both his testimony and report, Dr. Hurd identified multiple deficiencies in the manner in which Respondent made prescribing decisions.

For example, in his report, Dr. Hurd observed that Respondent performed "inappropriate or minimal exams" and that "[i]n case after case, patients presented with complaints suggestive of spine disease with low back pain and leg pain, which would suggest . . . disc disease and potential neurologic compromise." GX 35, at 4. He also noted that Respondent "used borderline [MRI] results in many cases to support the need for narcotic medication" and that "[i]n other cases, signific[an]t findings were noted but no appropriate physical exam was performed to see if this was a danger or risk to the patient." Id. Dr. Hurd then explained that:

A diligent and responsible approach to patients like this is to do a direct and appropriate neurologic examination, in this case, to the low back and lower extremities. An appropriate focused exam would include testing of muscle strength for each nerve root in the lumbar spine, testing reflexes at the patella and Achilles tendons[,] as well as conducting a sensory exam which would at minimum consist of lightly touching or scratching the patient's skin either with or without clothing to ascertain if there were sensory abnormalities such as decreased sensation, numbness, increased sensations or tingling when the skin is touched. It is not medically necessary to do a complete comprehensive exam at every visit depending on the period between visits but it certainly should be done at least once during a patient's tenure with the physician.

Id. Continuing, Dr. Hurd observed that:

In virtually every case, including the ones with video surveillance, [Respondent] only documented an attempt at testing reflexes at the patella and a gross spontaneous motor

exam when he asked the patient to lift their legs. This is not specific to each nerve root in the lumbar spine as would be expected in a comprehensive exam. No patient underwent a sensory exam that was either documented in the chart or demonstrated in video recordings that I reviewed.

Id.

Dr. Hurd then specifically addressed Respondent's treatment of each of the undercover officers. With respect to Officer Lawson, Dr. Hurd observed that Lawson's MRI report "demonstrated minor changes at L4-5 and L5-S1." Id. at 7. He explained that while Respondent told Lawson that "the discs were pressing on his spinal cord[,] [t]hey were not . . . as the spinal cord ends several levels above L4-5 in the spine." Id. Dr. Hurd then noted that while Lawson told Respondent that he had been in a Humvee accident, he asked no further questions about the accident. Id. Moreover, while Respondent asked Lawson if he had numbness or tingling in his legs, Lawson denied having either symptom. Id.

Dr. Hurd characterized Respondent's physical exam on Lawson as "cursory" as it was limited to three tests: 1) testing Lawson's patellar reflexes with a hammer, 2) having Lawson lie on his back on the exam table and lift each leg without Respondent resisting the movements to determine Lawson's muscle strength, and 3) having Lawson lie in the prone position and palpating his back muscles. Id.; see also Tr. 491-92. Dr. Hurd then identified four important tests that were not performed, including: 1) testing Lawson's leg strength against resistance to "either rule out or . . . in a more serious problem"; 2) performing sensory testing of the skin dermatomes of Lawson's legs to determine whether any abnormal MRI finding was either "minor" or "something that was clinically significant"; 3) testing Lawson's Achilles reflexes; and 4) testing the range of motion of Lawson's spine. GX 35, at 7.

Dr. Hurd also explained that "[t]he performance of a routine neurological exam" is warranted "on almost every patient's initial visit" even if the patient did not present with "a

strictly neurologic complaint.” Id. Dr. Hurd also explained that Respondent had at one point been board certified in internal medicine and would have known how to perform a neurologic exam. Id.

Regarding the visit, Dr. Hurd further observed that Respondent did not discuss with Lawson his “activities of daily living,” or “any restrictions to be placed upon him during work or leisure.” Id. at 7-8. Dr. Hurd also faulted Respondent for failing to discuss the risks and benefits of using controlled substances. Id. at 8. While Dr. Hurd found that Respondent did document in the medical record that Lawson had told him that neither Lortab nor Percocet had helped him, Dr. Hurd observed that Respondent “offered no other rationale for the narcotic prescription” which included 120 oxycodone 15mg for the month. Id.

With respect to Lawson’s second visit, Dr. Hurd noted that while Lawson said he had better pain relief on the “oxy 30s,” Respondent failed to perform a physical exam. Id. He also noted that Respondent increased the prescription to 90 oxycodone 30mg. Id.

Dr. Hurd noted that Lawson had been referred for an MRI before he was seen by Respondent. Id. Dr. Hurd stated that it was “unclear” why this “would occur” as apparently there was no medical indication for ordering an MRI (Respondent having yet to see Lawson) and there was “no emergency.” Id.

Applying the Georgia Board’s Guidelines on using controlled substances to treat pain, Dr. Hurd opined that Respondent did not comply with step one because he did not perform an appropriate history and physical. GX 35, at 8. He also noted that Respondent failed to comply with other provisions of the Guidelines by failing to refer Lawson to a specialist; failing to document his rationale for prescribing opiates; failing to review Lawson’s prescription record and obtain his medical records; and failing to discuss the risks and benefits of narcotics. Id.; see

also Tr. 494 (testimony of Dr. Hurd that “the first thing you need to do is . . . see if you can get any notes from the practice. Failing that, certainly you’d want to get some pharmacy records that showed what the patient was given.”).

In his testimony, Dr. Hurd also explained that it was a “red flag” that Lawson had told Respondent that his previous physician’s practice had been shut down. Tr. 494. Dr. Hurd further noted that Respondent did not take appropriate steps to verify Lawson’s claims. Id.

Dr. Hurd thus concluded that the oxycodone prescriptions Respondent issued TFO Lawson were not for a legitimate medical purpose. Id. at 492.

Regarding the visits of TFO Vickery, Dr. Hurd explained that his MRI report stated that he had “a ruptured disc that shoots out to the side of the spinal canal and pinches a nerve as it goes from the spine to the leg” and that “[t]his would be expected to cause pain in the left thigh and potentially some weakness” either extending or raising the leg. GX 35, at 9. Dr. Hurd observed that “[t]his would normally be tested for by having the patient either sit or lay down and have them extend (straighten) their leg while the examiner has [his] hand on the patient’s ankle to see if [the patient] ha[s] enough strength to straighten their leg against some resistance.” Id. Dr. Hurd also explained that “[a]nother test that would be performed would be a sensory exam which would involve touching, scratching or using a sharp pin to poke the skin to see if there was any numbness or increased sensitivity.” Id. According to Dr. Hurd, a physician would use these tests to determine whether a herniated disc has resulted in significant nerve damage. Id.

Dr. Hurd observed that Respondent’s physical of TFO Vickery was limited to checking his patellar reflexes, having him lay on his back and raise his legs, followed by having Vickery lay on his stomach and palpating his back. Id. While Dr. Hurd noted that it “was appropriate” to

test Vickery's patellar reflexes, he did not do an appropriate exam to test Vickery's leg strength. Id. Dr. Hurd also explained that "[t]here was no examination of the patient's peripheral nerves or his muscular strength to determine if the MRI finding might be valid." Id. Dr. Hurd then opined that Respondent "prescribed without . . . a legitimate medical indication" both 90 oxycodone 30mg and 30 Xanax 1mg. Id.; see also Tr. 539-40 (Dr. Hurd's testimony that the tests Respondent performed during the physical exam "are gross tests that don't discriminate between nerve levels"); id. at 549 (Explaining that "usually a straight leg raise" is performed by the doctor picking up the patient's leg to see if the "nerve back there is irritated, so it sends the pain down their leg. Having [the patient] pick it up by [himself] does not give you that same thing, because they can actively guard when they pick it up.").

With respect to Vickery's second visit, Dr. Hurd noted that "[n]o significant exam was performed [and] yet [Respondent] prescribed" 90 pills of Opana ER 40mg. GX 35, at 9. Dr. Hurd then observed that Opana ER is "to be taken every 12 hours and is not known to be given legitimately [at] 90 per month" as a prescription for sixty tablets "would suffice for its correct dosing." Id. As found previously, the Opana prescriptions Respondent wrote called for the drug to be taken TID, or three times a day, and not twice per day. Dr. Hurd also observed that while Respondent again prescribed Xanax to Vickery, "no discussion of the [TFO's] anxiety had taken place." Id.

In his testimony, Dr. Hurd further explained that "[i]t is important and incumbent upon a physician to document that there is some evidence of anxiety, and [that] you've reached a medical diagnosis" that "justif[ies] the treatment." Tr. 495. Dr. Hurd then opined that the Xanax prescription was not issued for a legitimate medical purpose.²⁰ Id. And when asked if the opioid

²⁰ On cross-examination, Respondent asked Dr. Hurd whether Vickery's "yes" answers to questions on an intake form regarding whether his pain made him "irritable" and "angry" suggested the presence of "some anxiety." Tr.

prescriptions that Respondent wrote at this visit were issued for a legitimate medical purpose, Dr. Hurd opined that “[t]hey were not.” Id. at 495-96.

The Government also asked Dr. Hurd about TFO’s Vickery offer during this visit of additional cash for extra drugs. Tr. 497. While Dr. Hurd explained that “it’s good that [Respondent] did not accept money,” TFO Vickery was “absolutely telling” Respondent that he was “going to traffic in drugs.” Id. at 498. Dr. Hurd then explained that a patient such as Vickery “should not be in any legitimate practitioner’s office.” Id.

As for Vickery’s third visit, in his report, Dr. Hurd observed that Respondent had documented in the progress note that the TFO was “[h]aving more problems with anxiety,” that he “continued to [complain of] severe back pain,” and that he was “requesting additional pain meds.” Id. at 9. Dr. Hurd again found that “no significant physical exam was done,” noting that there was “[n]o motor testing, no sensory testing, and no testing of reflexes.” Id. Dr. Hurd then noted that Respondent again prescribed Vickery 90 tablets of Opana ER 40mg, “which was outside the regular prescribing parameters of this drug,” and that he had also given Vickery 40 tablets of Percocet 10, as well as increased the Xanax prescription from 30 to 45 tablets. Id.

Regarding this visit, Dr. Hurd testified that TFO Vickery’s attempt to purchase Xanax for a friend should have resulted in Respondent terminating the doctor-patient relationship. Tr. 499-500. He further explained “that this is different than a patient . . . whom you suspect has addiction” and should be referred to “addiction treatment” and not given “more medicine.” Id. at 500. Instead, it “represented drug trafficking” on Vickery’s part. Id. Dr. Hurd then added that

534. Dr. Hurd answered that it “[s]uggests there’s anger and irritability present, not necessarily anxiety.” Id. at 535. Respondent then asked Dr. Hurd whether Vickery’s “yes” answer to “[d]oes this pain interfere with sleep?” suggested “anxiety or a need for Xanax.” Id. Dr. Hurd replied: “not specifically. If your pain interferes with sleep, it may just indicate the need to relieve the pain, as opposed to taking away anxiety.” Id. Of further note, on one of the intake forms, TFO Vickery provide a “No” answer to the question: “does the pain give you feelings of anxiety?” GX 27, at 24.

given Vickery's attempt "to bribe" him, it was not appropriate for Respondent "to increase the medicine that the patient just asked for," i.e., the Xanax. Id. at 501. Moreover, according to Dr. Hurd, this incident should have been documented in the patient record. Id. at 560. Yet it wasn't. See GX 27, at 26.

With respect to Vickery's fourth and final visit, Dr. Hurd noted that while Respondent changed his narcotic prescription from Opana 40mg to oxycodone 25mg and decreased the Xanax from 45 to 30 tablets, "he added [30] Soma, a potent muscle relaxant, to be taken at bed time." Id. at 10. Thus, Dr. Hurd found that Respondent "bumped up his sedative effect by giv[ing] him" the Soma. Id.

In his testimony, Dr. Hurd further noted the discussion between Vickery and Respondent during which Vickery changed his story regarding his pain level and Respondent observed that he did not think that Vickery was "that bad off" and that his urine drug screen "showed nothing in [his] system." Tr. 503. After explaining that Opana ER is an extended release medicine, which is supposed to last twelve hours between doses and that there is no reference in the literature to prescribing it three times a day, Id. at 503-4, Dr. Hurd also observed that Vickery was prescribed "a ton of medicine" and that he could not have run out of medicine "without going through withdrawal," and yet there was "no evidence this patient was in withdrawal." Id. at 504. Dr. Hurd thus concluded that "similar to the previous patient," Respondent's "care fell short according to the guidelines" in that "he did not perform an appropriate history and physical" and "did not do any physical exam of significance." GX 35, at 10. Dr. Hurd further faulted Respondent because "he did not refer [TFO Vickery] to an outside specialist" and "did not obtain any old records." Id.

The Government also entered into evidence Dr. Hurd's findings based on his review of the patient charts of J.L., A.B., J.B., K.C., S.P., L.C., S.G., V.S., L.L., H.W., and T.W. See GX 35, at 12-13; GX 36a. While these findings were not the principal focus of the Government's case, Dr. Hurd's findings with respect to these patients provides, in some respects, a more complete picture of Respondent's prescribing practices than the undercover visits because several of the patients made an extensive number of visits to Liberty.

For example, A.B., who was from Greeneville, Tennessee, made twelve visits to Liberty. GX 36a. At her first visit, A.B. said that she had been in a "severe" motor vehicle accident two years earlier and that her current prescriptions were 210 oxycodone 30mg, 120 oxycodone 15 mg, and 30 Xanax .25mg. Id. at 1. A.B. obtained an MRI at Greater Georgia Imaging the same day as her initial visit, which Respondent noted as being abnormal in his physical exam note. Id. Respondent diagnosed A.B. has having thoracic spasm, lumbar radiculopathy, and four bulging discs, with three of them (L5-S1, L3-4, L2-3) "involving" their respective nerve root. Respondent prescribed 180 oxycodone 30mg to A.B. at this visit. Id.

However, according to Dr. Hurd, A.B.'s MRI report presented "minimal findings" and Respondent's physical exam did not note a "neurologic abnormality." Id. at 2. Moreover, Respondent repeatedly provided A.B. with prescriptions for 180 oxycodone 30mg, although he did decrease the prescription twice (to 165 oxy 30mg and then to 180 oxy 20mg²¹) before he again prescribed 180 oxycodone 30mg at her eleventh monthly visit, when she reported her pain as a "seven." Id.

However, Dr. Hurd observed that at this visit, "[t]here was no change in her exam findings," and "to this date," Respondent had not done "a neurologic exam." Id. He further

²¹ According to Dr. Hurd, A.B. had reported that her pain with medication was a "three" at the visit during which Respondent reduced her medication to 165 tablets of oxycodone 30mg, and she reported that her pain with medication was a "two" at the visit where he reduced her medication to 180 oxycodone 20mg. GX 36a, at 2.

noted that “[t]his is the 11th monthly visit in a row that this patient has been treated with large doses of oxycodone . . . with minimal findings on MRI” and that A.B. had not been referred “for spinal injections, spinal surgery consultation, physical therapy, acupuncture, psychological evaluations, or any second opinion.” Id.

Regarding Respondent’s physical exams of A.B., Dr. Hurd identified seven items which were not documented as having been performed. More specifically, Dr. Hurd observed that there was no documentation of: 1) “an analysis of the patient’s gait”; 2) an examination of the range of motion of A.B.’s lumbar spine; 3) a sensory examination of A.B.’s arms and legs; 4) strength testing of A.B.’s arms and legs; 5) which “deep tendon reflexes were tested”; 6) a pupil examination to determine if narcosis existed; and 7) a mental status examination. Id. at 3. Dr. Hurd explained that “all of these exam techniques are designed to determine the clinical significance of the MRI findings” and “is a standard of care in determining the cause of pain and dysfunction in the back and lower extremities.” Id.

Also, notwithstanding that A.B. made twelve visits to Respondent between April 12, 2011 and March 14, 2012, Dr. Hurd found that neither “old [medical] records” nor “pharmacy records were referenced in the chart.” Id. at 2. Based on Respondent’s failure to obtain A.B.’s records, his failure to perform adequate physical examinations, his failure to use any treatments other than medication, Dr. Hurd concluded that Respondent lacked a legitimate medical purpose when he prescribed to A.B. Id. at 3-4.

J.B., who was from Rogersville, Tennessee, made twelve visits to Liberty which began on March 3, 2011. GX 36b, at 1. She complained of severe lower back pain caused by motorcycle and motor vehicle accidents. Id. She too obtained an MRI at Greater Georgia

Imaging on the morning of her initial visit. Id. She received 120 oxycodone 30mg at each visit. Id. at 2.

Here again, Dr. Hurd observed that Respondent did not review J.B.'s prior medical or pharmacy records (and there are no such records in her patient file, see GX 11), notwithstanding that at her initial visit, she wrote on one of the intake forms that her current medication included "7-8 Roxycodone 30mg, 5-6 Roxycodone 15mg (breakthrough pain)," and "Xanax to sleep 2mg (2 day)." GX 11, at 70; GX 36B, at 2. Moreover, Dr. Hurd found that there was no documentation that Respondent had performed the seven tests he identified as required by the standard of care in his review of A.B. GX 36B, at 2. He then observed that "[t]he MRI and physical findings do not . . . warrant treatment with that level of narcotic" and that the lack of exam findings with respect to these seven tests "suggests that there is no correlation between the patient's MRI and her physical findings." Id. He also noted that Respondent did not offer conservative therapy to J.B. including physical therapy, trigger point injections, epidural injections or a surgical referral. Id. Dr. Hurd thus concluded that Respondent's prescribing to J.B. did not meet "the standard of care for treating with opioids" and that he lacked a legitimate medical purpose. Id.

L.L., who was from Kingsport, Tennessee, made sixteen visits between January 14, 2011 and April 11, 2012. GX 36h. At his initial visit, L.L., who worked as a horsebreaker, complained that he had been having severe back pain for three years following a work related incident but denied "any numbness or tingling." Id. at 1. He also claimed that he had taken oxycodone 30mg, Dilaudid and Xanax 1mg. Id. L.L. presented an MRI, which had been done a year and a half earlier in Florida; the MRI found that he had a moderate size disc protrusion at L5-S1 with bulging of the annulus and bilateral nerve root effacement and a small disc

protrusion at L4-5 with no effacement of the nerve root. Id. at 2. The MRI Report explicitly “[r]ecommended correlation with the clinical symptoms and neurologic exam to assess the significance of the above findings.” Id.

Here again, Dr. Hurd found that Respondent did not document, with respect to any of the physical exams, the performance of any of the seven tests he previously identified (in discussing A.B.) as being part of the “standard of care in determining the causation of pain and dysfunction in the back and lower extremities.” Id. Yet Respondent prescribed 120 oxycodone 30mg (as well as 30 Xanax 1mg) which, at the next visit, he increased to 150 oxycodone 30mg (and 30 more Xanax 1mg), notwithstanding that the note for the second visit contained “no further delineation of the physical exam to corroborate the MRI findings and there [was] no mention of” an anxiety diagnosis (which was not listed until two months later). Id.

According to Dr. Hurd, L.L. requested more medication at his May 2011 visit, and Respondent increased his oxycodone prescription to 160 tablets, even though he again noted that “[t]here was no more delineation of the physical exam to demonstrate a diagnosis consistent with the MRI.” Id. at 3.

Dr. Hurd then found that at L.L.’s June 2011 visit, Respondent added a diagnosis of lumbar radiculopathy. Id. Dr. Hurd found, however, that Respondent had at no point “done a neuromuscular exam to delineate the reason for” this diagnosis. Id. He also noted that while at this visit, Respondent had decreased the amount of oxycodone 30mg by twenty pills, he then added a prescription for 60 Percocet 10/325, thus providing the same amount of oxycodone to L.L. Id. Dr. Hurd opined that there was “no medical rationale for this prescribing.” Id.

Dr. Hurd further found that Respondent maintained the same medication regimen through April 2012, even though L.L. continued to complain of pain at a level of 5 to 6 out of 10. Id. at

3. Respondent, however, never offered to refer L.L. for a spinal injection or a surgical consultation. Id. Nor did he ever offer to refer L.L. for “more conservative” treatment such as acupuncture or physical therapy. Id. at 3-4. Dr. Hurd also found that there was no evidence that Respondent had reviewed L.L.’s previous medical records. Based on his findings, Dr. Hurd found that Respondent’s prescribing to L.L. did not meet “the standard of care for treating with opioids” and that he lacked a legitimate medical purpose. Id.

H.W., who was from Midway, Tennessee, made twenty-three visits to Liberty beginning on April 28, 2011. GX 36I. She reported a history which included three motor vehicle accidents, a fall, and a fractured pelvis. Id. at 1. She complained of “severe lower back pain radiating down [her] right leg,” as well as “neck pain radiating down [her] right arm,” and reported that she was currently on 180 oxycodone 30mg, 90 oxycodone 15mg, and 60 Xanax 2mg. Id., see also GX 13, at 13. She also provided an MRI, which was done by a facility in Florida fifteen months earlier and which listed the patient’s date of birth as being “4/12/78.” GX 36I, at 2. However, H.W.’s driver’s license lists her date of birth as “11/26/88.” Id.

Respondent performed a physical exam and documented that he found severe tenderness over H.W.’s cervical trapezius muscle, her lumbar paravertebral muscles, and her sacrum, and tenderness over her sciatica. Id. His physical exam findings also included “DTR + 2,” and an abnormal straight leg lift and cross straight leg lift. Id. Respondent diagnosed H.W. as having herniated discs at L5-S1 and L4-5 and a bulging of the annulus fibrosis at L3-4 (each of which were listed as MRI findings), as well as having lumbar radiculopathy and cervical radiculitis. Id. at 1-2. He then prescribed 120 oxycodone 30mg and Xanax 1mg at this visit. Id. at 1.

Dr. Hurd again found that Respondent did not document having performed any of the seven tests (discussed above) at any of H.W.’s twenty-three visits. Id. at 2. While at her second

visit, Respondent noted that he would consider performing a trigger point injection, at H.W.'s third visit, he documented that she "was afraid" to have one done but would reconsider at her next visit. Id. According to Dr. Hurd, a trigger point injection was never done on H.W. Id.

At this visit, Respondent prescribed 130 oxycodone 30mg and 45 Xanax 1mg to H.W. Id. Dr. Hurd found that Respondent "continued to prescribe those same dosages and quantities at every visit that [he] reviewed." Id. He also observed that notwithstanding Respondent's "diagnoses of lumbar radiculopathy[,] cervical radiculitis[,] and [a] labral tear left hip[,] no treatment other than medications was noted." Id.

Dr. Hurd found that there were no prior medical records or pharmacy records for H.W. Id. He explained that "[i]n the absence of independent evidence . . . that she was prescribed and consumed [o]xycodone 30mg four to six times a day, [Respondent] [was] risking either an acute narcotic overdose, or, if not consumed by the patient, possible diversion." Id. at 3. He then observed that a positive urine drug screen "may indicate the patient has consumed some narcotic, but it does not indicate the dosage or total quantity" the patient has been prescribed or consumed. Id.

Noting that Respondent did not review H.W.'s prior medical records, and based on Respondent's failure to perform the seven tests listed above, Dr. Hurd opined "that there [was] no correlation between the patient's MRI and his physical findings." Id. at 2-3. He also opined that "[t]he MRI and physical findings [did] not . . . warrant treatment with that level of narcotic." Id. at 2. He thus concluded that "the standard of care for treating [with] opioids has not been met." Id. He further concluded that the prescriptions lacked a legitimate medical purpose. Id. at 3.

V.S., a 48-year old female from Coral Springs, Florida, saw Respondent eleven times between January 25, 2011 and March 5, 2012. GX 36G, at 1-2. She reported having been “in several bad car accidents” and having “recently . . . broken [her] right arm” which apparently was in a cast.” Id. at 1. She also complained of “severe low back pain” which made it “very difficult for her to perform any activities that [cause] pain” and reported that she had been taking oxycodone 30mg six times a day, Dilaudid 8mg for breakthrough pain, and Xanax 2mg, twice a day, “for two years.” Id.

V.S. presented an MRI, which had been done more than a year earlier, at a facility located in Boca Raton, Florida. Id. While the MRI report listed findings of three bulging discs, one of which (L5-S1) was causing narrowing of the right neuroforamen and another (L4-5) which causing encroachment of both neuroforamen, Dr. Hurd explained that this was a “mild to moderately abnormal MRI.” Id. at 1-2.

Notably, in the physical exam section of the progress note, Dr. Hurd found that Respondent documented only that he had palpated her paravertebral muscles in the area of V.S.’s lumbar spine (finding “severe tenderness”) and that he had V.S. perform a straight leg lift (which was “abnormal”). Id. at 1. Here again, Respondent did not perform any of the seven tests Dr. Hurd previously identified as necessary “to determine the clinical significance of the MRI findings,” which Dr. Hurd explained was “a standard of care in determining the causation of pain and dysfunction in the back and lower extremities.” Id. at 2-3.

Respondent nonetheless diagnosed V.S. as having chronic back pain (along with the three bulging discs). Id. at 1. Respondent prescribed to V.S. 180 tablets of oxycodone 30mg, 80 Dilaudid 8mg (one tablet every eight hours), and 60 Xanax 2mg (one tablet twice a day). Id.

At V.S.'s second visit, she again complained of "severe" back pain "when not on medication" and "severe pain" in her right arm which had screws in it. Id. at 2. She further reported that her pain was worse when she was not taking Xanax "because of her anxiety." Id. Yet the only test Respondent documented as having performed was palpating V.S.'s paravertebral muscles in her lumbar region. Id. Respondent diagnosed V.S. as having a "disc bulge L4-5 with neuroforaminal encroachment," and added a diagnosis of "lumbar radiculopathy." Id. He issued her prescriptions for 180 oxycodone 30mg, 50 Dilaudid 8mg, 60 Xanax 2mg, and 30 Flexeril, a non-controlled muscle relaxant. Id.

According to Dr. Hurd, Respondent issued V.S. the exact same three controlled substance prescriptions through her last visit of March 5, 2012. Id. Dr. Hurd found that there were "no new exam findings to corroborate the findings on MRI," further noting that Respondent never documented the performance of the seven tests he previously identified as the standard of care. Id. at 2-3. He also observed that there were no old medical records, nor pharmacy records "referenced in the chart." Id. at 2.

Based on the chart review, Dr. Hurd further observed that Respondent never considered offering trigger point injections or referral to specialists such as "an interventional spine physician who could perform an epidural steroid injection or . . . a spine surgeon to assess" whether surgery would reduce V.S.'s pain. Id. at 3. Dr. Hurd also noted that Respondent did not offer to refer V.S. for physical therapy, acupuncture, biofeedback therapy, a psychological assessment, or a second opinion. Id.

Dr. Hurd thus concluded that Respondent did not meet the standards for prescribing opioids with respect to V.S. Id. He further concluded that Respondent lacked a legitimate medical purpose when he prescribed controlled substances to V.S. Id.

T.W., a thirty-six year old male, saw Respondent fifteen times between February 4, 2011 and March 20, 2012. GX 9, at 2-16. T.W. presented with a history of a gunshot wound to his abdomen (fifteen years earlier) and a car accident (three years earlier) and complained of lower back pain, which according to the progress note, had gotten progressively worse, as well as “numbness and tingling down [his] left leg.” GX 36J; GX 9, at 83. He further reported that his pain was a 10 without medication and a 5 with medication. GX 9, at 83.

T.W. reported having seen a chiropractor, as well as having received decompression therapy and an injection of some sort. Id.; GX 36J. He also reported having seen other doctors for this pain and that oxycodone 30mg had provided him with relief and that he had obtain some relief on Percocet, but none from Lortab. GX 9, at 83; id. at 16. Yet T.W.’s file does not contain records from his prior doctors or pharmacy records. See generally GX 9.

T.W. presented an MRI report which he obtained from Greater Georgia Imaging on the same day as the day of his initial visit with Respondent. The MRI report (which did not include the name of the reading radiologist and was unsigned) found that T.W. had a left paracentral disc protrusion at L4-5 and a right far posterolateral disc protrusion at L3-4. GX 9, at 82. In the physical exam section of the progress note, Respondent documented four findings: 1) the existence of moderate to severe tenderness in the paravertebral muscles in the lumbar region; 2) the existence of severe tenderness in the left sciatic area; 3) that the straight leg lift was abnormal on the right side; 4) and that test of the Deep Tendon Reflexes was “+1.” GX 9, at 16.

With the exception of the latter test which did not specify which reflexes (knee or ankle) were tested, Respondent did not document having examined any of the other six items which Dr. Hurd explained are required to meet the standard of care. Id. Respondent diagnosed T.W. as having “lumbar radiculopathy,” “lumbar spasm,” and disc protrusions at L4-5 and L3-4. GX 9,

at 16. He then provided T.W. with a prescription for 30 oxycodone 30mg qd (one tablet per day), as well as Flexeril and Naproxen. Id. He also recommended that T.W. obtain an inversion table. Id.

T.W. returned on March 3, 2011, and claimed that the medication had lasted only six days. GX 9, at 15. Respondent documented his physical exam findings as “severe tenderness paravertebral muscles lumbar spine” and “moderate tenderness lumbar spine.” Id. He then increased T.W.’s oxycodone 30mg prescription to 120 tablets. Id. Respondent continued prescribing this quantity until T.W.’s visit on July 28, when the latter complained of “having more severe pain” and Respondent increased the prescription to 140 tablets. Id. at 10-14; GX 36J, at 2. Respondent continued to prescribe 140 tablets at each visit until his last visit on March 20, 2012, when T.W. again complained of “having more pain” and that the medication was “not lasting long enough.” GX 9, at 2-9; GX 36J, at 2. Respondent then increased the prescriptions to 155 tablets of oxycodone 30mg. GX 9, at 2.

Throughout this period, Respondent never documented findings on a physical exam other than that he found varying degrees of tenderness over T.W.’s paravertebral muscles in the lumbar region. GX 9, at 2-9. As Dr. Hurd found, the progress notes for the remaining 14 visits contain no documentation that Respondent examined any of the seven items he identified as part of the standard of care after T.W.’s first visit. GX 36J, at 2-3. Dr. Hurd thus opined that there was “no correlation between the patient’s MRI” and the physical exam findings and that “the MRI and physical findings” did not “warrant treatment with that level of narcotic. Id. at 3.

Dr. Hurd also observed that while the progress notes repeatedly listed diagnoses of “lumbar radiculopathy” and a bulging disc at L3 involving the nerve root, as well as that T.W. repeatedly rated his pain with medication at a 7-8, Respondent “never offered standard treatment

such as lumbar epidural steroid injections or [a] surgical referral.” *Id.* at 2. Dr. Hurd thus concluded that Respondent did not “meet the standard” for prescribing opioids and that the prescriptions he issued T.W. lacked a legitimate medical purpose. *Id.* at 3.

DISCUSSION

Section 304(a) of the Controlled Substances Act (CSA) provides that a registration to “dispense a controlled substance . . . may be suspended or revoked by the Attorney General upon a finding that the registrant . . . has committed such acts as would render his registration under section 823 of this title inconsistent with the public interest as determined under such section.” 21 U.S.C. § 824(a)(4) (emphasis added). With respect to a practitioner, the Act requires the consideration of the following factors in making the public interest determination:

- (1) The recommendation of the appropriate State licensing board or professional disciplinary authority.
- (2) The applicant’s experience in dispensing . . . controlled substances.
- (3) The applicant’s conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.
- (4) Compliance with applicable State, Federal, or local laws relating to controlled substances.
- (5) Such other conduct which may threaten the public health and safety.

Id. § 823(f).

“[T]hese factors are . . . considered in the disjunctive.” Robert A. Leslie, M.D., 68 FR 15227, 15230 (2003). It is well settled that I “may rely on any one or a combination of factors, and may give each factor the weight [I] deem[] appropriate in determining whether a registration should be revoked.” *Id.*; see also MacKay v. DEA, 664 F.3d 808, 816 (10th Cir. 2011); Volkman v. DEA, 567 F.3d 215, 222 (6th Cir. 2009); Hoxie v. DEA, 419 F.3d 477, 482 (6th Cir. 2005). Moreover, while I am required to consider each of the factors, I “need not make explicit findings

as to each one.” MacKay, 664 F.3d at 816 (quoting Volkman, 567 F.3d at 222 (quoting Hoxie, 419 F.3d at 482)).²²

The Government has the burden of proving, by a preponderance of the evidence, that the requirements for revocation or suspension pursuant to 21 U.S.C. § 824(a) are met. 21 CFR 1301.44(e). However, “once the [G]overnment establishes a prima facie case showing a practitioner has committed acts which render his registration inconsistent with the public interest, the burden shifts to the practitioner to show why his continued registration would be consistent with the public interest.” MacKay, 664 F.3d at 817 (citing Medicine Shoppe-Jonesborough, 73 FR 364, 387 (2008) (citing cases)).

Having considered all of the factors, I agree with the ALJ’s conclusion that the Government’s evidence with respect to factors two (Respondent’s experience in dispensing controlled substances) and four (Respondent’s compliance with applicable controlled substance laws), establishes that Respondent has committed acts which render his registration inconsistent with the public interest.²³ 21 U.S.C. § 824(a)(4).

²² In short, this is not a contest in which score is kept; the Agency is not required to mechanically count up the factors and determine how many favor the Government and how many favor the registrant. Rather, it is an inquiry which focuses on protecting the public interest; what matters is the seriousness of the registrant’s misconduct. Jayam Krishna-Iyer, 74 FR 459, 462 (2009). Accordingly, as the Tenth Circuit has recognized, findings under a single factor can support the revocation of a registration. MacKay, 664 F.3d at 821.

²³ As for factor one, the recommendation of the state licensing authority, the ALJ found that Georgia Composite Medical Board has not made an “express recommendation” in this matter. R.D. at 82. The ALJ further noted, however, Respondent’s testimony that the Board had subpoenaed some 46 patient files including five files which were presented to Dr. Hurd and that the Board declined to take any action against his medical license. Id. (citing Tr. 309). Respondent did not, however, identify the names of the patients whose files were reviewed by the Board. See Tr. 309. Moreover, while Respondent testified, in essence, that the Board had found no reason to act, he did not produce any official document from the Board setting forth its reasons for not pursuing sanctions against his license.

Although Respondent retains his state license, DEA has repeatedly held that while a practitioner’s possession of state authority constitutes an essential condition for maintaining a registration, see 21 U.S.C. §§ 802(21) & 823(f), it “is not dispositive of the public interest inquiry.” George Mathew, 75 FR 66138, 66145 (2010), pet. for rev. denied Mathew v. DEA, 472 Fed.Appx. 453, 455 (9th Cir. 2012); see also Patrick W. Stodola, 74 FR 20727, 20730 n.16 (2009); Robert A. Leslie, 68 FR 15227, 15230 (2003). As the Agency has long held, “the Controlled Substances Act requires that the Administrator . . . make an independent determination [from that made by state officials] as to whether the granting of controlled substance privileges would be in the public interest.” Mortimer

Factors Two and Four – Respondent’s Experience in Dispensing Controlled Substances and Record of Compliance with Applicable Controlled Substance Laws

To effectuate the dual goals of conquering drug abuse and controlling both the legitimate and illegitimate traffic in controlled substances, “Congress devised a closed regulatory system making it unlawful to manufacture, distribute, dispense, or possess any controlled substance except in a manner authorized by the CSA.” Gonzales v. Raich, 545 U.S. 1, 13 (2005).

Consistent with the maintenance of the closed regulatory system, a controlled substance may only be dispensed upon a lawful prescription issued by a practitioner. Carlos Gonzalez, M.D., 76 FR 63118, 63141 (2011).

Under a longstanding DEA regulation, a prescription for a controlled substance is not “effective” unless it is “issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.” 21 CFR 1306.04(a). Under the CSA, it is fundamental that a practitioner must establish a bonafide doctor-patient relationship in order to act “in the usual course of . . . professional practice” and to issue a prescription for a “legitimate medical purpose.” See United States v. Moore, 423 U.S. 122, 142-43 (1975); United States v. Lovern, 590 F.3d 1095, 1100-01 (10th Cir. 2009); United States v. Smith, 573 F.3d 639, 657 (8th Cir. 2009); see also 21 CFR 1306.04(a) (“an order purporting to be a prescription issued not in the usual course of professional treatment . . . is not a prescription within the meaning and intent

Levin, 57 FR 8680, 8681 (1992). Thus, while Respondent satisfies the CSA’s requirement that he be currently authorized to dispense controlled substances under the laws of the State in which he practices medicine, this factor is not dispositive either for, or against, the continuation of Respondent’s registration. Paul Weir Battershell, 76 FR 44359, 44366 (2011) (citing Edmund Chein, 72 FR 6580, 6590 (2007), pet. for rev. denied Chein v. DEA, 533 F.3d 828 (D.C. Cir. 2008)).

Regarding factor three, there is no evidence in the record that Respondent has been convicted of an offense related to the manufacture, distribution or dispensing of controlled substances. However, as there are a number of reasons why a person may never be convicted of an offense falling under this factor, let alone be prosecuted for one, “the absence of such a conviction is of considerably less consequence in the public interest inquiry” and is thus not dispositive. Dewey C. MacKay, 75 FR 49956, 49973 (2010), pet. for rev. denied MacKay v. DEA, 664 F.3d 808 (10th Cir. 2011).

of [21 U.S.C. § 829] and . . . the person issuing it, shall be subject to the penalties provided for violations of the provisions of law related to controlled substances”).

As the Supreme Court has explained, “the prescription requirement . . . ensures patients use controlled substances under the supervision of a doctor so as to prevent addiction and recreational abuse. As a corollary, [it] also bars doctors from peddling to patients who crave the drugs for those prohibited uses.” Gonzales v. Oregon, 546 U.S. 243, 274 (2006) (citing Moore, 423 U.S. 122, 135, 143 (1975)).

Both this Agency and the federal courts have held that “establishing a violation of the prescription requirement ‘requires proof that the practitioner’s conduct went “beyond the bounds of any legitimate medical practice, including that which would constitute civil negligence.”’” Laurence T. McKinney, 73 FR 43260, 43266 (2008) (quoting United States v. McIver, 470 F.3d 550, 559 (4th Cir. 2006). See also United States v. Feingold, 454 F.3d 1001, 1010 (9th Cir. 2006) (“[T]he Moore Court based its decision not merely on the fact that the doctor had committed malpractice, or even intentional malpractice, but rather on the fact that his actions completely betrayed any semblance of legitimate medical treatment.”).²⁴

²⁴ However, as the Agency has held in multiple cases, “the Agency’s authority to deny an application [and] to revoke an existing registration . . . is not limited to those instances in which a practitioner intentionally diverts a controlled substance.” Bienvenido Tan, 76 FR 17673, 17689 (2011) (citing Paul J. Caragine, Jr., 63 FR 51592, 51601 (1998)); see also Dewey C. MacKay, 75 FR, at 49974. As Caragine explained: “[j]ust because misconduct is unintentional, innocent, or devoid of improper motive, [it] does not preclude revocation or denial. Careless or negligent handling of controlled substances creates the opportunity for diversion and [can] justify” the revocation of an existing registration or the denial of an application for a registration. 63 FR at 51601.

“Accordingly, under the public interest standard, DEA has authority to consider those prescribing practices of a physician, which, while not rising to the level of intentional or knowing misconduct, nonetheless create a substantial risk of diversion.” MacKay, 75 FR, at 49974; see also Patrick K. Chau, 77 FR 36003, 36007 (2012). Likewise, “[a] practitioner who ignores the warning signs that [his] patients are either personally abusing or diverting controlled substances commits ‘acts inconsistent with the public interest,’ 21 U.S.C. § 824(a)(4), even if [he] is merely gullible or naïve.” Jayam Krishna-Iyer, 74 FR 459, 460 n.3 (2009); see also Chau, 77 FR, at 36007 (holding that even if physician “did not intentionally divert controlled substances,” State Board Order “identified numerous instances in which [physician] recklessly prescribed controlled substances to persons who were likely engaged in either self-abuse or diversion” and that physician’s “repeated failure to obtain medical records for his patients, as well as to otherwise verify their treatment histories and other claims, created a substantial risk of diversion and abuse”) (citing MacKay, 75 FR, at 49974).

As found above, both parties elicited the testimony of expert witnesses, who came to diametrically opposite conclusions regarding the lawfulness of the prescriptions. The ALJ ultimately resolved this issue, concluding that Dr. Hurd's opinion testimony was entitled to more weight than that of Dr. Warfield because of his greater familiarity with the standards of medical practice that exist in Georgia. I agree, and while I am mindful of Dr. Warfield's professional accomplishments and her testimony suggesting that Dr. Hurd was applying a "best possible practices" standard in evaluating Respondent's prescribing practices, rather than the actual standard of care as generally practiced by pain management physicians, I find that the evidence supports a finding that Respondent repeatedly breached the standard of care (applicable in Georgia) and did so in a manner which establishes that he acted outside of the usual course of professional practice and lacked a legitimate medical purpose in issuing many (if not all) of the prescriptions.

Notably, Dr. Warfield did not dispute Dr. Hurd's contentions that half of the patients whose MRIs show an abnormality do not have any pain and that an MRI alone "is not sufficient" to form a diagnosis of chronic pain. Tr. 452. Indeed, Dr. Warfield agreed with Dr. Hurd that a physical examination must be done and that a physician must determine whether the examination's findings are consistent with the MRI's findings and then correlate those findings with the patient's pain complaint. Compare Tr. 595-96 & 628 with id. at 452-54 and 485-86. Moreover, even Respondent acknowledged that "sometimes you can have an abnormal MRI, and a person is not having pain. That's why we do those exams . . . to check the nerve roots, to see if it's consistent with the MRI report. Id. at 287.

Dr. Hurd also specifically identified multiple tests (including examinations of the patient's gait, range of motion, sensory, strength, mental status, and pupils) that Respondent did

not perform in examining both the undercover officers and the chart-review patients that he maintained were required by the standard of care to properly diagnose the patients; he also explained why the straight leg lift was not an adequate test because it was not specific to each nerve root. Notwithstanding that Dr. Warfield reviewed Dr. Hurd's report in preparation for her testimony, she did not identify a single test among those which Dr. Hurd testified were required by the standard of care as being unnecessary to properly diagnose a patient.²⁵ Thus, I reject her testimony in which, while she agreed with Dr. Hurd "that the examinations were brief," she offered the conclusory assertion that she did "not believe that this in any way indicated that [Respondent's] practice was not legitimate." RX F2, at 3.

I therefore give substantial weight to Dr. Hurd's testimony and report in which he concluded that Respondent repeatedly failed to conduct adequate physical exams for diagnosing the undercover officers and various patients as having chronic pain which warranted the prescribing of oxycodone. So too, I give substantial weight to Dr. Hurd's conclusion that Respondent also prescribed Xanax without a legitimate medical purpose, because there was no evidence that he had properly evaluated whether the patients had anxiety. Moreover, given that for each of the patients, Dr. Hurd identified multiple tests (indeed, as many as seven different tests which should have been done but were not), I conclude that Respondent's breaches of the standard of care were not merely malpractice, but rather, establish that the prescriptions lacked a legitimate medical purpose and that he knowingly diverted controlled substances. 21 CFR 1306.04(a).

²⁵ Dr. Warfield also asserted that "how extensive a physical examination is and such is really up to the individual physician to decide for an individual patient." Tr. 597. Undoubtedly, the scope of an appropriate physical exam is based on the nature of a patient's pain complaint and symptoms. To the extent Dr. Warfield's statement suggests that there is no standard of care which governs the scope of an appropriate physical exam, it is refuted by numerous judicial decisions in both medical malpractice and criminal cases, medical board decisions involving allegations of unprofessional conduct, and Agency decisions involving allegations of unlawful prescribing.

This conclusion is buttressed by Dr. Hurd's testimony and report which identified multiple other ways in which Respondent failed to comply with the Georgia Board's Guidelines for the Use of Controlled Substances for the Treatment of Pain: Ten Steps. See RX A. It is also supported by the evidence of TFO's Vickery's undercover visits.

To be sure, Dr. Warfield took issue with Dr. Hurd's reliance on the Guidelines. More specifically, Dr. Warfield testified that she does not "see guidelines as being laws" and that "most reasonable physicians in the same situation don't know about those state guidelines." Tr. 597, 599-600. To similar effect, in a document which appears to be Respondent's post-hearing brief, Respondent writes that the Guidelines are not a statute or rule, but "are simply a guide to help physicians." Resp. Post-Hrng. Br., at 2. However, Respondent also argues that "[a]dherence to [the] guidelines improves quality medical practice and helps distinguish legitimate practice from foul play." Id.

The Government does not, however, argue that the Guidelines have the force and effect of law. Rather, the Guidelines are – as Respondent himself recognizes – probative evidence of the standards of professional practice that are applicable in Georgia to the use of controlled substances for treating chronic pain.²⁶ And as Dr. Hurd testified and documented in his report, measured against the Guidelines, Respondent's prescribing practices were deficient in other respects.

²⁶ Based on her experiences lecturing throughout the country, Dr. Warfield asserted that most physicians are unaware of the existence of the controlled substance prescribing guidelines that have been published by numerous States. However, many of the States have long published policy statements on the use of controlled substances to treat pain and it is not as if Dr. Warfield has conducted polling on the issue.

Moreover, even if knowledge of guidelines applicable to one's profession cannot be presumed in the same manner as is knowledge of duly promulgated laws and regulations, in his Exceptions, Respondent asserted that "[b]efore working at liberty center, [in] December 2010 I went online reviewing information regarding pain management on [the] Georgia composite medical board site." Resp. Exceptions, at 4. Of note, the Georgia Board adopted the Guidelines in January 2008.

First, Step Two of the Guidelines instructs the physician to “[c]reate a treatment plan” and to “consider referrals to appropriate specialists, such as neurologists, orthopedists . . . addictionologists, and psychiatrists.” Step Two also instructs that “[t]he written treatment plan should state objectives that will be used to determine treatment success,” as well as whether “any further diagnostic evaluations or treatments are planned.” Yet with the exception of a single patient to whom he offered a trigger point injection, the treatment plans documented in the patient charts, which were submitted for the record, provided only for the use of controlled substances. Moreover, Dr. Hurd found that Respondent never referred any of the patients whose files he reviewed to specialists, nor for other treatments such as physical therapy. Notably, this point was unchallenged by Dr. Warfield.

Step Four of the Guidelines instructs the physician to “[r]eview the patient’s prescription records and discuss the patient’s chemical history before prescribing a controlled drug.” Continuing, Step Four states that “[i]f the patient is new or otherwise unknown to you, at a minimum obtain an oral drug history and medication allergies, and discuss chemical use and family chemical history with the patient and obtain old records which may include pharmacy records.”

As to whether a physician is required to obtain a new patient’s old records prior to the initial prescribing of a controlled substance, the Guideline is not a model of clarity. In any event, it is unnecessary to decide whether Respondent breached the standard of care because he failed to obtain (or even attempt to obtain) the old records which purportedly existed for TFO Lawson (who made but two visits) because the evidence otherwise shows that he did breach the standard. As the evidence shows, TFO Vickery made four visits between August 22 and December 1, 2011, and yet Respondent made no effort to obtain the records which purportedly

existed for him. Most significantly, Dr. Hurd identified multiple patients who saw Respondent for a year or more and to whom he repeatedly prescribed controlled substances, and yet he did not obtain (or attempt to obtain) their records. Moreover, Respondent failed to obtain the records even when the patients claimed that they had previously been prescribed large doses of oxycodone, as well as other controlled substances such as Xanax, and were travelling long distances to see him.

Dr. Warfield unconvincingly defended Respondent's failure to obtain records. She asserted that "[m]ost physicians do not ask for old medical records" and that "[w]e don't do that in our practice." She also asserted that "[t]here has to be a certain amount of trust between the patient and the physician" so that if a patient tells her she had "back surgery in 1995," she doesn't "need the medical records from that hospital where you say you had that surgery."

Dr. Hurd did not, however, testify, and the Government makes no contention, that Dr. Mintlow was required to obtain medical records of such vintage. Moreover, while Dr. Warfield may deem it unnecessary to obtain patient records of any sort, including those establishing what medications have been previously and recently prescribed to a patient, this does not establish what the standard of care requires in any State, let alone Georgia, where the Medical Board has concluded otherwise. See RX A (Georgia Guidelines Step 4). And even if it is her practice not to obtain records, Liberty nonetheless required its patients to execute a form authorizing the release of their medical records including prescription profiles, progress notes, hospitalization reports, and diagnostic reports, and yet did not even attempt to obtain those records (such as prescription profiles) which would be available even if a patient's previous clinic had been shut down. See GX 27, at 18. So too, Respondent testified that the clinic he previously worked at would attempt to obtain prior records to verify the patients' treatment histories. Tr. 343-44. As

for why no attempts were made to obtain the records of the patients identified by Dr. Hurd, Respondent blamed this on Del Percio, even though he acknowledged that it was his responsibility. Id. at 344-45.

Nor does this Agency dispute Dr. Warfield's statement that there has to be a certain amount of trust between the patient and physician. However, when a patient represents that he/she has previously been prescribed large doses of powerful narcotics such as oxycodone 30mg (as well as other controlled substances such as benzodiazepines), which are highly abused and diverted, and may also have travelled a long distance bypassing numerous other potential treating physicians with no plausible explanation for doing so, there is ample reason to verify the patient's claim. Indeed, requiring verification of a patient's claims that he/she had previously received large doses of narcotics is fully supported by the CSA's prescription requirement, one purpose of which is to prevent the recreational abuse of controlled substances by "bar[ring] doctors from peddling to patients who crave the drugs for those prohibited uses" or to sell the drugs to others who seek to abuse them. Gonzales v. Oregon, 546 U.S. 243, 274 (2006) (citing Moore, 423 U.S. 122, 135, 143 (1975)).

There is additional evidence which supports the conclusion that Respondent prescribed controlled substances outside of the usual course of professional practice and lacked a legitimate medical purpose. In contrast to his failure to obtain the prior records of his patients, the evidence shows that Respondent would not see a patient unless that patient had already obtained an MRI. As found above, TFO Vickery testified that prior to his first visit, he twice attempted to see Respondent and was told by Del Percio that he needed an MRI before he could be seen by Respondent. Tr. 162-63. So too, TFO Manning attempted to see Respondent without an MRI

and was turned down by Del Percio, who told him that Respondent was “not going to risk his license.” RX G, Disc N-51.

Notably, there is no evidence that the undercovers were referred by another physician and thus would already have obtained their MRIs. So too, Dr. Hurd noted that in reviewing the patient files, he found “over and over again” that the patients were given an order by Liberty for an MRI before they were ever examined by Respondent. Tr. 514. Regarding this practice, Dr. Hurd explained that “[t]here is no reason to order an MRI . . . in the absence of an emergency, without examining a patient.” *Id.* This testimony was unchallenged by both Respondent and Dr. Warfield.

In his Exceptions, Respondent argues that “[i]n Georgia[,] [an] MRI is not required to make a diagnosis.” Resp. Exceptions, at 6. That is undoubtedly true. Yet Respondent was obviously aware that the Liberty patients could not see him without having previously obtained an MRI. Respondent, however, offered no explanation as to why Liberty’s patients were required to have had an MRI done before he even examined them and determined that an MRI was warranted. Here, the evidence supports the inference that the MRIs were required – as Del Percio explained to TFO Manning – to justify Respondent’s issuance of unlawful controlled substance prescriptions in the event law enforcement or regulators became aware of Liberty and investigated it.²⁷

Still more evidence that Respondent knowingly diverted controlled substances is provided by the undercover visits of TFO Vickery. On two occasions, Vickery attempted to purchase additional controlled substances for both himself and a friend and yet Respondent continued to prescribe controlled substances to him. More specifically, at Vickery’s second

²⁷ Indeed, DEA has encountered this practice in investigating numerous other rogue pain clinics. See Cynthia M. Cadet, 76 FR 19450, 19455 (2011); Jacobo Dreszer, 76 FR 19386, 19388 & n.8 (2011).

visit, after Respondent agreed to prescribe Opana to him, Vickery asked if he could also get some “15s,” a reference to oxycodone 15; while Respondent said no, Vickery then offered “to float” Respondent “a couple hundred bucks on the side.” While Respondent again said no, he nonetheless issued him prescriptions for 90 Opana ER 40mg (oxymorphone), a drug which is also a schedule II controlled substance (and more potent than oxycodone), as well as 30 Xanax 1mg. Moreover, upon receiving the prescriptions, Vickery complained that the previous Xanax prescriptions “did not last at all” and Respondent was “being stingy.”

Similarly, at the third visit, Vickery complained that the Opana “went pretty quickly” and asked for something for breakthrough pain. Moreover, Vickery then attempted to buy extra Xanax (actually showing him the cash), asserting that his buddy had asked him to see if Respondent would write him a prescription. While Respondent declined to write a Xanax prescription for Vickery’s purported buddy, he nonetheless increased the Xanax prescription to forty-five tablets.

As found above, Dr. Hurd testified that these incidents should have resulted in the Respondent’s termination of Vickery as a patient. Dr. Warfield disputed this. While she acknowledged that they were red flags, she asserted that they did not constitute a contraindication to providing drugs “to this patient for [his] pain.” Tr. 636. She then reasoned that:

Does this patient understand that you can’t just walk into a doctor’s office and say, you know, I have a friend who needs some medication; here’s some money? Does the patient just totally not understand that that’s illegal. I don’t know the answer to that question. What I understand here is that [Respondent] was offered money and outright refused it, and I think that’s what’s important to me when I read these records.

Id.

Notwithstanding Dr. Warfield's assertion, I conclude that patients are generally well familiar with why a prescription is required for certain drugs, especially controlled substances, and that a doctor must examine a patient before issuing prescription, and in any event, patients are also charged with knowledge of the law. Indeed, as found above, at each visit, Vickery was required to review and sign documents which warned that he could not sell, trade, or share medications, GX 27, at 10 (initial visit); or that selling or diverting medication is illegal. *Id.* at 22 & 24 (2nd visit); 28 & 30 (3rd visit); 34 & 36 (4th visit).

Beyond this, Respondent never testified that he continued to prescribe to Officer Vickery because he believed that this was simply a case of Vickery not knowing the law. Moreover, Vickery's statement to Respondent – after telling Respondent he had \$200 and showing him the cash – that “I don't know if you can do that,” hardly suggests a degree of naïveté on Vickery's part as to the legal requirements for obtaining prescriptions.

I also find unpersuasive Dr. Warfield's further contention that because Respondent refused Vickery's offer, this establishes that he was legitimately practicing medicine. Contrary to Dr. Warfield's understanding, both the courts and the Agency have long recognized that the wink and a nod manner in which Respondent prescribed to Officer Vickery violates the CSA.²⁸

See United States v. Moore, 423 U.S. 122, 142-43 (1975); United States v. Hooker, 541 F.2d

300, 305 (1st Cir. 1976) (holding that where physician “carried out little more than cursory

²⁸ I also find entirely unpersuasive Dr. Warfield's testimony justifying Respondent's failure to document Vickery's attempts to purchase additional drugs. In the absence of documentation of such an incident in the patient's medical record, a doctor with a busy practice who merely kept a mental note could well fail to remember the incident. Moreover, as Dr. Hurd explained, one of the purposes of the medical record is to enable any subsequent treating physician to properly evaluate the patient, the effectiveness of previous treatments, and where a patient represents that they had previously been treated with controlled substances, the prior physician's reasoning and the patient's truthfulness. Tr. 451, 469. Furthermore, the Guidelines explain that a patient's “history of substance abuse” should be documented in the medical record. RX A, at 2.

Given that physicians are expected to assess the risks (and benefits) of various treatments (including the risk of misuse, abuse and diversion, *see id.* at 3-4 (steps four, five and seven)), it is beyond dispute that documentation of a patient's prior attempts to bribe a doctor and obtain drugs is essential information for any subsequent physician who treats the patient and considers prescribing controlled substances.

physical examinations, if any, frequently neglected to inquire as to past medical history, and made little or no exploration of the type of problem a patient allegedly had, . . . the jury could reasonably have inferred that the minimal ‘professional’ procedures followed were designed only to give an appearance of propriety to appellant’s unlawful distributions”).²⁹

Furthermore, Dr. Warfield’s assertion that Respondent was engaged in the legitimate practice of medicine simply ignores TFO Vickery’s fourth visit. Indeed, in neither her report nor her testimony did Dr. Warfield even address Respondent’s prescribing to TFO Vickery at this visit, which resulted in prescriptions for 90 oxycodone 25mg, 30 Xanax 1mg, and 30 Soma.

However, as the evidence shows, Respondent knew that Vickery was not a legitimate pain patient as Vickery had been a week late for his appointment and did not have drugs in his system. Moreover, Respondent expressed his belief that Vickery was not having much pain and that he did not need anything other than Naproxen (a non-controlled drug) for his pain, prompting Vickery to change his pain level (and prompting laughter from Respondent), and then going so far as to claim that his “three” was somebody else’s “seven or eight.”

Moreover, when Vickery explained that he did not even like Naproxen and that he liked the oxycodone and was used to taking it, Respondent remarked that Vickery was dependent on narcotics and laughed. Respondent then said that he would try to wean him down to avoid “withdrawal problems,” but then expressed doubt that Vickery “would have that” as there was no oxycodone in his system, and laughed again.

²⁹ See also United States v. Joseph, 709 F.3d 1082, 1104 (11th Cir. 2013) (holding physician “acted without a legitimate medical purpose and outside the usual course of professional practice” where the evidence showed he “prescribed an inordinate amount of certain controlled substances, that he did so after conducting no physical examinations or only a cursory physical examination, [and] knew or should have known that his patients were misusing their prescriptions”).

Indeed, at multiple points in the video, Vickery attempted to explain why he needed more drugs notwithstanding that he was a week late for the visit and his urine was clear, prompting laughter from Respondent. Having viewed the video, I reject Respondent's testimony that he was laughing because "I smile all the time" or that his laughter was the result of his being "frustrated with" Vickery because he was trying to reduce Vickery's medication and "it looked like [Vickery] was trying to change it to something different." Tr. 372-73.

Contrary to Respondent's understanding, he – not Vickery – held the authority to prescribe controlled substances. Yet he continued to prescribe more controlled substances to Vickery, including more narcotics, notwithstanding the latter's statements that "I like what I take" and that he was "used to taking it," prompting Respondent to acknowledge that "we're talking about somewhat of a dependency here." Indeed, Respondent even agreed to increase the quantity of the oxycodone 25mg from 60 to 90 tablets after Vickery complained about the size of the prescription, and while he refused Vickery's request for Lortab, he then added a prescription for Soma after Vickery asked for the drug. And following this, Vickery promised that he would "be in more pain next time."

Respondent thus knew that Vickery was not a legitimate pain patient. In short, as the ALJ found, this visit "can only be described as a negotiation over the quantity of narcotics³⁰ Respondent would prescribe for Officer Vickery." R.D. at 44.

I therefore conclude that Respondent acted outside of the usual course of professional practice and lacked a legitimate medical purpose when he issued prescriptions to TFO Vickery and Lawson, as well as the patients A.B., J.B., L.L., H.W., V.S., and T.W. 21 CFR 1306.04(a). I further conclude that the Government's evidence with respect to factors two and four

³⁰ Soma is not a narcotic. However, the drug was controlled under the CSA because of its use by narcotic abusers to enhance the effects of narcotics. See Placement of Carisoprodol Into Schedule IV, 76 FR 77330, 77356 (2011).

establishes a prima facie showing that Respondent “has committed such acts as would render his registration . . . inconsistent with public interest.” 21 U.S.C. § 824(a)(4). I further hold that Respondent’s prescribing violations are egregious and warrant the revocation of his registration.

The ALJ also found that Respondent engaged in actionable misconduct because in December 2011, he became aware of a newsletter published by the Georgia Board which identified various characteristics of both pill mills and drug seeking patients. R.D. at 98. While Respondent admitted to having reviewed only the former portion, as the ALJ explained:

The similarities between the clinical practice he was leading and the features reported in the newsletter that are common to pill mills were striking, and were undeniable. [Respondent] knew his patient base was largely from out of state, and that many patients travelled a great distance to be treated there. He knew the owners had no medical background and that no other medically-trained persons worked at the clinic. He knew his patients were asking for oxycodone by name and by dosage, and he was aware that they were presenting MRIs from a common source – and that they arrived with the MRIs in hand prior to an initial office visit. He knew also the clinic was operating on a cash basis, and that he was directly benefiting from a share of that cash in a three-way split.

Id. at 99. The ALJ also noted that per the Board’s newsletter, Respondent could have “request[ed] an onsite ‘courtesy meeting’ with a Board agent,” if he had any questions about Liberty’s operations.³¹ R.D. at 100 (quoting GX 39, at 7).

Yet Respondent did not request a meeting with a Board agent and he continued to prescribe controlled substances for Liberty until April 2012, when a search warrant was executed at the clinic. GX 34, at 2 & 6. Moreover, Dr. Hurd’s report establishes that Respondent continued to unlawfully prescribe controlled substances during this period. While the ALJ discussed this evidence under factor five, it is more appropriately viewed as evidence probative

³¹ While the Board spelled out these red flags in its newsletter, the red flags presented by Liberty’s operations were so obvious that any physician who has practiced in legitimate settings would have quickly recognized the problematic nature of Liberty’s operations without the need for a newsletter, and any responsible physician – at least one holding a DEA registration – would have ceased practicing at such a clinic. Thus, I reject as incredible, Respondent’s contention that he was unfamiliar with the concept of red flags. Tr. 334.

of Respondent's experience in dispensing controlled substances. It is also evidence which is probative of his compliance with the CSA's prescription requirement as it refutes any suggestion that he was simply a physician who trusted his patients too much and was duped.

SANCTION

Under Agency precedent, where, as here, “the Government has proved that a registrant has committed acts inconsistent with the public interest, a registrant must “present sufficient mitigating evidence to assure the Administrator that [he] can be entrusted with the responsibility carried by such a registration.”” Medicine Shoppe-Jonesborough, 73 FR 364, 387 (2008) (quoting Samuel S. Jackson, 72 FR 23848, 23853 (2007) (quoting Leo R. Miller, 53 FR 21931, 21932 (1988))). “Moreover, because ‘past performance is the best predictor of future performance,’ ALRA Labs, Inc. v. DEA, 54 F.3d 450, 452 (7th Cir.1995), [DEA] has repeatedly held that where a registrant has committed acts inconsistent with the public interest, the registrant must accept responsibility for [his] actions and demonstrate that [he] will not engage in future misconduct.” Medicine Shoppe, 73 FR at 387; see also Jackson, 72 FR at 23853; John H. Kennedy, 71 FR 35705, 35709 (2006); Prince George Daniels, 60 FR 62884, 62887 (1995). See also Hoxie v. DEA, 419 F.3d at 483 (“admitting fault” is “properly consider[ed]” by DEA to be an “important factor[.]” in the public interest determination).

However, while a registrant must accept responsibility and demonstrate that he will not engage in future misconduct in order to establish that his/her continued registration is consistent with the public interest, DEA has repeatedly held these are not the only factors that are relevant in determining the appropriate sanction. See, e.g., Joseph Gaudio, 74 FR 10083, 10094 (2009); Southwood Pharmaceuticals, Inc., 72 FR 36487, 36504 (2007). Obviously, the egregiousness and extent of a registrant's misconduct are significant factors in determining the appropriate

sanction. See Jacobo Dreszer, 76 FR 19386, 19387-88 (2011) (explaining that a respondent can “argue that even though the Government has made out a prima facie case, his conduct was not so egregious as to warrant revocation”); Paul H. Volkman, 73 FR 30630, 30644 (2008); see also Paul Weir Battershell, 76 FR 44359, 44369 (2011) (imposing six-month suspension, noting that the evidence was not limited to security and recordkeeping violations found at first inspection and “manifested a disturbing pattern of indifference on the part of [r]espondent to his obligations as a registrant”); Gregory D. Owens, 74 FR 36751, 36757 n.22 (2009).

Moreover, as I have noted in several cases, “[n]either Jackson, nor any other agency decision, holds . . . that the Agency cannot consider the deterrent value of a sanction in deciding whether a registration should be [suspended or] revoked.” Gaudio, 74 FR at 10094 (quoting Southwood, 72 FR at 36504 (2007)); see also Robert Raymond Reppy, 76 FR 61154, 61158 (2011); Michael S. Moore, 76 FR 45867, 45868 (2011). This is so, both with respect to the respondent in a particular case and the community of registrants. See Gaudio, 74 FR at 10095 (quoting Southwood, 71 FR at 36503). Cf. McCarthy v. SEC, 406 F.3d 179, 188-89 (2d Cir. 2005) (upholding SEC’s express adoptions of “deterrence, both specific and general, as a component in analyzing the remedial efficacy of sanctions”).

Thus, in Gaudio, the Administrator “explained that ‘even when a proceeding serves a remedial purpose, an administrative agency can properly consider the need to deter others from engaging in similar acts.’” 74 FR at 10094 (quoting Southwood, 72 FR at 36504) (citing Butz v. Glover Livestock Commission Co., Inc., 411 U.S. 182, 187-88 (1973)); cf. McCarthy, 406 F.3d at 189 (“Although general deterrence is not, by itself, sufficient justification for expulsion or suspension, we recognize that it may be considered as part of the overall remedial inquiry.”); Paz Securities, Inc., et al. v. SEC, 494 F.3d 1059, 1066 (D.C. Cir. 2007) (agreeing with McCarthy).

In Gaudio, the Administrator further noted that the “[c]onsideration of the deterrent effect of a potential sanction is supported by the CSA’s purpose of protecting the public interest, see 21 U.S.C. § 801, and the broad grant of authority conveyed in the statutory text, which authorizes the [suspension or] revocation of a registration when a registrant ‘has committed such acts as would render [his] registration . . . inconsistent with the public interest,’ id. § 824(a)(4), and [which] specifically directs the Attorney General to consider [‘such other conduct which may threaten public health and safety,’ id. § 823(f)].” 74 FR at 10094 (quoting Southwood, 72 FR at 36504).³²

I conclude that Respondent has not accepted responsibility for his misconduct. Notably, at the hearing, Respondent continued to maintain that he had lawfully prescribed to TFOs Lawson and Vickery. Indeed, with respect to the latter, Respondent claimed that even his prescribing at the fourth visit was legitimate because “he [Vickery] still had pain.” Tr. 373. So too, with respect to the patients whose charts were reviewed by Dr. Hurd, Respondent failed to acknowledge that the prescriptions were unlawful. Moreover, when asked why he did not obtain prior records, Respondent explained that “I didn’t do it, because it was the understanding that Mark [Del Percio] was going to take care of those things.” Id. at 345. Respondent’s failure to acknowledge his misconduct is reason alone to find that he has not produced sufficient evidence to refute the Government’s showing that his registration is inconsistent with the public interest.

³² Unlike factors two (“[t]he applicant’s experience in dispensing”) and three (“[t]he applicant’s conviction record”), neither factor four (“Compliance with applicable laws related to controlled substances”) nor factor five (“Such other conduct which may threaten public health and safety”) contain the limiting words of “[t]he applicant.” As the Supreme Court has held, “[w]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.” Russello v. United States, 464 U.S. 16, 23 (1983). Thus, the text of factors four and five suggest that these factors are not limited to assessing the applicant’s compliance with applicable laws and whether he has engaged in “such other conduct,” but rather authorize the Agency to also consider the effect of a sanction on inducing compliance with federal law by other practitioners.

Even had Respondent made a sufficient showing that he accepts responsibility for his misconduct, he has failed to produce sufficient evidence of remedial measures to refute the Government's prima facie case. Indeed, the only evidence Respondent offered regarding remedial measures was his assertion that he would take a course (on two Saturday mornings) to become "board certified in pain management." Tr. 354. However, Respondent conceded that he "never got around to" doing it. Id. at 355-56.³³

Moreover, I conclude that revocation of Respondent's registration is warranted given the egregious nature of Respondent's misconduct and the need to deter other registrants from using their registrations to distribute controlled substances to those persons who seek the drugs to either personally abuse them or sell them to others. Here, the evidence shows that Respondent knowingly diverted controlled substances by issuing prescriptions outside of the usual course of professional practice and which lacked a legitimate medical purpose to numerous persons. See David A. Ruben, 78 FR 38363 (2013). Moreover, there is substantial evidence that Respondent prescribed controlled substances to multiple persons who obtained them for redistribution to others.

Such conduct strikes at the CSA's core purpose of preventing the abuse and diversion of controlled substances. See Jack A. Danton, 76 FR 60900, 60903 (2011); George Mathew, 75 FR 66138 (2010). Indeed, this Agency has revoked a practitioner's registration upon proof of as few

³³ In his Exceptions, Respondent lists some twenty-three things that he promises to do in the future, which he hopes "will eliminate many loopholes and help with the problem of drug diversion." Exceptions, at 2. These include, inter alia, that he "will familiarize [him]self with all of Georgia's rules, statute, law and regulations and follow them," he "will follow the . . . Georgia medical board pain management guidelines," "stay up-to-date with changes implemented by the Georgia medical board," "follow the board[]'s advice from medical newsletters . . . regarding red flags and pill mills," "investigate [the] patient's past history and past drug history," "perform additional physical exam techniques to help with the diagnosis," "pay close attention to urine drug test and perform the test myself," "correlate physical exam with radiological findings," "avoid seeing patients who travel long distance," discharge any patient "offering any kind of bribe," and "verify all past medical records" including patient's MRIs. Id.

Respondent's list of promises is not evidence in the case, and thus, I give it no weight. In any event, even if he had testified as to these promises and been found credible, because he has failed to acknowledge his misconduct, I would still hold that he has not refuted the conclusion that his registration is inconsistent with the public interest.

as two acts of intentional diversion and has further explained that proof of a single act of intentional diversion is sufficient to support the revocation of a registration. See MacKay, 75 FR at 49977 (citing Krishna-Iyer, 74 FR at 463 (citing Alan H. Olefsky, 57 FR 928, 928-29 (1992))).

While Respondent's misconduct would be egregious if it had been confined to Officer Vickery, it was not. As found above, the Government's Expert provided credible evidence that Respondent diverted controlled substances to at least six patients, over the course of a year or more. And even after Respondent became aware of the State Board's newsletter which listed various red flags associated with pills mills that were also present at Liberty, he continued to write unlawful prescriptions to these patients until the clinic was shut down.

I therefore conclude that the public interest necessitates that Respondent's registration be revoked and that any pending application be denied. Given the egregiousness of his misconduct, I further conclude that the public interest requires that this Order be effective immediately.

ORDER

Pursuant to the authority vested in me by 21 U.S.C. 824(a)(4) and 823(f), as well as 28 CFR 0.100(b) and 0.104, I order that DEA Certificate of Registration BM0288983, issued to Samuel Mintlow, M.D., be, and it hereby is, revoked. I further order that any application of Samuel Mintlow, M.D., to renew or modify the above registration, be, and it hereby is, denied. This Order is effective **immediately**.

Dated: December 30, 2014.

Thomas M. Harrigan,
Deputy Administrator.

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