FILED
SEP 04 2013
CLERK OF COURT
SUPREME COURT OF OHIO

The Supreme Court of Ohio

James E. Lundeen, Sr., M.D.

v.

State Medical Board of Ohio

Case No. 2013-0646

RECONSIDERATION ENTRY

Franklin County

It is ordered by the court that the motion for reconsideration in this case is denied.

(Franklin County Court of Appeals; No. 12AP-629)

Maureen O'Connor
Chief Justice

Franklin County Ohio Court of Appeals Clerk of Courts- 2013 Sep 04 12:15 PM-12AP000629

FILED
JUN 26 2013
CLERK OF COURT
SUPREME COURT OF OHIO

The Supreme Court of Ohio

James E. Lundeen, Sr., M.D.

v.

State Medical Board of Ohio

Case No. 2013-0646

ENTRY

Upon consideration of the jurisdictional memoranda filed in this case, the court declines to accept jurisdiction of the appeal pursuant to S.Ct.Prac.R. 7.08(B)(4).

(Franklin County Court of Appeals; No. 12AP-629)

Maureen O'Connor
Chief Justice

0A036 - T95

Franklin County Ohio Court of Appeals Clerk of Courts- 2013 Apr 25 10:54 AM-12AP000629

IN THE SUPREME COURT OF OHIO

13-0646

James E. Lundeen, Sr., M.D.	:	On Appeal from the Franklin
	:	County Court of Appeals, Tenth
Appellant,	:	Appellate District
	:	
-v.-	:	
	:	Court of Appeals
Ohio State Medical Board	:	Case Number 12-AP-000629
	:	
Appellee.	:	

Notice of Appeal of Appellant, James E. Lundeen, Sr., M.D.

James E. Lundeen, Sr., M.D. *pro se*
120 Hawthorne Lake Drive
Bloomington, Illinois 61704
(740) 415-6612
jelmd@ymail.com

—

Katherine J. Bockbrader, 0066472
Senior Assistant Attorney General
30 East Broad Street, 26th Floor
Columbus, Ohio 43215
(614) 466-8600 fax (866) 805-6094
Email katherine.bockbrader@ohioattorneygeneral.gov

Henry G. Appel, 0068479
Senior Assistant Attorney General
30 East Broad Street, 26th Floor
Columbus, Ohio 43215
(614) 466-8600 fax (866) 441-4738
Email henry.appel@ohioattorneygeneral.gov

Counsel for Appellee, Ohio State Medical Board

FILED
APR 24 2013
CLERK OF COURT
SUPREME COURT OF OHIO

Appellant, James E. Lundeen, Sr., M.D., hereby gives notice of appeal to the Supreme Court of Ohio from the judgment of the Franklin County Court of Appeals, Tenth Appellate District, entered in Court of Appeals Case No. 12-AP-000629 on March 28, 2013. This case raises substantial constitutional questions and is one of great public or general interest.

Respectfully submitted,

James E. Lundeen, Sr., M.D. *pro se*
120 Hawthorne Lake Drive
Bloomington, Illinois 61704
(740) 415-6612 fax (216) 397-1213
Email jelmd@ymail.com

Franklin County Ohio Court of Appeals Clerk of Courts- 2013 Apr 25 10:54 AM-12AP000629

Franklin County Ohio Court of Appeals Clerk of Courts- 2013 Apr 25 10:54 AM-12AP000629

Certificate of Service

I certify that a copy of the foregoing Notice of Appeal was sent on April 22, 2013, to the following by regular U.S. Mail, post prepaid and properly addressed:

Katherine J. Bockbrader, 0066472
Senior Assistant Attorney General
30 East Broad Street, 26th Floor
Columbus, Ohio 43215
(614) 466-8600

Henry G. Appel, 0068479
Senior Assistant Attorney General
30 East Broad Street, 26th Floor
Columbus, Ohio 43215
(614) 466-8600

Counsel for Appellee, Ohio State Medical Board

James E. Lundeen, Sr., M.D. *pro se*
Appellant

Dated: April 22, 2013

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

James E. Lundeen, Sr., M.D.,	:	
Appellant-Appellant,	:	
v.	:	No. 12AP-629 (C.P.C. No. 11CV-16295)
State Medical Board of Ohio,	:	(ACCELERATED CALENDAR)
Appellee-Appellee.	:	

JOURNAL ENTRY

For the reasons stated in the memorandum decision of this court rendered herein on March 28, 2013, it is the order of this court that appellant's applications for reconsideration and en banc consideration are denied.

SADLER, BROWN, and DORRIAN, JJ.

/S/ JUDGE

Franklin County Ohio Court of Appeals Clerk of Courts- 2013 Mar 28 4:11 PM-12AP000629

Franklin County Ohio Court of Appeals Clerk of Courts- 2013 Mar 28 4:11 PM-12AP000629

Tenth District Court of Appeals

Date: 03-28-2013

Case Title: JAMES E LUNDEEN SR MD -VS- OHIO STATE MEDICAL BOARD

Case Number: 12AP000629

Type: JOURNAL ENTRY

So Ordered

/s/ Judge Lisa L. Sadler

Court Disposition

Case Number: 12AP000629

Case Style: JAMES E LUNDEEN SR MD -VS- OHIO STATE MEDICAL BOARD

Motion Tie Off Information:

1. Motion CMS Document Id: 12AP0006292[redacted]980000
   Document Title: 01-28-2013-MOTION TO RECONSIDER
   Disposition: 3200

Franklin County Ohio Court of Appeals Clerk of Courts- 2013 Mar 28 4:11 PM-12AP000629

Franklin County Ohio Court of Appeals Clerk of Courts- 2013 Mar 28 1:05 PM-12AP000629

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

James E. Lundeen, Sr., M.D.,	:	
Appellant-Appellant,	:	
		No. 12AP-629
v.	:	(C.P.C. No. 11CV-16295)
State Medical Board of Ohio,	:	(ACCELERATED CALENDAR)
Appellee-Appellee.	:	

MEMORANDUM DECISION

Rendered on March 28, 2013

James E. Lundeen, Sr., M.D., pro se.

Michael DeWine, Attorney General, *Katherine J. Bockbrader*, and *Henry G. Appel*, for appellee.

ON APPLICATIONS FOR RECONSIDERATION AND CONSIDERATION EN BANC

SADLER, J.

{¶ 1} On January 28, 2013, appellant, James E. Lundeen, Sr., M.D., filed applications for reconsideration, pursuant to App.R. 26(A)(1), and for consideration en banc, pursuant to App.R. 26(A)(2), based on our January 17, 2013 decision in *Lundeen v. State Med. Bd. of Ohio*, 10th Dist. No. 12AP-629, 2013-Ohio-112. Finding neither obvious error warranting reconsideration nor an intra-district conflict warranting en banc consideration, we deny appellant's applications for the reasons set forth below.

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I. BACKGROUND

{¶ 2} In our January 17, 2013 decision, we affirmed a judgment of the Franklin County Court of Common Pleas that affirmed the order of the State Medical Board of Ohio ("the Board") permanently revoking appellant's license to practice medicine in Ohio. On appeal, appellant argued the Board's use of certified mail rendered the Board's orders void and stripped the Board of subject-matter jurisdiction. Appellant also challenged the constitutionality of portions of the Medical Practices Act, set forth in R.C. Chapter 4731. This court concluded appellant waived the right to appeal the issues asserted in his assigned errors because said issues were being raised for the first time on appeal. We also rejected appellant's argument that the Board's use of certified mail required a conclusion that the Board lacked subject-matter jurisdiction to which the waiver doctrine does not apply, and we also explained why the Board's use of certified mail was not inappropriate in this case. Appellant challenges our decision in his applications for reconsideration and en banc consideration. For the following reasons, we find both applications to be without merit.

II. APPLICATION FOR RECONSIDERATION

{¶ 3} We begin with appellant's application for reconsideration filed pursuant to App.R. 26(A)(1). When presented with an application for reconsideration, an appellate court must consider whether the application "calls to the attention of the court an obvious error in its decision or raises an issue for consideration that was either not considered at all or was not fully considered by the court when it should have been." *Matthews v. Matthews*, 5 Ohio App.3d 140 (10th Dist.1981), paragraph two of the syllabus. However, "[a]n application for reconsideration is not designed for use in instances where a party simply disagrees with the conclusions reached and the logic used by an appellate court." *State v. Owens*, 112 Ohio App.3d 334, 336 (11th Dist.1996), dismissed, appeal not allowed, 77 Ohio St.3d 1487 (1996).

{¶ 4} In his application for reconsideration, appellant asserts this court's decision contains "significant and serious errors" regarding the applicable statutes and laws. (Appellant's brief, 8.) Appellant contends our decision misquotes various statutory provisions and misapplies the law. Initially, we note we rejected appellant's arguments challenging service by certified mail on the basis that such arguments were waived for

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failure to have raised them below. Thus, even if appellant is correct in his assertion that the decision contains an inaccurate quotation, such is inconsequential and does not entitle appellant to reconsideration of our decision. Moreover, not only do we reject appellant's assertion that the law has been misapplied in setting forth the requisite statutory provisions, appellant sets forth the very basis of this court's explanation of why the Board's use of certified mail in this instance was not inappropriate. Specifically, appellant quotes the pertinent law, as was quoted in our decision, that R.C. 4731.22(G)(2) permits the use of "certified mail," and R.C. 1.02(G) indicates "registered mail" and "certified mail" are interchangeable terms. Thus, appellant has not provided a basis for reconsideration of our decision.

{¶ 5} Though appellant expresses clear disagreement with this court's conclusions, analysis, and treatment of the statutes, we do not find that appellant calls to our attention an obvious error warranting reconsideration nor does he raise an issue not considered or not fully considered by this court. *Matthews.* Disagreement with this court's analysis and conclusions is insufficient to meet the test for granting reconsideration. *See Nunley v. Wayne Builders Corp.*, 10th Dist. No. 98AP-1202 (Aug. 12, 1999).

{¶ 6} Accordingly, appellant's application for reconsideration is denied.

III. APPLICATION FOR EN BANC CONSIDERATION

{¶ 7} We now turn to appellant's application for en banc consideration. "[I]f the judges of a court of appeals determine that two or more decisions of the court on which they sit are in conflict, they must convene en banc to resolve the conflict." *McFadden v. Cleveland State Univ.*, 120 Ohio St.3d 54, 2008-Ohio-4914, paragraph two of the syllabus. The standard for seeking en banc consideration is outlined in App.R. 26(A)(2). To apply for en banc consideration, a party "must explain how the panel's decision conflicts with a prior panel's decision on a dispositive issue and why consideration by the court en banc is necessary to secure and maintain uniformity of the court's decisions." App.R. 26(A)(2)(b). "Consideration en banc is not favored and will not be ordered unless necessary to secure or maintain uniformity of decisions within the district on an issue that is dispositive in the case in which the application is filed." App.R. 26(A)(2)(a).

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{¶ 8} Appellant claims that our January 17, 2013 decision conflicts with prior decisions of this court rendered in *Columbus v. Sliker*, 30 Ohio App.3d 74 (10th Dist.1986), *Porter v. State Med. Bd. of Ohio*, 10th Dist. No. 05AP-1339, 2006-Ohio-5296, and *Doriott v. State Med. Bd. of Ohio*, 10th Dist. No. 05AP-1079, 2006-Ohio-2171. Though appellant contends we must convene en banc to resolve a conflict between these decisions, we see no conflict as the cases he cites are factually dissimilar.

{¶ 9} In *Sliker*, the defendant sought review of his conviction for driving without a valid operator's license and driving while under suspension in violation of the Columbus City Code. Because the Registrar of the Bureau of Motor Vehicles ("the bureau") did not comply with the requirements of R.C. 119.06 and 119.07, this court held the bureau's order cancelling the defendant's Ohio driver's license was invalid such that he could not be convicted of the subject offenses. Unlike the case before us, *Sliker* did not concern an appeal from an administrative agency nor a contention that the appellant's arguments were waived for failure to raise them below. Moreover, *Sliker* does not discuss subject-matter jurisdiction nor does it hold that the failure to comply with the requirements of R.C. 119.06 and 119.07 left the bureau without subject-matter jurisdiction.

{¶ 10} In *Porter*, the Board issued an order permanently revoking the appellant's license to practice medicine. The trial court reversed the Board's order after finding the Board's notice of hearing failed to comply with R.C. 119.07. Specifically, the trial court held that because certified mail service of the Board's notice of hearing was not completed and the Board did not then publish or make personal delivery service, the appellant did not lose his right to a hearing. Therefore, the trial court remanded the matter to the Board for further proceedings. This court affirmed.

{¶ 11} The facts in *Porter* are not analogous to those presented in the instant matter. *Porter* did not concern a waiver argument since ineffective service of the notice of hearing was the litigant's contention in the trial court as well as on appeal. Further, though appellant contends he did not "see" the notice sent by the Board, the record reflects service by certified mail was perfected in this case as opposed to being returned as unclaimed, as was the case in *Porter*. Additionally, like *Sliker*, *Porter* neither discusses subject-matter jurisdiction nor holds that a failure to comply with the requirements of R.C. 119.07 leaves the Board without subject-matter jurisdiction.

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{¶ 12} Finally, *Doriott* concerned an order of the Board that indefinitely suspended a license to practice medicine after the licensee failed to appear for an ordered examination to assess for impairment. The appellant argued the Board's failure to provide her with notice of her right to a pre- or post-decision hearing rendered the Board's order void. This court agreed and instructed the trial court to issue an order remanding the matter to the Board for further proceedings. Like *Sliker* and *Porter*, waiver was not at issue in *Doriott*, and the factual scenario presented in *Doriott* is not akin to that presented here. Further, while *Doriott* held the Board's order was void, it did not hold the Board lacked subject-matter jurisdiction.

{¶ 13} After review, we conclude our January 17, 2013 decision does not conflict with *Sliker*, *Porter* or *Doriott* but, rather, comports with the same. Because there is no conflict, we deny appellant's application for en banc consideration.

IV. CONCLUSION

{¶ 14} For the above reasons, we find appellant has failed to satisfy the grounds for reconsideration under App.R. 26(A)(1) and the grounds for en banc consideration in App.R. 26(A)(2). Accordingly, appellant's applications are denied.

Applications for reconsideration and en banc consideration denied.

BROWN & DORRIAN, JJ., concur.

0A017 - M37

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

James E. Lundeen, Sr., M.D.,	:	
Appellant-Appellant,	:	
v.	:	No. 12AP-629 (C.P.C. No. 11CV-16295)
State Medical Board of Ohio,	:	(ACCELERATED CALENDAR)
Appellee-Appellee.	:	

JUDGMENT ENTRY

For the reasons stated in the decision of this court rendered herein on January 17, 2013, appellant's two assignments of error are overruled, and it is the judgment and order of this court that the judgment of the Franklin County Court of Common Pleas is affirmed. Costs shall be assessed against appellant.

SADLER, BROWN, and DORRIAN, JJ.

/S/ JUDGE _____

Franklin County Ohio Court of Appeals Clerk of Courts- 2013 Jan 17 2:17 PM-12AP000629

Franklin County Ohio Court of Appeals Clerk of Courts- 2013 Jan 17 2:17 PM-12AP000629

Tenth Circuit Court of Appeals

Date: 01-17-2013

Case Title: JAMES E LUNDEEN SR MD -VS- OHIO STATE MEDICAL BOARD

Case Number: 12AP000629

Type: JEJ - JUDGMENT ENTRY

So Ordered

/s/ Judge Lisa L. Sadler

Franklin County Ohio Court of Appeals Clerk of Courts- 2013 Jan 17 12:43 PM-12AP000629

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

James E. Lundeen, Sr., M.D.,	:	
Appellant-Appellant,	:	
		No. 12AP-629
v.	:	(C.P.C. No. 11CV-16295)
State Medical Board of Ohio,	:	(ACCELERATED CALENDAR)
Appellee-Appellee.	:	

D E C I S I O N

Rendered on January 17, 2013

James E. Lundeen, Sr., M.D., pro se.

Michael DeWine, Attorney General, *Katherine J. Bockbrader*, and *Henry G. Appel*, for appellee.

APPEAL from the Franklin County Court of Common Pleas.

SADLER, J.

{¶ 1} Appellant, James E. Lundeen, Sr., M.D., appeals from a judgment of the Franklin County Court of Common Pleas affirming the order of appellee, State Medical Board of Ohio ("the board"), permanently revoking his license to practice medicine in Ohio. For the reasons that follow, we affirm the judgment of the trial court.

I. BACKGROUND

{¶ 2} In 1965, appellant received his license to practice medicine in the state of Ohio. By order dated May 11, 2011, the board found there was clear and convincing evidence of multiple violations of the Medical Practices Act as codified in R.C. Chapter 4731, and that appellant's continued practice presented a danger of immediate and

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serious harm to the public. Therefore, pursuant to R.C. 4731.22(G), the board summarily suspended appellant's license to practice medicine.[1]

{¶ 3} Appellant was provided a notice of opportunity for hearing alleging that over an approximate 34-year period he violated the standard of care with respect to 26 patients by the improper treatment and prescribing of controlled substances and other drugs of abuse. Specifically, the notice alleged that as to these 26 patients, appellant (1) failed to conduct appropriate physical examinations and failed to record objective physical-examination findings, (2) excessively and inappropriately prescribed narcotic analgesics and other drugs of abuse without regard to indications of possible addiction, drug abuse or diversion, (3) often prescribed increasing dosages of narcotics that were not supported by, or with no documentation of, an objective change in the medical status of the patient, and (4) utilized medical management and/or treatment that was not appropriate to the patients' diagnoses and/or their clinical situation.

{¶ 4} The administrative hearing took place over several days, to wit: August 22, 24-26, 29-30, September 27-28, 30, and October 5-7, 13, 2011. Among the evidence presented during the hearing was the testimony of two patients and the board's expert witness John W. Cunningham, M.D. Appellant did not appear at the hearing to testify, but, instead, provided a written statement that included his position and arguments. Appellant's statement, however, was not signed, made under oath, nor subject to examination.

{¶ 5} On November 18, 2011, the hearing examiner issued a 358-page report and recommendation ("hearing examiner's report"). The hearing examiner's report contained a detailed summary of the evidence as well as findings of fact and conclusions of law. The hearing examiner found numerous departures from the minimal standards of care and that "[t]he pattern of violations continued for many years and affected numerous patients." (Hearing examiner's report, 357.) The hearing examiner also noted appellant's failure to acknowledge that his prescribing practices were flawed. The hearing examiner

[1] R.C. 4731.22(G) allows the board to suspend an individual's certificate to practice without a prior hearing if it has been determined that there is clear and convincing evidence that an individual has violated division (B) of R.C. 4731.22, and that the individual's continued practice presents a danger of immediate and serious harm to the public.

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ultimately concluded the violations by appellant were so pervasive and serious that the public in Ohio could not be adequately protected by anything less than a permanent revocation of appellant's license to practice medicine in Ohio. After consideration at its December 14, 2011 meeting, the board adopted the hearing examiner's report and ordered that appellant's license to practice medicine in Ohio be permanently revoked.

{¶ 6} In accordance with R.C. 119.12, appellant filed an appeal in the Franklin County Court of Common Pleas. In the trial court, appellant challenged the testimony of the board's expert witness, Dr. Cunningham, and argued that due to actions of the Ohio Bureau of Workers' Compensation, he was precluded from fully participating in the administrative hearing. Appellant also argued the Ohio Attorney General's office improperly prosecuted his case and improperly interjected in the board's deliberations. Additionally, appellant argued that the board refused to enforce its subpoenas thereby precluding him from obtaining exculpatory evidence. Lastly, appellant asserted he was denied procedural and substantive due process. Regarding this last assertion, appellant set forth no specific due process violations, but, rather, stated in his brief to the trial court, "[h]undreds of procedural and substantive due process errors were committed during the Board's investigation, hearing, and deliberations. [Appellant] does not waive any of those violations as grounds to vacate the Board Order." (March 22, 2012 Brief, 14.) By judgment rendered June 28, 2012, the trial court addressed each of appellant's arguments and found all to be without merit.

II. ASSIGNMENTS OF ERROR

{¶ 7} Appellant now appeals and presents the following two assignments of error for our consideration:

> 1. The trial court lacked judicial authority and subject matter jurisdiction and/or exceeded its authority to preside over the proceedings in this matter. Thus, any judgments entered in this matter by the trial court are null and void.
>
> 2. The statutes utilized by the State Medical Board of Ohio (RC 4731.22 (B) (2), 4731.22 (B)(6) and 4731.22 (B)(20)) are unconstitutional "as-applied" to a disciplinary action

> culminating in a permanent medical license revocation, as they impose strict liability in the absence of a *mens rea* requirement, resulting in a penalty which is both harsh and stigmatic.

(Emphasis sic.)

III. STANDARD OF REVIEW

{¶ 8} In an administrative appeal, pursuant to R.C. 119.12, the trial court reviews an order to determine whether it is supported by reliable, probative, and substantial evidence and is in accordance with the law. *Levine v. State Med. Bd.*, 10th Dist. No. 10AP-962, 2011-Ohio-3653, ¶ 12; *Huffman v. Hair Surgeon, Inc.*, 19 Ohio St.3d 83, 87 (1985). The Supreme Court of Ohio has defined the concepts of reliable, probative, and substantial evidence as follows:

> (1) "Reliable" evidence is dependable; that is, it can be confidently trusted. In order to be reliable, there must be a reasonable probability that the evidence is true. (2) "Probative" evidence is evidence that tends to prove the issue in question; it must be relevant in determining the issue. (3) "Substantial" evidence is evidence with some weight; it must have importance and value.

Our Place, Inc. v. Ohio Liquor Control Comm., 63 Ohio St.3d 570, 571 (1992).

{¶ 9} The standard of review is more limited on appeal to this court. Unlike the trial court, this court does not determine the weight of the evidence. *Levine* at ¶ 13. In reviewing the court of common pleas' determination that the commission's order was supported by reliable, probative, and substantial evidence, this court's role is confined to determining whether the court of common pleas abused its discretion. *Id.* The term abuse of discretion connotes more than an error of law or judgment; it implies that the court's attitude is unreasonable, arbitrary or unconscionable. *Blakemore v. Blakemore*, 5 Ohio St.3d 217, 219 (1983). However, on the question of whether the commission's order was in accordance with the law, this court's review is plenary. *Univ. of Cincinnati College of Medicine v. State Emp. Relations Bd.*, 63 Ohio St.3d 339, 343 (1992).

IV. DISCUSSION

{¶ 10} On appeal, appellant seemingly abandons all of the arguments made in the trial court and asserts two arguments not previously raised in these proceedings. It is

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well-established that " '[a] party generally waives the right to appeal an issue that could have been, but was not, raised in earlier proceedings.' " *Abunku v. State Med. Bd.*, 10th Dist. No. 11AP-906, 2012-Ohio-2734, ¶ 34, quoting *Jain v. State Med. Bd.*, 10th Dist. No. 09AP-1180, 2010-Ohio-2855, ¶ 10. Appellant could have raised the issues he asserts for the first time on appeal, i.e., improper use of certified mail and constitutionality of portions of the Medical Practices Act, before the board as well as the trial court. However, a review of the record indicates appellant did not raise these allegations below.

{¶ 11} Appellant asserts that the arguments raised in his first assignment of error are not subject to waiver. Here, appellant contends the board's order of May 11, 2011, that summarily suspended his medical license, as well as the board's November 18, 2011 notice, that contained the hearing examiner's report and notified him that the report would be considered at the board's December meeting, are void because in both instances the board used certified mail rather than registered mail as is required by R.C. 119.07. It is appellant's position that because these notices are void, the board was left without subject-matter jurisdiction over these proceedings and the subsequent actions taken by the board are void. Therefore, appellant contends that, though raised for the first time on appeal, these arguments are not subject to waiver. Regardless of appellant's flawed conclusion that the board lacked subject-matter jurisdiction, most notably appellant's argument fails because the board's use of certified mail was not improper.

{¶ 12} Regarding summary suspensions, R.C. 119.07 provides that if a license is suspended without a prior hearing "notice of the agency's order shall be sent to the party by registered mail." However, R.C. 4731.22(G)(2) requires that the board "issue a written order of suspension by certified mail or in accordance with [R.C.] 119.07." With respect to the November 18, 2011 notice, R.C. 119.09, states, in relevant part, that a copy of a report and recommendation shall be "served upon the party or the party's attorney or other representative of record, by certified mail."

{¶ 13} Moreover, R.C. 1.02(G) provides, " '[r]registered mail' includes certified mail and 'certified mail' includes registered mail." *See also Schindler Elevator Corp. v. Tracy*, 84 Ohio St.3d 496, 498 (1999) (pursuant to R.C. 1.02(G), "registered mail" and "certified mail" are interchangeable terms); *Reichart-Spaeth v. Ohio Counselor & Social*

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Worker Bd., 2d Dist. No. 18521 (Mar. 16, 2001) (though R.C. 119.07 requires use of registered mail, pursuant to R.C. 1.02(G), use of certified mail is sufficient).

{¶ 14} Consequently, we conclude there is no merit to appellant's contention that the board's use of certified mail in these instances rendered void all subsequent action taken by the board and left the board without subject-matter jurisdiction over the proceedings. Accordingly, we overrule appellant's first assignment of error.

{¶ 15} In his second assignment of error, appellant argues that the board's disciplinary statute, as codified in R.C. 4731.22, is unconstitutional as applied to him because it lacks a mens rea requirement. Appellant, however, fails to provide any argument or legal authority to support his conclusory assertion.

{¶ 16} The burden of affirmatively demonstrating error on appeal rests with the party asserting error. *State ex rel. Petro v. Gold*, 166 Ohio App.3d 371, 392 (10th Dist.2006), citing App.R. 9; App.R. 16. Pursuant to App.R. 16(A)(7), an appellant must present his or her contentions with respect to each assignment of error presented for review and the reasons in support of those contentions, including citations to legal authorities. According to App.R. 12(A)(2), we may disregard an assignment of error if an appellant fails to cite to any legal authority in support of an argument as required by App.R. 16(A)(7). *See, e.g., In re C.C.*, 10th Dist. No. 04AP-883, 2005-Ohio-5163, ¶ 80; *Hall v. Tucker*, 161 Ohio App.3d 245, 263, 2005-Ohio-2674; *State v. Martin*, 12th Dist. No. CA99-01-003 (July 12, 1999); *Meerhoff v. Huntington Mtge. Co.*, 103 Ohio App.3d 164, 169 (3d Dist.1995). "[F]ailure to comply with the rules governing practice in the appellate courts is a tactic which is ordinarily fatal." *Kremer v. Cox*, 114 Ohio App.3d 41, 60 (9th Dist.1996).

{¶ 17} Furthermore, as indicated previously, the argument contained in appellant's second assignment of error is being asserted for the first time on appeal. Appellant provides neither explanation nor reasoning as to why this argument has not been waived for failure to raise the argument in earlier proceedings. *Abunku.*

{¶ 18} Based on the above grounds, we overrule appellant's second assignment of error.

V. CONCLUSION

{¶ 19} For the foregoing reasons, appellant's two assignments of error are overruled, and the judgment of the Franklin County Court of Common Pleas is hereby affirmed.

Judgment affirmed.

BROWN and DORRIAN, JJ., concur.

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IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

JAMES E. LUNDEEN, SR., M.D.,	:	
	:	
Appellant	:	CASE NO. 11CV-16295
	:	
vs.	:	JUDGE BEATTY
	:	
OHIO STATE MEDICAL BOARD,	:	
	:	
Appellee	:	

DECISION AND JUDGMENT ENTRY DENYING APPELLANT'S MOTION FOR STAY OF ENFORCEMENT DURING APPEAL FILED JULY 27, 2012

BEATTY, JUDGE

On June 28, 2012, the Court issued a Decision and Judgment Entry affirming the State Medical Board's Order permanently revoking Appellant's certificate to practice medicine and surgery in Ohio.

Appellant's July 27, 2012 Motion seeks a stay of the Court's Order; such a stay would be unavailing to Appellant as it would leave in place the Board's Order of permanent revocation. To the extent that Appellant is also seeking a stay of the Board's Order, such a stay was denied, after an evidentiary hearing, by the Magistrate's Decision filed January 17, 2012.

R.C. 119.12 provides that a stay may be granted upon a showing of unusual hardship from execution of the agency's order pending determination of the appeal. In *Bob Krihwan Pontiac-GMC Truck, Inc. v. GMC*, 141 Ohio App.3d 777, 783 (10th Dist. 2001), the Court identified the following factors as logical considerations when determining whether it is appropriate to stay an administrative order pending judicial review: (1) whether appellant has shown a strong or substantial likelihood or probability of success on the merits; (2) whether

appellant has shown that it will suffer irreparable injury; (3) whether the issuance of a stay will cause harm to others; and (4) whether the public interest would be served by granting a stay.

The Court has already determined the merits of this appeal. Appellant's July 27, 2012 Motion raises a new argument that the Board's Orders are void because they were sent by certified mail rather than registered mail. Appellant failed to raise this argument in this appeal, and has thereby waived it. *S&P Lebos, Inc. v. Ohio Liquor Control Comm'n*, 163 Ohio App.3d 803, 2005-Ohio-4552, ¶12 (10th Dist.). In addition, R.C. 1.02(G) provides that "registered mail" includes "certified mail." *See also Reichart-Spaeth v. Ohio Counsler & Soc. Worker Bd.*, 2nd Dist. No. 18521, 2001 Ohio App. LEXIS 1194, p. 8-9.

Appellant's Motion does not demonstrate specific harm from continuation of the suspension that has already been in place for fifteen months.

The public interest and the potential harm to others also weigh against a stay, as the Board's Hearing Examiner found a pattern of violations by Appellant that "are so pervasive and serious that that public in Ohio cannot be adequately protected by anything less than permanent revocation of Dr. Lundeen's medical license." (Report, p. 358).

For the foregoing reasons, Appellant's Motion for Stay of Enforcement During Appeal filed July 27, 2012 is hereby DENIED.

Franklin County Court of Common Pleas

Date:	08-09-2012
Case Title:	JAMES E LUNDEEN SR MD -VS- OHIO STATE MEDICAL BOARD
Case Number:	11CV016295
Type:	DECISION/ENTRY

It Is So Ordered.

/s/ Judge Laurel A. Beatty

Court Disposition

Case Number: 11CV016295

Case Style: JAMES E LUNDEEN SR MD -VS- OHIO STATE MEDICAL BOARD

Final Appealable Order: Yes

Motion Tie Off Information:

1. Motion CMS Document Id: 11CV0162952012-07-2799950000
   Document Title: 07-27-2012-MOTION TO STAY
   Disposition: MOTION DENIED

20877 - S8

IN THE COMMON PLEAS COURT OF FRANKLIN COUNTY, OHIO

James E. Lundeen, Sr., M.D.	)	CASE NO: 11CV 16295
26 Sandusky Street, Unit 30	)	
Plymouth, Ohio 44865	)	12APE07 • • 629
Appellant,	)	
vs.	)	
STATE OF OHIO, OHIO STATE	)	**NOTICE OF APPEAL**
MEDICAL BOARD,	)	
30 East Broad Street, 3rd Floor	)	
Columbus, Ohio 43215	)	
Appellee.	)	

FILED
COURT OF APPEALS
2012 JUL 27 PM 12:51
CLERK OF COURTS

Notice is hereby given that James E. Lundeen, Sr., M.D., hereby appeals to the Court of Appeals of Franklin County, Ohio, Tenth Appellate District from the final judgment order of Franklin County Court of Common Pleas Court Judge Laurel Beatty, entitled *Decision and Judgment Entry Affirming the Order of the State Medical Board of Ohio And Notice of Final Appealable Order* entered in this action on the 28th day of June 2012.

Respectfully submitted,

2012 JUL 27 PM 12:37
CLERK OF COURTS

James E. Lundeen, Sr., M.D., *pro se*
26 Sandusky Street, Unit 30
Plymouth, Ohio 44865
(740) 415-6612
(877) 725-1302 (fax)
jelmd@ymail.com

CERTIFICATE OF SERVICE

I hereby certify that a copy of this NOTICE OF APPEAL was delivered to the Ohio State Medical Board, 30 East Broad Street, Third Floor, Columbus, Ohio 43215 on the 27th day of July, 2012. I further certify that a true and accurate copy of the foregoing NOTICE OF APPEAL was sent by U.S. mail, postage prepaid, on the 27th day of July, 2012 to:

Henry Appel, Esquire
Senior Assistant Attorney General
Office of the Attorney General
30 East Broad Street, 26th Floor
Columbus, Ohio 43215

Katherine Bockbrader, Esquire
Senior Assistant Attorney General
Office of the Attorney General
30 East Broad Street, 26th Floor
Columbus, Ohio 43215

James E. Lundeen, Sr., M.D., *pro se*

Franklin County Ohio Clerk of Courts of the Common Pleas- 2012 Jun 28 2:03 PM-11CV016295
0A522 - H80

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

JAMES E. LUNDEEN, SR., M.D.,	:	
Appellant	:	CASE NO. 11CV-16295
vs.	:	JUDGE BEATTY
STATE MEDICAL BOARD OF OHIO,	:	
Appellee	:	

DECISION AND JUDGMENT ENTRY
AFFIRMING THE ORDER OF THE STATE MEDICAL BOARD OF OHIO
AND
NOTICE OF FINAL APPEALABLE ORDER

BEATTY, JUDGE

This is an appeal pursuant to R.C. 119.12 from a December 14, 2011, Order of the State Medical Board of Ohio (the "Board") permanently revoking Appellant's certificate to practice medicine and surgery in Ohio.

I. FACTS

On May 11, 2011, the Board issued a Notice of Summary Suspension and Opportunity for Hearing (the "Notice") to Appellant James E. Lundeen, Sr., M.D. The Board summarily suspended Appellant's certificate to practice medicine on the grounds that his continued practice presented a danger of immediate and serious harm to the public. The Board alleged that, with respect to 26 identified patients:

> Dr. Lundeen inappropriately treated these patients and/or failed to appropriately treat them, and/or failed to appropriately document his treatment of these patients. For example,
>
> (a) he failed to conduct appropriate physical examinations and did not record objective physical-examination findings such as height and weight, blood pressure, medication allergies,

reflexes present or absent, sensation, ability to stand, sit, lie, and/or walk on toes or heels;

(b) he excessively and inappropriately prescribed narcotic analgesics and other drugs of abuse despite indications of possible addiction, drug abuse, or diversion in some patients, and failed to appropriately refer such patients to an addictionologist;

(c) he often prescribed increasing dosages of narcotics that were not supported by an objective change in the medical status of the patients, and/or he failed to document that there was an objective change in the clinical status other than the fact that the patient required more analgesic medication; and/or

(d) his medical management and/or treatment was not appropriate to the patients' diagnoses and/or their clinical situation. (Notice, p. 1-2).

Appellant requested an administrative hearing, which was held on August 22, 24-26, and 29-30, September 27, 28 and 30, and October 5-7 and 13, 2011. During the hearing, the State presented the testimony of expert witness John W. Cunningham, M.D. and the testimony of two patients.

Appellant did not testify at the hearing or call an expert witness to testify at the hearing. Appellant submitted a written statement that was not under oath (Ex. Z) and a written report of David B. Ross, M.D. that was not under oath. (Ex. A).

In this appeal, Appellant's assignments of error do not specifically address the merits of the opinions of Dr. Cunningham concerning treatment of the 26 patients. Accordingly, only examples of those opinions will be set forth here to provide background.

A. Failure to Conduct Appropriate Physical Examinations

Dr. Cunningham testified that Dr. Lundeen's examination of Patient 3, diagnosed with lumbar disk displacement, was insufficient because there was no documentation that

he checked the patient's reflexes and sensation, and no discussion of the patient's past medical history. (T. at 344-46). For Patient 5, who had suffered "multiple crushing injuries," Dr. Cunningham stated that the patient "required a musculoskeletal exam of the neck, upper back, low back, and all four extremities," but these were not shown in Dr. Lundeen's records, which contained no objective findings as to reflexes, sensation, ability to stand, sit, lie, walk on toes or heels, etc. (St. Ex. 30 at 45; R&R at 78). Dr. Cunningham testified that Dr. Lundeen's examination of Patient 11 was "very, very inadequate" because the patient had injuries to the upper back, pelvis, wrist, knee, lower back, and ankle, but Dr. Lundeen did not examine all these areas or even note which knee, ankle or wrist was injured. (T. 446-448; R&R 154).

B. Inappropriate Prescribing of Narcotics Despite Indications of Abuse

Patient 1 reported that she ran out of Dilaudid on one occasion and that her drugs were stolen on another occasion. (T. 222-25). Dr. Cunningham testified that these reports were "red flags" that should have been "very, very alarming" when a patient is taking narcotics. (T. 226-28). Dr. Cunningham testified that the patient should have been referred to a specialist in addictionology, Dr. Lundeen should have been "more skeptical" of the patient's reports of pain, and he violated the standard of care by continuing to prescribe increasing dosages of narcotics to Patient 1. (T. 233-34).

Dr. Cunningham testified that Patient 9 suffered contusions in May 2000 that should have healed within days or weeks. (T. 421, 424-425). Dr. Lundeen prescribed Percocet for Patient 9 through July, 2001, Vicodin through July 2003, and Xanax and Soma through 2011. (R&R 143; St. Ex. 9 at 224-25). Dr. Cunningham stated that given the increasing narcotic dosage without objective changes in medical status, he was

concerned about narcotic dependency and opined that Patient 9 required referral to a physician skilled in diagnosing and treating narcotic addiction and dependence issues. (St. Ex. 30 at 75-80; R&R 145).

In August, 2009, Dr. Lundeen prescribed Percocet and Neurontin for Patient 22. (St. Ex. 22 at 46-48; R&R 262). On December 19, 2009, Patient 22 attempted suicide and admitted that he had taken another person's methadone. (St. Ex. 22A at 9; R&R 267). On December 30, 2009, Dr. Lundeen prescribed Percocet and Neurontin as before and added prescriptions for Dilaudid, Xanax, and Cymbalta. (St. Ex. 22 at 13, 46; R&R 263). Patient 22 testified that Dr. Lundeen never got up to examine him. (T. 598). Patient 22 testified that while he was a patient of Dr. Lundeen, he was arrested, and later convicted of, aggravated possession of prescription drugs. (T. 601). Dr. Cunningham testified that Patient 22's drug-seeking behavior was not addressed by Dr. Lundeen, nor was Patient 22's suicide attempt, and that Dr. Lundeen violated the standard of care by increasing Patient 22's narcotic medication. (T. 1060-61).

C. Increasing Dosages of Narcotics Unsupported by Objective Changes

On Patient 1's first visit in November 2002, Dr. Lundeen prescribed Vicodin. (St. Ex. 1 at 191-203; R&R 25-27). Within a year, Dr. Lundeen added Percocet and Valium, and by 2007, Dr. Lundeen was prescribing Lidoderm, Valium, Percocet, and Dilaudid for Patient 1. (*Id.*). Dr. Cunningham testified that he saw no explanation in Dr. Lundeen's records to justify the "huge increase in narcotics over time." (T. 220-22).

Patient 10 first saw Dr. Lundeen for a back sprain in February 2006. (St. Ex. 10 at 8-9, 19-144; R&R 146). At that visit, Dr. Lundeen prescribed Percocet, Flexoril, and Feldene. (St. Ex. 10 at 145; R&R 148). At the last recorded visit, Dr. Lundeen was

prescribing Magnacet, Dilaudid, Duragesic, Xanax, Tofranil, Flexeril, Triavil, Ambien, and Feldene. (St. Ex. 10 at 155; R&R 150). Dr. Cunningham testified that there appeared to be no medical reason for the substantial increase in Patient 10's narcotic medication, there was no attempt by Dr. Lundeen to determine the reason for Patient 10's need for increasing dosages, and that this violated the standard of care. (T. 437-438).

D. Inappropriate Medical Management or Treatment

Dr. Lundeen prescribed medications for Patient 4 for multiple major cardiac conditions, including congestive heart failure, hypertension, and atrial fibrillation. (St. Ex. 4 at 2-3; R&R 71-72). Dr. Cunningham testified that these conditions are life-threatening (T. 357-361, 367), but that Dr. Lundeen's records do not show that he listened to the patient's heart or checked for hardening of the carotid arteries. (T. 362-364). Dr. Cunningham testified that the standard of care required checking blood pressure, listening to the heart and lungs at every visit, and checking weight. (*Id.*).

Patient 15 testified that Dr. Lundeen prescribed Cymbalta, Lamictal, and Klonopin, psychiatric medications, without asking her about mental issues or symptoms or the conditions with which she had been diagnosed. (T. 591-592; R&R 209-210).

Dr. Cunningham testified that Dr. Lundeen prescribed Xanax, Celexa, and Zoloft to Patient 9 for anxiety and a personality disorder without any indication that he assessed her psychological conditions. (T. 425-426).

In his report, Dr. Ross stated that Dr. Cunningham did not demonstrate a "single event concerning medicinal pain management that clearly was substandard." (Ex. A at 45). Dr. Ross stated that Dr. Lundeen's care of the patients at issue did not warrant Board discipline. (*Id.* at 48).

In his written statement, Dr. Lundeen indicated that his care for the patients was authorized by the Bureau of Workers' Compensation ("BWC"), his work was subject to review by the BWC, his care was within minimal standards, and his use of controlled substances was within Board guidelines, statutes and rules. (Ex. Z).

II. FINDINGS OF THE BOARD

On November 18, 2011, the Hearing Examiner issued a 358-page Report and Recommendation. The Hearing Examiner concluded that with respect to the 26 patients, Appellant failed to conform to minimal standards of care and failed to maintain minimal standards applicable to the selection or administration of drugs. (R&R p. 356). The Hearing Examiner added:

> Dr. Lundeen's departures from the minimal standards of care were numerous. ...
> ...
> Dr. Lundeen has not acknowledged that his prescribing practices were flawed. If he had recognized the need to make substantial changes in his practices, there would be an argument for remediation.
>
> There were multiple violations. The pattern of violations continued for many years and affected numerous patients. ....
> ...
> Overall, the Hearing Examiner does not believe that Dr. Lundeen is amenable to improvement through education, monitoring, or other similar tools that the Board can use to protect the public. He has demonstrated enormous carelessness and arrogance that are central to the repeated violations demonstrated in the hearing record.
>
> In sum, the Hearing Examiner finds that violations by Dr. Lundeen are so pervasive and serious that the public in Ohio cannot be adequately protected by anything less than a permanent revocation of Dr. Lundeen's medical license. (R&R p. 357-358).

The Board addressed this matter at its December 14, 2011 meeting. One Board member criticized Appellant for "indiscriminate prescribing of multiple narcotics simultaneously," questioned how "patients could even function if they were taking all the

medications prescribed," and stated that "Dr. Lundeen's care primarily consisted of prescribing ever-increasing amounts of narcotics with little or no thought of trying different avenues of treatment or discussions of quality of life." (Minutes, p. 6). Another Board member commented that Appellant "has exhibited an extended pattern of insufficient diagnosis and insufficient treatment." (*Id.*, p. 6-7). On December 14, 2011, the Board issued an Order permanently revoking Appellant's medical certificate.

On December 29, 2011, Appellant filed this appeal.

III. LAW

When considering an appeal from an order of the Medical Board, a common pleas court must uphold the order if it is supported by reliable, probative, and substantial evidence and is in accordance with law. R.C. 119.12. *Pons v. Ohio State Med. Bd.*, 66 Ohio St.3d 619, 621 (1993).

The Court's scope of review of an agency's decision in an administrative appeal is limited. *Univ. of Cincinnati v. Conrad*, 63 Ohio St.2d 108, 110 (1980). The Court is to "give due deference to the administrative resolution of evidentiary conflicts" because the fact finder had the opportunity to observe the witnesses and weigh their credibility. (*Id.*) The Court "will not substitute its judgment for the Board's where there is some evidence supporting the Board's Order." *Harris v. Lewis*, 69 Ohio St.2d 577, 578 (1982).

The Ohio Supreme Court has recognized that the General Assembly granted the Medical Board a broad measure of discretion. *Arlen v. State*, 61 Ohio St.2d 168, 174 (1980). In *Farrand v. State Med. Bd.*, 151 Ohio St. 222, 224 (1949), the court stated:

> ... The purpose of the General Assembly in providing for administrative hearings in particular fields was to facilitate such matters by placing the decision on facts with boards or commissions composed of men equipped

> with the necessary knowledge and experience pertaining to a particular field. ...

"Accordingly, when courts review a medical board order, they are obligated to accord due deference to the board's interpretation of the technical and ethical requirements of the medical profession." *Landefeld v. State Med. Bd.*, 10th Dist. No. 99AP-612, 2000 Ohio App. LEXIS 2556, p. 9.

IV. THE COURT'S FINDINGS AND CONCLUSIONS

Before addressing Appellant's Assignments of Error, the Court will address Appellant's Motion for Order Requiring the Board to File a Complete Record of Proceedings, or in the alternative, Motion to Supplement the Record filed March 6, 2012.

Appellant's Motion requests an Order that the Board include in the record the following documents for its December 14, 2011 and January 11, 2012 meetings: draft minutes, proposed changes to minutes, audio recordings, and transcripts of audio recordings. Pursuant to Ohio Admin. Code 4731-9-01(A), the Board's final approved meeting minutes "constitute the official record of its proceedings." Accordingly, draft minutes and proposed changes to the minutes are not part of the official record. Under the Rule, audio recordings of the meetings constitute "transitory documents." Moreover, no transcript of the meetings was prepared, inasmuch as Respondent did not engage a court reporter as permitted by Ohio Admin. Code 4731-9-01(B). While Appellant has also requested minutes of the January 11, 2012 meeting, the minutes of the December 14, 2011 meeting reflect the Board's consideration and disposition of this matter. For these reasons, Appellant's Motion is denied.

Appellant's First Assignment of Error asserts that Dr. Cunningham did not, and could not, provide an adequate review of Dr. Lundeen's care because Dr. Cunningham is

not qualified in Dr. Lundeen's area of practice, Dr. Cunningham had an alleged conflict of interest that was concealed from the Board, and all of the relevant records and evidence were not provided for his review.

In *Leak v. State Med. Bd*, 10th Dist. No. 09AP-1215, 2011-Ohio-2483, ¶12, the Court held as follows: "[W]hen the board does hear expert testimony, the expert must be capable of expressing an opinion grounded in the particular standard of care applicable to the area of practice for the physician facing discipline."

The State's expert witness, Dr. Cunningham, has been licensed to practice medicine in Ohio since 1969 and has practiced in the area of occupational medicine for over thirty years. (State's Ex. 29; T. 156-159). Since 1984, Dr. Cunningham has been board-certified in occupational medicine. (State's Ex. 29; T. 157-158). Occupational medicine is a subspecialty of preventative medicine, and focuses on workers, industry, and the workplace environment. (T. 156-159).

Appellant argues that Dr. Cunningham is not qualified to opine regarding Dr. Lundeen's subspecialty, "permanent total disability" treatment. However, Appellant has presented no evidence that "permanent total disability" is a recognized medical specialty. The evidence establishes that Dr. Lundeen practices occupational medicine, the area in which Dr. Cunningham is board-certified. Dr. Cunningham testified that he has experience treating patients with occupational injuries, patients with chronic pain, and patients who are off work with disabilities. (T. 1349-1353). He also has experience in providing controlled substances for management of pain in these patients. (T. 1352). The record shows that Dr. Cunningham was qualified to, and did, express opinions as to the standard of care applicable to the area of practice of Dr. Lundeen.

Appellant contends that Dr. Cunningham had a conflict of interest in that some of the patient files initially provided to him were files he had previously reviewed at the request of the BWC. Dr. Cunningham testified that pursuant to instructions from the Board, he did not review or offer opinions in this case on any patient records that he had previously reviewed for the BWC. (T. 1156-1157). Thus, he had not previously reviewed records of any of the 26 patients relevant to this case. While Appellant argues that this alleged conflict was not disclosed, the information was disclosed at the hearing and is part of the hearing record reviewed by the Board. (T. 1153-1157). Appellant has not established the existence of any conflict of interest relevant to this case.

Appellant asserts that complete patient files were not provided to Dr. Cunningham prior to his review. The evidence is that Dr. Cunningham prepared an initial report (St. Ex. 30), and that after additional patient records were provided to him, he provided a supplemental report on August 3, 2011 (St. Ex. 30A; T. 173-174; R&R 9-10). Dr. Cunningham's opinions regarding Dr. Lundeen's care and treatment of the patients did not change. (St. Ex. 30; R&R 10). The supplemental report was provided to Appellant prior to the start of the hearing, and Appellant's counsel questioned Dr. Cunningham about both reports at the hearing. (*See* T. 1157-1161).

As the finder of fact, the Board was entitled to find credible, and rely upon, the evidence presented by the Board, including the testimony of Dr. Cunningham. The Court is not to substitute its judgment for that of the Board. For the foregoing reasons, the Court concludes that Appellant's First Assignment of Error is without merit.

Appellant's Second Assignment of Error asserts that the "BWC precluded Dr. Lundeen from fully participating in the Medical Board Hearing." Appellant states that

the BWC's threats of civil and criminal prosecution left him with no alternative but to assert his Fifth Amendment rights and submit his arguments and contentions in writing rather than testify at the hearing.

In *Urban v. State Med. Bd.*, 10th Dist. No. 03AP-426, 2004-Ohio-104, ¶33, a physician argued that the Board violated his due process rights by proceeding with disciplinary action while a criminal prosecution was pending, as he could defend himself only by giving up his Fifth Amendment rights. The Court rejected this argument, holding that "the Fifth Amendment protection against compulsory, self-incriminating testimony does not extend to prohibit civil litigation while the possibility of criminal prosecution exists." Similarly, in *Walker v. State Med. Bd.*, 10th Dist. No. 01AP-791, 2002-Ohio-682, p. 14, the Court rejected a physician's argument that her due process rights were violated when the Board proceeded with disciplinary action after she asserted her Fifth Amendment rights. The Court stated: "Merely because appellant and her counsel felt that her testimony was strategically vital to her defense does not violate or implicate any Fifth Amendment guarantee. The potential loss of her medical license does not, in and of itself, raise a claim of compulsion by the state."

Ohio law is clear that the Board could proceed with disciplinary action regardless of whether Appellant chose to testify. Accordingly, Appellant's Second Assignment of Error is without merit.

Appellant's Third Assignment of Error asserts that one of the prosecuting Assistant Attorney Generals impermissibly took part in the Board's post-hearing deliberations.

The minutes of the Board's December 14, 2011 meeting reflect that during the discussion of this matter, a Board member mentioned that he had taken notice of "Dr. Lundeen's lack of basic equipment and supplies" in his office. (R. 16, p. 20377). The Notice of Opportunity for Hearing letter had included allegations regarding the condition of Dr. Lundeen's offices, allegations that the Hearing Examiner found were not established by the evidence. (R&R p. 356). The minutes reflect that the following then occurred:

> Mr. Appel asked for an opportunity to speak briefly to clarify the record. Dr. Suppan recognized Mr. Appel. Mr. Appel noted that Dr. Strafford and Mr. Hairston have made reference to Dr. Lundeen's alleged lack of supplies. Mr. Appel stated that that allegation was not proven and therefore is not part of the hearing record. Mr. Appel cautioned the Board not to rely on that allegation in making its decision. (R. 16, p. 20377).

In *DeBlanco v. St. Med. Bd.*, 78 Ohio App.3d 194, 198 (10th Dist. 1992), the Court stated that "Under R.C. 119.10, the Assistant Attorney General assigned to represent the agency in the prosecution is not entitled to take part in the board's post-hearing deliberations." In that case, the Court found that there had been no showing of "undue influence exerted by the Attorney General" and no evidence of prejudice to the appellant. (*Id.*).

In *Korn v. Ohio Medical Bd.*, 61 Ohio App.3d 677, 686, (10th Dist. 1988), the Court held that "In order to support reversal of a judgment, the record must show affirmatively not only that error intervened, but that such error was to the prejudice of the party seeking such a reversal."

The record reflects that Appellant did not object to the statement by Mr. Appel. The statement by Mr. Appel clarifies that the issue of the condition of Dr. Lundeen's offices was not before the Board. The statement is thus not an effort to influence the

substantive conclusions of the Board on the issues that were before the Board. In addition, because the statement is an effort to prevent the Board from considering discipline against Appellant based on allegations that had been found not to have been established, the statement is to the benefit of Appellant. The Court finds that there has been no showing of "undue influence" by the Assistant Attorney General or prejudice to Appellant. Accordingly, Appellant's Third Assignment of Error is overruled.

Appellant's Fourth Assignment of Error asserts that the Board refused to enforce subpoenas, precluding Dr. Lundeen from obtaining exculpatory evidence. Specifically, Appellant contends that the BWC failed to complete production of documents seized from him in March, 2011.

In response to Appellant's subpoenas, the Hearing Examiner ordered that the BWC produce records relating to Patients 1 through 26 and other documents relating to allegations in the Notice. (Aug 10, 2011 Entry at p. 12). On August 18, 2011, the BWC produced to Dr. Lundeen a computer disk with copies of all seized records relating to Patients 1 through 26 and another disk containing copies of other documents seized from Dr. Lundeen's office. (T. 1701, 1858).

During the hearing, Appellant asserted that the BWC had not produced all of the documents and other materials seized from his office. The BWC responded that it had produced all patient records, but that it was continuing to search for additional documents requested, such as bankruptcy records. (T. 1702-1703, 1710).

Dr. Lundeen began presentation of his case on October 6, 2011. At that time, the Hearing Examiner set a deadline of October 13, 2011 for the BWC to complete its production of documents. (T. 1801). On the scheduled date, the BWC produced

additional documents. (T. 1825). The Hearing Examiner confirmed that the BWC had produced the records relating to Patients 1 through 26. (T. 1875). Appellant's counsel argued that certain documents had not been produced, but mentioned only documents concerning Dr. Lundeen's employees and documents concerning Dr. Lundeen's office, such as records of inventory and purchases and travel records. (T. 1873-1876). The Hearing Examiner noted that there was no explanation of why documents concerning Dr. Lundeen's employees were relevant to any allegations in the Notice. (T. 1875). As noted, the allegations relating to Dr. Lundeen's offices were found not to be established by the evidence, and thus were not a basis for the Board's discipline.

A party challenging an agency's failure to issue or enforce a subpoena is required to demonstrate prejudice. *Burneson v. Ohio State Racing Comm'n*, 10th Dist. No. 08AP-794, 2009-Ohio-1103, ¶22. The record shows that the Board acted to enforce the subpoenas to the BWC, and that voluminous documents were produced, including the records relating to Patients 1 through 26, the patients whose care is at issue in this proceeding. Appellant has not shown any material non-compliance with the subpoenas or that the BWC failed to produce any documents that are relevant to this case. Appellant thus has failed to show any prejudice.

For the foregoing reasons, Appellant's Fourth Assignment of Error is overruled.

Appellant's Fifth Assignment of Error asserts that the Board made "hundreds" of procedural and substantive due process errors, but does not specify, or include argument on, the alleged errors. It is not the duty of the Court to create arguments for the parties or search the record for evidence to support them. *Sisson v. Ohio Department of Human*

Services, 9th Dist. No. 2949-M, 2000 Ohio App. LEXIS 1691, p. 6. Appellant's Fifth Assignment of Error is overruled.

For the foregoing reasons, the Court finds that the Board's Order is supported by reliable, probative and substantial evidence and is in accordance with law. The Board's Order is **AFFIRMED**. This is a final, appealable Order. Costs to Appellant.

IT IS SO ORDERED.

Franklin County Court of Common Pleas

Date:	06-28-2012
Case Title:	JAMES E LUNDEEN SR MD -VS- OHIO STATE MEDICAL BOARD
Case Number:	11CV016295
Type:	DECISION/ENTRY

It Is So Ordered.

/s/ Judge Laurel A. Beatty

Court Disposition

Case Number: 11CV016295

Case Style: JAMES E LUNDEEN SR MD -VS- OHIO STATE MEDICAL BOARD

Case Terminated: 18 - Other Terminations

Final Appealable Order: Yes

Motion Tie Off Information:

1. Motion CMS Document Id: 11CV0162952012-03-0699980000
   Document Title: 03-06-2012-MOTION TO COMPEL - GENERAL
   Disposition: MOTION DENIED

2. Motion CMS Document Id: 11CV0162952012-01-3199980000
   Document Title: 01-31-2012-OBJECTION TO
   Disposition: MOTION IS MOOT

Franklin County Ohio Clerk of Courts of the Common Pleas- 2011 Dec 29 3:04 PM-11CV016295

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STATE MEDICAL BOARD
OF OHIO

IN THE COMMON PLEAS COURT OF FRANKLIN COUNTY, OHIO
AND
BEFORE THE STATE MEDICAL BOARD OF OHIO

JAMES E. LUNDEEN, SR., M.D. **26 Sandusky Street** **Plymouth, OH 44865** **Appellant,** **vs.** **STATE MEDICAL BOARD OF OHIO,** **30 East Broad Street, 3rd Floor** **Columbus, OH 43215** **Appellee.**	)	**CASE NO.** _____ **Category F** **JUDGE** _____ **NOTICE OF APPEAL**

James E. Lundeen, Sr., M.D., ("Dr. Lundeen"), Appellant, hereby gives Notice of Appeal on questions of law and fact to the Court of Common Pleas, Franklin County, Ohio, pursuant to Chapter 119 of the Ohio Revised Code. Dr. Lundeen appeals from the Order of the Ohio State Medical Board ("Board") dated December 14, 2011, (mailed December 15, 2011). A copy of the Board Order is attached hereto as Exhibit 1.

The grounds for the appeal and the errors complained of known at this time are as follows:

I. The Order of the Board should be reversed on the basis that the Order is not supported by reliable, probative and substantial evidence and is not otherwise in accordance with law;

II. The Order of the Board should be reversed because some Board Members failed to recuse themselves from Board discussions and voting, despite their bias, personal animus and conflicts of interest relating to Dr. Lundeen's matter;

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STATE MEDICAL BOARD
OF OHIO

III. The Order of the Board should be reversed because the Order was not approved and confirmed by the minimum requisite number of qualified votes required by Revised Code §4731.22;

IV. The Order of the Board should be reversed because the evidence produced during the Administrative Hearing demonstrates that the Board lacked a good faith basis to make the allegations contained in Dr. Lundeen's Citation Letter dated May 11, 2011 ("Citation Letter").

V. The Order of the Board should be reversed because Dr. Lundeen was never given access to, or provided copies of, his personal property and patient medical records necessary for defending against the allegations contained in the Citation Letter.

VI. The Order of the Board should be reversed because throughout the entire administrative proceeding the Board worked in collusion with the Ohio Bureau of Workers' Compensation ("BWC") to withhold medical records from both the States expert witness, and from Dr. Lundeen, and both agencies refused to comply with subpoenas and the Board refused to enforce subpoenas issued for medical records and personal property held by the BWC.

VII. The Order of the Board should be reversed because the State failed to establish during the hearing the appropriate "minimal standard of care" for to the treatment of Permanent Total Disability patients as defined by the BWC; nor did the Board – purporting to act as its own expert witness – establish any cognizable or medically recognized appropriate minimal standard of care for the treatment of Permanent Total Disability patients;

VIII. The Order of the Board should be reversed because the Board failed to consider relevant evidence that:

a. the State of Ohio through its agencies have prohibited Dr. Lundeen is from using the "OARRS" system,

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STATE MEDICAL BOARD OF OHIO

b. Dr. Lundeen employed extensive procedures used to identify and dismiss patients and prospective patients exhibiting drug-seeking behavior, and

c. the unique nature of Dr. Lundeen's medical practice;

IX. The Order of the Board should be reversed because the Order of Summary Suspension was invalid due to Board Staff improperly withholding key evidence from the State's expert witness and from Board Members.

X. The Order of the Board should be reversed because R.C. § 4731.22 is unconstitutional on its face and as applied to Dr. Lundeen as it fails to set a standard of evidence required to establish the validity of Board Disciplinary Action.

Appellant reserves the right to add additional assignments of error and grounds for appeal once the transcript of proceedings has been completed and counsel has an opportunity to review the record.

Respectfully submitted,
GRAFF & MCGOVERN, L.P.A.

Douglas E. Graff, Esq. (0013222)
Levi J. Tkach, Esq. (0086025)
Counsel for James E. Lundeen Sr., M.D.
604 East Rich Street
Columbus, Ohio 43215-5341
(614) 228-5800
(614) 228-8811 Fax
doug@grafflaw.com

STATE MEDICAL BOARD
OF OHIO
2012 JAN -4 AM 11:56

Franklin County Ohio Clerk of Courts of the Common Pleas- 2011 Dec 29 3:04 PM-11CV016295

0A135 - Y50

CERTIFICATE OF SERVICE

I hereby certify that foregoing NOTICE OF APPEAL was filed by hand delivery this 29 day of December 2011 with the State Medical Board of Ohio at 30 East Broad Street, 3rd Floor, Columbus, Ohio 43215; and that a true and accurate copy was e-filed with the Franklin County, Ohio, Court of Common Pleas: service on Board's counsel by hand delivery to:

Henry Appel, Esq.
Assistant Attorney General,
Health & Human Services Section
30 East Broad Street, 26th Floor,
Columbus, Ohio 43215

Douglas E. Graff, Esq.
Levi J. Tkach, Esq.

STATE MEDICAL BOARD
OF OHIO
2012 JAN -4 AM 11: 57

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

December 14, 2011

James E. Lundeen, Sr., M.D.
26 Sandusky Street
Plymouth, OH 44865

RE: Case No. 11-CRF-055

Dear Doctor Lundeen:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Patricia A. Davidson, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on December 14, 2011, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal must be commenced by the filing of a Notice of Appeal with the State Medical Board and the Franklin County Court of Common Pleas. The Notice of Appeal must set forth the Order appealed from and state that the State Medical Board's Order is not supported by reliable, probative, and substantive evidence and is not in accordance with law. The Notice of Appeal may, but is not required to, set forth the specific grounds of the appeal. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 91 7199 9991 7030 3311 0714
RETURN RECEIPT REQUESTED

Douglas E. Graff, Esq.
CERTIFIED MAIL NO. 91 7199 9991 7030 3311 0721
RETURN RECEIPT REQUESTED

Mailed 12-15-11

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Patricia A. Davidson, State Medical Board Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on December 14, 2011, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of James E. Lundeen, Sr., M.D., Case No. 11-CRF-055, as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.

Lance A. Talmage, M.D.
Secretary

(SEAL)

December 14, 2011
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*	
	*	CASE NO. 11-CRF-055
JAMES E. LUNDEEN, SR., M.D.	*	

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on December 14, 2011.

Upon the Report and Recommendation of Patricia A. Davidson, State Medical Board Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that:

> The certificate of James E. Lundeen, Sr., M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

Lance A. Talmage, M.D.
Secretary

(SEAL)

December 14, 2011
Date

STATE MEDICAL BOARD
OF OHIO

2011 NOV 18 PM 2:26

THE STATE MEDICAL BOARD OF OHIO

In the Matter of	*	
		Case No. 11-CRF-055
James E. Lundeen, Sr., M.D.,	*	
		Hearing Examiner Davidson
Respondent.	*	

REPORT AND RECOMMENDATION

Basis for Hearing

In a Notice of Summary Suspension and Opportunity for Hearing [Notice] dated May 11, 2011, the State Medical Board of Ohio notified James E. Lundeen, Sr., M.D., that, pursuant to Ohio Revised Code Section [R.C.] 4731.22(G), the Board had summarily suspended his certificate to practice medicine and surgery in Ohio. In addition, the Board notified Dr. Lundeen that it intended to determine whether to take disciplinary action against his certificate based on allegations including the following:

- During the period from about October 1977 through about March 2011, Dr. Lundeen undertook the care of 26 patients (identified in a confidential patient key) to whom he prescribed controlled substances and/or drugs of abuse.

- Dr. Lundeen inappropriately treated these patients and/or failed to appropriately treat them, and/or failed to appropriately document his treatment of these patients. For example,

  (a) he failed to conduct appropriate physical examinations and did not record objective physical-examination findings such as height and weight, blood pressure, medication allergies, reflexes present or absent, sensation, ability to stand, sit, lie, and/or walk on toes or heels;

  (b) he excessively and inappropriately prescribed narcotic analgesics and other drugs of abuse despite indications of possible addiction, drug abuse, or diversion in some patients, and failed to appropriately refer such patients to an addictionologist;

  (c) he often prescribed increasing dosages of narcotics that were not supported by an objective change in the medical status of the patients, and/or he failed to document that there was an objective change in the clinical status other than the fact that the patient required more analgesic medication; and/or

  (d) his medical management and/or treatment was not appropriate to the patients' diagnoses and/or their clinical situation.

- Dr. Lundeen's practice situation is "atypical from standard medical practice" in several ways, including the following: he operates approximately 12 medical offices across the state

of Ohio; he works at his Portsmouth office one day every two weeks; he treats approximately 90 patients per day at the Portsmouth office, working about 11 hours per day; Dr. Lundeen often has 30 to 40 people waiting for him at one time at the Portsmouth office; he has no employees or staff at the Portsmouth office; a "high percentage" of his patients received controlled substances; he travels 178 miles from his residence to the Portsmouth office; and he has no clinical privileges at a hospital in Scioto County, where Portsmouth is located.

- On March 16, 2011, investigators conducted a "raid" on Dr. Lundeen's medical office in Plymouth, Ohio. A video-recording was made that allegedly shows things such as (a) Dr. Lundeen's failure to maintain his medical office in a clean, sanitary and/or safe condition, and (b) his failure to equip and/or supply the office adequately or appropriately, and/or the equipment and/or supplies were not in a readily available location to practice medicine appropriately. The Board set forth examples of conditions that were not sufficiently clean, sanitary and/or safe. The Board also listed examples of the alleged lack of equipment and supplies, such as a scale to measure height and weight, an examination table with paper, a blood-pressure cuff, latex gloves or other appropriate gloves, and sanitation materials such as hand-sanitizer or a sink for washing hands.

In addition, the Board alleged that Dr. Lundeen, during an interview with Board investigators, had made various statements about his practice of medicine, as recited in the Notice.

Further, the Board alleged that Dr. Lundeen is subject to discipline under the following statutory provisions:

- R.C. 4731.22(B)(2) as in effect prior to March 9, 1999, with respect to Dr. Lundeen's acts, conduct, and/or omissions from October 1977 through March 8, 1999, that constitute the "failure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease."

  R.C. 4731.22(B)(2) as currently in effect, with respect to Dr. Lundeen's acts, conduct, and/or omissions on or after March 9, 1999, that constitute the "failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease."

- R.C. 4731.22(B)(6), with respect to Dr. Lundeen's acts, conduct, and/or omissions from October 1977 through March 2011 that constitute the "departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established."

- R.C. 4731.22(B)(20), with respect to Dr. Lundeen's acts, conduct, and/or omissions from November 11, 1998, through November 29, 2009, that constitute "violating or attempting to

violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," with reference to violation of Rule 4731-21-02 as in effect at that time.

The Board stated that Rule 4731-21-05, as in effect at that time, provides that a violation of Rule 4731-21-02 also constitutes violations of R.C. 4731.22(B)(2) and 4731.22(B)(6).

- R.C. 4731.22(B)(20), with respect to Dr. Lundeen's alleged acts, conduct, and/or omissions on or after November 30, 2009, that constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," with reference to violation of Ohio Administrative Code Section [Rule] 4731-21-02 as currently in effect.

  The Board stated that Rule 4731-21-05, as currently in effect, provides that a violation of Rule 4731-21-02 also constitutes violations of R.C. 4731.22(B)(2) and 4731.22(B)(6).

The Board received Dr. Lundeen's written request for hearing on June 10, 2011. (St. Ex. 28)

Appearances

Mike DeWine, Attorney General, and Katherine Bockbrader and Henry Appel, Assistant Attorneys General, for the State of Ohio. Douglas E. Graff and Levi J. Tkach, Esqs., on behalf of Dr. Lundeen.

Hearing Dates: August 22, 24-26, and 29-30, 2011; September 27, 28 and 30, 2011; and October 5-7 and 13, 2011.

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PAGINATION OF STATE'S EXHIBITS

Some of the State's exhibits have only odd-numbered pages. For example, State's Exhibit 4A has a total of 86 pages that are numbered 1 through 171. The reason is that, when the State initially scanned some of its documentary exhibits into *pdf* format, it copied and paginated not only the front of each page, but also the blank back side of the document. At the Hearing Examiner's request, and with the agreement of the Respondent, these exhibits were condensed by omitting thousands of blank pages in the *pdf* exhibits. Most of the citations to exhibits in this report are citations to the large bold-font number in the lower right-hand corner of the page, but there may be occasional citations to the "Electronic pg." number in the center.

SUMMARY OF EVIDENCE

All exhibits and the transcript, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

Background

1. In 1965, Dr. Lundeen received his license to practice medicine in Ohio. (Resp. Ex. J) His curriculum vitae sets forth his education and employment history. (Resp. Ex. I) Dr. Lundeen has stated that he formerly held a medical license in Michigan but let it lapse. (St. Ex. 34A at 11; Resp. Ex. J at 7)

2. Dr. Lundeen did not appear at the hearing to testify. However, Dr. Lundeen provided a written statement of his position, arguments and contentions, as permitted under Ohio Administrative Code 4731-13-01(E). Dr. Lundeen's written statement was not made under oath and was not signed. Further, his statements were not subject to cross-examination by the State or observation by the Hearing Examiner. (Resp. Ex. Z; Tr. at 1724-1734)

3. Dr. Lundeen submitted documents as attachments to his written statement of his position, arguments, and contentions. The documents were not authenticated by affidavit, or by a witness' testimony under oath. (Resp. Ex. A-Z; Tr. at 1740-1819)

4. In March 2011, Dr. Lundeen was interviewed regarding his medical practice by Board investigators, and the audio recording of that interview is in the record along with a transcript of the interview. (St. Ex. 34, 34A)

5. Dr. Lundeen provided, in his written position statement, a description of his education, training and experience. (Resp. Ex. Z) He described his background as follows, in part:

> With degrees in electrical engineering, chemistry and medicine, Dr. Lundeen is primarily a scientist. Dr. Lundeen has had a U.S. Patent issued this year (2011) that will profoundly impact the treatment of pain by controlling barometric

pressure indoors to relieve weather-related pain. [Citation by Respondent to Resp. Ex. L]

Dr. Lundeen founded Lundon Software, Inc. in 1983 and has developed industry standard receptor-binding data-analysis software used worldwide in pharmaceutical research and development. This software has been used in both clinical and research use in the treatment of human breast cancer. [citation to Resp. Ex. R] * * *

* * *

In 1990, Dr. Lundeen opened an office in Cleveland and Parma, Ohio for the care and treatment of acute and chronic injuries. * * * In 2000, Dr. Lundeen became certified as an Independent Medical Examiner. [citation to Resp. Ex. S]

* * *

Dr. Lundeen has submitted several patent applications for new indications for older medications and has spent considerable time and effort in his attempts to foster improved patient care. He has been successful with a method patent, which issued in 2011 for controlling pain by controlling indoor barometric pressure. [citation to Resp. Ex. L]

Dr. Lundeen is launching a new pharmaceutical research and development corporation for new medication discovery and development. His expertise in receptor biology and data analysis is known internationally. He will apply his clinical experience with his research experience to launch the new corporation.

* * *

The programs developed by Dr. Lundeen for his company, Lundon Software, Inc. utilize rigorous, exact physical chemical equations performing non-linear least squares regression analysis of one- and two-site radioligand receptor bind assay data. A discussion of his work is contained in the book chapter entitled "Computer Analysis of Binding Data" which he co-authored, and is found in Receptor Binding in Drug Research, Marcel Dekker, Inc. 1986 Ed. Robert O'Brien.

* * *

An internationally recognized expert in the field, Dr. Lundeen was an invited guest speaker at the 3rd International Conference on Pharmaceuticals and Endocrine Disrupting Chemicals in Water.

* * *

In early 2011, the United States Patent and Trademark Office granted patent number 7,926,483 to James E. Lundeen, Sr., M.S., M.D., CIME and Inventor, for his invention titled: "System for Controlling Pressure in Defined Environment and Associated Method." [citation to Resp. Ex. L] This invention

> will make it possible to create the barometric pressure conditions in a room or a vehicle to provide the type of pain relief people feel on a beautiful day.
>
> Widespread applicability of this invention exists for a number of industries, including the Heating and Cooling Industry (HVAC), the Building Industry and the Medical Field. Such pressure-controlled rooms will be highly desirable in the Hotel Industry as well. There is enormous potential for job creation on a global scale as well as significant manufacturing facilities and distribution centers.

(Resp. Ex. Z)

Dr. Lundeen's Office Locations, Hospital Privileges

6. According to Dr. Lundeen's recorded interview in March 2011, he maintained 12 offices in Ohio as of March 2011. (St. Ex. 34, St. Ex. 34A at 2) Similarly, patient records show that Dr. Lundeen listed 12 or more offices on his business stationery. (E.g., St. Ex. 1 at 1, 20, 37, 228, 249, 253, 275, 283, 447, 471, 629)

7. During an interview in March 2011, Dr. Lundeen stated that he has hospital privileges at Hardin Memorial Hospital in Kenton, Ohio. He stated that he served as the occupational medicine physician. He explained that this meant that, while patients injured at work might initially be treated in the emergency department, they would see Dr. Lundeen to obtain their return-to-work documentation. Dr. Lundeen stated that he has no other hospital privileges. (St. Ex. 34, 34A at 9-10)

Dr. Lundeen's Medical Records Generally

8. Many of Dr. Lundeen's patient records are maintained in a system of electronic medical records, including the following separate items:

   - Progress notes regarding the patient's office visits. These narrative notes are also referred to in the hearing record as Dr. Lundeen's "visit notes" or "SOAP" notes (based on the description of subjective complaints, objective measurements, assessment, and the treatment plan). Dr. Lundeen's progress notes typically have a heading at the top identifying the patient's name, address, claim number, Social Security number, date of injury, and date of birth, followed by a list of diagnosed conditions and the date of the visit.
   - Dr. Lundeen's letters to attorneys, Managed Care Organizations [MCOs], the Bureau of Workers' Compensation [BWC], and others. These letters include extensive opinion reports on disability issues and allowances of new conditions in BWC claims, and letters requesting approval for tests such as MRIs.
   - Drug Utilization Report. This is a computerized listing of the patient's medication prescriptions, stating the patient name, prescribing date, the starting and ending dates for

the drug's use, the drug's name, strength, frequency per day, total number, refills, method of delivery (by mouth, transdermal, etc.), prescriber, and claim number.

- Computerized listing of the patient's appointments.
- A compilation of messages to and from Dr. Lundeen and memoranda regarding matters such as telephone calls from patients and pharmacies, contacts with consulting healthcare providers, communications with patients' attorneys, etc., under the heading "Dump of Patient Data."

(See St. Exs. 1 through 26, patient records received from Dr. Lundeen for patients identified as Patients 1 through 26. These exhibits consist of Dr. Lundeen's electronic medical records, with a few copies of paper records included, received directly from Dr. Lundeen.)

9. In addition, Dr. Lundeen maintained files of paper records for his patients. These files tend to include documents such as the patients' handwritten new-patient questionnaires, "medication contracts" signed by patients, letters received from attorneys, documents from other healthcare providers, documents from the BWC, and drafts of progress notes that are maintained in the electronic medical records. (See State's Exhibits 1A through 12A, and 14A through 26A, which are copies of paper documents maintained by Dr. Lundeen regarding Patients 1 through 12 and Patients 14 through 26.)

State's Expert Witness - John W. Cunningham, M.D.

10. John W. Cunningham, M.D., testified as an expert witness on behalf of the State. Dr. Cunningham received his medical degree from the Ohio State University [OSU] in 1969, completed an internship at the University of Illinois Hospitals, and completed a surgery residency at Riverside Methodist Hospital and OSU in 1973. He has been licensed to practice medicine in Ohio since 1969. (St. Ex. 29; Tr. at 156-159; Ohio eLicense Center at *<https://license.ohio.gov/lookup/ default.asp?division =78>*, query on Oct. 17, 2011)

11. Dr. Cunningham testified that his practice specialty is occupational medicine, which is a subspecialty of preventive medicine. He explained that occupational medicine focuses on workers, industry, and the environment of the workplace. He stated that he began practicing in this area in 1978 and then obtained specialized training: in 1983, he earned a master's degree in preventive medicine at OSU and completed a residency program in preventive medicine at Riverside Methodist Hospital. (St. Ex. 29; Tr. at 157-159)

12. Dr. Cunningham testified that he has been board-certified since 1984 by the American Board of Preventive Medicine in the subspecialty of occupational medicine. He previously held a specialty-board certification in emergency medicine but allowed that certificate to expire. Dr. Cunningham further testified regarding the nature of his medical practice, his hospital privileges, and work for government agencies. Among other things, he noted that he had done independent medical examinations [IMEs] and file reviews for the BWC. (Tr. at 157-158, 252-276, 1147-1152, 1241-1243; St. Ex. 29)

13. Dr. Cunningham testified that he has been certified to perform IMEs by the American Board of Independent Medical Examiners, the same organization that certified Dr. Lundeen to perform IMEs. Dr. Cunningham explained that this IME board is not one of the recognized specialty boards such as pediatrics, obstetrics, and preventive medicine, but that this IME certificate is necessary to perform disability examinations. (Tr. at 252-254)

14. In addition to reviewing medical records for each of the 26 patients identified in the Notice, Dr. Cunningham testified that he reviewed copies of prescriptions, Dr. Lundeen's appointment books/ledgers for a few dates, and a video-recording that shows the inside of Dr. Lundeen's office in Plymouth, Ohio. (Tr. at 160, 164-173)

15. In April and May 2011, Dr. Cunningham provided an individual report for each of the 26 patients identified in the Notice, using the medical records received directly from Dr. Lundeen, which are State's Exhibits 1 through 26. For the most part, these records consist of Dr. Lundeen's electronic medical records for the 26 patients at issue. (St. Ex. 30 at 10–177; Tr. at 24-29, 31-33, 37-38 43-56, 65-66, 72-74, 162-174; St. Exs. 39-43)

16. Dr. Cunningham also provided a summary, discussing his overall views on Dr. Lundeen's care of the 26 patients at issue. (St. Ex. 30 at 1-4) In addition, Dr. Cunningham provided a commentary on Dr. Lundeen's statements made during an interview with Board investigators in March 2011. (St. Ex. 30 at 5-10)

17. At the end of July 2011, Dr. Cunningham was given more of Dr. Lundeen's medical records to review for patients at issue in the Notice. These additional medical records consisted of copies of paper records that had been maintained by Dr. Lundeen for Patients 1 through 12 and Patients 14 through 27. These records had been in the possession of the BWC since March 16, 2011, when the BWC and other government agencies conducted searches of several of Dr. Lundeen's locations pursuant to search warrants and seized his office files.[1] The Board subsequently obtained copies of some of the seized documents in the BWC's possession pursuant to an investigatory subpoena issued to the BWC. At the Board's request, Dr. Cunningham reviewed the additional patient records in August 2011, which were designated as State's Exhibits 1A through 12 A, and 14A through 26A. Dr. Cunningham stated that some of these additional records

[1] When Dr. Lundeen initially provided his medical records to the Board in response to a subpoena for certain patients' records, he provided a copy of his electronic medical records for the named patients, and he added a few paper records that were in his possession at the time. He could not provide all his paper medical records because most of his paper files for the named patients had been seized and were in the custody of the BWC. According to Board employees who testified at the hearing, the medical records for Patients 1-26 that were received directly from Dr. Lundeen were combined and marked as State's Exhibits 1 through 26. They further testified that Dr. Lundeen's patient records received *via the BWC* for Patients 1-26 were marked as State's Exhibits 1A through 12A, and 14A through 26A, as there were no copies received for Patient 13. (See, e.g., Tr. at 24-40, 43-56, 60, 65-67, 71-74, 88, 100-111, 162-174, St. Exs. 34, 37, 39-43; Resp. Exs. E, W)

In addition, a BWC employee testified that State's Exhibits 1A-12A and 14A-26A consist of documents seized from Dr. Lundeen regarding Patients 1-26, which were subsequently identified, copied, and provided to the Board in response to an investigatory subpoena. (Tr. at 770-822)

were duplicates of records that he had already reviewed. However, some of the additional records were significant documents that he not reviewed previously, such as pain contracts signed by patients. (Tr. at 173-175, 1157-1160, 1163, 1174-1175; St. Ex. 30A)

18. On August 3, 2011, Dr. Cunningham provided a supplemental report regarding the additional patient records. In this supplemental report, Dr. Cunningham modified some of his findings based on the additional information he had received. For example, in his initial report, Dr. Cunningham had faulted Dr. Lundeen for not having entered into pain-medication contracts with his patients who received narcotic medications for non-acute conditions, but, in his addendum report, Dr. Cunningham noted that there *were* "pain contracts" for the majority of Dr. Lundeen's patients. However, Dr. Cunningham concluded that Dr. Lundeen had failed to enforce the contracts, so that his ultimate opinion regarding Dr. Lundeen's care and treatment of the patients had not changed. (St. Exs. 30A; Tr. at 174)

Overview of Dr. Cunningham's Opinions

19. In each of his separate reports for Patients 1 through 26, Dr. Cunningham concluded that Dr. Lundeen's treatment or care of the patient had constituted one or more departures from, or failures to conform to, the minimal standards of care; and/or had constituted one or more failures to maintain minimal standards acceptable to the selection and administration of drugs, or failures to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease. He also opined with regard to whether Dr. Lundeen had complied with the Board's rules on the treatment of intractable pain. (St. Ex. 30, 30A, 30B) In his reports and testimony, Dr. Cunningham opined, among other things,

- that almost all the 26 patients were placed on Valium or Xanax very early in their treatment, regardless of the diagnosis;
- that, with few exceptions, the narcotic dosages prescribed by Dr. Lundeen increased without documented justification for the increase on an objective medical basis;
- that there were no drug screens ordered by Dr. Lundeen for patients receiving narcotics, either random screens or "for cause" screens;
- that messages and notations made by Dr. Lundeen's staff included significant information that were not reflected in the patient's office-visit notes and treatment plans;
- that there were many instances when the Drug Utilization Reports would show that a new drug was prescribed for a patient, but Dr. Lundeen did not give any explanation in the office-visit notes as to why he had added that drug, or he gave an inadequate explanation that was based solely or primarily on the patient's assertion of having more pain;
- that physical examinations by Dr. Lundeen were rare and usually occurred on the first visit;

- that Dr. Lundeen's usual practice after the first visit was to observe the patient's gait, to ask the patient to bend forward from the waist, bend to the sides, and bend backward, and to tell the seated patient to lift each foot from the floor, and perhaps to ask the patient to turn his/her head to the side; and that he did not physically examine for tenderness or swelling, check for crepitus, test for sensation, and so forth;
- that the examinations as described in the patient notes are frequently inadequate in that, for example, Dr. Lundeen did not state the specific location of pain, did not physically examine and describe the area said to be painful, and did not measure atrophy or state the side on which he had observed it;
- that Dr. Lundeen did not adequately document patients' height, weight, blood pressure, pulse, medication allergies, or other basic information;
- that Dr. Lundeen would state, regarding an initial visit, that the patient's prior medications would be continued and unchanged and that the patient was not having adverse effects, without specifically identifying the names and dosages of the prior medications;
- that Dr. Lundeen did not adequately consider the side effects of narcotic medications, such as dizziness, falling, and/or chemical dependence; and
- that, although there were "drug contracts" in the majority of the 26 patient files, there was no formal periodic renewal of drug contracts, and, when there were indications of drug-seeking behavior and/or potential violation of the contracts, Dr. Lundeen did not document that he had talked with the patient about the problems and did not confront patients about possible violations of the contract.
- Further, Dr. Cunningham opined that Dr. Lundeen sometimes selected the wrong drug, such as the following: prescribing Soma for chronic symptoms, far beyond the acute stage of injury or surgery; prescribing Valium and similar drugs on a long-term basis for muscle spasm; prescribing Lidoderm patches for muscular and/or spinal problems; and prescribing narcotics to treat contusions for many months after a contusion would have healed.

(St. Ex. 30, 30A; Tr. at volumes 2-4, 8-10)

David B. Ross, M.D.

20. David B. Ross, M.D., submitted several letters containing his opinions, which are referred to herein as his "report." However, Dr. Ross did not testify at the hearing. His statements and opinions were not provided under oath, subject to cross-examination and subject to observation by the Hearing Examiner. Indeed, because he did not appear at the hearing, he was not formally offered as an expert witness, and was not ruled to be qualified to testify as an expert witness. (Resp. Exs. A, Z at 1; Tr. at vols. 10-13)

21. Dr. Ross provided a copy of his curriculum vitae. He stated, among other things, that he obtained his undergraduate degree from Johns Hopkins University and his medical degree from the University of Miami in 1979, followed by a residency program in neurology Longwood Area Training Program associated with Harvard Medical School. (Resp. Ex. A at 1-2; Resp. Ex. B)

22. Dr. Ross set forth his views on basic science, pain management, standards for expert testimony, and the methodology used by the Board in the present action. (Resp. Ex. A at 2-9) Dr. Ross also commented on Dr. Lundeen's interview with Board investigators as described in the Notice. (Resp. Ex. A at 5)

23. Dr. Ross also stated that an assistant had generated statistics regarding Dr. Lundeen's prescribing, but the data was not provided to the Hearing Examiner. The exhibits mentioned at the end of Dr. Ross' report were not offered into evidence. (St. Ex. A at 49, *et sequ.*)

Overview of Dr. Ross' Opinions

24. In his report, Dr. Ross focused more on providing a detailed assessment of Dr. Cunningham's opinions than providing a detailed assessment of Dr. Lundeen's care of the patients at issue. (Resp. Ex. A at 1-50) In addition, Dr. Ross stated explicitly that he did not support the type of pain management provided by Dr. Lundeen:

> While *I do not support* Dr. Lundeen's method of treatment of musculoskeletal pain, I am fully aware that there is a substantial number of practicing physicians who use his technique.
>
> * * *
>
> I *do not agree with* the type of pain management provided by Dr. Lundeen. If he lived in South Florida and did Workers Compensation work in my area, I would be *one of his most vocal and tenacious opponents*. * * * On the other hand, I consider myself an honest and thorough physician able to accept that in an imprecise field, differences of opinion and honest argumentation are healthy in a search for clarity and truth.

(Resp. Ex. A at 7, 16; emphasis added)

25. With regard to Dr. Lundeen's care of the 26 patients as issue, Dr. Ross stated in his written report that he had looked for "overt" problems that indicated a "consistent" tendency of Dr. Lundeen toward substandard practice of medicine, and had "found no such tendency." (Resp. Ex. A at 48)

26. With regard to Dr. Lundeen's interview with Board investigators, Dr. Ross stated that, while he personally found Dr. Lundeen's statements to be arrogant and/or condescending, he did not see in them any proof of wrongdoing. Dr. Ross found Dr. Lundeen's

statements to be "peculiar," but he stated that Dr. Lundeen's views were technically correct with respect to diagnostic testing, narcotics use, and whether disrobing is needed during office visits with the vast majority of patients with musculoskeletal-pain complaints. (Resp. Ex. A at 5)

27. Dr. Ross opined that the State's expert witness, Dr. Cunningham, did not demonstrate a "single event concerning medicinal pain management that clearly was substandard." (Resp. Ex. A at 45)

28. However, Dr. Ross acknowledged that Dr. Lundeen's care of two patients did give him "pause" concerning pain management. Nonetheless, he said that "further analysis" was needed before he could draw any conclusions and that he "would be interested in hearing Dr. Lundeen's account before making further comment."[2] (Resp. Ex. A at 48)

29. Dr. Ross also opined that Dr. Lundeen's care of these two patients did not warrant Board discipline of Dr. Lundeen:

> Even if a negative impression remains, these two instances do not create sufficient cause by which to suspend or expel Dr. Lundeen from the practice of medicine in any jurisdiction with which I am familiar. They might suggest some need for education; but they do not rise even to the level of censure.

(Resp. Ex. A at 48)

30. In his written report, Dr. Ross discussed at length the five guidelines published by the American College of Occupational and Environmental Medicine [ACOEM] regarding the chronic use of opioids to treat pain. (See Resp. Ex. A at 20-25; see, also, *Guidelines for Chronic Use of Opioids* (2008 & 2011), available at the ACOEM website at <*www.acoem.org* >, accessed 10/15/11.) The five ACOEM guidelines may be summarized as follows:

> (1) The routine use of opioids for treatment of chronic non-malignant pain is not recommended. However, selected patients may benefit from judicious use.
>
> (2) Selected patients with chronic persistent pain, neuropathic pain, or CRPS[3] that is not controlled well with non-opioid treatment (shown by decreased

[2] The report is dated June 13, 2011, and Dr. Ross did not provide further comment at a later time.

[3] The publication did not define CRPS, but the acronym most likely refers to "Complex regional pain syndrome." This syndrome or one of its subcategories was previously known as "reflex sympathetic dystrophy." See, e.g., Medscape Reference, at <http://emedicine.medscape.com> ; National Center for Biotechnology Information, Nat'l Library of Medicine, Nat'l Inst. of Health, PubMed, Subedi et al., "Complex Regional Pain Syndrome (CRPS Type 1) in an Adolescent," at <http://www.ncbi. nlm.nih.gov/pmc/articles/PMC3111559>; accessed 10/15/11.

function attributable to pain) may be tried on opioids, but other approaches should be used first. Patients with depression, a history of psychological disorder, and/or a history of drug abuse/dependence are often at greater risk for a poor outcome and should be treated cautiously. Patients receiving opioids should be monitored regularly for efficacy, adverse effects, compliance, and "surreptitious use" of medication.

(3) Patients being considered for opioid treatment should be asked about prior substance abuse. Screening tools should be used that have been developed for use in populations receiving or considering opioids.

(4) "Opioid contracts" should be used when treating chronic-pain patients with opioids. Because many patients do not adhere to such agreements, the agreements should be used in conjunction with a urine drug-screening program.

(5) Routine use of urine screening for drugs is recommended for all patients on chronic opioids, because there is evidence that urine screens can identify aberrant opioid use and other substance use that otherwise is not apparent to the treating physician.[4]

31. Dr. Ross, in criticizing Dr. Cunningham's opinions regarding Dr. Lundeen's care of Patient 1, itemized "Twelve Mistakes" that he believes were made by Dr. Cunningham in rendering his opinions. When reviewing Dr. Cunningham's opinions on Patients 2 through 26, Dr. Ross referred back to this list of Mistakes 1 through 12. (Resp. Ex. A at 28-31)

32. In general, Dr. Ross opined that Dr. Cunningham used "mostly his personal opinions and biases without scientific or medical foundation." He also opined that Dr. Cunningham "shows an appalling lack of knowledge about the medications used in the management of pain" and "demonstrates a lack of knowledge about national trends in medical record keeping" as well as "a severe lack of knowledge about what

[4] The Hearing Examiner notes that, while the guidelines published by a national organization may constitute reliable evidence of the standard of care, such guidelines do not necessarily or conclusively constitute the "minimal standard of care" in Ohio that must be met or exceeded under Ohio Revised Code 4731.22(B)(2) and (B)(6). In some circumstances, the practices recommended by a professional organization may constitute the minimal standard of care in Ohio, but, on the other hand, a guideline may describe a standard between best practices and the minimal standard of care. Dr. Ross declined to adopt the ACOEM Guidelines as the minimal standard of care, stating that they are recommendations only. Dr. Cunningham based a number of his conclusions on the ACOEM guidelines in conjunction with other standards, and he testified that the ACOEM guidelines are "the only peer-reviewed practice guidelines for occupational medicine" of which he is aware. (Tr. at 1141-1142) In addition, the Hearing Examiner notes that the ACOEM guidelines available at the organization's website are dated as the 2008/2011 edition.

It is therefore important that the Board, which has substantial collective expertise regarding the minimal standard of care in Ohio, should apply its own expertise in assessing and determining the minimal standard of care for the periods of time at issue.

is meaningful in the assessment of a chronic pain patient." In reviewing Dr. Cunningham's 26 reports regarding patient care, Dr. Ross found many of Dr. Cunningham's conclusions to be "egregiously inappropriate." (Resp. Ex. A at 28-49)

33. Dr. Ross stated, among other things:

> * * * I find Dr. Cunningham and the Board's actions extremely loathsome and significantly frightening. * * * In 30 years of medical experience I have never participated in a governmental or authoritarian procedure that so thoroughly and repetitively undermined and ignored the cannons of fairness, scientific inquiry, rational thought, and formal-informal logic. * * * The abuse herein of process draws comparisons to the activities of the McCarthy era and the Salem witch trials. In both cases, authoritarian parties ignored common sense, fair play, and science for personal motivations (power, revenge, etc) under the guise of performing service toward the common good. I find it hard to see the difference between the actions during those ignominious periods of our national history and the actions of the State Board of Ohio in this case.

(Resp. Ex. A at 16)

Controlled Substance Schedules

34. Under the federal Controlled Substances Act, which is codified at 21 U.S.C. § 801 et seq., drugs are divided into five "schedules." The classification is based on whether the substance has a currently accepted medical use, the relative abuse potential of the drug, and the likelihood of drug dependence resulting from the drug's use. See 21 C.F.R. § § 1308.11 through 1308.15; Dept. of Justice, Drug Enforcement Admin., Office of Drug Diversion, "Controlled Substance Schedules," at <*www.deadiversion.usdoj.gov/schedules/index.html#define*>, accessed 10/15/11.

Schedule I Substances

35. Schedule I substances have a high potential for abuse, have no currently accepted medical use in the United States, and may be used only in certain research. Some examples of Schedule I drugs are heroin, LSD, and methylenedioxy-methamphetamine, which is known as "ecstasy." (See "Controlled Substance Schedules," supra.)

Schedule II Medications

36. Schedule II substances have a high potential for abuse and may lead to severe psychological or physical dependence. Examples include:

- **morphine** (**Avinza**, Kadian, Roxanol)[5]
- **oxymorphone** (**Opana**, Numorphan)
- **hydromorphone** (**Dilaudid**, an instant release formulation, and **Exalgo**, an extended release formulation)
- **oxycodone** (Oxycontin, OxycontinER, OxyIR, Roxicodone, Endocodone, and Percolone), methadone (Dolophine)
- meperidine (Demerol), and **fentanyl** (**Duragesic**, Sublimaze).

(E.g., "Controlled Substance Schedules," supra; Drug Enforcement Admin., "Drug Intelligence Brief" (May 2011), at <www.justice.gov/dea/pubs/states/phila_opana.pdf >; National Institutes of Health, National Inst. of Drug Abuse, "Prescription Drug Abuse Chart" at <www.nida.nih. gov/DrugPages/PrescripDrugsChart.html>, accessed 10/15/11; DEA, "Hydromorphone," at <www.deadiversion.usdoj.gov/drugs_concern/hydromorphone.htm>, accessed 10/26/11).

Schedule II also includes stimulants such as amphetamines (Dexedrine, Adderall) and barbiturates and their derivatives such as amobarbital and pentobarbital. (See "Controlled Substance Schedules," supra.)

37. In addition, the drug **oxycodone,** a narcotic/opioid analgesic in Schedule II,

- has brand names including **Oxycontin, Oxycontin ER** (extended release), and **OxyIR** (immediate release), which are schedule II drugs;
- may be manufactured in combinations with other medications, and, when combined with acetaminophen (Tylenol), has brand names including **Percocet, Magnacet,** Endocet, Roxicet, and Tylox, which are Schedule II drugs;
- may be combined with aspirin, and the resulting medication has brand names including Percodan, Endocan, and Roxiprin, which are Schedule II drugs; and

[5] Morphine is an "opiate," a narcotic derived from the opium poppy plant. An "opioid" drug has morphine-like characteristics and is often synthetically or semi-synthetically produced. (E.g., Dept. of Justice, National Drug Intelligence Center, "Controlled Prescription Drugs, at "www.justice.gov/ndic/pubs38/38661/rx.htm); Medical Dictionary, "Opioid," at <http://medical-dictionary.thefreedictionary.com/opioid>; accessed 10/10/11. In this Report, the word "opiate" and "opioid" may be used interchangeably.

- has potential side effects including lightheadedness, drowsiness, weakness, dizziness, fainting, difficulty breathing, slowed breathing, hallucinations, constipation, swelling, hives, rash, and difficulty swallowing.

(National Library of Medicine, Nat'l Institutes of Health, MedLine Plus, at <www.nlm.nih.gov/medlineplus/druginfo/meds/a682132.html >), accessed 10/15/11; PHYSICIANS' DESK REFERENCE (Thompson PDR 1995, 2001, 2006)

38. When oxycodone is combined with acetaminophen, the drug's strength is described using two numbers, such as 5/325. The first number is the amount of oxycodone in the tablet, and the second number is the amount of acetaminophen. For example, when Percocet is described as "5/325 mg," there are 5 milligrams of oxycodone and 325 milligrams of acetaminophen in one tablet. (See, e.g., "Percocet," at Rx List-Drug Index, at <www.rxlist.com/percocet-drug.htm>, accessed 10/10/11)

    Similarly, a Vicodin ES tablet (a Schedule III drug) is described as "7.5/750," which means that it contains 7.5 milligrams of hydrocodone and 750 milligrams of acetaminophen. (See, e.g., "Vicodin," at <www.drugs. com/pro/ Vicodin-es.html>, accessed 10/10/11)

39. **Avinza** is a brand name for morphine in a long-acting formulation. According to the manufacturer, an Avinza long-acting capsule is usually taken once per day. The dosing options include 30 mg, 45 mg, 60 mg, 75 mg, 90 mg, and 120 mg. (See "Morphine" at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000590>; King Pharmaceuticals, Inc., "Avinza," at <www.avinza.com>; accessed 10/23/11.)

Schedule III Medications

40. Schedule III substances have a lesser potential for abuse than those in Schedules I and II. Abuse of these drugs can lead to moderate to low physical dependence or high psychological dependence. Examples include combination products containing less than 15 milligrams of **hydrocodone**[6] per dosage unit (including **Vicodin, Norco, Lorcet, Lortab, and Anexsia,** which are **hydrocodone and acetaminophen**) and products containing not more than 90 milligrams of codeine per dosage unit (such as Tylenol with Codeine). (See "Controlled Substance Schedules," supra; "Hydrocodone/acetaminophen," at <www. medicinenet.com/ hydrocodone acetaminophen-oral/article.htm>, accessed 10/15/11; Tr. at 191.)

41. Also included are buprenorphine products (Suboxone and Subutex) used to treat opioid addiction. See "Controlled Substance Schedules," supra.

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[6] Dr. Cunningham noted that hydrocodone is stronger than morphine. (Tr. at 219-220) He provided a publication showing the relative strengths of analgesic medications, which states that two-thirds of a milligram of hydrocodone is equivalent to one milligram of morphine. (St. Ex. 45)

Schedule IV Medications

42. Schedule IV substances have a lower potential for abuse when compared to substances in schedule III. Narcotic drugs in Schedule IV include propoxyphene (Darvon and Darvocet-N 100) and **pentazocine** (Talwin).

    Other Schedule IV substances include **alprazolam (Xanax)**, **clonazepam (Klonopin)**, **diazepam (Valium)**, lorazepam (Ativan), midazolam (Versed), temazepam (**Restoril**), and triazolam (**Halcion**), and clorazepate (Tranxene). ("Controlled Substance Schedules," supra.)

43. Because **Talwin/pentazocine** was abused, the version **Talwin NX** was developed, containing naloxone to counter the desired effect of ingesting crushed tablets. A tablet of Talwin NX contains 50 mg of pentazocine and .5 mg of naloxone.

    Talacen is a brand name for the combination of pentazocine and acetaminophen, and a caplet contains 25 mg of the narcotic and 650 mg acetaminophen. (E.g., DEA, Office of Diversion Control, "Controlled Substances by CSA Schedule," at <www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf>; U.S. Food & Drug Admin., "Talacen," at <www.fda.gov/Safety/MedWatch/Safety Information/ucm250245.htm>; MedLine, "Pentazocine," at <www.nlm.nih.gov/medlineplus/druginfo/meds/ a601092.html>; "Talacen," at <www. drugs.com/pro/talacen.html>; "Talwin," at <www.rxlist.com/talwin_nx-drug.htm>; accessed 10/21/11.)

44. Dr. Cunningham testified that **Valium** is usually prescribed for anxiety. He stated that it is a regulated drug that is abused. He noted that Valium can be used to treat muscle spasm, but this use is very rare and is for the period immediately following an injury, not for chronic spasm. He testified that Valium is for the "acute phase of injury" that lasts only hours or days. As an example, he explained that a patient who is miserable with an acute stiff neck will respond very well to Valium. In addition, Dr. Cunningham testified that Valium can work well with certain spinal cord and GAVA receptors during the acute processes. Further, Valium is sometimes used "off label" to help a person sleep. When asked what is required when a physician decides to write a prescription for Valium, Dr. Cunningham testified that the physician "has to justify why he's doing that, and why he's putting the person on a particular drug. You know, you can say 'she's very anxious, she's not sleeping well,' or whatever the reason is. But I think he has to record that as a minimal standard of why he's giving this person this medication." (Tr. at 196-198, 1366-1367)

45. Dr. Cunningham testified that **Xanax** is similar to Valium, in the category of benzodiazepines, as is Klonopin. When asked whether Xanax is a "psych" medication or for pain, or both, Dr. Cunningham answered: "You see a lot of it used in patients with chronic pain, but it's basically a psychotropic drug." (Tr. at 312)

Schedule V Medications

46. Schedule V substances have a lower potential for abuse relative to those listed in Schedule IV and consist primarily of preparations containing limited quantities of narcotics. These medicines are generally used to treat cough, mild pain, and diarrhea, such as cough medicines containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams, such as **Phenergan with Codeine.** (See "Controlled Substance Schedules," supra.)

Other Drugs

47. **Soma** is carisoprodol, a muscle relaxant. (Tr. at 312, 323) Soma is not a controlled substance under federal law. (Fed. Reg., March 26, 2010, vol. 75, no. 58, pp. 14538-14539, available at Federal Register Online, at <http://edocket.access.gpo.gov/2010/pdf/2010-6763.pdf>, accessed 10/25/11)

48. **Triavil** is a combination of **perphenazine** and **amitriptyline**. Amitriptyline (Elavil) is a tricyclic antidepressant with sedative properties, and perphenazine is in a group of drugs called phenothiazines that is used to treat anxiety and agitation. Therefore, Triavil is both an antidepressant and tranquilizer. When the strength is referred to as "4-25," the dose has 4 milligrams of perphenazine and 25 milligrams of amitriptyline. (E.g., Nat'l Library of Medicine, Nat'l Inst. of Health, "Triavil," at <www.ncbi.nlm.nih.gov/pmc/articles/ PMC19304 64/pdf/canmedaj016010002.pdf>; Stanford School of Medicine, Psychiatric Medications, "Amitriptyline and Perphenazine," at <http://whatmeds.stanford.edu/medications/amit_perp.html>; "Amitriptyline and perphenazine," at <www.drugs.com/mtm/amitriptyline-and-perphenazine.html>; "Amitriptyline," at <www.medicinenet.com/amitriptyline/article.htm>; accessed 10/26/11.)

49. With regard to the use of a **Lidoderm** patch, Dr. Cunningham testified that Lidocaine is a local anesthetic that numbs the skin. He explained that if a person is having a cut stitched, physicians will inject Lidocaine for that pain. However, Lidocaine also comes in a medication-filled pad that allows the Lidocaine to be absorbed into the skin. Dr. Cunningham testified that the medication in Lidoderm patches does not get past the skin into the ligaments, bones, joint capsules, muscles or nerve roots, and that it simply makes the skin numb. Thus, Dr. Cunningham testified that a Lidoderm patch is not appropriately used for chronic pain from musculoskeletal injuries, as it does not reach the pain generators. (Tr. at 200-204, 1371-1373)

    In contrast, a **Duragesic** patch delivers fentanyl, a Schedule II narcotic. (See Schedule II Medications, above; see, also, Tr. at 342-344.)

50. The acronym **NSAID** refers to a nonsteroidal anti-inflammatory drug. This is a category of medications that includes aspirin, ibuprofen (Advil, Motrin) and naproxen (Aleve, Naprosyn). (Nat'l Library of Medicine, Nat'l Inst. of Health, "Drugs and

Supplements," at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000173>, accessed 10/10/11.

51. **Phenergan**, a brand of promethazine, is an antihistamine, sedative, and anti-nausea drug. A prescription is required but the drug is not a scheduled substance unless the formulation states "with Codeine." Phenergan VC includes phenylephrine and is typically used to treat itching, runny nose, sneezing, and congestion due to allergies or the common cold. (Nat'l Library of Medicine, Nat'l Inst. of Health, "Promethazine," at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000637>); Drug Information Online, "Phenergan VC," at <www.drugs.com/mtm/phenergan-vc.html>; MedicineNet, "Promethazine, Phenergan," at <www.medicinenet.com/promethazine/article.htm>; accessed 10/15/11)

Prescribing & Diagnostic Methods Generally

Abbreviations Used in Prescribing

52. The following abbreviations are used by physicians when prescribing, to indicate how many times per day the patient is instructed to take the medication:

q.d. = to be taken *once* per day.

b.i.d. = to be taken *two times* per day

t.i.d. = to be taken *three times* per day

q.i.d. = to be taken *four times* per day

h.s. = to be taken *at bedtime*

p.r.n. = to be taken *as needed*

p.o. = to be taken by mouth

The abbreviation "1 **q4h**" means "Take 1 every 4 hours."

(Tr. at 195-196, 384. See, also, MedicineNet, "Definitions," at <www.medterms.com/script/main/art.asparticlekey=51 57>, "Master List of Prescription Abbreviations," at <www.everypatientsadvocate.com/columns/prescriptionabbreviations.pdf>, accessed 10/18/11).

Prescribing for "Breakthrough" Pain

53. Dr. Cunningham testified that, when a longer-lasting pain medication has been prescribed, the physician may also prescribe a short-acting pain medication for "breakthrough" pain. He stated that, when a narcotic such as Percocet is prescribed for breakthrough pain, the physician should state that the medication is to be taken *p.r.n.* or "as needed." He stated that, when a physician prescribes a pain medication to be taken "b.i.d." or "t.i.d.," that medication is to be taken the stated number of times per day, and he opined that such a prescription is not appropriate for breakthrough pain. (Tr. at 1396-1397, 1404-1407)

Physical Examinations: Straight Leg Raising

54. The acronym SLR is used in Dr. Lundeen's medical records to denote an examination method involving "straight leg raising." Dr. Cunningham explained that this maneuver should be performed with the patient lying prone on the examination table, as the physician raises the patient's straight leg. The physician raises the patient's foot, keeping the patient's leg straight, to see if and when radicular pain results. This maneuver is sometimes called Lesegue's sign. (Tr. at 185-186, 1622-1625)

55. Dr. Cunningham stated that a "positive" result on an SLR test is "back pain and leg pain at the same time" with the pain in a specific pattern of distribution. He stated that the purpose is to try to keep the patient's leg straight and see if the patient has radicular pain at some point as the leg is raised. Thus, an SLR examination is performed to see whether there is nerve-root involvement as shown by the pain distribution. The maneuver is not performed to evaluate the leg's range of motion or muscle strength. (Tr. at 183-186, 1626-1627)

56. Dr. Cunningham stated that an SLR test can be performed with the patient in a seated position, but the results are more accurate when the test is performed with the patient supine. Dr. Cunningham testified that, regardless of whether the patient is seated or supine, the proper method is for the physician to lift the patient's foot, *not* for the patient to lift his or her own leg. Dr. Cunningham testified that he does the test both ways, with the patient supine and the patient seated, and the results should be consistent. (Tr. at 183-185, 1624-1625)

57. Dr. Lundeen stated in his recorded interview and in his patients' progress notes that he did only a seated SLR test, with the patient sitting in a chair. This involves asking a seated patient to lift his/her foot, toward straightening the leg. Dr. Cunningham testified that having the patient perform this movement voluntarily is not the correct procedure. (St. Exs. 1-26; St. Ex. 34, St. Ex. 34A at 17; Tr. at 183-186, 1622-1625)

58. Dr. Cunningham explained that, when the patient is seated, a measurement of 90 degrees would mean that the foot has been lifted up until the leg is completely straight. When there is a zero-degree angle of SLR, it means that the seated patient did not lift his/her foot off the floor. (Tr. at 187, 418-419, 1622-1625) Dr. Cunningham further testified that straight leg raising from a seated position, at less than 70 degrees, is not thought to cause biomechanical stress on the low back. (Tr. at 185)

Physical Examinations: Atrophy

59. With regard to making chart notations regarding observations of muscle atrophy, Dr. Cunningham indicated that a visual description by the physician is not sufficient. He testified that the standard of care requires a clinical measurement. Therefore, if the muscles of a patient's calf appear atrophied, the minimal standard of care requires the physician to measure the circumference of both calves. (Tr. at 187-191)

60. Dr. Cunningham explained how a spinal injury can cause atrophy of muscles and stated that the extent of the atrophy is important. A difference of less than half an inch between the limbs is a normal variation, but a greater variation is significant. He also explained that it is important to re-measure when seeing a patient for many months to determine whether the atrophy is worsening. (Tr. at 187-191)

61. Dr. Cunningham not only opined that a general observation of "atrophy" without noting measurements of the comparative circumferences violates the standard of care, but he also opined that the patient's chart should reflect whether the atrophy is on the right or left side. (Tr. at 187-191)

Physical Examinations: Sensory Examination

62. Dr. Cunningham testified that a sensory examination of the lower extremities should be done when there has been a low-back injury. This involves testing both legs for sensation, to evaluate the function of nerves coming from the lower spine. Dr. Cunningham stated that he tests the inside, top, and outside of each foot, and the inside and outside of each calf to see if sensation is equal from right to left. (Tr. at 379-380)

Pain-Medication Contracts When Prescribing Drugs of Abuse

63. Dr. Cunningham testified regarding the nature of "pain contracts." He stated in part:

> A. Basically, it's putting the patient on notice that they are going to take the medications as prescribed. They are not going to abuse them. They are not going to go to another doctor or another provider to get additional medications, unbeknownst to the prescribing physician.
>
> And, in other words, the person providing the pain medication says, "I will give the pain medication to control your pain, but you will not abuse them or over use them, and nor will you go get more medication from another provider. And if you violate any of these things, then there will be consequences." The usual consequence is that the patient is dismissed from the practice.
>
> Q. In your supplemental report that you identified, even though there had been pain contracts for the majority of these patients, you indicated that it didn't change your opinion.
>
> A. Well, this is a classic example. The first time this happened when she [Patient 1] called in and said that she had run out of the medicine, prematurely in my opinion, she should have been counseled and asked to sign another pain contract, and said, "This is your last chance." And that didn't occur.
>
> And most pain management physicians renew the contract periodically. They usually do it annually, or every six months. I don't think there's any rule about

> that. But they always make sure that the patient understands what the rules of the game are, which is that, "You're not going to overuse the drugs, and you're not going to get drugs from somebody else, and you're not going to divert the drugs."

(Tr. at 231-233)

Patient 1

General Information

52. Patient 1, a female born in 1951, sustained a work-related injury to her lower back in 2000 when trying to help a heavy person into bed at a nursing home. According to a December 2003 letter written by Dr. Lundeen, the patient's workers' compensation claim was allowed for "847.2 lumbar sprain," and that was also the diagnosis he used in treating her. Patient 1 first visited Dr. Lundeen for treatment on November 22, 2002. (St. Ex. 1 at 3, 21, 39, 191)

64. Medical records for Patient 1 were admitted as State's Exhibits 1 and 1A. Dr. Cunningham's initial written opinion is set forth at State's Ex. 30, pages 14 to 22, and his supplemental report is set forth at State's Exhibit 30A, pages 2 to 3 and 14 to 15. Dr. Cunningham's testimony regarding this patient begins at page 176 of the hearing transcript. Dr. Ross' opinion is set forth in Respondent's Exhibit A, pages 28 to 31, and Dr. Lundeen's written opinion is set forth in Respondent's Exhibit Z, page 10.

April & August 2002

53. In April 2002, prior to becoming a patient of Dr. Lundeen, Patient 1 obtained an IME report from Dr. Lundeen regarding her percentage of impairment from the 2000 injury. Dr. Lundeen included a discussion of the patient's medical history, personal history, and employment history, as well as his findings upon examination. Dr. Lundeen noted that Patient 1's treatment had consisted of hot packs, cold packs, rest, and Mobic.[7] (St. Ex. 1 at 3-5)

54. In August 2002, Dr. Lundeen provided an IME opinion regarding the patient's impairment from a sprained left ankle in 2001. Dr. Lundeen included a discussion of the patient's medical and personal/employment history, as well as his findings upon examination. He listed current medications as "none." (St. Ex. 1 at 7-9)

First Patient Visit - November 2002

65. Dr. Lundeen's progress notes for Patient 1's visit on November 22, 2002, state:

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[7] Mobic is a brand name for meloxicam, an NSAID. See Nat'l Library of Medicine, Nat'l Inst. of Health, "Drugs and Supplements," at <*www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000173/*>, accessed 10/10/11.

SUBJECTIVE: This patient is new to this medical practice. She sustained injuries at work when a heavy client fell on her. Medical records are available on this date. A pain history booklet has been completed and reviewed by this physician today. Has severe pain in back and legs, more in left leg. Current medications: Vicodin and Motrin. Self-employed, daycare, kin care, 3 grandchildren; county pays her to care for them. *Electronically signed and dated: James Lundeen, Sr, MD, CIME 22-Nov-2002 18:44:51.66.*

OBJECTIVE: Seated straight leg raising, SLR, R 10 degrees, SLR L 10 degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: list to right. Station (balance): left foot drags. Stronger lower extremity right. *Electronically signed and dated: James Lundeen, Sr, MD, CIME 22-Nov-2002 18:45:37.67.*

ASSESSMENT: Any reason(s) recovery has been delayed: weak legs due to back condition. PHYSICAL CAPACITIES: standing at one time 5 minutes; standing total in 8 hour period 4 hours; sitting at one time 30 minutes; sitting total in 8 hour period 4-6 hours; lifting (pounds): frequently 2; occasionally 5; maximum (rarely) 7; kneeling: can't; bending: very difficult; climbing steps: avoids steps; exposure to unprotected heights: must avoid; working around moving machinery: must avoid; operating a motor vehicle or tow motor: city driving only; exposure to extremes of weather conditions: must avoid cold. Need for vocational rehabilitation: application was denied by MCO according to claimant. Objective findings: see section in this note labeled Objective. Treatment plan: frequency of MD examinations monthly. Factors that are unrelated to the work related condition but are impacting recovery: none. *Electronically signed and dated: James Lundeen, Sr, MD, CIME 22-Nov-2002 18:49:15.04.*

PLAN: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. Minimize use of narcotic medication, take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx controlled/narcotic medications. Patient understand [sic] potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency or addiction will be made. A moderate degree of dependency is normal and should be anticipated with the usage of such controlled/narcotic medication(s). Beyond a normal reasonable degree of day to day dependency on such medications for ADL's,[8] abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons. Employment status = self-employed, see Subjective section of this note.

[8] ADLs are "activities of daily living." (Tr. at 1052)

Recheck in 2-3 weeks. *Electronically signed and dated: James Lundeen, Sr, MD, CIME 22-Nov-2002 18:49:44.64.*[9]

(St. Ex. 1 at 39-40, emphasis added)

Patient 1's List of Medications Prescribed by Dr. Lundeen

66. Dr. Lundeen maintained, separate from his narrative progress notes for Patient 1, a computerized list of her prescription medications, called the Drug Utilization Report. (St. Ex. 1 at 191-203) Dr. Lundeen recorded that he prescribed the following drugs:

Rx Date	Diagnosis	Medication	Strength	Qty/Freq
11/22/02	lumbar sprain	Vicodin ES	7.5/750	1 t.i.d.
11/22/02	lumbar sprain	Motrin	800 mg	1 t.i.d.
1/03/03	lumbar sprain	Vicodin ES	7.5/750	1 t.i.d.
1/03/03	lumbar sprain	Motrin	800 mg	1 t.i.d.
2/28/03	lumbar sprain	Vicodin ES	7.5/750	1 t.i.d.
2/28/03	lumbar sprain	Motrin	800 mg	1 t.i.d.
3/13/03	lumbar sprain	Motrin	800 mg	1 t.i.d.
3/13/03	lumbar sprain	Vicodin ES	7.5/750 mg	1 t.i.d.
3/13/03	lumbar sprain	**Percocet**	**5/325 mg**	**1 b.i.d.**

[prescriptions continued, charts omitted]

5/08/03	lumbar sprain	Percocet	5/325 mg	1 b.i.d.
5/08/03	lumbar sprain	Motrin	800 mg	1 t.i.d.
5/08/03	lumbar sprain	Vicodin ES	7.5/750 mg	1 t.i.d.
6/06/03	lumbar sprain	Vicodin ES	7.5/750 mg	1 t.i.d.
6/06/03	lumbar sprain	Tofranil[10]	25 mg	1 t.i.d.
6/06/03	lumbar sprain	Percocet	5/325 mg	1 b.i.d.
6/06/03	lumbar sprain	Motrin	800 mg	1 t.i.d.

[prescriptions continued, charts omitted]

[9] The Hearing Examiner notes that the most reliable documentation of the patient's current diagnoses is found in two sources: (1) Dr. Lundeen's letters to MCOs and attorneys in which he states the diagnoses and allowed conditions at a specific point in time; and (2) Dr. Lundeen's computerized Drug Utilization Report for each patient, in which he states the condition for which each prescription was written on a specific day. In contrast, some of the print-outs of electronic progress notes do not appear to state the diagnoses that were current at the time of the visit. It appears that, when Dr. Lundeen's electronic progress notes were printed out in 2011 in response to the Board's subpoena, the computer field in the progress notes titled "DIAGNOSIS" may have been populated by the list of diagnoses currently in the computer rather than the diagnoses on the date of the office visit, at least with respect to some patients. *Compare, e.g.,* St. Ex. 1 at 21, 191-192 *with* St. Ex. 1 at 39; compare St. Ex. 9 at 6, 14, and 22 *with* St. Ex. 9 at 46, 49. However, this phenomenon did not appear in all the patient files. See, e.g., St. Ex. 7.

[10] Tofranil (imipramine) is a tricyclic antidepressant. It has also been used to treat incontinence and bedwetting. (Nat'l Library of Medicine, Nat'l Institutes of Health, "Imipramine," at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000667>, accessed 10/21/11)

10/2/03	lumbar sprain	Quinine	260 mg	1 q.d.
10/2/03	lumbar sprain	Tofranil	25 mg	1 t.i.d.
10/2/03	lumbar sprain	Percocet	5/325 mg	1 t.i.d.
10/2/03	lumbar sprain	Motrin	800 mg	1 t.i.d.
10/2/03	lumbar sprain	Vicodin ES	7.5/750mg	1 t.i.d.
11/17/03	lumbar sprain	Motrin	800 mg	1 t.i.d.
11/17/03	lumbar sprain	Hydrocodone/acetaminophen	7.5/750 mg	1 t.i.d.
11/17/03	lumbar sprain	Tofranil	25 mg	1 t.i.d.
11/17/03	lumbar sprain	Percocet	5/325 mg	1 t.i.d.
11/17/03	lumbar sprain	**Valium**	**10 mg**	**1 q.d.**
12/15/03	lumbar sprain	Motrin	800 mg	1 t.i.d.
12/15/03	lumbar sprain	Tofranil	25 mg	1 t.i.d.
12/15/03	lumbar sprain	Valium	10 mg	1 q.d.
12/15/03	lumbar sprain	Percocet	5/325 mg	1 t.i.d.
12/15/03	lumbar sprain	Hydrocodone/acetaminophen	7.5/750 mg	1 t.i.d.
1/07/04	lumbar sprain	Percocet	5/325 mg	1 t.i.d.
1/07/04	lumbar sprain	Motrin	800 mg	1 t.i.d.
1/07/04	lumbar sprain	Phenergan VC	6.25/5cc	1 q4
1/07/04	lumbar sprain	Valium	10 mg	1 q.d.
1/07/04	lumbar sprain	Hydrocodone/acetaminophen	7.5/750 mg	1 t.i.d.
1/07/04	lumbar sprain	Tofranil	25 mg	1 t.i.d.

[prescriptions continued, chart omitted]

3/08/04	lumbar sprain	**Vicodin ES** [11]	7.5/750mg	1 t.i.d.
3/08/04	lumbar sprain	Motrin	800 mg	1 t.i.d.
3/08/04	lumbar sprain	Tofranil	25 mg	1 t.i.d.
3/08/04	lumbar sprain	Valium	10 mg	1 q.d.
3/08/04	lumbar sprain	**Hydrocodone/acetaminopher**	7.5/750mg	1 t.i.d.
3/08/04	lumbar sprain	**Percocet**	5/325 mg	1 t.i.d.
3/30/04	lumbar sprain	Motrin	800 mg	1 t.i.d.
3/30/04	lumb/lmbsac dsc degen	**Percocet**	**7.5/325 mg**	1 t.i.d.
3/30/04	lumb/lmbsac dsc degen	Valium	10 mg	1 q.d.
3/30/04	lumb/lmbsac dsc degen	Vicodin ES	7.5/750 mg	1 t.i.d.
3/30/04	lumb/lmbsac dsc degen	Tofranil	25 mg	1 t.i.d.
4/27/04	lumb/lmbsac dsc degen	Valium	10 mg	1 q.d.
4/27/04	lumb/lmbsac dsc degen	Tofranil	25 mg	1 t.i.d.
4/27/04	lumb/lmbsac dsc degen	Vicodin ES	7.5/750 mg	1 t.i.d.
4/27/04	lumb/lmbsac dsc degen	Percocet	7.5/325 mg	1 t.i.d.
4/27/04	lumbar sprain	Motrin	800 mg	1 t.i.d.

[prescriptions continued, charts omitted]

[11] In March 2004, the daily doses included: Vicodin at 7.5/750 mg x 3; Hydrocodone/acetaminophen at 7.5/750 mg x 3, and Percocet at 5/325 mg x 3. These prescriptions therefore equal 45 mg of hydrocodone per day, 15 mg of oxycodone per day, and 4,825 acetaminophen per day. On top of that were 10 milligrams of Valium every day.

7/08/04	lumb/lmbsac dsc degen	Valium	10 mg	1 q.d.
7/08/04	lumb/lmbsac dsc degen	Tofranil	25 mg	1 t.i.d.
7/08/04	lumb/lmbsac dsc degen	Vicodin ES [last]	7.5/750 mg	1 t.i.d.
7/08/04	lumb/lmbsac dsc degen	Percocet	7.5/325 mg	1 t.i.d.
7/08/04	lumbar sprain	Motrin	800 mg	1 t.i.d.
7/08/04	lumb/lmbsac dsc degen	Lidoderm patch	5 %	1 q.d.

[prescriptions continued, chart omitted]

9/15/04	lumb/lmbsac dsc degen	Valium	10 mg	1 q.d.
9/15/04	lumbar sprain	Motrin	800 mg	1 t.i.d.
9/15/04	lumb/lmbsac dsc degen	Tofranil	25 mg	1 t.i.d.
9/15/04	lumb/lmbsac dsc degen	Lidoderm patch	5%	**2 q.d.**
9/15/04	lumb/lmbsac dsc degen	**Percocet**	7.5/325 mg	**1 q.i.d.**

[prescriptions continued, charts omitted]

1/04/06	lumb/lumbosac disc degen	Tofranil	25 mg	1 t.i.d.
1/04/06	lumb/lumbosac disc degen	Valium	10 mg	1 q.d.
1/04/06	lumb/lumbosac disc degen	**Lyrica**	100 mg	1 t.i.d.
1/04/06	lumb/lumbosac disc degen	Lidoderm patch	5%	2 q.d.
1/04/06	lumbar sprain	Motrin	800 mg	1 t.i.d.
1/04/06	lumb/lumbosac disc degen	Percocet	7.5/325 mg	1 q.i.d.

[prescriptions continued, charts omitted]

12/20/06	lumb/lumbosac disc degen	Lidoderm patch	5%	2 q.d.
12/20/06	lumb/lumbosac disc degen	Valium	10 mg	1 q.d.
12/20/06	lumb/lumbosac disc degen	**Percocet**	7.5/325 mg	**1 five x day**
12/20/06	lumbar sprain	Motrin	800 mg	1 t.i.d.
12/20/06	lumb/lumbosac disc degen	Lyrica	50 mg	1 five x day
12/20/06	lumb/lumbosac disc degen	Tofranil	25 mg	1 t.i.d.

[prescriptions continued, charts omitted]

2/22/07	lumb/lumbosac disc degen	**Dilaudid**	**4 mg**	**1 b.i.d.**
2/22/07	lumb/lumbosac disc degen	Lidoderm	patch 5%	2 q.d.
2/22/07	lumb/lumbosac disc degen	Tofranil	25 mg	1 t.i.d.
2/22/07	lumb/lumbosac disc degen	Valium	10 mg	1 q.d.
2/22/07	lumbar sprain	Motrin	800 mg	1 t.i.d.
2/22/07	lumb/lumbosac disc degen	Percocet	7.5/325 mg	1 five x day
2/22/07	lumb/lumbosac disc degen	Lyrica	50 mg	1 five x day

3/13/07	lumb/lumbosac disc degen	Dilaudid	4 mg	1 b.i.d.
3/13/07	lumb/lumbosac disc degen	Tofranil	25 mg	1 t.i.d.
3/13/07	lumb/lumbosac disc degen	Lyrica	50 mg	1 five x day
3/13/07	lumb/lumbosac disc degen	Valium	10 mg	1 q.d.
3/13/07	lumbar sprain	Motrin	800 mg	1 t.i.d.
3/13/07	lumb/lumbosac disc degen	Lidoderm	patch 5%	2 q.d.
3/13/07	lumb/lumbosac disc degen	Percocet	7.5/325 mg	1 five x day

[prescriptions continued, charts omitted]

11/14/07	lumb/lumbosac disc degen	Dilaudid	4 mg	1 b.i.d.
11/14/07	lumb/lumbosac disc degen	Tofranil	25 mg	1 t.i.d.
11/14/07	lumbar sprain	Motrin	800 mg	1 t.i.d.
11/14/07	lumb/lumbosac disc degen	Valium	10 mg	1 q.d.
11/14/07	lumb/lumbosac disc degen	Lyrica	50 mg	1 five x day
11/14/07	lumb/lumbosac disc degen	Percocet	7.5/325 mg	1 five x day
12/12/07	lumb/lumbosac disc degen	**Dilaudid**[12]	4 mg	**1 t.i.d.**
12/12/07	lumb/lumbosac disc degen	Lyrica	50 mg	1 five x day
12/12/07	lumbar sprain	Motrin	800 mg	1 t.i.d.
12/12/07	lumb/lumbosac disc degen	**Valium**[13]	10 mg	**1 t.i.d.**
12/12/07	lumb/lumbosac disc degen	Tofranil	25 mg	1 t.i.d.
12/12/07	lumb/lumbosac disc degen	Percocet	7.5/325 mg	1 five x day

[prescriptions continued, charts omitted]

12/23/09	lumb/lumbosac disc degen	Dilaudid	4 mg	1 t.i.d.
12/23/09	lumb/lumbosac disc degen	Lyrica	50 mg	1 five x day
12/23/09	lumbar sprain	Motrin	800 mg	1 t.i.d.
12/23/09	lumb/lumbosac disc degen	Valium	10 mg	1 t.i.d.
12/23/09	lumb/lumbosac disc degen	Tofranil	25 mg	1 t.i.d.
12/23/09	lumb/lumbosac disc degen	Percocet	7.5/325 mg	1 five x day

[prescriptions continued, charts omitted]

12/14/10	lumb/lumbosac disc degen	Dilaudid	4 mg	1 t.i.d.
12/14/10	lumb/lumbosac disc degen	Lyrica	50 mg	1 five x day
12/14/10	lumbar sprain	Motrin	800 mg	1 t.i.d.
12/14/10	lumb/lumbosac disc degen	Valium	10 mg	1 t.i.d.
12/14/10	lumb/lumbosac disc degen	Tofranil	25 mg	1 t.i.d.
12/14/10	lumb/lumbosac disc degen	Percocet	7.5/325 mg	1 five x day

[prescriptions continued, charts omitted]

[12] The previous Dilaudid dose was twice per day, and the new frequency is three times per day.

[13] The previous frequency of the Valium dose was once per day. The new dose of "t.i.d.." tripled on this date. (Tr. at 213) The progress notes are quoted below.

3/08/11	lumb/lumbosac disc degen	**Dilaudid**	4 mg	**1 t.i.d.**
3/08/11	lumb/lumbosac disc degen	Lyrica	50 mg	1 five x day
3/08/11	lumbar sprain	Motrin	800 mg	1 t.i.d.
3/08/11	lumb/lumbosac disc degen	**Valium**	10 mg	**1 t.i.d.**
3/08/11	lumb/lumbosac disc degen	Tofranil	25 mg	1 t.i.d.
3/08/11	lumb/lumbosac disc degen	Percocet	7.5/325 mg	1 five x day

(St. Ex. 1 at 191-196, emphasis added)

October 2002: Patient 1's Medication Contract

55. Prior to her first visit with Dr. Lundeen, Patient 1 signed a medication contract regarding her receipt and use of pain medications from Dr. Lundeen:

> In order to establish a clear understanding of the Lundeen Medical Group, Incorporated philosophy regarding medication, we require the following agreement be signed by our patients. The purpose of this contract is to establish a clear policy for the prescription and use of pain medication prescribed to you by this medical practice. This agreement is a necessary part in maintaining the trust and confidence which is crucial to a patient/physician relationship.
>
> I use *[store name written by the patient]* Pharmacy, located at *[address written]*, phone number *[number written]*, for all of my medications. If I change pharmacies for any reason, I will notify the Lundeen Medical Group and advise if this is a temporary or permanent change.
>
> I agree that the Lundeen Medical Group may contact ANY pharmacy to request a list of prescribed medication, which has been filled in my name.
>
> I will not seek to get medication from another health-care provider while the Lundeen Medical Group is prescribing medication, unless instructed to do so by this medical practice, or in case of emergency. In any event, I will notify the Lundeen Medical Group promptly if I was prescribed any other narcotic or controlled medication.
>
> I understand that it is my responsibility to keep myself and others safe from harm while I am taking medications that may have adverse effects, such as drowsiness or dizziness. I will avoid drinking alcohol, operating machinery or motorized vehicles while taking such medications.
>
> I agree that I will not take my medication more frequently than it is prescribed, unless instructed to do so my [*sic*] this medical practice.

> I understand that prescriptions will NOT be refilled early for any reason, including loss or theft. I understand that the consequence for my failure to safeguard my medication will be a period of time without medication.
>
> I will not share, sell or trade my medication under any circumstance.
>
> I understand that if I miss my appointment, my controlled medication will not be filled until I am examined, if appropriate at the time of examination.
>
> I understand that if I do not comply with this agreement, I may be terminated as a patient from the Lundeen Medical Group without 30 days notice.
>
> I, _____*[signature of Patient 1]*_____, have read and understand this agreement. I, _*[initials written]*_, have been given a copy of this agreement. DATE _*10-28-02*_ Social Security Number_*[number written by patient]*

(St. Ex. 1 at 319)

Selected 2003 Progress Notes – Patient 1

67. On January 3, 2003, Dr. Lundeen noted that Patient 1 was having problems with balance:

> SUBJECTIVE: Since the patient's last visit, the patient's condition has not changed. Activities impaired include: *balance,* right leg drags, both legs are weak. Pain is noted by patient in regions of back and both legs. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include *balance is worse.* Electronically signed and dated: James Lundeen, Sr, MD, CIME 3-Jan-2003 19:09:30.79.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 20 degrees, SLR L 10 degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: slow, list to right. Electronically signed and dated: James Lundeen, Sr, MD, CIME 3-Jan-2003 19:10:03.03.
>
> ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued. Consideration of relative costs of medications has been made in selecting medications for treatment of injuries sustained in this industrial claim. NKDA [no known drug allergies]. Will add quinine to control feet and leg cramps. Electronically signed and dated: James Lundeen, Sr, MD, CIME 3-Jan-2003 19:10:28.15.
>
> PLAN: The patient has been advised that one or more of the RX medications are potentially addictive or habit-forming. The patient desires to continue the

> medication(s) in order to maximize therapeutic benefit. Every effort will be made to keep the quantities of such medications as low as possible. Employment status = day care through county. Electronically signed and dated: James Lundeen, Sr, MD, CIME 3-Jan-2003 19:10:46.07.

(St. Ex. 1 at 41-42, emphasis added)

68. On March 13, 2003, Dr. Lundeen noted that Patient 1 had fallen, and that Percocet was being added to her medications:

> SUBJECTIVE: Since the patient's last visit, the patient's condition is much worse. *Fell* due to left leg weakness [on] 2/4/03, unable to work since fall. Activities impaired include: all back ADLs. Pain is noted by patient in regions of back, legs. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are much less effective without adverse or intolerable side effects. Never had any back surgery. Last MRI in 2002.[14] [signature omitted]
>
> OBJECTIVE: Seated straight leg raising, SLR, R 5 degrees, SLR L 5 degrees, increased spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Slow difficult ambulation. [signature omitted]
>
> ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will be supplemented with Percocet for severe pain control. Consideration of relative costs of medications has been made in selecting medications for treatment of injuries sustained in this industrial claim. [signature omitted]
>
> PLAN: The patient has been advised that one or more of the RX medications are potentially addictive or habit-forming. The patient desires to continue the medication(s) in order to maximize therapeutic benefit. Every effort will be made to keep the quantities of such medications as low as possible. Employment status = unable to perform day care services since 2/4/3 due to her back condition and leg weakness. Need new MRI. C84 from 2/4/3. [signature omitted]

(St. Ex. 1 at 42, emphasis added)[15]

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[14] The MRI was done in March 2002 to rule out stenosis and disc herniation. The MRI showed "some degenerative disc at the L5-S1 level," and the "remaining vertebral bodies and disk spaces were of normal height and alignment." There was "no evidence of stenosis or disc herniation." (St. Ex. 1 at 657)

[15] with regard to Patient 1's visit on March 13, 2003, Dr. Cunningham criticized that Dr. Lundeen did not state the specific location of the patient's reported pain and did not state whether the area was swollen or tender upon examination. He also criticized Dr. Lundeen for not stating a measurement of the atrophy. (Tr. at 192-194)

69. On September 5, 2003, Dr. Lundeen stated under the Subjective heading, among other things, that the patient complained of "more pain" and that bladder control was "good" with medication. He further stated that Patient 1 needed "physical therapy and reconditioning." (St. Ex. 1 at 48)

70. On October 3, 2003, the diagnoses remained unchanged. Progress was noted in bladder and bowel control with imipramine, which the patient was taking at 25 milligrams three times per day, with "tolerable side effects" of dry mouth and eyes. In the Assessment, Dr. Lundeen stated: "Based on the patient's examination findings, history of injury and present complaints, the medications will be supplemented with quinine to control leg and foot cramps." (St. Ex. 1 at 49)

71. On November 17, 2003, the Drug Utilization Report for Patient 1 shows that Dr. Lundeen added Valium, 10 milligrams once per day. (St. Ex. 1 at 191) However, in his narrative notes, Dr. Lundeen said nothing about adding Valium:

> SUBJECTIVE: Since the patient's last visit, the patient's condition continues. Activities impaired include: back, legs, bladder. Pain is noted by patient in regions of back, legs. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include more pain in lower back.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 5 degrees, SLR L 5 degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: list to right. Station (balance): left foot drags a bit.
>
> ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, *the medications will be continued* to treat pain.
>
> PLAN: The patient has been advised that one or more of the RX medications are potentially addictive or habit-forming. The patient desires to continue the medication(s) in order to maximize therapeutic benefit. Every effort will be made to keep the quantities of such medications as low as possible. Employment status = not able to work.

(St. Ex. 1 at 26, 50; emphasis added, signatures omitted)

Dr. Cunningham's Comment on the November 2003 Visit – Patient 1

72. With regard to Patient 1's visit in November 2003, Dr. Cunningham criticized Dr. Lundeen for prescribing Valium without making any diagnosis of anxiety or otherwise explaining why he was adding a new drug to the patient's prescriptions. (Tr. at 196-197; St. Ex. 1 at 50, 191)

December 2003 – Patient 1

73. On December 9, 2003, Dr. Lundeen provided an extensive written report opining that the workers' compensation claim should be allowed for an aggravation of preexisting degenerative disk disease at L5-S1. He stated that the existing diagnosis was "Sprain Lumbar Region," and he included his progress notes for several office visits. (St. Ex. 1 at 22-27)

74. On December 15, 2003, Dr. Lundeen's notes include comments regarding Patient 1's problems with balance, falling, and needing a walker in order to ambulate:

> SUBJECTIVE: * * * Pain is noted by patient in regions of back, legs. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include: fell due to weak legs and spasms. This patient takes imipramine daily to control both bladder and bowel sphincter muscles. The current dosage is 25 mg and the frequency is 3x daily. Tolerable side effects include: dry mouth. The dosage and frequency will be continued. Needs a walker for balance.
>
> OBJECTIVE: Seated straight leg raising, SLR, R zero degrees, SLR L zero degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: cane is insufficient.
>
> ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued.
>
> PLAN: The patient has been advised that one or more of the RX medications are potentially addictive or habit-forming. [Omitted: narcotic use information] Employment status = unable to work due to this injury. Recheck in 3-4 weeks. Notice: This medical service provider relies on the review of this medical note for adjudication of the corresponding billed charge(s). If this bill is paid, the payer acknowledges (or implies) that this note was read and that all criteria necessary to release payment for services have been met. Otherwise, the bill will be rejected by the payer if any data is not compatible with payment of the corresponding bill. No other remedy will be available to the payer once payment has been made. In addition, payment of this bill for these notes provides this medical service provider with a reasonable basis to provide future medical care for the same conditions with similar medical notes without prior authorization. The payer has a duty to review these notes prior to payment of the corresponding services. Such review includes ICD codes, CPT codes, facility fees if applicable and the content of the actual notes, subjective, objective, assessment and plan. This Notice applies to this date of service and to all future dates of service for this injury claim: 00-[number omitted].

(St. Ex. 1 at 51-52, signatures omitted)

2004 – Patient 1

75. According to Dr. Lundeen's Drug Utilization Report for Patient 1, the condition of "lumbar/lumbosacral disc degeneration" was allowed as a workers' compensation condition between the Patient 1's visits in February and March 2004. The condition was added as a diagnosis in Dr. Lundeen's records. (St. Ex. 1 at 191-192; see, also, St. Ex. 1 at 28)

76. On June 22, 2004, the Drug Utilization Report lists the addition of Lidoderm patches. However, Dr. Lundeen did not state in his progress notes why he had added a new prescription for Lidoderm patches:

> SUBJECTIVE: This patient is seen today at Zanesville, Ohio. Since the last visit, the patient's condition continues. Activities impaired include: back, legs, bladder. Pain is noted by patient in regions of back, legs. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. *New problems include none.* Progress is noted in: none.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 25 degrees, SLR L zero degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: cane-4 leg. Station (*balance*): left leg drags. Stronger lower extremity right. Motor function of R leg is grade 4 out of 5 in L4, grade 4 out of 5 in L5 and grade 3+ out of 5 in S1. Motor function of the L leg is grade 3 out of 5 in L4, grade 3 out of 5 in L5 and grade 3 out of 5 in S1. Flexion 15 degrees, extension 5 degrees, right lateral flexion 15 degrees and left lateral flexion zero degrees. 16
>
> ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, *the medications will be continued.*
>
> PLAN: The patient has been advised that one or more of the RX medications are potentially addictive or habit-forming. The patient desires to continue the medication(s) in order to maximize therapeutic benefit. Every effort will be made to keep the quantities of such medications as low as possible. Employment status = TT [temporary total disability]. Recheck in 4 weeks.

(St. Ex. 1 at 60; signatures omitted, emphasis added)

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[16] Dr. Cunningham explained that "flexion" most likely refers to bending forward at the waist, and that lateral flexion would be bending to the sides, with "extension" referring to bending backward. (Tr. at 211-212)

77. On September 15, 2004, Dr. Lundeen doubled the dose of Lidoderm, and he increased the Percocet dose (7.5/325 mg) from three times per day to four times per day. He explained his prescribing rationale as follows:

> SUBJECTIVE: This patient is seen today at Zanesville, Ohio. Since the last visit, the patient's condition is much worse, balance is worse, falls easily due to her back condition in this claim. Activities impaired include: back and legs adls, bladder. Pain is noted by patient in regions of back, legs. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include back more painful, sleep worse, left leg worse. Progress is noted in: bladder control with imipramine.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 5 degrees, SLR L zero degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: 4-legged cane.
>
> ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued. Percocet increased and Lidoderm increased to reduce pain.
>
> PLAN: The patient has been advised that one or more of the RX medications are potentially addictive or habit-forming. The patient desires to continue the medication(s) in order to maximize therapeutic benefit. Every effort will be made to keep the quantities of such medications as low as possible. Employment status = TT and SSD. Recheck in 4 weeks.

(St. Ex. 1 at 63; signatures omitted)

78. Dr. Cunningham criticized the lack of documentation by Dr. Lundeen to support the increased dosage of medications in September 2004. (St. Ex. 1 at 60-63, 191-194; Tr. at 202-206)

December 2005 Letter Regarding Prescription Medication – Patient 1

79. In December 2005, Dr. Lundeen submitted a letter regarding the topic of "Prescription Medication," stating that the medications he had prescribed for Patient 1 were "medically necessary, effective and safe for her use" with regard to her back injury. (St. Ex. 1 at 30-21) His report included the following:

> DIAGNOSES
> 847.2 SPRAIN LUMBAR REGION
> 722.52 LUMB/LUMBOSAC DISC DEGEN

RECENT EXAMINATION
December 7, 2005

Subjective: Service location: Zanesville, Ohio. Since the last visit, the patient's condition continues without significant change. Pain level today = 6. Activities impaired include: back. Pain is noted by patient in regions of back. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. New problems include more pain. *Attempting weight loss.*

Objective: Seated straight leg raising, SLR, R 5 degrees, SLR L 5 degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: four-legged. [*sic*: probably a reference to a four-legged cane.]

Assessment: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued unchanged.

Plan: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2. Patient to minimize use of such narcotic medication(s), to take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx narcotic medications. Patient understand [sic] potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency or addiction will be made. A moderate degree of dependency is normal and should be anticipated with the usage of such narcotic medication(s). Beyond a normal reasonable degree of day to day dependency on such medications for ADL's, abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons. The next scheduled appointment with this examiner is in 4 weeks.

SUMMARY

As a result of the injuries sustained in this industrial accident and despite conservative treatment, [Patient 1] continues to have pain and symptoms in her back. The medications prescribed:
Percocet and Lidoderm patches are prescribed in combination for control of back pain.
Motrin is an NSAID.
Valium is prescribed to reduce anxiety to aid in sleep.
Tofranil is prescribed for bladder and bowel incontinence control from spinal injury in this claim.

> Based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it is my opinion, that: the prescribed medications provide adequate relief of painful symptoms and allow the patient to perform her daily living activities. Furthermore, I maintain that [Patient 1's] medications are medically necessary, effective and safe for her use.

(St. Ex. 30-31, emphasis added)

January 2006 – Patient 1

80. On January 4, 2006, the Drug Utilization Chart shows that Dr. Lundeen added Lyrica for Patient 1.[17] (St. Ex. 1 at 194) In the progress notes for January 4, 2006, Dr. Lundeen stated his rationale for adding Lyrica as follows:

> SUBJECTIVE: Service location: Zanesville, Ohio. Since the last visit, the patient's condition continues without significant change. Pain level today = 6. Activities impaired include: back, legs. Pain is noted by patient in regions of back, legs. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. New problems include balance may be worse.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 5 degrees, SLR L 5 degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: 4-legged cane.
>
> ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will be modified as follows: added Lyrica for more pain control.
>
> PLAN: One or more medications from this physician are classified as non-narcotic, yet controlled substance(s). The use of such medication(s) is justified based on the patient's subjective and objective examination findings and is necessary in order for the patient to perform activities of daily living. * * * The next scheduled appointment with this examiner is in 3 weeks.

(St. Ex. 1 at 194)

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[17] Lyrica is the brand name for pregabalin, an anticonvulsant used to relieve neuropathic pain (pain from damaged nerves), which can result from diabetes or shingles. The drug has also been used to treat fibromyalgia. In addition, pregabalin is used with other drugs to treat certain types of seizures. (Nat'l Library of Medicine, "Pregabalin," at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH 0000327>, accessed 10/21/11.)

81. In his progress notes for Patient 1 dated January 26, 2006, Dr. Lundeen stated that he was reducing the amount of Lyrica because it was "too effective and makes her dizzy." (St. Ex. 1 at 93)

Dr. Cunningham's Opinions

82. Dr. Cunningham discussed the prescription for Lyrica, an anticonvulsant drug that has been shown to be helpful for radicular pain, that is, pain due to compromise of the nerve root at the spine. However, Dr. Cunningham stated that Dr. Lundeen did not explain in his progress notes why Lyrica was appropriate for Patient 1, based on her diagnoses. Dr. Cunningham also faulted the lack of any objective basis in the progress notes to support more medication. Further, he noted that the patient had rated her pain as 6 on that date, and had also rated it the same on the prior visit. Further, the SLR test had essentially the same results as previously. Dr. Cunningham opined that the examination as set forth in the January 4, 2006 notes does not satisfy the standard of care for prescribing the additional medication. (Tr. at 177-179, 204-206)

83. Dr. Cunningham also focused on the repeated statements in Patient 1's progress notes that the patient reported problems with balance and falling. Dr. Cunningham noted that the patient had been placed on Lyrica due to her frequent falls, but there was no objective evidence of neurological compromise at the spinal level to support the use of Lyrica. Dr. Cunningham noted that the "original MRI report of the low back, from 03/07/02, demonstrated degenerative disc disease at L5-S1 without stenosis or disc herniation, i.e., no neurologic compromise, on an objective medical basis." Also, after the patient said that the Lyrica was making her dizzy, the dose was simply lowered and the drug was continued. (Tr. at 177-194; St. Ex. 30 at 18)

84. In addition, Dr. Cunningham noted that Patient 1 was taking more narcotics and was also taking Valium. Dr. Cunningham opined that the standard of care requires at a minimum that Dr. Lundeen should have explored further the question of why the patient was falling, but that Dr. Lundeen recorded only that the patient had reported problems with balance, falling, and needing a cane. Dr. Cunningham stated that Dr. Lundeen's "physical examinations throughout are not specific enough or objective enough to determine whether or not this individual's difficulties with balance and ambulation, and frequent falls are related to the central nervous system * * * or if these difficulties are related to the low back." Dr. Cunningham was concerned that the patient could have had a central nervous system problem such as TIAs or stroke, or the medications could have been causing dizziness and weakness. He was also concerned that, after the patient reported dizziness and falling, the medications were continued. (Tr. at 177-194, 220-222; St. Ex. 30 at 15)

85. Further, Dr. Cunningham testified that Patient 1 should have been given a thorough physical examination including a neurological examination, or Dr. Lundeen should

have referred the patient for a neurological consultation. Dr. Cunningham stated the medical records did not show those things being done. (Tr. at 177-181)

April 2006 Letter – Patient 1

86. In April 2006, Dr. Lundeen provided a report letter opining that Patient 1 is permanently and totally disabled. He included a discussion of the patient's medical, personal, and employment histories, as well as his findings upon examination. (St. Ex. 1 at 11-16)

July 2006 Letter Regarding Prescription Medications – Patient 1

87. In July 2006, Dr. Lundeen wrote a letter supporting his prescribing of Valium for Patient 1. (St. Ex. 1 at 32-33) After setting forth the progress notes for June 2006, Dr. Lundeen stated:

> As a result of the injuries sustained in this industrial accident and despite conservative treatment, [Patient 1] continues to have pain and symptoms in her lower back and legs. Valium is prescribed for control of many symptoms associated with this lower back injury including: control of lower back muscle spasms, to assist sleep which is restless due to pain and symptoms. Furthermore, it is also effective in control of anxiety which seems directly to have been caused by the allowed work injury. Anxiety is a consequence of the pain and suffering with resultant impaired function and financial problems as well as insecurity about her future.
>
> Based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it is my opinion, that: Valium is medically necessary and provides adequate control of symptoms associated with the allowed conditions in this claim.

(St. Ex. 1 at 32-33)

September 2006 Letter Regarding Disability – Patient 1

88. In a letter dated September 13, 2006, Dr. Lundeen provided a report regarding permanent total disability. (St. Ex. 1 at 34-36) He stated in part:

> As a direct result of the injuries sustained in this claim, and despite conservative ongoing treatment since the date of injury, [Patient 1] has significant pain in her lower back with pain radiation down through her left buttock into the left leg and foot. She reports weakness in both legs, left worse than right, with numbness in her left leg with frequent episodes of her leg "giving away" for no apparent reason.

Dr. Bowden states "no muscle weakness ascertained". This is a direct contradiction to my examination findings as well as the findings of Dr. Waldbaum who evaluated [Patient 1] on May 21, 2004 at the request of the Bureau. Dr. Waldbaum states "The client is unable to do active hip flexion on the left and was unable to fully extend the left lower extremity with some give-way on testing strength".

Dr. Bowden also states "toe and heel walking could be achieved". This is also a direct contradiction to my examination findings as well as the findings of Dr. Waldbaum who states "She is unable to toe walk, to heel walk, nor to squat". Dr. Waldbaum also reports "[Patient 1] had difficulty getting up from the chair and walking down the corridor into the room". Furthermore, Dr. Waldbaum reported "there do not appear to be any significant superimposed pain behaviors".

Furthermore the 9-17-04 IME report of Dr. Ortega prepared at the request of the Bureau states "she was not able to stand or walk on her toes or heels". Dr. Ortega also states "at best, sedentary work and very light duty would be the only thing that this injured worker can perform in the face of marked limitation in her ability to do activities of daily living". It should also be noted, according to [Patient 1] she told Dr. Bowden that she could not perform heel or toe walking, however he intimidated [Patient 1] into trying, which she was not able to do.

During my examinations of [Patient 1] over the last several years, I have noted that she is unable to rise from a seated chair position to a free standing position unless she applied downward pressure from both hands to propel herself upwards. Such inability to stand without use of upper extremity assistance indicates a serious back condition resulting in bilateral lower extremity weakness.

[Patient 1's] functional limitations are extreme. The barriers that prevent her return to employment include: intractable low back pain and significant left lower extremity pain and weakness. Furthermore, she is unable to ambulate without the assistance of a standard walker or quad cane.

[Omitted: progress notes from the patient's visit on September 7, 2006]

Summary: [I]t appears to this examiner that the goal of Dr. Bowden's report was to discredit the patient's intractable pain, marked lower bilateral extremity weakness and extreme functional limitations. It remains my opinion that [Patient 1] is permanently and totally disabled as a direct result of the injuries she sustained in this claim.

(St. Ex. 1 at 34-36)

Dilaudid Prescription in February 2007 – Patient 1

89. Dr. Lundeen's Drug Utilization Report shows that Dr. Lundeen added Dilaudid for Patient 1 on February, 22, 2007.[18] The dose was 4 milligrams, to be taken twice per day. (St. Ex. 1 at 196; Tr. at 207-217)

90. However, Dr. Lundeen's chart notes for February 22, 2007, make no mention of prescribing Dilaudid for Patient 1:

> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 9-10. Activities impaired include: back, legs, *balance*. Office: ZA. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: unable to work due to her injuries.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 15 degrees, SLR L 5 degrees, severe spasms present in lower back. Gait: four-legged cane. Stronger lower extremity right. Flexion 25 degrees, extension 5 degrees, right lateral flexion 15 degrees and left lateral flexion 10 degrees.
>
> ASSESSMENT: *No major change in medications prescribed.*
>
> PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2. [Omitted: general information regarding narcotic use.] The next scheduled appointment with this examiner is in 4 weeks.

(St. Ex. 1 at 109; signatures omitted, emphasis added)

Dr. Cunningham's Opinion Regarding the February 2007 Prescribing

91. Dr. Cunningham opined that Dr. Lundeen's prescribing of Dilaudid without including any notation in the progress notes that he was adding another narcotic medication constituted a violation of the standard of care. In addition, Dr. Cunningham testified that the physical examination as reflected in the chart notes was not sufficient to justify adding Dilaudid to the drugs the patient was already receiving, and the prescription violated the standard of care for that reason as well. (Tr. at 207-211)

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[18] Dilaudid is hydromorphone, which is four times stronger than morphine, in that 1 mg of hydromorphone is equivalent to 4 mg of morphine. Hydromorphone is also more potent than oxycodone. (Tr. at 210-215; St. Ex. 45)

June 2007 Report

92. In June 2007, Dr. Lundeen sent a letter opining that a psychiatric evaluation was medically necessary with regard to the patient's back injury in 2000. Dr. Lundeen reviewed the patient's status, noting among other things that the patient had reported "frequent falls," which he said was due to the left leg. Dr. Lundeen further stated that Patient 1 had reported changes in appetite, sleep disturbances, anxiety, and depression as a consequence of her industrial injury. Dr. Lundeen also noted the opinions set forth in the 2003 report of Dr. Higgins and the 2004 report of Dr. Otega [sic]. (St. Ex. 1 at 17-18)

December 2007 Progress Notes – Patient 1

93. On December 12, 2007, Dr. Lundeen increased Patient 1's dosages of Valium and Dilaudid, which he explained as follows:

> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 8-9. Activities impaired include: back, legs, bladder, balance. Office: Cambridge, Ohio. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: SSD. *Needs Valium and Dilaudid medications increased in daily amounts.*
>
> OBJECTIVE: Seated straight leg raising, SLR, R 5 degrees, SLR L zero degrees, spasms present in lower back. Gait: quad cane. Flexion 25 degrees, extension 5 degrees, right lateral flexion 5 degrees and left lateral flexion 5 degrees.
>
> ASSESSMENT: *No major change in medications prescribed. Dilaudid and Valium increased to treat symptoms of her allowed back conditions.*
>
> PLAN: Medications from this physician include more than one scheduled narcotic medications in the strong DEA classification group 2. Patient to minimize use of such narcotic medication(s), to take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx narcotic medications. Patient understand [sic] potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency or addiction will be made. A moderate degree of dependency is normal and should be anticipated with the usage of such narcotic medication(s). Beyond a normal reasonable degree of day to day dependency on such medications for ADL's, abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons. Use of multiple medications due to severity of

symptoms and difficulty with dose titration with single drug from this category. The next scheduled appointment with this examiner is in 4 weeks.

(St. Ex. 1 at 128)[19]

February 2010 Letter – Patient 1

94. In February 2010, Dr. Lundeen wrote to the MCO regarding TENS-unit supplies for Patient 1. He noted among other things that the patient had reported that "she does have 50-60 percent relief of lower back pain with the use of the TENS unit."[20] (St. Ex. 1 at 37)

Messages Regarding Telephone Contacts, Papers Received, Etc.

95. In his electronic medical records, Dr. Lundeen maintains, under the heading "Dump of Patient Data," separate from the progress notes for office visits, a compilation of the messages and notations regarding telephone calls, documents received, follow-up contacts, etc., regarding each patient. The notations regarding Patient 1 include the following (with the date and time in the top line):

> 00-593612 X 28 - Feb-2003 09:37:42.42 SMITHC
> Patient was rescheduled from 2-27-03 to 3-13-03, she will be out of her meds today and would like enough called in to last until she is seen. Please advise if meds can be called in.
>
> 00-593612 X 28-Feb-2003 10:01:15.58 SMITHC
> Called in Vicodin ES # of 45, Motrin # of 45.
>
> * * *
>
> 00-593612 X 7-Jul-2003 12:53:39.14 COLEMANL
> In the stuff that you left for me while I was gone is a letter dated June 24,2003 from [patient's attorney]. He indicates he met with patient on 6/17/03 and she confirmed that medication has been Rx'd and use of cane has been recommended, but there are little other significant medical interventions being undertaken at this time. He would like to know if PT, referral to rehab or possible consult with spine specialist could be considered. Please advise, thanks.
>
> * * *
>
> 00-593612 X 29-Sep-2003 10:10:27.20 CLOWS
> Patient called and said that her leg gave out and she fell. She wanted to know if she could take 2 percocet or vicodin to help with the increased pain. She wanted to see what you said before doing anything. Please advise, thanks.

[19] Dr. Cunningham testified that this examination was not sufficient to assess pain and increase the doses of Dilaudid and Valium on this date. (Tr. at 211-212)

[20] A TENS unit provides transcutaneous electrical nerve stimulation and is used to treat muscular pain. (Tr. at 217-218)

* * *

00-593612 X 24-Jun-2004 11:29:38.70 COLEMANL
IME performed on 5-21-04 by Dr. Naomi Waldbaum recommends EMG/NCV of the lower extremities to check for possible radiculopathy, she also recommends left hip s-rays [*sic*] after the fall she took this past winter. Please advise if you want us to complete a C9 for the same, thanks.

* * *

00-593612 X 21-Feb-2005 14:42:49.55 COLEMANL
JEL [Dr. Lundeen]: IME performed on 1-7-05 indicates she has reached MMI. Your e-notes over the last six months or more indicate only supportive treatment in the form of Rx medication and office visits. In the past she has undergone PT and one injections with no benefit, she refused more injections. Has she reached MMI or is there some additional active treatment you would like to request, please advise, thanks.

* * *

00-593612 X 7-Aug-2006 09:12:34.58 SMITHC
Patient called, she is out of the hospital but does not have any of her meds. They only gave her certin [sic] things as she does have cancer and you do treat her. They did not give her any pain meds, she takes Percocet and would like something called in for pain and also her valium. Please advise, thanks.

* * *

00-593612 X 13-Feb-2007 11:29:16.29 COLEMANL
Appt on 2-13-07 canceled because of weather, the following Rx were called in to Northside [telephone number] Lorcet 10/650 1 po every 4 hours as needed #60; Tofranil 25 mg 1 po t.i.d #30; Valium 10 mg 1 po daily #10; Motrin 800 mg 1 po t.i.d #30. No refills on all.

* * *

00-593612 X 9-Apr-2007 15:13:07.05 CLOWS
She called and said that she pulled some muscles this weekend taking her ham in and out of the oven. She said that she is out of the Dilaudid and the Percocet is not taking the edge off. She wanted to know if something could be called in to last until her appointment on Friday. Please advise, thanks.

00-593612 X 9-Apr-2007 15:36:21.07 CLOWS
Lidoderm patches 2 per day, box of 30 called in to Northside pharmacy per JEL.

* * *

00-593612 X 8-May-2007 10:29:20.66 CLOWS
She called and said that her home was burglarized. They stole money and her medication. I advised her that her medications would not be replaced. She understood and said that she may need to go to the ER before her next appointment.

* * *

00-593612 X 20-Dec-2007 14:27:10.65 CLOWS
She called yesterday and said that she has fallen four different times in the last four days. She said that her left knee is swollen nad [sic] **is bruised. She hit her elbow and hit her head on the washer.** She wanted to know what she can do. Can she be scheduled to see you on Monday? Please advise, thanks.

* * *

00-593612 X 2-Apr-2008 14:45:08.47 SCOTTJ
received a phone call from Crystal at CVS Pharmacy, they state at of [*sic*] 4/1/08 they can not fill her script for Lioderm [sic] or Valium as they are not covered by BWC, they are covered by medicade [sic] and they need a special script for these. * * * Please advise. She also stated this will be for everyone starting Oct 1.

* * *

00-593612 X 17-Nov-2008 16:00:11.62 COLEMANL
FYI: [Patient 1] had an appt in ZA today at 3:20, according to JEL she did not show, he can not wait for her to show and is leaving ZA office now to head to GV. Since she did not show, she did not receive the medications that appear on her Rx list written today. Per JEL, if she calls we can phone in Rx to last her until we get her re-scheduled (everything except Dilaudid and Percocet).

00-593612 X 18-Nov-2008 11:29:47.68 SEXTONS
Per JEL I called in a Rx of Lorcet 10/650mg 1 tab 6 x a day PO Qty 78 with No Refills. to North Side pharm. @ 740-454-6970.

* * *

00-593612 X 4-Dec-2008 11:10:24.20 COLEMANP
Received another fax from OSU Medical Center (Op. Report) Pre-Op Dx: Right complex adnexal mass. Post-Op Dx: Right complex adnexal mass, consistent with seromucinous cystadenoma on frozen section. * * *

00-593612 X 5-Dec-2008 07:53:17 LUTZC
Discharge instructions received from OSU Medical Center.

* * *

290526524 7-Apr-2009 10:00:15.55 SCOTTJ
[Patient 1] called and asked us to call the Hotline for Ohio Dept of job and family services. She said they will not pay for her medication and she only had enough money to pay for (20) valium. When she called the hotline per her representative they told her to have her physician to call them @ 877 518-1546. Please advise.

00-593612 X 9-Apr-2009 11:38:29.74 SEXTONS
[Patient 1] just called regarding her Rx of Zanax [sic]. Please read previous memo.

* * *

00-593612 X 30-Apr-2009 09:46:03.84 SEXTONS

[Patient 1] just called. * * * [Patient 1] has been admitted for pneumonia. She will only be in for a couple of days. There are treating her with steroids and antibiotics. [Patient 1] will call when she gets released.

* * *

00-593612 X 13-Aug-2009 09:22:59.32 SCOTTJ
[Patient 1] called **said she fell** getting out of bed over the weekend and then fell in the living room hitting her tailbone. Went to the emergency room. They took X rays and a catscan (I told her to have them fax information to us). They are suggesting an MRI. Please advise.

* * *

00-593612 X 4-Dec-2009 15:57:53.19 LUTZC
[Patient 1] called. **She said that she has looked everywhere and double checked with the pharmacy and states she does not have the Percocet Rx written for her appt in ZA 11-27-09.** She wondered if it was still in your brief case? She asked if you could look. Thank you.

00-593612 X 11-Dec-2009 08:39:32.86 SCOTTJ
[Patient 1] called this morning inquring [sic] about her prescription for percacet [sic].

00-593612 X 14-Dec-2009 09:51:28.74 LUTZC
[Patient 1] **called to see if you had a chance to look and see if you still had her Percocet RX. She has not been able to locate it and the pharmacy does not have it. She is telling me now that she is about out of the Dilaudid because she does not have the Percocet.**

00-593612 X 18-Dec-2009 10:24:21.79 COLEMANL
[Patient 1] **has not found her Rx for Percocet. Her appt is not until 12/24, she is having a hard time and wanted to know if you would approve us calling in something** for pain until her appt on 12/24/09, please advise, thanks.

00-593612 X 18-Dec-2009 14:08:06.33 COLEMANL
Per JEL phoned in the following Rx to Northside Pharmacy (740-453-0508), spoke to pharmacist: Lorcet 10/650 mg to take 1 by mouth 5 x day, #35 with no refill.

(St. Ex. 1 at 206-218, emphasis added)

96. The computerized messages and notations compiled in the Dump of Patient Data are excerpted above, but additional message show numerous activities performed with regard to Patient 1, including the following: obtaining approval for an MRI of the lumbar spine, scheduling the MRI, stating a summary of the MRI report (4/23/03), obtaining approval for a TENS unit and supplies, obtaining approval for physical therapy (1/9/04), arranging for physical therapy sessions, requesting records from the physical therapist, communications with patient's attorney regarding additional treatment modalities for patient, providing therapy notes and treatment notes to the

MCO, noting Dr. Lundeen's recommendation for a consultation with a spine specialist, requesting approval from the MCO/BWC for a consultation with the specialist, arranging the consultation with the specialist's office, receiving notes from the specialist regarding joint injections received by patient, noting patient's statements regarding injections, requesting approval for EMG/NCV for lower extremities and x-rays of left hip as recommended by Dr. Waldbaum's IME report in May 2004 (7/27/04), contacting the patient to schedule the EMG and other tests, doing follow-up with other physicians' offices to schedule tests, making arrangements for a Functional Capacities Evaluation, scheduling the FCE, requesting a psychiatric consultation for the patient, interacting with the MCO regarding this consultation request and other matters, noting contacts from the patient's attorney regarding treatment and disability issues, providing a certification so that the patient could obtain a "handicap sticker" for parking, sending documentation to Community Action to obtain an air conditioner for Patient 1, and completing medical certifications for the utility companies to keep her power on. (St. Ex. 1 at 206-224)

Dr. Cunningham's Further Opinions Regarding Patient 1

97. Dr. Cunningham testified that he saw no explanation in Dr. Lundeen's records that can justify "the huge increase in narcotics over time" for Patient 1. (Tr. at 220-222)

98. Dr. Cunningham opined that, when the patient contacted Dr. Lundeen's office in April 2007 reporting that she had pulled a muscle and was out of Dilaudid and that the Percocet was not helping enough, and when she called again in May 2007 reporting that her drugs had been stolen, these were indications of drug abuse or diversion. Dr. Cunningham stated that these requests for more drugs should cause concern as to whether the patient was abusing or diverting the drugs. Dr. Cunningham observed that, when narcotics are being prescribed for certain types of pain complaints, diversion of the narcotics—selling them or giving them away—is always a possibility.[21] (Tr. at 222-225)

99. Dr. Cunningham testified that the patient's reported events—running out of Dilaudid and then stating that her medications were stolen—were "red flags" that should be "very, very alarming" when a patient is taking narcotics or mood-altering drugs. (Tr. at 226-228) Dr. Cunningham opined that the appropriate thing for the physician to do when the patient reports that she had run out of her medication, is to be counseled at the next office visit regarding the use of the medication, and that medications will not be refilled prematurely, and to note that discussion in the patient's chart. (Tr. at 227-228)

100. Dr. Cunningham testified that it was not enough that the patient's request for additional pain medication was refused. He opined that "it violated the standard of care for him to take

[21] As quoted above, Dr. Lundeen's staff informed Patient 1 in May 2007 that her prescription would not be replaced, and the patient did not get new medication as requested. However, Dr. Cunningham focused on the fact that requests had been made, and that the requests should have caused a concern that the patient was taking more narcotics than prescribed or that her drugs otherwise were not lasting for the full month as prescribed. (Tr. at 223-226, 232-233)

no other action." After the second request for replacement of medications, the patient should have been referred to a specialist in addictionology. In addition, it violated the standard of care to continue prescribing the narcotics to Patient 1 and to increase the dose. Further, after two such incidents, the physician should be "more skeptical" of the patient's reports of pain at subsequent visits. The subsequent progress notes include no mention of the patient's telephone calls regarding her need for additional prescriptions. (St. Ex. 1 at 113-119; Tr. at 225, 233-234)

101. With respect to what the standard of care would "require" in such circumstances, Dr. Cunningham stated:[22]

> Q. Does the standard of care require him to release [the patient], or were there other things that he could do?
>
> A. Well, I think in this day and age of narcotics and mood altering drugs, I think that that is the standard of care. If you're going to give all these very potent medications and people are potentially abusing them or diverting them, most physicians don't want to be part of that.
>
> * * *
>
> I would say ever since -- I shouldn't have said "this day and age". I should have said that, you know, provision of narcotics on an outpatient basis, you have to monitor it very closely.
>
> And that's been true even before the epidemic of patients taking medication for chronic pain, which really has been an epidemic in the last 15 years, which it's always been there. I mean, the issue of possible addiction and/or diversion has always been there whenever you are providing narcotics as an outpatient.
>
> * * *
>
> Q. In 2007, when this occurred, would the standard of care require a physician to refer this patient to an addictionologist after these two events occurred?
>
> A. If she were my patient, I would send her, yes.
>
> Q. Does the standard of care require him to send her, or take other action?
>
> A. Well, it requires him to not be a party -- If she is diverting or is abusing, it's the doctor's responsibility to find that out, as to the extent that he can, and address the issue appropriately. And if she is -- if she's addicted, or tolerant, or dependent, she should have been

[22] As set forth below, Dr. Cunningham testified further on this topic during his cross-examination.

> referred to a physician skilled in diagnosing and treating those issues.
>
> Q. Did you see anything in the record to indicate that he inquired or probed her at all to see, you know, what was really going on here?
>
> A. No. And that's one of my biggest complaints about Dr. Lundeen's records. The "dump the data" section we were talking about is never incorporated in his office visit records.
>
> There's no mention, almost never, in Dr. Lundeen's records when something like this comes up in the dump the data section. He doesn't even reflect them in his treatment records.
>
> Q. * * * So you're saying when someone calls in and reports something like that, when medications were stolen, "I washed them, flushed them down the toilet," whatever, he doesn't generally put that in his progress notes?
>
> A. I would put that in the progress notes. And, in fact, I would *probably* send the person a certified letter on the day that I was informed.[23]

(Tr. at 228-231)

102. Dr. Cunningham noted, with respect to Patient 1's first visit, that Dr. Lundeen noted only that the patient had been taking Vicodin and Motrin, but did not state the dosages the patient had been receiving. (St. Ex. 1 at 191)

103. In his written report (St. Ex. 30), Dr. Cunningham opined as follows:

> 1. Was the physical examination appropriate? No. At no time between 11/2/20[0]2 and 03/09/11 were the physical examination findings described by Dr. Lundeen appropriate and/or comprehensive, on an objective medical basis, in regards to this individual's low back and lower extremity difficulties under these Ohio BWC claim allowances, *for which he was exclusively treating this individual, from my interpretation of these records.*[24]

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[23] Upon further questioning, Dr. Cunningham testified that sending a certified letter, while a good practice, is not required, but that it is required to confront the individual, discuss the pain contract and whether it was violated, and to put the individual on a random drug-screening program if the patient stays in the doctor's practice. Dr. Cunningham stated that this discussion with the patient can be conducted orally, but should then be documented. (Tr. at 1431-1435)

[24] As discussed in detail below, Dr. Cunningham frequently referred to the "allowed conditions" in the patient's BWC claim. Dr. Cunningham testified that, when the patient was a BWC patient, Dr. Lundeen's diagnoses were consistently the same as the BWC allowed conditions, and that, therefore, when he uses the term "allowed

2. Were the diagnostic tests appropriate? Yes. This individual had an MRI in 2002, prior to first seeing Dr. Lundeen, and she also had an MRI in 2003 after seeing Dr. Lundeen. She also had an EMG of the low back and both lower extremities prior to seeing Dr. Lundeen, which was normal in all respects, and both MRI's did not demonstrate any neurologic compromise at any vertebral level, including the degenerative disc disease noted at any low back intervertebral level, including the degenerative disc disease noted at L5-S1 on both MRI studies.

3. Was the proper diagnosis established? Yes. The proper diagnosis was established prior to Dr. Lundeen's initial evaluation of this individual on 11/22/02.

4. Was the physician's medical management appropriate to the clinical situation? No. At no time was the physician's management appropriate to the diagnosis for multiple reasons. There are multiple discussions early in this file of urinary bladder difficulties, which are not in any way related to these Ohio BWC claim allowances, for which this individual was provided with various medications, including Imipramine, which is a tricyclic antidepressant. This reviewer cannot understand how a tricyclic antidepressant would have any therapeutic effect on urinary bladder incontinence. This individual was placed on Lyrica for the treatment of her frequent falls, and there is no objective evidence of neurologic compromise at the spinal level to support the use of Lyrica in this individual. Most importantly, there is a note that the Lyrica caused her to be dizzy and then the dose was lowered, but the drug was continued. The psychotropic drugs this individual was provided are also not supported * * *. The Lidoderm patches are also not reasonably related to these Ohio BWC claim allowances; in fact, in recent years, the Ohio BWC has not supported Lidoderm patches for any diagnosis, other than post-herpetic neuralgia.

Most importantly, this is an individual whose total narcotic dosage dramatically increased between 11/22/02 and 03/09/11, without any objective change in medical status being described in regards to this claim, which causes the concern for narcotic dependency and/or addiction and/or tolerance.

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conditions" or "BWC diagnoses" in his written reports, those terms are synonymous with "Dr. Lundeen's diagnoses." (Tr. at 1627-1630)

5. Was the physician's medical management appropriate to the clinical situation? No. In addition to inappropriate medications, as discussed under question #4, there is clear evidence that in 2003 this individual was exhibiting "drug seeking" behavior when she stated that she had lost her prescription and then a few days later called back and advised that someone had broken into her home and stolen her medications. * * * At that time, in this reviewer's opinion, this individual should have been promptly and immediately referred to a physician skilled in the diagnosis and management of individual's who have narcotic dependency and/or addiction and/or tolerance.

6. Was the treatment appropriate to the diagnosis? See questions # 4 and #5.

7. Was the treatment appropriate to the clinical situation? No, for multiple reasons, as discussed above. Most importantly, Dr. Lundeen seemed to place great emphasis of strength of this individual's lower extremities. However, he knew from the first day he saw this individual that her EMG and nerve conduction study of the low back and both lower extremities was normal and the 2002 low back MRI showed no neurologic compromise. However, he did not pursue any other cause for her "balance difficulties" or multiple references to falling, either by referring this individual to a neurologist or performing a neurologic examination of the central nervous system, which is not contained in these records. This reviewer wonders if the frequent falls were related to her medications prescribed by Dr. Lundeen.

8. Did the physician's timely and appropriately respond to complications? No. See answer to question #7.

9. Were the physician's medical reports and/or notes for this patient appropriate? If not, please explain. All of the abnormal physical examination findings are subjectively based. He has no objective physical examination findings described in any of these records, including his multiple statements that this individual has "spasms." The vast majority of the records generated by Dr. Lundeen and his staff are computerized "boiler plate" records with repetitious identical language.

10. Was the medical record documentation complete, clear and concise? No. See answer to question #9. No height, no weight, no blood pressure, and no medication allergies are contained in this

record, and there is no past medical history contained in Dr. Lundeen's records.

A. Whether Dr. Lundeen's treatment/care constituted a departure from or failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient was established, in violation of Section 4731.22(B)(6), Ohio Revised Code.

No. Unfortunately, Dr. Lundeen's treatment and care constituted multiple significant departures or failure from conformity to minimal standards of care of similar practitioners under the same or similar circumstances. Clearly, Dr. Lundeen did not rely upon the objective medical tests, i.e., the low back MRI's and the EMG, which showed no neurologic compromise. One of the MRI's and the EMG were carried out prior to Dr. Lundeen's initial evaluation of this individual. Also, there are no objective physical examination findings in Dr. Lundeen's records, as discussed above. In addition, earlier in this claim, Dr. Lundeen was treating this individual for unrelated urinary bladder incontinence, which was not related to these claim allowances, and which is far outside the scope of the claim allowances for which the Ohio BWC had allowed this claim, and was financially responsible for the care of this individual while under the care of Dr. Lundeen for this date of injury. Other medications also provided, as discussed above, were outside of the scope of these claim allowances. The medications provided by Dr. Lundeen are far outside of the Ohio BWC treatment guidelines and also the peer reviewed treatment guidelines, such as the Official Disability Guides and the Occupational Medicine Practice Guidelines, for enumerable reasons. The Occupational Medicine Practice Guidelines is published by the American College of Occupational and Environmental Medicine, which is one of the two governing bodies for the practice of occupational medicine, the other being the American Board of Preventive Medicine.

B. Whether Dr. Lundeen failed to maintain minimal standards acceptable to the selection and administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease, in violation of Section 4731.22(B)(2), Ohio Revised Code.

Unfortunately, Dr. Lundeen failed to maintain the minimal standards applicable to the selection and administration of drugs. There is no objective evidence that this individual's medical status in regards to

> the low back and lower extremity symptoms objectively changed in any way subsequent to Dr. Lundeen's initial examination of this individual on 11/22/02 through his most recent treatment of 03/09/11. No random drug screens were performed and there is no notation that they were possibly to be performed.
>
> Also, this individual's ever increasing level of narcotic medication, without objective change in medical status in regards to her low back and lower extremity complaints, especially when there is clear evidence of probable "drug seeking" behavior in 2003, when this individual required prompt referral to a physician skilled in narcotic addiction/tolerance/dependence issues, falls well below the minimal standard of narcotic medication management.
>
> The frequent falling episodes may have been related to over medication by Dr. Lundeen. There is no mention in these records that this individual was having any adverse effects from her medications; however, the total narcotic dosage continued to increase and this individual continued to fall, and some of those falls may have been due to the side effects of her medications. In addition, multiple medications were provided which were wholly unrelated to these claim allowances, including Lyrica and multiple psychotropic drugs, for the reasons discussed above.
>
> C. Whether Dr. Lundeen's treatment of the aforementioned patients complies with the Board's intractable pain rules, Rules 4731-21-01 through 06, Ohio Administrative Code (to the extent that you determine that those rules are applicable in this matter).
>
> See answer to question B. The most glaring omission in these records is that I see no evidence that the 10/28/02 "pain contract" signed by this individual and contained within the record was first of all NOT enforced and was not periodically and formally renewed, which, in this reviewer's opinion, was appropriate throughout the course of Dr. Lundeen's care of this individual. [25]

(St. Ex. 30 at 18-21)

104. In his supplemental report issued in August 2011, Dr. Cunningham noted that the additional medical records for Patient 1 included several IMEs that had been requested by the BWC and a November 2003 consultation by Dr. Higgins at the request of Dr. Lundeen. Dr. Cunningham stated, however, that nothing in the additional medical records altered his previously stated

[25] The Hearing Examiner notes that Dr. Cunningham's written reports have relevance to the question of what information the Board had before it when deciding to order a summary suspension of Dr. Lundeen's medical license.

opinions that Dr. Lundeen, in his care of Patient 1, "failed to maintain the minimal standards applicable to the selection of or administration of drugs," and that his treatment, "on a medical basis, did not constitute reasonable and appropriate treatment of intractable pain." (St. Ex. 30A at 3, 15)

Dr. Lundeen's Written Defense – Patient 1

105. As noted above, Dr. Lundeen did not testify at the hearing. However, he provided a written position statement regarding each of the patients at issue. With respect to Patient 1, Dr. Lundeen stated, among other things, that the patient's most recent medications (Percocet, Valium, imipramine, Motrin, Lyrica and Dilaudid) had increased over time "due to the severity of her symptoms." He also asserted that these medications are currently "approved" in her BWC claim. (Resp. Ex. Z) Dr. Lundeen further stated in his written defense:

> Dr. Lundeen's care of Patient 1 has been authorized by the Bureau of Worker's Compensation for each service, diagnosis, medication, and prescriptions provided. Dr. Lundeen's work has been subject to prospective, concurrent and retrospective peer review by case managers, nursing managers, and physician and medical directors, including the medical policy review committees at the Bureau of Workers Compensation. At all times Dr. Lundeen's care to Patient 1 was within or above the minimum standard of care; and, Dr. Lundeen's use of controlled substances for the management of chronic intractable pain were within the guidelines of the State Medical Board of Ohio, its statutes and administrative rules.

(Resp. Ex. Z)

Patient 2

General Information

106. Patient 2, a male born in 1949, sustained an industrial injury in 1992. Dr. Lundeen's medical records with Dr. Lundeen date back to 1997. Dr. Lundeen's diagnoses were a tear and derangement of the left lateral meniscus, generalized anxiety disorder, and panic disorder, which were the same as the allowed conditions in the workers' compensation claim. (St. Ex. 2 at 7, 28, 36; Tr. at 306-308)

107. Medical records from Dr. Lundeen's office for Patient 2 were admitted as State's Exhibits 2 and 2A. Dr. Cunningham's initial written opinion is set forth at State's Exhibit 30 at 23 to 29, and his supplemental report is set forth at State's Exhibit 30A, pages 3 and 14 to 15. His testimony regarding this patient is found in the hearing transcript at pages including

pages 306 to 339. Dr. Ross' opinion is in Respondent's Exhibit A at page 32 to 33, and Dr. Lundeen's written opinion is in Respondent's Exhibit Z at page 12.

August 1999 – Patient 2

108. Dr. Lundeen's drug charts for Patient 2 shows that he added Xanax to the patient's prescriptions as of August 17, 1999, to treat the patient's panic disorder. However, Dr. Lundeen's notes for that visit do not mention the new drug:

> SUBJECTIVE: Since the patient's last visit, the patient's condition is worse. Activities impaired include stand, walk. Pain is noted left knee. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include more pain in left knee. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date.
>
> OBJECTIVE: The left knee is examined today. Flexion is maximum at 75 degrees of angulation. Extension deficit (degrees) is 25. Must wear brace for joint stabilization.
>
> ASSESSMENT: The patient has pain which is ongoing and is intense in severity. Sleep quality is adversely affected.
>
> PLAN: A combination of Rx and Rx/controlled medication(s) is the current medication plan. The specific information is available in the patient's chart and/or computer account this SOAP note database [*sic*]. The use of controlled medication(s) is justified based on the patient's subjective and objective examination findings and is necessary in order for the patient to perform ADL's. Employment status: TT.

(St. Ex. 2 at 76, signatures omitted)

Dr. Cunningham's Opinion Regarding the Prescription for Xanax – Patient 2

109. Dr. Cunningham observed that the patient's Drug Utilization Report states that Xanax was prescribed to treat his panic disorder, but the office notes do not document that Dr. Lundeen conducted any assessment of panic disorder or anxiety disorder. Dr. Cunningham opined that prescribing Xanax without documenting an assessment of the condition for which the drug was prescribed is below the standard of care. Further, he criticized that the progress notes say nothing about adding a new controlled substance for the patient. (Tr. at 315-317, 329-330)

December 2002 Letter Regarding Prescription Medication – Patient 2

110. In a December 12, 2002 letter regarding Patient 2's prescription medications, Dr. Lundeen stated:

> Topic: prescription medication
>
> * * *
>
> DIAGNOSES
> 836.1 TEAR LAT MENISC KNEE-CUR
> 717.40 DERANG LAT MENISCUS NOS[26]
> 300.02 GENERALIZED ANXIETY DIS
> 300.01 PANIC DISORDER
>
> EXAMINATIONS
>
> November 27, 2002
> **Subjective:** Since the patient's last visit, the patient's condition remains severe. Activities impaired include: balance, ambulation, weight bearing on legs, carrying, many adls are very limited. Pain is noted by patient in regions of knees, legs, hips, back. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects.
>
> **Objective:** Left knee movements are limited, painful and audible popping is noted. Cane for balance. Knee is unstable.
>
> **Assessment:** Based on the patient's examination findings, history of injury and present complaints, the medications will be continued. Consideration of relative costs of medications has been made in selecting medications for treatment of injuries sustained in this industrial claim.
>
> **Plan:** The patient has been advised that one or more of the RX medications are potentially addictive or habit-forming. The patient desires to continue the medication(s) in order to maximize therapeutic benefit. Every effort will be made to keep the quantities of such medications as low as possible. Employment status = none.

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[26] The abbreviation "NOS" in the ICD-9 medical codes means "Not Otherwise Specified." The abbreviation "NEC" means Not Elsewhere Classifiable." (E.g., American Medical Ass'n, "ICD-9 CM Official Coding Guidelines (2008 ed.), at <www.ama-assn.org/resources/doc/cpt/icd9cm_coding_guidelines_08_09_full.pdf>, accessed 11/1/11)

SUMMARY

As a result of the injuries sustained in this industrial accident and despite conservative treatment, [Patient 2] continues to have pain and symptoms in his left knee.

The medications prescribed:
Xanax is prescribed for anxiety.
Salflex is an NSAID.
Klonopin and Soma are prescribed for painful muscle spasms.
Lorcet is prescribed for moderate to severe pain.
Prilosec is prescribe for gastric upset which is an unfortunate, however common side effect of many medications including the Salflex.

Dr. Spreng performed a file review on October 24, 02 and indicates that [Patient 2] no longer requires medication. I do not agree with Dr. Spreng. Dr. Spreng has not examined [Patient 2]. Dr. Spreng has not participated in the ongoing care and treatment of [Patient 2] since 1995, while this examiner has had the distinct advantage of direct observation of the patient.

Based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it is my opinion, that: the prescribed medications provide adequate relief of painful symptoms and allow the patient to perform his daily living activities. Furthermore, I maintain that [Patient 2] medications are medically necessary, effective and safe for his use.

(St. Ex. 36-37, signatures omitted)

111. On February 21, 2007, Dr. Lundeen sent a letter to the BWC regarding Patient 2's prescription medications and listing further diagnoses:

Topic: prescription medications.

* * *

DIAGNOSES
836.1 TEAR LAT MENISC KNEE
717.40 DERANG LAT MENISCUS NOS
300.02 GENERALIZED ANXIETY DIS
300.01 PANIC DISORDER
300.4 NEUROTIC DEPRESSION

RECENT EXAMINATION
January 4, 2007

Subjective: Mansfield office. Since the last visit, the patient's condition continues without significant change. Pain level today = 7-8. Activities impaired include: left knee. Pain is noted by patient in regions of injury.

Objective: The left knee is examined today. Flexion is maximum at 90 degrees of angulation. Extension deficit (degrees) is 25.

Assessment: No change in medications prescribed.

Plan: The next scheduled appointment with this examiner is in 8 weeks.

SUMMARY

As a result of the injuries sustained in this industrial accident and despite conservative treatment, [Patient 2] continues to have pain and symptoms mainly in his left knee.

The medications prescribed:
Lorcet is prescribed for control of moderate to severe left knee pain.
Xanax is prescribed for control of anxiety.
Salflex is an NSAID.
Soma is prescribed for control of left leg spasms.
Prilosec is prescribed for control of gastric upset which is an unfortunate however common side effect of the Salflex and the Lorcet.

Medications from this physician include one or more narcotic medications. The treatment rationale for a mixture of such medications is to titrate symptom control optimally with the least amount of stronger medication in conjunction with medication(s) in milder class(es). The goal is to control symptoms efficiently and with the safest medications which are effective for this patient's symptoms.

Based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it is my opinion, that: the prescribed medications provide adequate relief of painful symptoms and allow the patient to perform his daily living activities.

Furthermore, I maintain that [Patient 2]'s medications are medically necessary, effective and safe for his use.

(St. Ex. 2 at 38-39; emphasis added)

112. The Drug Utilization Report for Patient 2 includes the following:

Rx Date	Diagnosis	Medication	Strength	Qty/Freq.	[Daily Dose]
1/21/97	Tear Lat Menisc Knee	Talacen[27]	"none"	1 q.i.d.	100mg/2600mg
1/21/97	Tear Lat Menisc Knee	Meclomen	50 mg	1 t.i.d.	
1/21/97	Tear Lat Menisc Knee	Prevacid	30 mg	1 a.m.	
		* * *			
7/16/99	Tear Lat Menisc Knee	Salflex	750 mg	1 t.i.d.	
7/16/99	Tear Lat Menisc Knee	Soma	350 mg	1 q.i.d.	
7/16/99	Tear Lat Menisc Knee	**Talwin NX**	"none"	1 q.i.d.	200 mg
7/16/99	Tear Lat Menisc Knee	Prilosec	20 mg	1 b.i.d.	
		* * *			
8/17/99	Tear Lat Menisc Knee	Prilosec	20 mg	1 b.i.d.	
8/17/99	Panic Disorder	Xanax	0.50 mg	1 t.i.d.	
8/17/99	Tear Lat Menisc Knee	Soma	350 mg	1 q.i.d.	
8/17/99	Tear Lat Menisc Knee	Salflex	750 mg	1 t.i.d.	
8/17/99	Tear Lat Menisc Knee	**Talwin NX**	"none"	1 q.i.d.	200 mg
		* * *			
1/09/04	Tear Lat Menisc Knee	Soma	350 mg	1 q.i.d.	
1/09/04	Tear Lat Menisc Knee	**Lorcet**	10/650mg	1 q.i.d.	40/2600 mg
1/09/04	Gener Anxiety Dis	**Xanax**	**1.00 mg**	1 q.i.d.	4.0 mg
1/09/04	Tear Lat Menisc Knee	Salflex	750 mg	1 t.i.d.	
1/09/04	Tear Lat Menisc Knee	Prilosec	20 mg	1 b.i.d.	
		* * *			
3/01/07	Gener Anxiety Dis	Xanax	1.00 mg	1 q.i.d.	4.0 mg
3/01/07	Tear Lat Menisc Knee	Salflex	750 mg	1 t.i.d.	
3/01/07	Tear Lat Menisc Knee	Prilosec	20 mg	1 b.i.d.	
3/01/07	Tear Lat Menisc Knee	Soma	350 mg	1 q.i.d.	1400 mg
3/01/07	Tear Lat Menisc Knee	**Magnacet**	10/400mg	1 h.s.	10/400 mg
3/01/07	TEAR LAT MENISC KNEE	**Lorcet**	10/650mg	1 five x day	50/3250
		* * *			
12/02/09	Tear Lat Menisc Knee	Prilosec	20 mg	1 b.i.d.	
12/02/09	Tear Lat Menisc Knee	Salflex	750 mg	1 t.i.d.	
12/02/09	Tear Lat Menisc Knee	Lorcet	10/650 mg	1 five x day	50/3250
12/02/09	Gener Anxiety Dis	Xanax	1.00 mg	1 q.i.d.	
12/02/09	Tear Lat Menisc Knee	Magnacet	10/400mg	1 h.s.	10/400 mg
12/02/09	Tear Lat Menisc Knee	Soma	350 mg	1 q.i.d.	1400 mg

[27]Talacen and Talwin NX are discussed above on page 17. Meclomen (meclofenamate) and Salflex (salsalate) are NSAIDs. Prevacid is used for stomach upset, a side effect of non-selective NSAIDS. (Tr. at 313; discussions at <www.rxlist.com>, and <www.ncbi. nlm.nih.gov/pubmedhealth> ; Cornell Medical College, "Guidelines," at <www.hss.edu/conditions_guidelines-reduce-side-effects-nsaids.asp>; and "NSAIDs and Stomach Irritation," at <www.nsaids.info/nsaids/nsaid-and-stomach-irritation>; accessed 11/14/11.

* * *

2/24/11	Tear Lat Menisc Knee	**Lorcet**	10/650 mg	1 five x day	50/3250 mg
2/24/11	Gener Anxiety Dis	**Xanax**	1.00 mg	1 q.i.d.	4.0 mg
2/24/11	Tear Lat Menisc Knee	Prilosec	20 mg	1 b.i.d.	
2/24/11	Tear Lat Menisc Knee	Soma	350 mg	1 q.i.d.	1400 mg
2/24/11	Tear Lat Menisc Knee	Salflex	750 mg	1 t.i.d.	
2/24/11	Tear Lat Menisc Knee	**Magnacet**	10/400mg	1 h.s.	10/400 mg

(St. Ex. 2 at 193-203)

Dr. Cunningham's Opinions – Patient 2

113. Dr. Cunningham opined that the combination of Lorcet 10/650 (five times per day) and Magnacet 10/400 (once per day) meant that the patient was getting very high doses of acetaminophen every day for many years. Dr. Cunningham stated that, although the daily dose of 3,650 milligrams was under the maximum recommended dose of 4,000 milligrams or 4 grams per day, there was a risk of liver or kidney damage due to the very high doses of acetaminophen for such a long period of time, and that Dr. Lundeen should have done a liver-function test and kidney-function test at some point. Dr. Cunningham stated that he saw no indication in the medical record that Dr. Lundeen had considered or ordered such tests. (Tr. at 325-327; see, also Tr. at 375, 497-498)

114. Dr. Cunningham further testified that the use of Soma, which relaxes the skeletal muscles, is appropriate for a short time following an injury or surgery, no longer than three months. He opined that Soma is for acute situations, not for chronic pain management. He stated that, when the knee pain comes from the joint, as here, a muscle relaxant is not effective in treating the pain. Dr. Cunningham noted that Dr. Lundeen had prescribed Soma starting in 1997 and continuing to February 2011, and he testified that the prescribing of Soma for Patient 2 did not comport with the standard of care for this patient's medical condition as stated in the patient's chart. (Tr. at 318-319, 323-324)

115. Dr. Cunningham also testified that there was insufficient documentation of the patient's allergies, and of basic information such as height, weight, and blood pressure, which he viewed as a violation of the standard of care. Dr. Cunningham opined that, when new medications are added, the physician should check the patient's chart regarding any allergies. He noted that Dr. Lundeen asked about allergies in the new-patient questionnaire, but did not add allergies to the electronic information so that it would print out in every progress note. In addition, Dr. Cunningham opined that, when a physician is seeing a patient over many years, the data regarding weight and height should be re-measured periodically. However, he declined to conclude that it was a violation of the standard of care to fail to obtain these measurements once per year, because it depends on what is being treated. (Tr. at 330-335)

116. In explaining what he had meant when he wrote in his report that Dr. Lundeen's physical examinations of the knee were incomplete, Dr. Cunningham testified that Dr. Lundeen did not describe whether there was effusion/swelling around the knee, did not discuss the presence or absence of crepitus, and did not have the patient do a knee flexion while lying down, which is more accurate than performing a seated flexion of the knee. (Tr. at 338-339)

117. Dr. Cunningham also opined that the changes in medications–from Talacen/Meclomen/ Prevacid in the beginning to Lorcet/Magnacet/Xanax/Soma/Salflex in 2011—was not explained by Dr. Lundeen's statements in the patient's medical records. Dr. Cunningham further opined that the increase in dosages over time was done without an adequate rationale in the patient's chart. (Tr. at 326-329)

118. However, the Hearing Examiner notes that Dr. Cunningham's testimony was based to some extent on his belief that the original three medications consisted merely of two anti-inflammatory medicines (Meclomen and Talacen) and a medicine for stomach upset (Prevacid). He testified that "Talacen is an anti-inflammatory." (Tr. at 313)[28]

119. In his written report, Dr. Cunningham opined that Dr. Lundeen had failed to meet the minimal standards of care with respect to his care of Patient 2. Dr. Cunningham further opined that Dr. Lundeen had failed to maintain minimal standards applicable to the selection and administration of drugs for Patient 2, and had failed to comply with the Board's rules regarding the treatment of intractable pain. He explained these opinions at length. (St. Ex. 30 at 26-29)

Dr. Lundeen's Written Defense – Patient 2

120. As noted above, Dr. Lundeen did not testify at the hearing. However, he provided a written defense regarding each of the patients at issue. With respect to Patient 2, Dr. Lundeen stated, among other things:

> * * * Patient 2 is now on SSD as well as BWC PTD [permanent total disability] for his allowed conditions, which include derangement and tears of his left knee, generalized anxiety disorder and panic disorder. He sustained injuries in June of 1992. Patient 2 became a treating patient in July of 1995. His initial medications Dr. Lundeen prescribed included Talacen, Meclomen and Prevacid. In August of 1999 Dr. Lundeen took over prescribing of Patient 2's psych medications, which

[28]However, it appears that Talacen is a Schedule IV (milder) narcotic, a combination of pentazocine and acetaminophen. See authorities cited above in the discussion of Schedule IV Medications, at page 18; see, also, Food & Drug Admin., "Talacen (Pentazocine Hydrochloride And Acetaminophen) Tablets," at <www.fda.gov/ Safety/MedWatch/SafetyInformation/ucm250245.htm>; "Pentazocine/acetaminophen–oral, Talacen," at <www.medicinenet. com/pentazocine acetaminophen-oral/article.htm>; accessed 11/6/11. Despite this apparent mistake, it may nonetheless be true that the changes in medication were substantial changes and increases that are not adequately explained in Dr. Lundeen's notes. The Board, with its collective medical expertise, may consider this question when making its determination.

at that time was Xanax 0.5 mg 3x day. Patient 2 had knee surgery with Dr. Gibson and then with Dr. Kay.

Patient 2's condition has deteriorated with time. Attempts were made through BWC, including common pleas court, to add his back and right knee conditions to his claim, to no avail. Ultimately SSD and BWC granted Patient 2 permanent total benefits despite the limited claim allowances. BWC has found as reasonably related to his allowances his current medications including Soma, Lorcet, Prilosec, Salflex, Xanax and Magnacet. He uses a walker for stability.

* * *

Dr. Lundeen's care of Patient 2 has been authorized by the Bureau of Worker's Compensation for each service, diagnosis, medication, and prescriptions provided.

Dr. Lundeen's work has been subject to prospective, concurrent and retrospective peer review by case managers, nursing managers, and physician and medical directors, including the medical policy review committees at the Bureau of Workers Compensation.

At all times Dr. Lundeen's care to Patient 2 was within or above the minimum standard of care; and, Dr. Lundeen's use of controlled substances for the management of chronic intractable pain were within the guidelines of the State Medical Board of Ohio, it's [sic] statutes and administrative rules.

(Resp. Ex. Z)

Patient 3

General Information

121. Patient 3, a male born in 1950, sustained an industrial injury in 2004. Dr. Lundeen's records indicate that Patient 3 first visited Dr. Lundeen on March 17, 2009. In a letter dated July 1, 2009, Dr. Lundeen indicated that his diagnosis, "aggravation of pre-existing sprain/strain at L4-5 with radiculitis, right," was the same as the allowed condition in the patient's workers' compensation claim. In that letter, Dr. Lundeen discussed an MRI report obtained by the patient's previous physician in 2008. (St. Ex. 3 at 6)

122. Medical records for Patient 3 were admitted as State's Exhibits 3 and 3A. Dr. Cunningham's initial written opinion is set forth at State's Exhibit 30 at pages 30 to 35, and his supplemental opinion is at State's Exhibit 30A, pages 3 to 4 and 14 to 15. Dr. Cunningham's testimony regarding this patient is in the hearing transcript including pages 340-354. Dr. Ross' opinion is set forth in Respondent's Exhibit A at pages 32 to 33, and Dr. Lundeen's written opinion is at Respondent's Exhibit Z at page 12.

March 2009 – Patient 3's First Visit

123. Dr. Lundeen's records show that he prescribed the following medications at the patient's first visit in March 2009:

Rx Date	Diagnosis	Medication	Strength	Qty/Freq.
3/17/09	Lumbar Disc Displacement	VicodinHP[29]	10/660 mg	1 q.i.d
3/17/09	Lumbar Disc Displacement	Duragesic	50 mcg/hr	1 every 3 days
3/17/09	Lumbar Disc Displacement	Valium	10 mg	1 b.i.d.
3/17/09	Lumbar Disc Displacement	Zanaflex	4 mg	1 t.i.d.
3/17/09	Lumbar Disc Displacement	Ambien	10 mg	1 h.s.

(St. Ex. 3 at 64)

124. In his notes on March 17, 2009, Dr. Lundeen stated as follows with regard to his examination of Patient 3 and the planned treatment:

> SUBJECTIVE: Since his last visit with his former POR, the patient's condition continues without significant change. Pain level today = 7 with medication. Activities impaired include: lower back, ED. Office: Springfield, Ohio. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: will return to full duty effective next Monday.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 40 degrees, SLR L 35 degrees, spasms present in lower back. Gait: a bit slow. Stronger lower extremity today: left leg mostly. Flexion 25 degrees, extension 5 degrees, right lateral flexion 20 degrees and left lateral flexion 20-25 degrees.
>
> ASSESSMENT: No major change in medications prescribed since last seen by his former POR.
>
> PLAN: The next scheduled appointment with this examiner is in 4 weeks. Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2 and one or more in group 3. The patient is to minimize use of such narcotic medication(s), to take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx narcotic medications. Patient understand [sic] potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency

[29] Dr. Cunningham testified that "HP" means "high potency." This dose contains 10 milligrams of hydrocodone to be taken four times per day. Zanaflex is a muscle relaxant and Ambien is a sleep medication. (Tr. at 343-344)

> or addiction will be made. A moderate degree of dependency is normal and should be anticipated with the usage of such narcotic medication(s). Beyond a normal reasonable degree of day to day dependency on such medications for ADL's, abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons. More than one type of narcotic medication is utilized to adjust the pain control to optimal effect and minimize the use of the stronger type from group 2. Requires medications. C9 for PT and 12 treatments.

(St. Ex. 3 at 19-20, signatures omitted)

Dr. Cunningham's Opinions Regarding the March 2009 Care – Patient 3

125. Dr. Cunningham opined that Dr. Lundeen's examination on March 17, 2009, was insufficient. He pointed to the lack of documentation that Dr. Lundeen checked the patient's reflexes and sensation. He noted the lack of discussion of the past medical history, medications prescribed by the prior physician, allergies, and other health problems if any. Dr. Cunningham opined that the examination did not comport with the standard of care for an initial visit. (Tr. at 344-346)

126. Dr. Cunningham further opined that the examination as documented did not justify all the prescriptions that were prescribed on March 17, 2009. The Valium was not supported by the documentation because it is an anti-anxiety agent and there was no report of an examination with regard to anxiety. The Ambien was acceptable. However, the muscle relaxant Zanaflex was not supported for the same reason that Dr. Cunningham had discussed with regard to the muscle relaxant Soma, that it was not an appropriate drug for chronic pain. (Tr. at 346-347)

December 2009 Visit – Patient 3

127. In December 2009, Dr. Lundeen added a prescription for Dilaudid, as shown in the Drug Utilization Report in the patient's electronic medical records:

Rx Date	Diagnosis	Drug	Strength	Qty/Freq.
11/25/09	Lumbar Disc Displacement	Valium	10 mg	1 b.i.d.
11/25/09	Lumbar Disc Displacement	Duragesic	50mcg/hr	1 every 3 days
11/25/09	Lumbar Disc Displacement	Ambien	10 mg	1 h.s.
11/25/09	Lumbar Disc Displacement	VicodinHP	10/660mg	1 q.i.d.
11/25/09	Lumbar Disc Displacement	Zanaflex	4 mg	1 t.i.d.

12/23/09	Lumbar Disc Displacement	Zanaflex	4 mg	1 t.i.d.
12/23/09	Lumb/Lumbosac Disc Degen	**Dilaudid**	4 mg	1 q.d.
12/23/09	Lumbar Disc Displacement	VicodinHP	10/660mg	1 q.i.d.
12/23/09	Lumbar Disc Displacement	Valium	10 mg	1 b.i.d.
12/23/09	Lumbar Disc Displacement	Ambien	10 mg	1 h.s.
12/23/09	Lumbar Disc Displacement	Duragesic	50mcg/hr	1 every 3 days

(St. Ex. 3 at 63-64)

128. According to Dr. Cunningham, Dr. Lundeen's office-visit notes for December 23, 2009, do not show any objective change in the patient's status to justify the addition of Dilaudid. He found that the following statement by Dr. Lundeen was insufficient: "Based on the patient's examination findings, history of injury, and present complaints, the medications will change to Dilaudid added to reduce pain." Dr. Cunningham stated that the notes for the November and December visits have almost identical language regarding the symptoms and clinical observations, with only a slight difference in the degree of straight-leg raising. Dr. Cunningham opined that Dr. Lundeen had failed to document an objective basis for increasing the narcotic dosage. (St. Ex. 3 at 39, Tr. at 348-350)

Patient 3: 2009 – 2011

129. From December 2009 through March 2011, Dr. Lundeen prescribed the same medications for Patient 3. (St. Ex. 3 at 64-66)

130. However, in April 2010, Dr. Lundeen began attributing the medications to an earlier injury that Patient 3 had sustained in 1983. Then, in September 2010, Dr. Lundeen again attributed all the prescriptions to treating the 2004 injury, until December 2010, when the medications were again said to be treating the 1983 injury. Finally, in 2011, all the prescriptions were said to be treating the 2004 injury. (St. Ex. 3 at 64-66)

131. With regard to the 1983 industrial injury, Dr. Lundeen set forth the following diagnoses in his progress notes for April 15, 2010: 722.10 lumbar disc displacement, 847.2 sprain lumbar region, 724.4 lumbosacral neuritis NOS, lumbar/lumbosacral disc degeneration, 353.8 nerve root/plexus disorder NEC, 738.4 acquired spondylolisthesis. (St. Ex. 3 at 11-12) Dr. Lundeen also stated with regard to the 1983 injury:

> April 15, 2010
> SUBJECTIVE: Since the last visit under claim 04-****** [number omitted], the patient's condition continues without significant change. Pain level today = 9. Activities impaired include: back, legs, balance. Office: PH. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or

intolerable side effects from medications. Employment status: none. SERS income.

OBJECTIVE: Seated straight leg raising, SLR, R 5 degrees, SLR L 5 degrees, spasms present in lower back. Gait: even. Flexion 30 degrees, extension 5 degrees, right lateral flexion 15 degrees and left lateral flexion 15 degrees.

ASSESSMENT: No major change in medications prescribed.

PLAN: The next scheduled appointment with this examiner is in 4 weeks. Random drugs tests approximately twice a year. [Omitted: narcotic use information] Not able to work due to his back injury conditions.

(St. Ex. 3 at 11-12, signatures omitted)

132. By October 2010, Dr. Lundeen's diagnoses with regard to the 2004 workers' compensation claim were as follows: 847.2 sprain lumbar region, 722.52 lumbar/lumbosacral disc degeneration, and 724.4 lumbosacral neuritis NOS. (St. Ex. 3 at 4, 9)

133. According to the Drug Utilization Report, the patient was given prescriptions on December 23, 2010, January 13, 2011, and January 29, 2011, which was more than every four weeks or every month:

Rx Date	End Date	Diagnosis	Drug	Strength	Qty/Freq.	#
12/23/10	1/18/11	Lumbar Disc Displacement	Zanaflex	4 mg	1 t.i.d.	78
12/23/10	1/18/11	Lumbar Disc Displacement	Ambien	10 mg	1 h.s.	26
12/23/10	1/18/11	Lumb/Lumbsac Disc Degen	Dilaudid	4 mg	1 q.d.	26
12/23/10	1/18/11	Lumbar Disc Displacement	Valium	10 mg	1 b.i.d.	52
12/23/10	1/22/11	Lumbar Disc Displacement	Duragesic	50mcg/hr	1 every 3 days	10
12/23/10	1/18/11	Lumbar Disc Displacement	VicodinHP	10/660mg	1 q.i.d.	104
1/13/11	2/12/11	Lumbar Disc Displacement	Duragesic	50mcg/hr	1 every 3 days	10
1/13/11	2/10/11	Lumbar Disc Displacement	Zanaflex	4 mg	1 t.i.d.	84
1/13/11	2/10/11	Lumbar Disc Displacement	Ambien	10 mg	1 h.s.	28
1/13/11	2/10/11	Lumbar Disc Displacement	VicodinHP	10/660mg	1 q.i.d.	112
1/13/11	2/10/11	Lumbar Disc Displacement	Valium	10 mg	1 b.i.d.	56
1/13/11	2/10/11	Lumb/Lumbosac Disc Degen	Dilaudid	4 mg	1 q.d.	28
1/29/11	2/26/11	Lumbar Disc Displacement	VicodinHP	10/660mg	1 q.i.d.	112
1/29/11	2/26/11	Lumbar Disc Displacement	Ambien	10 mg	1 h.s.	28
1/29/11	2/26/11	Lumbar Disc Displacement	Valium	10 mg	1 b.i.d.	56
1/29/11	2/26/11	Lumb/Lumbosac Disc Degen	Dilaudid	4 mg	1 q.d.	28
1/29/11	2/26/11	Lumbar Disc Displacement	Zanaflex	4 mg	1 t.i.d.	84
1/29/11	2/28/11	Lumbar Disc Displacement	Duragesic	50mcg/hr	1 every 3 days	10

(St. Ex. 3 at 66)

134. However, in his progress notes for those dates, Dr. Lundeen did not explain the reasons for the additional visits and the additional prescriptions:

> **December 23, 2010**
> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 9. Activities impaired include: back, legs, gait, balance. Office: SP. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. *The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective.* No adverse or intolerable side effects from medications. Employment status * * *.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 15 degrees, SLR L 10 degrees, severe and tense spasms present in lower back. Gait: antalgic. Flexion 30 degrees, extension 5 degrees, right lateral flexion 15 degrees and left lateral flexion 15 degrees.
>
> ASSESSMENT: No major change in medications prescribed.
>
> PLAN: *The next scheduled appointment with this examiner is in 4 weeks.* [Omitted: narcotic use information]
>
> * * *
>
> **January 13, 2011**
> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 10. Activities impaired include: back, legs, gait, balance. Office: SP. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. *The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective.* * * * .
>
> OBJECTIVE: Seated straight leg raising, SLR, R zero degrees, SLR L zero degrees, severe and tense spasms present in lower back. Gait: antalgic. Flexion 25 degrees, extension 5 degrees, right lateral flexion 10 degrees and left lateral flexion 10 degrees.
>
> ASSESSMENT: No major change in medications prescribed. Needs C84 completed.
>
> PLAN: *The next scheduled appointment with this examiner is in 4 weeks.* [Omitted: narcotic use information] Needs C84 completed.
>
> * * *

> **January 29, 2011**
> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 10. Activities impaired include: back, legs, gait, balance. Office: SP. Pain is noted by patient in regions of injury. * * * *The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective.* * * *.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 5 degrees, SLR L 5 degrees, severe spasms present in lower back. Gait: antalgic. Flexion 25 degrees, extension 5 degrees, right lateral flexion 10 degrees and left lateral flexion 10 degrees.
>
> ASSESSMENT: No major change in medications prescribed. C84 good through 3-10-11. Cane recommended.
>
> PLAN: The next scheduled appointment with this examiner is in 4 weeks. [Omitted: narcotic use information]

(St. Ex. 3 at 55-59, emphasis added)

135. In the Dump of Patient Data in Dr. Lundeen's electronic medical records, there are messages regarding a Functional Capacity Evaluation in May 2009. There are also messages in January and February 2011 regarding a neurosurgical consultation, followed by an entry noting that the consultant's report had been received, and reciting some of the findings. (St. Ex. 3 at 68, 74)

136. In a letter dated February 25, 2011, a physician assistant in the office of Dr. Robbins, the consulting neurosurgeon, provided a report of his physical examination of Patient 3. The report provides a detailed description of the patient's complaints and detailed findings regarding the physical examination, including the patient's heel-walking ability, toe-walking ability, gait, deep tendon reflexes, muscle strength, dorsiflexion of the foot, and a "positive result" on the straight-leg raising test on the right side at a certain angle. (St. Ex. 3 at 91)

Dr. Cunningham's Opinions – Patient 3

137. Dr. Cunningham opined that Dr. Lundeen's documentation did not justify the prescriptions he gave to Patient 3 from December 2009 through March 2011. (Tr. at 350)

138. Dr. Cunningham, in his written report, stated that the diagnostic tests ordered by Dr. Lundeen were appropriate, as were his diagnoses. However, Dr. Cunningham opined that the prescribing of narcotics was not appropriate:

> In my medical opinion, Dr. Lundeen does not justify the increasing total narcotic analgesic dosage, starting out with a Duragesic patch and then having Vicodin HP added to it on the second office visit, which then continued. In my medical opinion, Dr. Lundeen does not support this rather potent level of narcotic administration on the basis of this individual's chronic low back pain who, in fact,

> early in the treatment of Dr. Lundeen was working full time, from my interpretation of these records.

(St. Ex. 30 at 33) In addition, Dr. Cunningham found that the physical examinations were not appropriate:

> At no time between 03/17/09 and 03/29/11 were the physical examination findings described by Dr. Lundeen appropriate and/or comprehensive, on an objective medical basis in regards to this individual's low back and lower extremity complaints, for which this individual was being exclusively treated by Dr. Lundeen, from my interpretation of these records. One needs only to compare the physical exam findings reported by Dr. Robbins' office with the records of Dr. Lundeen.

(St. Ex. 30 at 32) Further, Dr. Cunningham stated that the documentation was insufficient, as the patient's records included "No height, weight, blood pressure, list of medication allergies, or past medical history are contained within these records." (St. Ex. 30 at 34)

139. In his initial report, Dr. Cunningham had faulted Dr. Lundeen for not having a pain contract with the patient. However, upon being provided with additional medical records, Dr. Cunningham advised that there was a copy of Patient 3's pain contract in Dr. Lundeen's records. In addition, Dr. Cunningham noted other records, such as the new-patient questionnaire with list of allergies (showing none) and a list of current medications, and medical records from the prior treating physician, including multiple imaging reports. (St. Ex. 30A at 3-4)

140. Dr. Cunningham also opined:

> Unfortunately, Dr. Lundeen's treatment and care constituted multiple significant departures or failure from conformity to minimal standards of care of similar practitioners under the same circumstances. The medications have been extensively discussed above. The narcotic medications, in this reviewer's opinion, are not supported on the basis of Dr. Lundeen's documentation. There is no evidence of any objective change in medical status in regards to this individual's low back and lower extremity symptoms during the approximate two years that Dr. Lundeen treated this individual. * * *
>
> * * *
>
> Unfortunately, Dr. Lundeen failed to maintain the minimal standards applicable to the selection and administration of drugs. There is no objective evidence that this individual's medical status in regards to his low back and lower extremities has changed in any way during the approximate two year period that Dr. Lundeen was treating this individual. * * * There is no documentation in Dr. Lundeen's notes that there is any objective change in this individual's

> medical status, other than the fact that he was requiring more analgesic medication.

(St. Ex. 30 at 34)

Dr. Lundeen's Written Defense – Patient 3

141. With regard to Patient 3, Dr. Lundeen's written defense includes the following:

> Patient 3's current medication profile includes: Dilaudid 4 mg 1x daily for pain; Valium 10 mg 2x daily for leg muscle spasms; Vicodin 10 mg 4x daily for pain; Zanaflex 4 mg 3x daily for leg and back muscle spasms and Duragesic 50 mcg/hr. His current medications are a good reflection of the initial medications Dr. Lundeen began and are below the stronger medications he took from his prior physician.
>
> * * *
>
> Dr. Lundeen's care of Patient 3 has been authorized by the Bureau of Worker's Compensation for each service, diagnosis, medication, and prescriptions provided.
>
> Dr. Lundeen's work has been subject to prospective, concurrent and retrospective peer review by case managers, nursing managers, and physician and medical directors, including the medical policy review committees at the Bureau of Workers Compensation.

(Resp. Ex. Z)

Patient 4

General Information – Patient 4

142. According to Dr. Lundeen, Patient 4, a male born in 1935, began seeing Dr. Lundeen when Dr. M. Hajjar abruptly terminated his medical practice. Dr. Lundeen noted that there were no medical records from Dr. Hajjar. Patient 4 was a Medicare patient, not being seen for an industrial injury, and he first visited Dr. Lundeen on June 4, 2009. (St. Ex. 4 at 42, 47; St. Ex. 4a at 37, 87)

143. Medical records for Patient 4 were admitted as State's Exhibits 4 and 4A. Dr. Cunningham's initial written opinion is set forth in State's Exhibit 30 at pages 36 to 42, and his supplemental opinion is set forth in State's Exhibit 30A, pages 4 to 5 and 14 to 15. Dr. Cunningham's testimony regarding this patient's care is found in the hearing transcript at pages including 355 to 369. Dr. Ross' opinion is set forth at Respondent's Exhibit A, page 33, and Dr. Lundeen's written opinion is at Respondent's Exhibit Z, pages 12 to 13.

June 2009 – Patient 4's First Visit

144. Dr. Lundeen stated as follows regarding Patient 4's visit on June 4, 2009:

DIAGNOSIS:

428.0 CONGESTIVE HEART FAILURE
272.0 PURE HYPERCHOLESTEROLEM[IA]
401.9 HYPERTENSION NOS
823.82 FX TIBIA W FIBULA NOS-CL[OSED]
041.1 STAPH INFECTION NOS
427.31 ATRIAL FIBRILLATION
717.7 CHONDROMALACIA PATELLAE
347 CATAPLEXY AND NARCOLEPSY

June 4, 2009
SUBJECTIVE: Pain level today = 9 for knees and leg. Activities impaired include: gait, stance. Office: West Union, Ohio (WU). Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Has hypertension, elevated cholesterol, prior right tib fib fx with chronic staph aureus infection, atrial fibrillation, congestive heart failure secondary to atrial fibrillation, insomnia and more. Demerol makes him feel "goofy". NKDA [no known drug allergy]. Right handed.

OBJECTIVE: Takes Coumadin for chronic treatment. No pitting edema, well controlled CHF [congestive heart failure] and afib. Gait is very painful and balance is not good.

ASSESSMENT: Medication selection: here today to get established as a new patient and to get Rx written. Chart reviewed today with patient. Wears an uniboot.

PLAN: The next scheduled appointment with this examiner is in 4 weeks. Medications from this physician include more than one scheduled narcotic medications in the strong DEA classification group 2. Patient to minimize use of such narcotic medication(s), to take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx narcotic medications. Patient understand [sic] potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency or addiction will be made. A moderate degree of dependency is normal and should be anticipated with the usage of such narcotic medication(s). Beyond a normal reasonable degree of day to day

> dependency on such medications for ADL's, abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons. Use of multiple medications due to severity of symptoms and difficulty with dose titration with single drug from this category. *CII medications modified, as this physician does not write for Oxycontin.*[30]

(St. Ex. 4 at 2-3; signatures omitted, emphasis added)

145. According to the patient's Drug Utilization Report, Dr. Lundeen prescribed the following drugs at the patient's first visit in June 2009:

Date	Diagnosis	Drug	Strength	Qty/Freq.
6/04/09	Fx tibia w fibula	**Percocet**	**10/325 mg**	**2 q.i.d.**
6/04/09	Fx tibia w fibula	**Dilaudid**	**8 mg**	**1 every 6 hrs**
6/04/09	Fx tibia w fibula	**OxyIR**	**5 mg**	**1 every 4 hrs**
6/04/09	Pure hypercholesterolem	Lipitor	20 mg	1 h.s.
6/04/09	Atrial fibrillation	Coreg	25 mg	1 b.i.d.
6/04/09	Hypertension	Vasotec	10 mg	1 b.i.d.
6/04/09	Fx tibia w fibula	Dalmane	30 mg	1 h.s.
6/04/09	Atrial fibrillation	Lanoxin	0.25 mg	1 a.m.

(St. Ex. 4 at 42, emphasis added)

Final Visit in November 2010 – Patient 4

146. The Drug Utilization Report for Patient 4 shows that Dr. Lundeen prescribed the following drugs at the patient's last visit in November 2010:

Date	Diagnosis	Drug	Strength	Freq.
11/23/10	Fx tibia w fibula	Coumadin	3 mg	1 a.m.
11/23/10	Fx tibia w fibula	**OxyIR**	**5 mg**	**1 every 4 hrs**
11/23/10	Fx tibia w fibula	**Klonopin**	**2.00 mg**	**1 h.s.**
11/23/10	Fx tibia w fibula	**Percocet**	**10/325 mg**	**2 q.i.d.**
11/23/10	Chondromalacia patellae	**Dilaudid**	**8 mg**	**1 five times daily**
11/23/10	Fx tibia w fibula	Dalmane	30 mg	1 h.s.
11/23/10	Cataplexy and narcolepsy	Zoloft	50 mg	1 b.i.d.

[30]Although Dr. Lundeen insisted that he did not prescribe Oxycontin, Oxycontin is simply a brand name for oxycodone, which he frequently prescribed. For example, OxyIR is an immediate-release form of oxycodone, and Patient 4 was prescribed 5 milligrams to be taken every four hours. In addition, Percocet and Magnacet contain oxycodone. Patient 4's dose of oxycodone in this Percocet prescription was 10 mg per tablet, and he was directed to take two tablets at a frequency of four times per day, which is 80 mg of oxycodone per day. Further, Dr. Lundeen eventually prescribed 8 mg of Dilaudid five times per day, and Dilaudid (hydromorphone) is more than twice as potent as oxycodone. (St. Ex. 4 at 42-46; St. Ex. 45; Tr. at 366-367)

11/23/10	Congestive heart failure	Provigil[31]	200 mg	1 a.m.
11/23/10	Congestive heart failure	Lanoxin	0.125 mg	1 a.m.
11/23/10	Congestive heart failure	Pepcid	20 mg	1 b.i.d.
11/23/10	Pure hypercholesterolem	Zocor	20 mg	1 a.m.
11/23/10	Hypertension	Coreg	25 mg	1 b.i.d.
11/23/10	Hypertension	Vasotec	10 mg	1 b.i.d.

(St. Ex. 4 at 45-46, emphasis added)

Dr. Cunningham's Opinions – Patient 4

147. Dr. Cunningham noted that the patient had very serious, life-threatening conditions. He explained that Coumidin is an anticoagulant, a blood thinner, and that Coreg and Vasotec are for hypertension, which is high blood pressure. Lanoxin is digitalis for the heart, and Lipitor treats cholesterolemia, which is high cholesterol. Dr. Cunningham stated that Dalmane is a sleep aid. (Tr. at 357-361, 367)

148. Dr. Cunningham opined that the examination as documented during the patient's first visit was insufficient for the diagnoses listed. He noted that Dr. Lundeen did not report that he listened to the patient's heart and lungs, or listened in the neck for bruits with regard to hardening of the carotid arteries. Further, Dr. Lundeen did not discuss the narcolepsy diagnosis. (Tr. at 362-364; Ex. 30 at 38-40, 30A)

149. Dr. Cunningham opined that, given the diagnoses relating to the heart, the physician at a minimum should check the patient's blood pressure, pulse, and weight, and check for edema and listen to the heart and lungs at every visit. He found only one time when the pulse had been recorded and one blood pressure. (Tr. at 362-363; St. Exs. 30 at 37-38, 30A)

150. Dr. Cunningham also noted that there was no physical examination regarding the chondromalacia or fracture, except to note that gait was painful and balance was not good. (Tr. at 366)

151. Dr. Cunningham opined that the medication dosages were not justified by the medical records for Patient 4. He noted that the patient was receiving three narcotic drugs: Oxy IR, Dilaudid, and Percocet, and that the combination of these drugs, and the strengths of the drugs, were not supported by the office-visit charts that Dr. Lundeen had written. (Tr. at 367)

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[31] Coumidin, which is warfarin, reduces blood-clotting and is used for certain types of heart conditions, and Provigil is a stimulant used to treat symptoms of narcolepsy. Accordingly, the drugs and diagnoses appear to be mismatched in Dr. Lundeen's drug list for Patient 4. (Tr. at 359; St. Ex. 30 at 36-42; see, also, "Provigil" at <www.provigilweb.org>; "Warfarin," at <www.ncbi.nlm.nih. gov/pubmedhealth/PMH0000634>; accessed 10/21/11.)

152. In addition, Dr. Cunningham noted that Dr. Lundeen had not stated when the fracture had occurred, and yet he was still prescribing narcotics for the fracture in November 2010, about 18 months after the patient's first visit. Dr. Cunningham acknowledged that, even though most fractures of the lower leg heal in six to eight weeks, chronic pain could continue past that time. However, Dr. Cunningham opined that Dr. Lundeen, in his office-visit notes, failed to state enough information to support the level of potent narcotics. Dr. Cunningham opined that the standard of care required that Dr. Lundeen document the information that supported the use of these Schedule II narcotics for Patient 4. (Tr. at 366-369)

153. Dr. Cunningham stated that narcolepsy and cataplexy are essentially similar to sleep apnea, and he disagreed with Dr. Lundeen's treatment. (Tr. at 359; St. Ex. 30 at 38-42)

Additional Opinions in Dr. Cunningham's Written Report – Patient 4

154. Dr. Cunningham stated that the lack of monitoring the patient's weight and blood pressure was shown throughout the patient's records, and that the presence or absence of edema was mentioned in only the first two office visits. (St. Ex. 30 at 39-42)

155. In addition to concluding that Dr. Lundeen's examinations were insufficient as documented, Dr. Cunningham concluded that "Dr. Lundeen failed to maintain the minimal standards applicable to the selection and administration of drugs" with regard to the narcotics that Dr. Lundeen prescribed for the patient's knee and leg conditions. (St. Ex. 30 at 42)

156. In his initial report, Dr. Cunningham had criticized the lack of blood tests to monitor Patient 4's use of Coumidin, an anticoagulant. He explained that the physician must make sure that the drug level is not too high or low by ordering INR tests.[32] However, upon reviewing the additional medical records that were later provided to him, Dr. Cunningham noted that Dr. Lundeen had ordered blood tests and that there were lab results on file. In addition, he noted that there had been a cardiology consultation in November 2009 at Dr. Lundeen's request. Further, Dr. Cunningham noted the presence of a drug contract in the patient's file. (St. Ex. 30 at 39; St. Ex. 30A at 4-5)

157. Nonetheless, in his supplemental report following his review of the additional patient records, Dr. Cunningham stated that nothing in the additional medical records altered his opinion that Dr. Lundeen's care of Patient 4 failed to constitute reasonable and appropriate of the patient's pain and failed to meet the minimal standards applicable to the selection or administration of drugs. (St. Ex. 30A at 15)

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[32] The blood-clotting test for patients taking warfarin (Coumidin) has several names, including Protime, Prothrombin time, PT, and INR (international normalized ratio). See St. Ex. 4A at 79, 84; see, also, Mayo Clinic, "Prothrombin Time Test," at <www.mayo clinic.com/health/prothrombin-time/MY00150>; "PT/INR Test," at <www.ptinr.com>; accessed 10/20/11.

Dr. Lundeen's Written Defense – Patient 4

158. With regard to Patient 4, Dr. Lundeen's written defense includes the following:

> * * * Dr. Lundeen continued Patient 4's prior medications but would not write for Oxycontin and changed Patient 4's pain medications. Patient 4 was thoroughly worked up by Dr. Lundeen's former physician assistant in 2009 and has been followed monthly through November 2010 when last seen. To Dr. Lundeen's knowledge, Dr. Lundeen's care has been charity care. Patient 4 monitored his blood pressure at home and reviewed same with Dr. Lundeen or the physician assistant at office visits. Patient 4's INR's were ordered monthly as evidenced in the EMR memo section where an order for 6-months is noted; other orders are in his chart.

(Resp. Ex. Z at 12-13)

Patient 5

General Information

159. Patient 5, a male born in 1953, suffered serious injuries in 2000. He first visited Dr. Lundeen in July 2010. The diagnosis by Dr. Lundeen was "926.8 Multiple crushing injuries, trunk." (Tr. at 370-371; St. Ex. 5 at 2)

160. Medical records for Patient 5 were admitted as State's Exhibits 5 and 5A. Dr. Cunningham's initial written opinion is set forth in State's Exhibit 30 at pages 43 to 46, and his supplemental report is set forth at State's Exhibit 30A at pages 5 and 14-15. Dr. Cunningham's testimony regarding this patient is found in the hearing transcript at pages including 369 to 376. Dr. Ross' opinion is set forth in Respondent's Exhibit A, page 34, and Dr. Lundeen's written opinion is set forth in Respondent's Exhibit Z, pages 13 to14.

First Visit

161. The patient's file includes new-patient forms dated in June and July 2010. These forms include information regarding the patient's list of current medications (including Oxycontin 30mg, 6 times per day), a list of treating physicians and prior imaging studies, and previous treatments including physical therapy, needle therapy, a special bed, a TENS unit, and "killing nerve ends." There is a drug contract signed July 9, 2010. In addition, the patient's records include prior physician's notes and lab results, starting in 2006 and continuing into 2010. (St. Exs. 5, 5A)

162. Dr. Lundeen made the following notes regarding Patient 5's first visit on July 27, 2010:

> SUBJECTIVE: This patient is new to this Marion medical practice.
> Employment status: not employed. Patient sustained injuries while working

> [for a railroad]. When patient was struck * * *, he was dragged down the track, he was DOA at the hospital, and revived twice after. Patient suffered Lumbo Sacral Thoracic Radiculitis, Lumbosacral Disc Degeneration, Abdominal Flank Pain, Lumbar Spondylosis, Vertebral Collapse, Sprain of Neck, Sprain Thoracic, Osteoarthritis; knee, and Depression. Descriptions of neck and back pain as Sharp, stabbing, burning, unbearable pain. Surgeries: 2 abdominal hernias, 2 right shoulder, L ankle reconstruction, 1 right elbow reconstruction, crushed vertebrae and disc in neck, thoracic, and lower back. Medical records available on this date. A pain history booklet has been completed and reviewed by this physician today. Pain level: 7 today, sometimes pain level as high as 9-10 (10 most severe). Regions of pain: Neck, Right Shoulder, Back, Legs. Also noted: Gerd, Hepatitis C, Arthritis, High Blood Pressure, Post Traumatic Stress Disorder, past renal failure, and multiple falls from tripping. This patient is not receiving controlled or narcotic medication from any physician outside of this medical practice at this time. [33]
>
> OBJECTIVE: Seated straight leg raising, SLR, R 25 degrees, SLR L 25 degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: even, nearly. Stronger lower extremity right. The right shoulder is examined today. Flexion is 125 degrees, extension is 45 degrees, abduction is 90 degrees, adduction is 50 degrees, internal rotation with the elbow abducted at or near shoulder level is 90 degrees, external rotation with the elbow abducted at or near shoulder level is 10 degrees.
>
> ASSESSMENT: Based on the patient's examination findings, history of injury, and present complaints the medications selected will be as follow: Exalgo, Percocet, 10/325, and Soma 350 mg. Addendum: Exalgo cancelled due to price.
>
> PLAN: The next scheduled appointment with this examiner is in 4 weeks. [Omitted: narcotic use information] More than one type of narcotic medication is utilized to adjust the pain control to optimal effect and minimize the use of the stronger type from group 2.

(St. Ex. 5 at 2-3, signatures omitted)

Dr. Cunningham's Opinion Regarding the First Visit – Patient 5

163. Dr. Cunningham testified that the physical examination as documented was more of an examination than Dr. Lundeen usually reports, but was still lacking in important elements. He stated that there was no mention of the range of motion for the neck or back, and no mention of reflexes or a sensory examination. There was no discussion of the lower limbs

[33] GERD refers to gastroesophageal reflux disease.

other than the SLR, no measurement regarding atrophy, and no statement of height and weight. There was no discussion of imaging or testing. Dr. Cunningham stated that, due to the extensive nature of the injuries, Dr. Lundeen really needed to do a complete physical examination. (Tr. at 372)

Further Prescribing for Patient 5

164. In August 2010, Patient 5 was seen again. Dr. Lundeen set forth the following notes regarding the visit:

> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 8. Activities impaired include: trunk, shoulder, back, pelvis, legs. Office: MR. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications.
>
> OBJECTIVE: The right shoulder is examined today. Flexion is 120 degrees, extension is 45 degrees, abduction is 90 degrees, adduction is 55 degrees, internal rotation with the elbow abducted at or near shoulder level is 90 degrees, external rotation with the elbow abducted at or near shoulder level is 15 degrees.
>
> ASSESSMENT: No major change in medications prescribed.
>
> PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2. * * * Recheck in 4 weeks.

(St. Ex. 5 at 4, signatures omitted)

165. The patient's Drug Utilization Report shows that Dr. Lundeen substituted Dilaudid for Exalgo, both of which are opioid drugs (hydromorphone). (St. Ex. 5 at 6)

Date	Drug	Strength	Freq.	Daily Dose
7/27/10	Exalgo	8 mg	1 t.i.d.	24 mg hydromorphone
7/27/10	Soma	350 mg	1 q.i.d.	1,400 mg
7/27/10	Percocet	10/325 mg	3 q.i.d.	120 mg oxycodone/3,900 mg acetaminophen
8/24/10	Percocet	10/325 mg	3 q.i.d.	120 mg oxycodone/3,900 mg acetaminophen
8/24/10	Soma	350 mg	1 q.i.d.	1,400 mg
8/24/10	Dilaudid	8 mg	1 t.i.d.	24 mg hydromorphone

(St. Ex. 5 at 6)

166. The August 2010 prescriptions continued through December 2010. (St. Ex. 5 at 6)

167. The Drug Utilization Report and an electronic list of appointments indicates that the patient ceased seeing Dr. Lundeen after the December 2010 visit. The electronic medical records include no progress notes after September 2010. (St. Ex. 5)

168. However, Dr. Lundeen's files for Patient 5 include March 2011 questionnaires regarding health history, medications, pain assessment, etc., and there is also a second signed drug contract. However, evidence presented at the hearing demonstrated that these March 2011 documents in Patient 5's file were for a different patient with the same name as Patient 5. In fact, Patient 5 had died by January 31, 2011, the date of a coroner's report stating that the cause of death was hypertensive cardiovascular disease. (St. Ex. 5 at 16-30, Resp. Ex. O)

Dr. Cunningham's Opinion Regarding the Patient's Medications – Patient 5

169. Dr. Cunningham opined that the prescription for Soma was not appropriate for the 2000 injury, because, as he had previously discussed, that muscle relaxant is for the acute stage lasting no more than three months after the most recent injury or surgery. (Tr. at 374)

170. In addition, Dr. Cunningham testified that the total dose of acetaminophen for Patient 5 was close to the maximum recommended daily dose. Dr. Cunningham stated that, due to the high amount of acetaminophen from July through December 2010, Dr. Lundeen should have ordered liver-function tests every three to six months after starting the patient on the level of Percocet. He testified that there is no indication that Dr. Lundeen ordered such testing. (Tr. at 374-376, see, also, Tr. at 375, 497-498)

171. Further, although Dr. Cunningham acknowledged that Patient 5 had been hurt "pretty much everywhere" in the 2000 accident and was "lucky to be alive," he nevertheless testified that Dr. Lundeen had not provided sufficient information or explanations to support the use of the potent narcotics he had prescribed to Patient 4. (Tr. at 371; St. Ex. 30 at 40-41)

172. Dr. Cunningham opined that Dr. Lundeen's treatment and care of Patient 5 departed from or failed to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. He stated, among other things:

> Clearly, this individual required a musculoskeletal exam of the neck, upper back, low back, and all four extremities, which was not contained in Dr. Lundeen's records. There were no objective findings within these records, such as height, weight, reflexes present or absent, sensation, ability to stand or sit, or sit and lie, or walk on toes or heels, reach above head, etc. Dr. Lundeen did not justify the use of two potent narcotic analgesics simultaneously beginning with the first visit in his records, and the use of Soma skeletal muscle relaxant was not supported as being reasonably related to this individual's medical management beginning with Dr. Lundeen's initial evaluation of this individual.

(St. Ex. 30 at 45)

173. Dr. Cunningham further opined that "Dr. Lundeen failed to maintain the minimal standards applicable to the selection and administration of drugs," in that the Soma skeletal muscle relaxant was inappropriate and that Dr. Lundeen did not set forth a justification for two potent narcotic analgesics to be provided simultaneously to Patient 5. (St. Ex. 30 at 45)

Dr. Lundeen's Written Defense – Patient 5

174. Dr. Lundeen's written defense includes the following:

> [Patient 5] has a complex medical history well documented in his chart and his initial note. Patient 5 was lasted examined on December 14, 2010. Dr. Lundeen's office learned that Patient 5 passed away on December 30, 2010 with a call from a relative of his on January 6, 2011. Patient 5 did complete detailed forms and pain contract prior to his initial July 2010 visit.
>
> [Omitted: Information about the other patient with the same name as Patient 5, but who was shown to be a different individual.]
>
> * * *
>
> Dr. Lundeen's care of Patient 5 has been authorized by the Bureau of Worker's Compensation for each service, diagnosis, medication, and prescriptions provided. Dr. Lundeen's work has been subject to prospective, concurrent and retrospective peer review by case managers, nursing managers, and physician and medical directors, including the medical policy review committees at the Bureau of Workers Compensation.

(Resp. Ex. Z at 6 at 13-14)

Patient 6

General Information

175. Patient 6, born in 1973, sustained an industrial injury in 2000. Dr. Lundeen's records indicate that Patient 6 first visited the practice in November 2003. The diagnoses stated by Dr. Lundeen, which were the same as the allowed conditions in Patient 6's workers' compensation claim, were "847.2 sprained lumbar region" and "722.10 lumbar disc displacement" with respect to two levels. (St. Ex. 6 at 5, 11-172)

176. Medical records for Patient 6 were admitted as State's Exhibits 6 and 6A. Dr. Cunningham's initial written opinion is set forth at State's Exhibit 30, pages 47 to 56, and his supplemental opinion is set forth at State's Exhibit 30A, pages 5 to 6 and 14 to 15. Dr. Cunningham's testimony regarding this patient is found in the transcript at pages including pages 377 to 386. Dr. Ross' opinion is set forth at Respondent's Exhibit A at page 34, and Dr. Lundeen's written opinion is set forth at Respondent's Exhibit Z at page 14.

2004 Report Letter – Patient 6

177. In February 2004, Dr. Lundeen provided an opinion letter regarding Patient 6's temporary total disability, including the following:

> HISTORY OF INJURY
> [Patient 6] is a 30 year old male who presented himself to this office for expert medical care and advice for injuries he received [in] 2000. At that time he was lifting * * * and felt a pop in his lower back and had shooting pain.
>
> EXAMINATIONS
>
> November 19, 2003
> **Subjective:** This patient is new to this medical practice. He sustained injuries to his back at work. Same employer, prior injury with surgery. Medical records only partially available on this date. A pain history booklet has been completed and reviewed by this physician today. This patient begin imipramine to improve or control: bladder urgency, depression, sleep deprivation and pain. Not working and not able to work due to his back. Needs a new MRI.
>
> **Objective:** Seated straight leg raising, SLR, R 20 degrees, SLR L 45 degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: slow due to back and bilateral leg muscle atrophy. Motor function of R leg is grade 3+ out of 5 in L4, grade 3+ out of 5 in L5 and grade 3 out of 5 in S1. Motor function of the L leg is grade 4 out of 5 in L4, grade 4 out of 5 in L5 and grade 3+ out of 5 in S1. Flexion 35 degrees, extension 15 degrees, right lateral flexion 15 degrees and left lateral flexion 15 degrees.
>
> **Assessment:** Based on the patient's examination findings, history of injury and present complaints, the medications will be Lorcet for disc pain, Flexeril for spasms, Restoril for sleep, Tofranil for bladder urgency mainly -- due to HNP of lumbar spine. Based on the patient's examination, I have recommended testing to include a new MRI of the lumbar spine, with and without gadolineum, to assess his discs and nerve roots. NKDA. [No Known Drug Allergies]
>
> **Plan:** The patient has been advised that one or more of the RX medications are potentially addictive or habit-forming. The patient desires to continue the medication(s) in order to maximize therapeutic benefit. Every effort will be made to keep the quantities of such medications as low as possible. Employment status = none. Last worked 2/9/2000. Tests ordered or pending today = C9 for new lumbar MRI. Recheck in 4 weeks.

December 19, 2003
Subjective: Since the patient's last visit, the patient's condition continues. Activities impaired include: back, legs, bladder & bowel -- some sudden loss of bladder control. Pain is noted by patient in regions of back, legs, rectum. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include frequent severe rectum spasms. The patient has returned today to review test results of MRI: L4-5 and L5-S1 DDD [degenerative disk disease] and protruding/HNP [protruding/herniated nucleus pulposus] at both levels.[34]

Objective: Seated straight leg raising, SLR, R 10 degrees, SLR L 30 degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: slow.

Assessment: Based on the patient's examination findings, history of injury and present complaints, the medications will be supplemented with Klonopin to control leg spasms and severe rectal spasms.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. Employment status = TT. Other request made or pending today = C9 for PT 3x week for 12 weeks. Recheck in 4-8 weeks.

February 13, 2004
Subjective: Since the patient's last visit, the patient's condition continues. Activities impaired include: back, legs, bladder & bowel control, erections. Pain is noted by patient in regions of back, legs. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects.

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[34] In his report regarding Patient 6 (St. Ex. 30 at 48), Dr. Cunningham commented with regard to this MRI:

> Dr. Lundeen asked for a repeat low back MRI to be performed on his initial evaluation of this individual, and Dr. Lundeen described the MRI as showing an L4-5 and L5-S1 DDD and protruding/HNP at both levels. However, the radiologist's MRI report is not contained within the file, but the report was stated to show "Stable examination when compared to April 5, 2002. Disc desiccation is again noted at L4-5 and L5-S1. Again, there is evidence of right-sided laminectomy at L4-5. However, no recurrent disc herniation is noted. There is mild disc bulging noted without central canal or neuroforaminal stenosis. There is central canal protrusion at L4-5 without canal or foraminal stenosis. The appearance is stable. The conus medullaris is normal."

(See St. Ex. 6A at 269)

Objective: Seated straight leg raising, SLR, R 15 degrees, SLR L 40 degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: list to left. Station (balance): right foot drags partially. Stronger lower extremity left. Motor function of R leg is grade 3 out of 5 in L4, grade 3 out of 5 in L5 and grade 3 out of 5 in S1. Motor function of the L leg is grade 4 out of 5 in L4, grade 4 out of 5 in L5 and grade 4- out of 5 in S1.

Assessment: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued to treat his symptoms.

Plan: Employment status = TT. Recheck in 8 weeks. * * *

SUMMARY
[Patient 6] has a long-standing history of low back pain. He had a laminectomy in 1997. He re-injured his lower back on February 19, 2000 while he was lifting * * * and felt a pop in his lower back and had shooting pain. He switched physician of record to this medical practice and was first seen by this physician on November 19, 2003. Based on the patient's examination findings, history of injury and present complaints I recommended testing to include a new MRI of the lumbar spine, with and without gadolinium [sic], to assess his discs and nerve roots. The MRI did not reveal any new or changed circumstances. Therefore a request for physical therapy evaluation and treatment was submitted and approved. The goals of therapy were to help decrease pain, increase range of motion for functional activities, improve gait and increase sitting and standing duration.

[Patient 6] attended 9 visits between 1-8-04 and 2-9-04, he was compliant with all aspects of his approved treatment and did make some progress with range of motion, gait and overall a decrease in his pain levels. At this point, I would recommend continued physical therapy to be incorporated with a vocational rehabilitation program with the focus on returning to employment.

It is doubtful that [Patient 6] will be unable [sic] to return to his former position of employment and therefore vocational rehabilitation program would be beneficial. However, it is also my opinion that additional physical therapy incorporated into the vocational rehab will be necessary to continue his progress.

(St. Ex. 6 at 5-8)

178. Messages in the computer system indicate that Patient 6 completed four weeks of physical therapy in February 2004. In addition, it appears that Dr. Lundeen submitted a request for vocational rehabilitation for Patient 6 in March 2004, but the request was denied. (St. Ex. 6A at 85, 91, 99, 107-109, 115, 185; St. Ex. 6 at 209-212, 247)

179. Dr. Lundeen prescribed the following medications to Patient 6 at the first three visits:

Rx Date	Diagnosis	Medication	Strength	Qty/Freq.
11/19/03	Lumbar Disc Displacement	Lorcet	10/650 mg	1 5 x day
11/19/03	Lumbar Disc Displacement	Restoril35	7.5 mg	1 h.s.
11/19/03	Lumbar Disc Displacement	Tofranil	25 mg	1 b.i.d.
11/19/03	Lumbar Disc Displacement	Flexeril	10 mg	1 q.i.d.
12/19/03	Lumbar Disc Displacement	Tofranil-PM	75 mg	1 q.d.
12/19/03	Lumbar Disc Displacement	Klonopin	1.00 mg	1 t.i.d.
12/19/03	Lumbar Disc Displacement	Restoril	7.5 mg	1 h.s.
12/19/03	Lumbar Disc Displacement	Lorcet	10/650 mg	1 5 x day
12/19/03	Lumbar Disc Displacement	Tofranil	25 mg	1 b.i.d.
12/19/03	Lumbar Disc Displacement	Flexeril	10 mg	1 q.i.d.
2/13/04	Lumbar Disc Displacement	Tofranil-PM	75 mg	1 q.d.
2/13/04	Lumbar Disc Displacement	Restoril	7.5 mg	1 h.s.
2/13/04	Lumbar Disc Displacement	Lorcet	10/650 mg	1 five x day
2/13/04	Lumbar Disc Displacement	Klonopin	1.00 mg	1 t.i.d.
2/13/04	Lumbar Disc Displacement	Flexeril	10 mg	1 q.i.d.

(St. Ex. 6 at 186)

Dr. Cunningham's Opinion of the First Visit – Patient 6

180. Dr. Cunningham opined that the examination performed at Patient 6's first visit was not sufficient. Dr. Cunningham noted the lack of examination of reflexes and the lack of a sensory examination of the lower extremities, which should be done when there are low-back injuries. (Tr. at 379-380)

2004 – 2007, Patient 6

181. Dr. Lundeen continued to prescribe for Patient 6 through 2004, 2005, 2006, and 2007. For a period of time, the prescriptions included Lidoderm patches, and Xanax was added in May 2004. Detrol was added in 2005. (St. Ex. 6 at 64, 189-198)

182. In the Dump of Patient Data for Patient 6, a staff member noted on June 24, 2004, the contents of an electromyography and nerve conduction studies:

> Reieved [sic] EMG/NCV report. Conclusion: The presence of denervation in the right lower lumbar could be a localised sign of paraspinal muscles radiculopathy versus a denervation from the surgery. There is no sign of radiculopathy, neuropathy or myopathy in the right leg. Wael Karim, M.D.

(St. Ex. 6 at 204)

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35 Dr. Cunningham testified that Restoril is a sleep aid. (Tr. at 378)

183. In the progress notes for Patient 6's visit on July 1, 2004, Dr. Lundeen discussed the EMG and nerve conduction studies:

> * * * EMG/NCV test was not very helpful and probably under-reported the true nature of his right leg condition.
>
> * * *
>
> ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued. EMG/NCV report considered, but not relied on for patient care.

(St. Ex. 6 at 28, signatures omitted)

184. In a letter to the BWC dated April 17, 2006, Dr. Lundeen wrote in support of his prescribing for Patient 6. (St. Ex. 6A at 65-67)

> As a result of the injuries sustained in this industrial accident and despite conservative treatment, [Patient 6] continues to have pain and symptoms in his lower back, legs, ED, bladder & bowel.
>
> The medications prescribed:
> Triavil, Flexeril and Xanax are prescribed in combination for control of severe muscle spasms.
> Lyrica and Lorcet are prescribed in combination for control of moderate to severe lower back pain.
> Tofranil PM is prescribed for bowel control which is a symptom of this lower back injury.
> Restoril is prescribed to assist sleep which is restless due to low back pain and symptoms.
> Detrol LA is prescribed for control of bladder urgency which is a symptom of this low back injury.
> Colace is prescribed to prevent constipation which is an unfortunate however very common side effect of narcotic pain medications.
>
> Multiple narcotic medication use: Medications from this physician include one or more narcotic medications. The treatment rationale for a mixture of such medications is to titrate symptom control optimally with the least amount of stronger medication in conjunction with medication(s) in milder class(es). The goal is to control symptoms efficiently and with the safest medications which are effective for this patient's symptoms.
>
> Based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it is my opinion, that: the prescribed medications provide adequate relief of

> painful symptoms and allow the patient to perform his daily living activities. Furthermore, I maintain that [Patient 6]'s medications are medically necessary, effective and safe for his use.

(St. Ex. 6A at 65)

185. On May 4, 2006, Dr. Lundeen prescribed the following for Patient 6, according to the Drug Utilization Report in his electronic medical records:

Drug	Strength	Qty/Freq.
Restoril	7.5 mg	1 h.s.
Lorcet	10/650 mg	1 five x day
Flexeril	10 mg	1 q.i.d.
Colace	100 mg	1 t.i.d.
Detrol LA	4 mg	1 q.d.
Triavil	4-25	1 b.i.d.
Xanax	1.00 mg	1 t.i.d.
Tofranil PM	75 mg	1 q.d.
Lyrica	75 mg	1 t.i.d.

(St. Ex. 6 at 191-192)

186. On May 5, 2006, the BWC issued an order stating that it would not pay for the following medications prescribed by Dr. Lundeen:

- anti-anxiety drugs including but not limited to alprazolam,
- skeletal muscle relaxants including but not limited to cyclobenzaprine HCL,
- urinary tract antispasmodics including but not limited to Detrol LA,
- TCA/phenothiazine combination including but not limited to amitriptyline with perphenazine, and
- tricyclic antidepressants including but not limited to Tofranil PM.

The BWC also stated that its decision was "based on the physician drug review completed 4-28-06, by Dr. Shy." (St. Ex. 6A at 195-197)

187. In September 2006, Dr. Lundeen added another narcotic analgesic, Avinza, at a strength of 30 milligrams, twice per day, according to his Drug Utilization report in the patient's electronic medical records. (St. Ex. 6 at 191)

Consultation for Epidural Injections – Patient 6

188. The messages in the electronic Dump of Patient Data in December 2006 show that, starting in December 2006, Dr. Lundeen and his staff were working to get approval for Patient 6 to have epidural injections from another physician. However, in April 2007, a staff member noted that the patient had advised that he did not want any more epidural injections. (St. Ex. 6 at 213-214)

2008 Issue Regarding Prescription Medications – Patient 6

189. In January 2008, Dr. Lundeen wrote to the BWC regarding Patient 6's prescription medications. He stated, among other things:

> As a result of the injuries sustained in this industrial accident and despite conservative treatment, [Patient 1] continues to have pain and symptoms in his lower back, legs, ED, bladder & bowel.
>
> The medications prescribed:
> Flexeril and Xanax are prescribed in combination for control of severe muscle spasms.
> Magnacet, Avinza, and Duragesic patches are prescribed in combination for control of ongoing severe lower back pain.
> Tofranil PM is prescribed for bladder & bowel control which is a symptom of this low back injury.
> Restoril is prescribed to assist sleep which is restless due to low back pain and symptoms.
> Colace is prescribed to prevent constipation which is an unfortunate however very common side effect of narcotic pain medications.
> Lyrica is prescribed for control of nerve pain in the lower extremities.
>
> Multiple narcotic medication use: Medications from this physician include one or more narcotic medications. The treatment rationale for a mixture of such medications is to titrate symptom control optimally with the least amount of stronger medication in conjunction with medication(s) in milder class(es). The goal is to control symptoms efficiently and with the safest medications which are effective for this patient's symptoms.
>
> Based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it is my opinion, that: the prescribed medications provide adequate relief of painful symptoms and allow the patient to perform his daily living activities. Furthermore, I maintain that [Patient 1]'s medications are medically necessary, effective and safe for his use.

(St. Ex. 6 at 11-12)

190. In a letter dated September 5, 2008, Dr. Lundeen again wrote to the BWC regarding Patient 6's medications:

> Topic: prescription medications.
>
> As a result of the injuries sustained in this industrial accident and despite conservative treatment, [Patient 6] continues to have pain and symptoms in his lower back and legs.
>
> The medications prescribed to treat the pain and symptoms related to the allowed conditions in this claim: Fentanyl patch; Avinza; Magnacet are all prescribed to control chronic lower back pain.
>
> RECENT EXAMINATION
> August 15, 2008
>
> **Subjective:** Since the last visit, the patient's condition continues without significant change. Pain level today = 8. Activities impaired include: back, legs. Office: PO. Pain is noted by patient in regions of injury. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: laid off.
>
> **Objective:** Seated straight leg raising, SLR, R 15 degrees, SLR L 15 degrees, spasms present in lower back. Gait: even. Flexion 25 degrees, extension 5 degrees, right lateral flexion 5 degrees and left lateral flexion 5 degrees.
>
> **Assessment:** No major change in medications prescribed.
>
> **Plan:** The next scheduled appointment with this examiner is in 4 weeks.
>
> SUMMARY
> [Patient 6] has chronic low back pain and symptoms as a direct result of the injuries sustained in this claim.
>
> Multiple narcotic medication use: Medications from this physician include one or more narcotic medications. The treatment rationale for a mixture of such medications is to titrate symptom control optimally with the least amount of stronger medication in conjunction with medication(s) in milder class(es). The goal is to control symptoms efficiently and with the safest medications which are effective for this patient's symptoms.
>
> Based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it is my opinion, that: the prescribed medications provide adequate relief of painful symptoms and allow the patient to perform his daily living activities. Furthermore, I

> maintain that [Patient 6]'s medications are medically necessary, effective and safe for his use.

(St. Ex. 6 at 13-14)

191. On September 18, 2008, a review of Patient 6's medications was performed at the BWC's request by Robert A. Hess, M.D., FAACP, CIME. Dr. Hess was asked the following questions:

> 1. Are the therapeutic classes of drugs utilized by the injured worker reasonably related to the treatment of or the control of symptoms associated with the allowed conditions in the claim?
>
> 2. Are the therapeutic classes of drugs utilized by the injured worker medically necessary and appropriate for the treatment of or the control of symptoms associated with the allowed conditions in the claim?
>
> 3. Was there enough information from the prescribing physician that provided adequate medical justification that the therapeutic classes of drugs being utilized by this injured worker are medically necessary, appropriate and reasonably related to the treatment of or the symptoms associated with the allowed conditions in the claim?

(St. Ex. 6A at 25) In his September 2008 report, Dr. Hess answered the questions as follows:

> Analysis: [Patient 6] injured his low back [in] 2000 when lifting * * * and felt shooting pain in the lower back. He had a previous laminectomy in 1988. An MRI on 1/02/01 noted annular tears at L4-5 and L5-S1 that did not product a significant degree of effacement on the ventral portion of the thecal sac. He complains of symptoms of low back pain with radicular pain to the right leg. He has been followed by Dr. Lundeen for pain management. His current medications include the following: Narcotic Analgesics (Fentanyl, Avinza and Magnacet), Laxatives (Docusate), Anticonvulsant (Lyrica), Non Barbiturate sedative (Restoril) and Tricyclic Antidepressant (Tofranil).
>
> In a letter dated 9/5/08, Dr. Lundeen notes the multiple narcotic analgesics are for control of chronic lower back pain. He notes that since the patient's last visit that the condition continues without significant change and the pain is 8/10. Under the summary he indicates that the use of one or more narcotic medications is to titrate symptom control optimally with the least amount of stronger medication in conjunction with medications in milder class.
>
> Conclusion: In conclusion, I have read and reviewed the available medical records and accept the findings and allowed conditions.

1. The use of narcotic analgesics, laxatives, anticonvulsants, non-barbiturate sedatives and tricyclic antidepressants would not be reasonably related to the treatment of or the control of symptoms associated with the allowed conditions in the claim. The use of the above classes of medications are used for chronic neuropathic pain. The IW [injured worker] however does not have evidence of a chronic pain syndrome secondary to neuropathic pain as a result of his injuries. It also would not appear that the current regimen is beneficial for treatment of any pain since the IW subjectively rates his pain continually as an 8 out of 10 with the current medications.
2. For the reasons noted above the use of narcotic analgesics, laxatives, anticonvulsants, non-barbiturate sedatives and tricyclic antidepressants would not be medically necessary or appropriate for the treatment of or the control of symptoms associated with the allowed conditions of the claim.
3. In the office notes and letter from Dr. Lundeen there was insufficient medical justification that the therapeutic classes of drugs being utilized by this injured worker are medically necessary, appropriate and reasonably related to the treatment of or the symptoms associated with the allowed conditions in this claim.

(St. Ex. 6A at 25-27)

192. On September 22, 2008, the BWC issued an order denying reimbursement for

- narcotic analgesics such as but not limited to Magnacet, Avinza, and Fentanyl,
- laxatives such as but not limited to Docusate Sodium,
- anticonvulsants such as but not limited to Lyrica, and
- tricyclic antidepressants.

The BWC stated that its decision was based on Dr. Hess' report. (St. Ex. 6A at 21)

193. In a letter dated October 9, 2008, Patient 6's attorney informed Dr. Lundeen of the BWC's decision and stated an intention to appeal.[36] (St. Ex. 6A at 13)

194. In a letter dated October 24, 2008, Dr. Lundeen wrote:

> Topic: prescription medications
>
> As you are aware, the Bureau has denied the continued use of prescription medications based on a file review of Dr. Robert A. Hess dated September 18, 2008.

[36] The Hearing Examiner did not see a disposition on any appeal in Dr. Lundeen's patient records as provided in State's Exhibits 6 and 6A.

> Dr. Hess concludes that the use of narcotic analgesics, laxatives, anticonvulsants, non barbiturate sedatives and tricyclic antidepressants would not be reasonably related to the treatment of or the control of symptoms associated with the allowed conditions in the claim. "The use of the above classes of medications are used for chronic neuropathic pain. The IW however does not have evidence of a chronic pain syndrome secondary to neuropathic pain as a result of his injuries." Dr. Hess' statement is not factually correct, and therefore; should not be relied upon.
>
> A file review was performed on April 28, 2006 by Stephen C. Shy who indicates that: H3A (narcotic analgesics) are indicated for the treatment of moderate to severe pain syndromes. "Use of this medication would be appropriate for treatment the allowed conditions in this claim". Clearly, Dr. Hess' conclusion regarding the use of the prescribed medications (chronic neuropathic pain) is not factually correct.
>
> Furthermore, Dr. Hess should know that medications, while categorized in a therapeutic class, are often prescribed to treat symptoms outside its standard classification. For example, Benadryl is categorized as an antihistamine and generally prescribed to treat allergic symptoms. However, it is also an effective nighttime sedative.
>
> Dr. Hess has not examined [Patient 6]. His opinion's [sic] are based on a limited and factually incorrect file review. Furthermore, it appears to this examiner that the goal of Dr. Hess' file review was to discredit patient [*sic*], to misinterpret the diagnostic testing and subjective/objective medical findings, and to rebut that the current medical evidence is not attributable to the original injury.
>
> I stand firmly by my letter dated September 5, 2008.

(St. Ex. 6 at 15-16)

2009 - Issues Regarding Prescription Medications for Patient 6

195. As of March 2009, Dr. Lundeen was prescribing the following for Patient 6:

Duragesic	50 mcg/hr	1 q.o.d.	[every other day][37]
Xanax	1.00 mg	1 t.i.d.	[three times per day]
Avinza	30 mg	1 q.i.d.	[four times per day]
Magnacet	10/400mg	1 q4°	[every four hours]

(St. Ex. 6 at 195-196)

[37] The abbreviation *q.o.d.* means "every other day." (E.g., U. Conn. Health Center, at <http://patientsafety.uchc.edu/professionals/medication/ medication.html>; Inst. for Safe Med. Practices, at <www.ismp.org>; accessed 10/23/11.)

196. Staff messages in the Dump of Patient Data state that Dr. Lundeen received a communication from Medco in March 2009 regarding concerns about Patient 6's narcotic medications:

> 00-327152 X 31-Mar-2009 08:58:11.90 COLEMANL
> Received a letter from Medco which indicates that patient is receiving medications that have similar pharmacologic effects: Fentanyl and Avinza. Patients who received duplicate therapy may exhibit additive side effects without further therapeutic benefit. I have placed this is JEL's tray as advised.

(St. Ex. 6 at 207-208)

197. In addition, Dr. Lundeen's records for Patient 6 includes a June 2009 letter to him from Laurie Greenberg, M.D., the medical director of Medco, regarding prescriptions written by Dr. Lundeen. In her letter, Dr. Greenberg explained Medco's desire to provide safety and health considerations.[38] Among other things, Dr. Greenberg asked Dr. Lundeen to review the information provided in the letter and to make any changes in the patient's therapy that he found appropriate. (St. Ex. 6A at 1-3)

198. In her June 2009 letter, Dr. Greenberg included the following list of prescriptions that Dr. Lundeen had written for Patient 6:

Date of Service	Drug	Strength	Qty.	Days Supply	Prescriber
6-10-09	Alprazolam	1 mg	90	30	Lundeen, James
6-10-09	Fentanyl	50 mcg/hr	15	30	Lundeen, James
6-10-09	Magnacet	10/400 mg	180	30	Lundeen, James
6-10-09	Avinza	30 mg	120	30	Lundeen, James
5-15-09	Alprazolam	1 mg	90	30	Lundeen, James
5-15-09	Fentanyl	50 mcg/hr	15	30	Lundeen, James
5-15-09	Magnacet	10/400 mg	180	30	Lundeen, James
5-15-09	Avinza	30 mg	120	30	Lundeen, James
4-16-09	Alprazolam	1 mg	90	30	Lundeen, James
4-16-09	Fentanyl	50 mcg/hr	15	30	Lundeen, James
4-16-09	Magnacet	10/400 mg	180	30	Lundeen, James
4-16-09	Avinza	30 mg	120	30	Lundeen, James
3-18-09	Alprazolam	1 mg	90	30	Lundeen, James
3-18-09	Fentanyl	50 mcg/hr	15	30	Lundeen, James
3-18-09	Magnacet	10/400 mg	180	30	Lundeen, James
3-18-09	Avinza	30 mg	120	30	Lundeen, James

(St. Ex. 6A at 1-3)

[38] From certain statements in the letter, it appears that Medco was a pharmacy or a prescription-benefits manager for Patient 6.

199. In addition, Dr. Greenberg stated as follows under "Considerations for Review" and provided a list of references to medical literature:

> **Safety: Utilization Analysis with Opioid/Narcotic Analgesics**
>
> Our claims record suggests that your patient has received several recent prescriptions for opioid/narcotic analgesics. There may be a pattern of use that places your patient at increased risk for adverse drug events based on the number of prescriptions filled and the cumulative days supply. Patients should be counseled about rise of overdose, both to themselves and to others with whom they might share medication. Please consider a review of your patient's pain management regimen to determine where changes in therapy are warranted, especially in cases where the patient's pain may not be well controlled.
>
> **References**
>
> 1. Analgesics and Antipyretics. In: American Hospital Formulary Service 2004; 28:08.
> 2. Hall: Patterns of Abuse Among Unintentional Pharmaceutical Overdose Fatalities. JAMA 2008 Dec. 10; 300(22):2613-20.
> 3. McLellan: Prescription opioids, overdose deaths, and physician responsibility (editorial). JAMA 20008; 300(22):2672-3.
> 4. Am Pain Soc/Am Acad Pain Medicine, Clin Guidelines for use of chronic opioid therapy for chronic noncancer pain, Journal of Pain 2009; 10:113-130.

(St. Ex. 6A at 1)

200. In August 2009, Dr. Greenberg sent another letter to Dr. Lundeen regarding the prescriptions for Patient 6. She provided a list of the medications from April 2009 through August 2009. She again asked Dr. Lundeen to review the information and the considerations provided, including the following "Considerations for Review":

> **Safety: Therapy Duplication with AVINZA and FENTANYL**
>
> A review of your patient's active prescription profile indicates that your patient may be receiving drugs that have similar pharmacologic effects: AVINZA and FENTANYL. Patients who receive duplicative therapy may exhibit additive side effects without further therapeutic benefit. If you have recently switched your patient's therapy, please ensure that the patient has discontinued the previous agent.
>
> **References**:
> 1. ASHP: OPIATE AGONISTS, AHFS DRUG INFO 2007; SEC 28:08:08 G K McEvoy, Ed.

2. Am Pain Soc/Am Acad Pain Medicine, Clin Guidelines for use of chronic opioid therapy for chronic noncancer pain, Journal of Pain 2009; 10:113-130.

(St. Ex. 6A at 4-7)

2010 and 2011 Prescriptions – Patient 6

201. Throughout the remainder of 2009, through 2010 and into 2011, the prescriptions continued for Xanax (alprazolam) and three narcotic analgesics: Avinza (morphine), Duragesic patches (fentanyl), and Magnacet (oxycodone and acetaminophen). (St. Ex. 6 at 196-198)

202. For example, the prescriptions in March and April 2010 were as follows, according to Dr. Lundeen's Drug Utilization Report in the patient's electronic records:

Date	Drug	Strength	Qty/Freq	#	
3/03/10	Duragesic	50 mcg/hr	1 q.o.d.	15	
	Magnacet	10/400mg	1 q4°	180	(six times per day)
	Xanax	1.00 mg	1 t.i.d.	90	
	Avinza	30 mg	1 q.i.d.	120	
3/17/10	Magnacet	10/400mg	1 q4°	180	
	Lortab	10/500	2 q.i.d.	180	
	Avinza	30 mg	1 q.i.d.	120	
	Duragesic	50 mcg/hr	1 q.o.d.	15	
	Cialis	20 mg	1 q.d.	3	(with 5 refills)
	Xanax	1.00 mg	1 t.i.d.	90	
4/09/10	Duragesic	50 mcg/hr	1 q.o.d.	15	
	Magnacet	10/400mg	1 q4°	180	
	Avinza	30 mg	1 q.i.d.	120	
	Xanax	1.00 mg	1 t.i.d.	90	

(St. Ex. 6 at 197) However, the progress notes for March 17 and April 9, 2010, do not explain why the patient had additional visits and additional prescriptions. In addition, the progress notes for March 17, 2010, state that the patient is to be seen in "8 weeks." (St. Ex. 6 at 162-167, 216)

203. Further, Dr. Lundeen's electronic medical records include no progress notes for a visit on March 3 2010, and the computerized list of appointments for Patient 6 does not list an appointment for March 3, 2010. (St. Ex. 6 at 162-167, 216; St. Ex. 6 at 1-218)

204. Dr. Lundeen's records for Patient 6 include a report of the controlled substances dispensed to Patient 6 by Ohio pharmacies for the 12-month period ending in June 2010; that is, the patient's medical records include a report from the Ohio Automated Rx Reporting System

[OARRS] regarding drugs dispensed to Patient 6 from July 2009 through June 2010. The report shows that no controlled drugs were prescribed by other providers. (St. Ex. 6A at 403-405)

However, the report indicates that Dr. Lundeen provided *two* prescriptions for Duragesic patches (fentanyl) to Patient 6 on January 13, 2010, each for 15 patches, constituting a supply for 30 days or longer, and that one of these prescriptions was filled in January 2010 and the other was filled in March 2010. (St. Ex. 6A at 403-405) However, Dr. Lundeen's Drug Utilization Report shows only one prescription for Duragesic, 15 patches, on January 13, 2010. (St. Ex. 6 at 196)

Similarly, the OARRS report indicates that Dr. Lundeen wrote two prescriptions for Duragesic patches to Patient 6 on March 17, 2010, each for 15 patches. The OARRS report states that one of these prescriptions was filled in April 2010 and the other prescription was filled in May 2010.[39] (St. Ex. 6A at 403) However, Dr. Lundeen's Drug Utilization Report shows only one prescription for Duragesic, 15 patches, on March 17, 2010. (St. Ex. 6 at 197)

205. In September 2010, Dr. Lundeen increased Patient 6's the dose of Duragesic (fentanyl) to 75 mcg per hour. (St. Ex. 6 at 197)

206. At Patient 6's most recent visit on March 18, 2011, Dr. Lundeen prescribed:

Date	Drug	Strength	Qty/Freq	#
3/18/11	Xanax	1.00 mg	1 t.i.d.	90
3/18/11	Avinza	30 mg	1 q.i.d.	120
3/18/11	Percocet	10/325 mg	1 q4°	180
3/18/11	Duragesic	75 mcg/hr	1 q.o.d.	15

(St. Ex. at 198)

Dr. Cunningham's Opinions – Patient 6

207. Dr. Cunningham testified that Avinza, Percocet, and Duragesic are three "very potent" narcotics. He opined that the medical records did not show physical examinations that justified the prescriptions for these narcotics. (Tr. at 383-384)

208. Dr. Cunningham further testified that he saw no support in the patient's records to support the prescription for Xanax, an anti-anxiety medication. He stated that there was no indication in the records that Dr. Lundeen was monitoring the patient's anxiety levels, despite his prescribing of an anti-anxiety medication. (Tr. at 383, 386)

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[39] It is important to be aware that the OARRS database is a secondary source and that the report itself makes clear that the State of Ohio "does not warrant the above information to be accurate or complete" and directs inquiries to the pharmacy that dispensed the drug. The relevance is that this OARRS report was filed in Patient 6's medical records and presents information that is not consistent with Dr. Lundeen's Drug Utilization Report, which is also in Patient 6's medical records.

209. When asked whether the Triavil was appropriate for Patient 6, Dr. Cunningham stated that "a lot of physicians put chronic pain patients on antidepressants" because "people who have chronic pain have a tendency to be somewhat depressed." In contrast, Dr. Cunningham opined that Dr. Lundeen's documentation did not support the Flexeril. He opined that, at that stage of the treatment, the muscle relaxant was not justified. (Tr. at 386)

210. In his written report, Dr. Cunningham commented that all the physical examinations relied on subjectively based testing, without objective tests being performed. For example, Dr. Cunningham stated that he did not see documentation of a "single deep tendon reflex being tested." Further, "the straight leg raising reported by Dr. Lundeen was always in the sitting position, and was described as being significant at less than 70 degrees straight leg raising in the sitting position throughout the record." In addition, Dr. Cunningham noted that there were no drug screening results in the patient's medical records, nor were any drug screens discussed in the patient's progress notes. Dr. Cunningham relied on the objective evidence in the EMG and nerve conduction study, finding Dr. Lundeen's observations to be at odds with the objective evidence. (St. Ex. 30 at 51-53)

211. In his written report regarding the care of Patient 6, Dr. Cunningham's conclusions included the following:

> At no time between November 2003 and March 2011 were the physical examination findings described by Dr. Lundeen appropriate and/or comprehensive, on an objective medical basis, in regards to this individual's low back and lower extremity difficulties under this claim for which he was exclusively treating this individual, from my interpretation of these records.
>
> * * * The MRI and the EMG tests carried out in late 2003 and early 2004 were appropriate and necessary, and demonstrated, in the case of the MRI, a stable and unchanged appearance of the low back since a prior MRI, and the EMG and nerve conduction study demonstrated no evidence of radiculopathy, plexopathy, or myopathy, on an objective medical basis, in regards to the right lower extremity, which was this individual's primary complaint. Consequently, there is no objective evidence of neurologic compromise involving the lower extremities.
>
> * * * Was the proper diagnosis established? Yes. The proper diagnosis was established long prior to Dr. Lundeen's first seeing this individual on 11/19/03. In fact, his MRI in 2003 was stable in appearance from a prior study.
>
> * * * At no time was the physician's management appropriate to the diagnosis for multiple reasons. This individual's bowel and bladder dysfunction, and his erectile dysfunction are not in any way related to the claim allowance diagnoses for which he was being treated. Also, the psychotropic drugs on which this individual has been maintained since his initial visit of 11/19/03 have not been supported as being

reasonably related to these claim allowances. Also, Dr. Lundeen's statement that the 2004 EMG/NCS objective results would not be considered was not appropriate. In addition, this individual's ever-increasing dosages of narcotic analgesics between November 2003 and March 2011 are not supported on an objective medical basis.

* * * On the basis of the objective medical criteria, the MRI and the EMG of 2003 and 2004, with no documented objective change in status prior to this individual's most recent available treatment of 03/18/11, the vast majority of this individual's constellation of medications provided by Dr. Lundeen are clearly not supported as being reasonably related to this claim.

* * * No skeletal muscle relaxant can be considered to be therapeutic and/or maintenance for more than a 3-month period. Dr. Lundeen first evaluated this individual on 11/19/03, which was more than 3 ½ years after the date of injury. Also, no psychotropic medication or Lyrica was supported as being reasonable.

* * * Was the treatment appropriate to the clinical situation? No, for the multiple reasons discussed above. There has been no objective change in medical status ever since this individual's 2003 low back MRI and early 2004 EMG and nerve conduction study. However, his narcotic dosage continued to increase, which causes the concern of drug dependency and/or addiction and/or tolerance. In addition, the psychotropic medications and Lyrica were inappropriate. There is no evidence in this file that this individual ever underwent a random drug screen under the direction of Dr. Lundeen regarding his rather potent narcotic medications in the last several months.

* * * This individual should have been referred to a physician skilled in addiction and/or drug dependency and/or tolerance long ago because there was no objective change in medical status in regards to this claim since November 2003 and early 2004, when this individual underwent an MRI and an EMG, including until the most recent available office visit record of Dr. Lundeen of 03/18/11, which demonstrated no objective change in medical status with ever increasing total narcotic dosages.

* * * No height, weight, blood pressure, or medication allergies are contained in this record. Also, no records other than computerized records generated by Dr. Lundeen and his staff are contained in this file, such as imaging report, diagnostic tests, or prior records.

* * *

A. Whether Dr. Lundeen's treatment/care constituted a departure from or failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient was established, in violation of Section 4731.22(B)(6), Ohio Revised Code.

> No. Unfortunately, Dr. Lundeen's treatment and care constituted multiple significant departures or failure from conformity to minimal standards of care of similar practitioners under the same or similar circumstances. * * * The medications provided by Dr. Lundeen are far outside of the Ohio BWC treatment guidelines and also the peer-reviewed treatment guidelines, such as the Official Disability Guide and the Occupational Medicine Practice Guidelines, for innumerable reasons. The Occupational Medicine Practice Guidelines is published by the American College of Occupational and Environmental Medicine, which is one of the two governing bodies for the practice of occupational medicine, the other being the American Board of Preventive Medicine.
>
> B. Whether Dr. Lundeen failed to maintain minimal standards acceptable to the selection and administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease, in violation of Section 4731.22(B)(2), Ohio Revised Code. Unfortunately, Dr. Lundeen failed to maintain the minimal standards applicable to the selection and administration of drugs. There is no objective evidence that this individual's medical status in regards to his low back and lower extremity symptoms changed in any way subsequent to Dr. Lundeen's initial evaluation of him on 11/19/03 until he most recently treated this individual on 03/18/11. In relatively recent records of Dr. Lundeen in his care of this individual for more than seven years, there is mention of random urine drug screen testing, but there are no such records available for review. Also, this individual's ever-increasing dosages of narcotic analgesics over time are clear indications that this rather young individual has the potential of narcotic dependency and/or addiction and/or tolerance and required prompt referral to a physician skilled in narcotic addiction/tolerance/dependence issues. There is no mention in these records that this individual was having any adverse effects from his medications; however, his total narcotic dosage continued to increase dramatically in recent years, over and above what one would expect in the normal course of an individual who initially had a stable status in regards to the original low back MRI and the original EMG and nerve conduction study. There is no documentation in Dr. Lundeen's notes that there is any objective change in this individual's status other than the fact that he was requiring more analgesic medication.

(St. Ex. 30 at 50-53)

212. In his supplemental written report. Dr. Cunningham described documents including the Medco letters, the physical-therapy records from 2004, several BWC documents, the pain contract signed at the time of Patient 6's first visit to Dr. Lundeen, the report of Dr. Hess (identified as a neurosurgeon by Dr. Cunningham), the records from the prior treating physician, and information regarding MRIs in 2000, 2001, and 2003. (St. Ex. 30A at 4-5)

213. Dr. Cunningham acknowledged that there was a pain contract in the file for Patient 6, although it was never revised. In addition, Dr. Cunningham emphasized that there were specific warnings given to Dr. Lundeen regarding the narcotic analgesics that he was prescribing to Patient 6. He did not change the final opinions he had stated in his original report with regard to the care provided by Dr. Lundeen for Patient 6. (St. Ex. 30A at 13-14)

Dr. Lundeen's Written Defense – Patient 6

214. With regard to Patient 6, Dr. Lundeen's written position includes:

> [Patient 6] sustained multi-level lumbar disc herniations * * * over 11 years ago in February 2000. Dr. Lundeen first evaluated Patient 6 in late 2003 for his injuries. Patient 6 had undergone unsuccessful back surgery. He was unable to work, had developed bladder urgency, depression, sleep deprivation and increased pain symptoms following surgery. Dr. Lundeen requested a new MRI with and without gadolinium to assess for epidural fibrosis, a highly probable rationale for Patient 6's spinal symptoms. Physical therapy and injections were attempted. Two surgical consultants did not recommend further surgery.
>
> Various medications attempted for control of his complex symptoms since 2003 have included Lorcet, Restoril, Tofranil (imipramine), Flexeril, Klonopin, Xanax, Triavil, Tofranil-PM, Lidoderm patch, Colace, Detrol LA, Lyrica, Avinza, Magnacet, Duragesic, Cialis, and Percocet, in various combinations over 7-8 years. BWC stopped paying for Lidoderm, which was helping Patient 6.
>
> Patient 6's most recent medication profile [was] allowed under BWC as medically necessary and reasonably related to his allowances * * *.

(Resp. Ex. Z at 14)

Patient 7

General Information

215. Patient 7, born in 1957, sustained two industrial injuries, the first in 1991 and the second in 2002. Dr. Lundeen began seeing him as a patient in July 1997. With respect to the injury that occurred in 1991, the allowed conditions in the workers' compensation claim were "Sprain/strain right arm and elbow; impingement syndrome right shoulder, gamekeepers condition right thumb; and chronic ulnar collateral ligament tear right thumb." Dr. Lundeen set forth the diagnoses in his progress notes as follows:

> 726.2 SHOULDER REGION DIS NEC
> 727.03 TRIGGER FINGER

840.9 SPRAIN SHOULDER/ARM NOS
841.0 SPRAIN RADIAL COLLAT LIG

(St. Ex. 6 at 2, 68-69)

216. Patient 7 suffered another industrial injury in August 2002 when a 300-400 pound beam fell on him. Dr. Lundeen described the workers' compensation claim allowances as follows: "Contusion scalp/head, brain conditions nec, cl skull vlt fx coma NOS left, extradural hem coma NOS right and left. open wound of scalp left, bulging disc C7-T1; ddd degen disc dis C6-C7, C5-C6, C4-C5, C3-C4; cervical spinal stenosis; sprain shoulder/arm nos bilateral shoulder; sprain of knee & leg nos bilateral; sprain of neck; sprain lumbar region; contusion of knee bilateral; posttraum arth leg right; impingement syndrome right; tear rotator cuff right; prolonged posttraumatic stress, postraumatic arth leg, right." Dr. Lundeen initially listed the following diagnoses:

920. CONTUSION FACE/SCALP/NCK
873.0 OPEN WOUND OF SCALP
800.26 CL SKULL VLT FX-COMA NOS
852.46 EXTRADURAL HEM-COMA NOS
852.46 EXTRADURAL HEM-COMA NOS
348.8 BRAIN CONDITIONS NEC

(St. Ex. 6 at 19, 71) At later dates, additional conditions were added to Dr. Lundeen's diagnoses and to the workers' compensation allowed conditions, including arthritic changes, temporomandibular disorder, a rotator cuff tear, a knee injury, posttraumatic stress, post-concussion syndrome, and a respiratory abnormality. (St. Ex. 7 at 17, 22, 63)

217. Medical records for Patient 7 were admitted as State's Exhibits 7 and 7A. Dr. Cunningham's initial written opinion is set forth at State's Exhibit 30, pages 57-65, and his supplemental opinion is set forth at State's Exhibit 30A, page 6 and 14 to 15. His testimony regarding this patient is found in the transcript at pages including 387 – 413. Dr. Ross' opinion is set forth at Resp. Ex. A at 35, and Dr. Lundeen's written opinion is set forth at Resp. Ex. Z at 14-15.

July 1997 – Patient 7's First Visit to Dr. Lundeen

218. Dr. Lundeen's progress notes for Patient 7's first examination are as follows:

July 28, 1997
SUBJECTIVE: This patient is new to this medical practice. He sustained injuries at work when he slipped while moving a heavy appliance. Injuries to entire right arm. Surgery for a tendon transplant to the right thumb and right elbow; surgeon at AGH, Akron, Ohio. Not presently working. Plans to continue his education. Patient requests therapy and medications.

> OBJECTIVE: Right shoulder ROM: 50-70 percent of normal, flexion > abduction. Right elbow ROM: noted hyperextension of the joint! This is due to the elbow injury. Right thumb ROM: IP and MP joints very limited due to injury and surgical scars. Tenderness in all mentioned areas.
>
> ASSESSMENT: Chronic benign pain of moderate to severe nature. No pain-free day anymore.
>
> PLAN: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. Minimize use of narcotic medication, take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx controlled/narcotic medications. Patient understand [*sic*] potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency or addiction will be made. A moderate degree of dependency is normal and should be anticipated with the usage of such controlled/narcotic medication(s). Beyond a normal reasonable degree of day to day dependency on such medications for ADL's, abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons.

(St. Ex. 7 at 68, signatures omitted)

219. Dr. Lundeen prescribed Salflex 650 mg, four times per day; Sinequan 50 mg, one at night; and Duract 25 mg, three times per day.[40] (St. Ex. 7 at 298)

Opinion Of Dr. Cunningham Regarding First Examination – Patient 7

220. Dr. Cunningham opined that the physical examination for Patient 7 in July 1997 was not adequate. He stated that there are six ranges of motions for the shoulder, four for the elbow, and five for the thumb, but Dr. Lundeen did not state the ranges for each joint involved. He mentioned only flexion and abduction for the shoulder, and mentioned only two joints of the thumb, which can be measured for flexion, extension, adduction, abduction, and opposition. (St. Ex. 391-392)

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[40]Sinequan (doxepine) is a tricyclic antidepressant used to treat depression and anxiety. Nat'l Library of Medicine, "Doxepine," at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000668>, accessed 10/27/11.

Durac (bromfenac) was an NSAID that the Food and Drug Administration removed from the market in June 1998 due to excessive danger of liver toxicity. See FDA, "Duract," at <www.fda.gov/Drugs/ResourcesForYou/Consumers/Questions Answers/ucm073043.htm>; see, also, "Duract," at <www.medicinenet.com/bromfenac/article.htm>, accessed 10/27/11. Dr. Lundeen did not prescribe Duract to Patient 7 after October 1997. (St. Ex. 7 at 298)

August 1998 to October 1998 – Patient 7

221. On August 5, 1998, Dr. Lundeen prescribed the following drugs for the shoulder injuries:

8/05/98	Phrenilin Forte	50/650 mg	1 q.i.d.
8/05/98	Elavil	100 mg	1 h.s.
8/05/98	Trilisate	1000 mg	1 t.i.d.
8/05/98	Vicodin ES	7.5/750	1 b.i.d.
8/05/98	Prilosec	20 mg	1 b.i.d.

(St. Ex. 7 at 298)

222. On October 9, 1998, Dr. Lundeen added Xanax, 1 mg, in place of the Elavil. (St. Ex. 7 at 298)

New Prescriptions and Increases in Doses – Patient 7

223. The Vicodin ES prescriptions at 7.5/750 mg as shown in 1998 continued for many months, although the frequency of that dose was increased from twice per day to five times per day in October 2002, after the second industrial accident in August 2002. On October 7, 2004, Dr. Lundeen changed the medication to Vicodin HP, 10/660 mg, five times daily. (St. Ex. 7 at 301-309; Tr. at 393)

224. On October 7, 2004, Dr. Lundeen prescribed the following drugs for Patient 7, adding Soma (carisoprodol) at that time:

Contusion Face/Scalp/Nck	Xanax	1.00 mg	1 b.i.d.
Contusion Face/Scalp/Nck	Motrin	800 mg	1 t.i.d.
Contusion Face/Scalp/Nck	Vicodin HP	10/660mg	1 five x day
Brain Conditions Nec	Soma	350 mg	1 q.i.d.

(St. Ex. 7 at 301, emphasis added)

225. Dr. Lundeen explained the addition of Soma as follows in his progress notes for October 7, 2004:

Diagnosis:

717.7	CHONDROMALACIA PATELLAE
873.0	OPEN WOUND OF SCALP
800.26	CL SKULL VLT FX-COMA NOS
852.46	EXTRADURAL HEM-COMA NOS
348.8	BRAIN CONDITIONS NEC
524.6	TEMPOROMANDIBULAR JT DIS
352.0	OLFACTORY NERVE DISORDER

October 7, 2004
SUBJECTIVE: This patient is seen today at Akron, Ohio. Since the last visit, the patient's condition continues. Activities impaired include: right shoulder, neck, right knee movements. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include more pain and spasms recently.

OBJECTIVE: Cervical spine range of motion: 45 degrees right lateral rotation, 45 degrees left lateral rotation, 25 degrees right lateral flexion, 5 degrees left lateral flexion, 15 degrees forward flexion and 5 degrees of neck extension; movements are painful.

ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued, Soma added.

PLAN: The patient has been advised that one or more of the RX medications are potentially addictive or habit-forming. The patient desires to continue the medication(s) in order to maximize therapeutic benefit. Every effort will be made to keep the quantities of such medications as low as possible.
Employment status = TT.

(St. Ex. 7 at 139, signatures omitted)

226. The Hearing Examiner notes that the date of the patient's visit as stated in the progress notes usually matches the electronic signature by Dr. Lundeen on the progress notes. However, the progress notes for Patient 7's visit on July 8, 2005, were electronically signed by Dr. Lundeen on July 6, 2007. (St. Ex. 7 at 157)

227. In September 2005, the dosage of Xanax was increased, as shown in the Drug Utilization Report:

Date	Diagnosis	Drug	Strength	Qty/Freq.
9/01/05	Temporomandibular Jt Disor	Vicodin HP	10/660 mg	1 five times daily
9/01/05	Contusion Face/Scalp/Nck	Motrin	800mg	1 t.i.d.
9/01/05	Brain Conditions Nec	Xanax	1.00 mg	1 b.i.d.
9/01/05	Brain Conditions Nec	Soma	350 mg	1 q.i.d.
9/29/05	Brain Conditions Nec	Xanax	1.00 mg	1 t.i.d.
9/29/05	Brain Conditions Nec	Soma	350 mg	1 q.i.d.
9/29/05	Contusion Face/Scalp/Nck	Motrin	800 mg	1 t.i.d.
9/29/05	Temporomandibular Jt Disor	Vicodin HP	10/660 mg	1 five times daily

(St. Ex. 7 at 302)

228. Dr. Lundeen's chart notes for September 29, 2005, explain the increased Xanax as follows:

> September 29, 2005
> SUBJECTIVE: Employment status: TT benefits from this claim for physical conditions. Service location: Akron, Ohio.
>
> OBJECTIVE: The right shoulder is examined today. Flexion is 125 degrees, extension is 45 degrees, abduction is 90 degrees, adduction is 50 degrees, internal rotation with the elbow abducted at or near shoulder level is 90 degrees, external rotation with the elbow abducted at or near shoulder level is 15 degrees.
>
> ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued unchanged.
>
> PLAN: Medications from this physician include one or more scheduled narcotic medications in the moderate DEA classification group 3. Patient to minimize use of such narcotic medication(s), to take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx narcotic medications. Patient understand [sic] potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency or addiction will be made. A moderate degree of dependency is normal and should be anticipated with the usage of such narcotic medication(s). Beyond a normal reasonable degree of day to day dependency on such medications for ADL's, abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons. The next scheduled appointment with this examiner is in 4 weeks. Xanax increased from 2x to 3x daily.

(St. Ex. 7 at 163, signatures omitted)

229. In a letter to the BWC dated August 15, 2006, Dr. Lundeen maintained that the medications he prescribed were "medically necessary, effective and safe" for Patient 7's use. Dr. Lundeen stated that the Xanax was prescribed for spasms, Vicodin was for pain, and "Carisoprodol is a muscle relaxant." (St. Ex. 7 at 66-67)

2007 Prescriptions - Patient 7

230. The following staff notation appears in Patient 7's electronic medical records for February 15, 2007:

> Per approval from JEL the following Rx were called in yesterday to Walgreen's pharmacy automated physician line 330-764-4399: Motrin 800 mg 1 po t.i.d # 30; Soma 350 mg 1 po q.i.d #40; Vicodin HP 10/660 mg 1 po 5 times daily #50. All with no refills.

(St. Ex. 7 at 333, emphasis added)

231. According to the Drug Utilization Report, Dr. Lundeen first prescribed Magnacet, a combination of oxycodone and acetaminophen, in March 2007. The report does not reflect the prescriptions called in to the pharmacy on February 14, 2007:

1/16/07	Chondromalacia Patellae	Motrin	800 mg	1 t.i.d.
1/16/07	Extradural Hem-Coma Nos	Carisoprodol	350 mg	1 q.i.d.
1/16/07	Chondromalacia Patellae	Vicodin HP	10/660 mg	1 five times daily
1/16/07	Chondromalacia Patellae	Valium	10 mg	1 t.i.d.
2/23/07	Chondromalacia Patellae	Motrin	800 mg	1 t.i.d.
2/23/07	Extradural Hem-Coma Nos	Carisoprodol	350 mg	1 q.i.d.
2/23/07	Chondromalacia Patellae	Valium	10 mg	1 t.i.d.
2/23/07	Chondromalacia Patellae	Vicodin HP	10/660 mg	1 five times daily
3/26/07	Chondromalacia Patellae	Magnacet	10/400mg	1 q.d.[41]
3/26/07	Extradural Hem-Coma Nos	Carisoprodol	350 mg	1 q.i.d.
3/26/07	Chondromalacia Patellae	Valium	10 mg	1 t.i.d.
3/26/07	Chondromalacia Patellae	Motrin	800 mg	1 t.i.d.
3/26/07	Chondromalacia Patellae	Vicodin HP	10/660 mg	1 five times daily
4/23/07	Chondromalacia Patellae	Magnacet	10/400mg	1 q.d.
5/21/07	Chondromalacia Patellae	Magnacet	10/400mg	1 q.d.

(St. Ex. 7 at 303-306)

232. On April 25, 2007, according to a message documented in the computer system, a pharmacist called Dr. Lundeen's office to verify whether Dr. Lundeen wanted Patient 7 to take both the Magnacet and the Vicodin HP as prescribed. The pharmacist was "concerned about the amount of acetaminophen." Dr. Lundeen was asked to verify whether he wanted Patient 7 to take the Vicodin HP five times per day and the Magnacet one time per day. (St. Ex. 7 at 333)

233. The compilation of messages and notations shows no documentation of a response to the pharmacist's inquiry. (St. Ex. 7 at 333) In addition, the subsequent progress notes include no discussion of the amount of acetaminophen being prescribed. (St. Ex. 7 at 199-203) According to the Drug Utilization Report, the Magnacet prescriptions continued unchanged through November 2009. (St. Ex. 7 at 306) A notation in the March 2007 progress notes states

[41] The Magnacet prescription provided, per day, 10 mg of oxycodone and 400 mg of acetaminophen. The Vicodin prescription provided, per day, 50 mg of hydrocodone and 3,300 mg of acetaminophen.

that the Magnacet was for breakthrough pain, but the prescription as written directs the medication is to be taken once per day. (St. Ex. 7 at 197, 303-304)

234. In addition, Dr. Lundeen's Drug Utilization Report for Patient 7 states that only one drug was prescribed on April 23, 2007: the Magnacet, as noted in the chart above. Thus, the prescriptions for Vicodin, Valium, Carisoprodol, or Motrin were discontinued on April 23, 2007 (and did not resume in May 2007). However, Dr. Lundeen stated in the patient's progress notes for April 23, 2007: *"No major change in medications prescribed."* (St. Ex. 7 at 199, emphasis added)

Continued Prescriptions for Soma (Carisoprodol)

235. The prescriptions for carisoprodol continued through March 2011, when Dr. Lundeen prescribed 350 mg of carisoprodol to be taken four times per day to treat the following condition: "Extradural Hem-Coma Nos." (St. Ex. 7 at 308)

Dr. Cunningham's Opinions Regarding the Prescriptions – Patient 7

236. Dr. Cunningham opined that the chart documentation by Dr. Lundeen did not justify the prescriptions for Xanax and Vicodin, in that Dr. Lundeen did not appropriately document his reasons for adding these medications initially, and then subsequently raising the dose. (Tr. at 392-394)

237. Dr. Cunningham further opined that prescribing Soma beyond the acute phase of injury was not appropriate. He opined that no muscle-relaxant medication is reasonably related to the head injury or knee injury so long after the date of injury. He testified that, although Soma/carisoprodol had been prescribed for a brain condition in 2004, Dr. Lundeen's notes did not support the prescription. He stated that he "could not imagine" why a muscle relaxant such as Soma would be prescribed for a brain condition. (St. Ex. 408-413; St. Ex. 30 at 63)

Dr. Cunningham's Opinion Regarding the Mental Status Exam in October 2002

238. On October 5, 2002, Dr. Lundeen examined Patient 7, about six weeks the severe injury in August 2002. Dr. Cunningham noted that the physical examination was more thorough than usually seen in Patients 1 through 26. In addition, Dr. Lundeen's notes show that he did "some neurologic exam" including a mental status examination. However, Dr. Cunningham opined that the neurologic examination and the mental status examination were not thorough enough, especially given the short period of time since the traumatic injury to the head. (St. Ex. 7 at 394-401)

Dr. Cunningham's Written Opinions

239. Dr. Cunningham's written report included the following opinions with regard to Patient 7's care for the 1991 injury:

A. Whether Dr. Lundeen's treatment/care constituted a departure from or failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient was established, in violation of Section 4731.22(B)(6), Ohio Revised Code.

Unfortunately, Dr. Lundeen's treatment and care constituted multiple significant departures or failures from conformity to the minimal standards of care in similar practitioners under the same circumstances for [the 1991 injury]. As noted above, there are no objective physical examination findings, except for subjectively based findings; there are no recorded height, weight, reflexes present or absent, sensation, and/or statements as to the functional use of the right upper extremity, although this individual in his most recent office visit record in regards to this claim from Dr. Lundeen had 100 pounds of grip strength, according to Dr. Lundeen. The medications provided by Dr. Lundeen are far outside the Ohio BWC treatment guidelines and also the peer-reviewed treatment guidelines, such as the Official Disability Guides and the Occupational Medicine Practice Guidelines, for multiple reasons, as discussed above. The Occupational Medicine Practice Guidelines are published by the American College of Occupational and Environmental Medicine, which is one of two governing bodies in the practice of occupational medicine, the other being the American Board of Preventive Medicine.

B. Whether Dr. Lundeen failed to maintain minimal standards acceptable to the selection and administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease, in violation of Section 4731.22(B)(2), Ohio Revised Code.

Unfortunately, Dr. Lundeen failed to maintain the minimal standards applicable to the selection and administration of drugs. There is no objective evidence that this individual's medical status in regards to this right upper extremity injury changed in any significant way during the period of treatment of Dr. Lundeen from 07/28/97 to 08/19/00. However, this individual's ever increasing dosages of narcotic analgesics and other mood-altering drugs over time are clear indications that this individual had the potential for narcotic dependency and/or addiction and/or tolerance.
* * *

(St. Ex. 30 at 57)

240. Dr. Cunningham's written report included the following opinions with regard to Dr. Lundeen's care of Patient 7's with regard to his 2002 injuries:

A. Whether Dr. Lundeen's treatment/care constituted a departure from or failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient was established, in violation of Section 4731.22(B)(6), Ohio Revised Code.

No. Unfortunately, Dr. Lundeen's treatment and care constituted multiple significant departures or failures from conformity to minimal standards of care of similar practitioners under the same or similar circumstances. The physical examinations performed, except for the original office visit record, and the medications provided were clear departures from minimal standards of care from similar practitioners. Dr. Lundeen's medications were outside of the Ohio BWC treatment guidelines and the peer reviewed treatment guidelines, such as the Official Disability Guides and the Occupational Medicine Practice Guidelines, for the reasons discussed above. The Occupational Medicine Practice Guidelines is published by the American College of Occupational and Environmental Medicine, which is one of the two governing bodies for the practice of occupational medicine, the other being the American Board of Preventive Medicine.

B. Whether Dr. Lundeen failed to maintain minimal standards acceptable to the selection and administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease, in violation of Section 4731.22(B)(2), Ohio Revised Code.

Unfortunately, Dr. Lundeen failed to maintain the minimal standards applicable to the selection and administration of drugs. As discussed above, the classes of medications provided were in many respects not supported, and the increased total narcotic dosage over time, especially when this individual's head injury difficulties seem to have improved dramatically after the beginning of Dr. Lundeen's treatment, is not supported, which raises the question as to whether or not this individual had the potential for narcotic dependency and/or addiction and/or tolerance, and this issue was not addressed by Dr. Lundeen in his records.

(St. Ex. 30 at 64-65)

241. In his initial report, Dr. Cunningham provided an extensive review of Dr. Lundeen's care of Patient 7 with regard to the 2002 injury. However, the Hearing Examiner notes that some of the items that Dr. Cunningham faulted Dr. Lundeen for not having done (certain consultations and tests) were found by Dr. Cunningham to be included in the additional medical records subsequently provided to him. Dr. Cunningham also noted in his supplemental report that there was a pain contract in Patient 7's file. (St. Exs. 30, 30A)

242. However, during the hearing, Dr. Cunningham testified that his review of the additional records had not changed his ultimate opinion regarding whether Dr. Lundeen had violated the standard of care. (Tr. at 412)

Dr. Lundeen's Written Defense – Patient 7

243. Dr. Lundeen summarized some of Patient 7's history, and he asserted, among other things, that his care of Patient 7 had been "authorized by the Bureau of Worker's Compensation for each service, diagnosis, medication, and prescriptions provided, except for Soma." (Resp. Ex. Z)

Patient 8

General Information

244. Patient 8, a male born in 1949, suffered an industrial injury in 1977. The diagnoses stated by Dr. Lundeen, which are the same as the conditions allowed in the patient's workers' compensation claim, are "725.2 Lumbago,[42] 724.6 Disorders of sacrum, and 724.5 Backache NOS." (St. Ex. 8 at 5, 21-271)

245. In a letter dated May 14, 2008, Dr. Lundeen stated that he had been treating Patient 8 since August 2, 1993. In a letter dated December 8, 2008, Dr. Lundeen stated that he had been treating Patient 8 since December 1996.[43] The earliest medical records consist of a Drug Utilization Report listing the drugs prescribed by Dr. Lundeen for Patient 8 in March 1997 . (St. Ex. 8 at 14, 19-21, 273)

246. Medical records for Patient 8 were admitted as State's Exhibits 8 and 8A.[44] Dr. Cunningham's initial written opinion is set forth in State's Exhibit 30 at pages 66 to 71, and his supplemental opinion is set forth in State's Exhibit 30A, pages 6 to 7 and 14 to 15. Dr. Cunningham's testimony regarding Patient 8 is found in the transcript starting at page 414. Dr. Ross' opinion is set forth in Respondent's Exhibit A, page 35, and Dr. Lundeen's written opinion is set forth in Respondent's Exhibit Z, pages 15 to 16.

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[42] Lumbago is pain in the lower back. (St. Ex. 30 at 66)

[43] This discrepancy does not affect the central issues regarding Dr. Lundeen's care of Patient 8 starting in 1997 and continuing into 2011. (Tr. at 414-420)

[44] In State's Exhibit 8A, there are pages that appear to have nothing to do with Patient 8 but are medical records for a different patient of Dr. Lundeen. See St. Ex. 8A at 9-11.

1997 – Patient 8

247. According to the Drug Utilization Report, Dr. Lundeen prescribed the following drugs for Patient 8 on March 11, 1997:

Date	Drug	Strength	Freq.	Refills
3/11/97	Vicodin ES	7.5/750 mg	1 q.i.d.	3
3/11/97	Soma	350 mg	1 t.i.d.	3
3/11/97	Valium	10 mg	1 t.i.d.	3

(St. Ex. 8 at 273)

248. The earliest progress notes in Dr. Lundeen's electronic records are for a visit on November 7, 1997, as follows:

> SUBJECTIVE: Since the patient's last visit, the patient's condition is same. Activities impaired include lower back. Pain is noted lower back. No other practitioner is currently prescribing medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include recent heart transplant.
>
> OBJECTIVE: SLR R 10 degrees, SLR L 30 degrees, spasms present in lower back. Gait slow with cane and right foot drop brace. Station (balance) list to left. Stronger lower extremity left. Motor function of R leg is grade 3 out of 5. Motor function of the L leg is grade 4 out of 5.
>
> ASSESSMENT: The patient has pain which is chronic in nature and is intense in severity. A good understanding of the patient's conditions, medical history and other important facts are integrated into the current treatment plan.
>
> PLAN: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. Minimize use of narcotic medication, take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx controlled/narcotic medications. Patient understand [sic] potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency or addiction will be made. A moderate degree of dependency is normal and should be anticipated with the usage of such controlled/narcotic medication(s). Beyond a normal reasonable degree of day to day dependency on such medications for ADL's, abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons. Employment status none.

(St. Ex. 8 at 21, signatures omitted)

249. At that November 1997 visit, Dr. Lundeen prescribed the same medications for Patient 8 except that only one refill was provided for each drug. (St. Ex. 8 at 273)

1999 to 2003 Prescriptions – Patient 8

250. In June and July 1999, Dr. Lundeen reported the following prescriptions for Patient 8:

Date	Drug	Strength	Qty/Freq		#
6/18/99	Carisoprodol	350 mg	1	three x day	93
6/18/99	Valium	10 mg	1	three x day	90
6/18/99	Lortab	10/500 mg	2	three x day	180
7/09/99	Percocet	5/325 mg	1	three x day	30
7/09/99	Valium	10 mg	1	three x day	30
7/19/99	Valium	10 mg	1	three x day	63
7/19/99	Carisoprodol	350 mg	1	three x day	63
7/19/99	Lortab	10/500 mg	2	three x day	102
7/19/99	Percocet	5/325	1	three x day	63
8/09/99	Carisoprodol	350 mg	1	three x day	105
8/09/99	Percocet	5/325	1	*four* x day	120
8/09/99	Lortab	10/500	2	three x day	210
8/09/99	Valium	10 mg	1	three x day	105

(St. Ex. 8 at 273)

251. The prescriptions for Patient 8 in December 2002 and February 2003 are listed by Dr. Lundeen as follows to treat lumbago, backache, and disorders of the sacrum:

Date	Start	End	Diagnosis	Drug	Strength	Qty/ Freq	#
12/26/02	12/26	3/20	Lumbago	Valium	10 mg	1 t.i.d.	84 (2 refills)
12/26/02	12/26	6/12	Lumbago	Soma	350 mg	1 t.i.d.	84 (5 refills)
12/26/02	12/26	1/23	Backache NOS	Percocet	10/325 mg	1 four x day	112
12/26/02	12/26	1/23	Disord of sacrum	Lortab	10/500 mg	1 t.i.d.	84
12/26/02	12/26	1/23	Disord of sacrum	Percocet	10/325 mg	1 four x day	112
12/26/02	12/26	1/23	Lumbago	Percocet	10/325 mg	1 four x day	112
			* * *				
2/13/03	2/13	5/14	Backache NOS	Diazepam	10 mg	1 t.i.d.	90 (2 refills)
2/13/03	2/13	5/15	Disord of sacrum	Lortab	10/500 mg	1 t.i.d.	90 (2 refills)
2/13/03	2/13	3/15	Backache NOS	Percocet	10/325 mg	1 five x day	150
2/13/03	2/13	3/15	Disord of sacrum	Percocet	10/325 mg	1 five x day	150
2/13/03	2/13	3/15	Lumbago	Percocet	10/325 mg	1 five x day	150

(St. Ex. 8 at 277)

252. The electronic progress notes for Patient 8 in December 2002 and February 2003 explain the prescriptions as follows:

December 26, 2002
SUBJECTIVE: Since the patient's last visit, the patient's condition is ongoing. Activities impaired include: back. Pain is noted by patient in regions of back. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include back.

OBJECTIVE: Seated straight leg raising, SLR, R 5 degrees, SLR L 5 degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: cane.

ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued. Consideration of relative costs of medications has been made in selecting medications for treatment of injuries sustained in this industrial claim.

PLAN: The patient has been advised that one or more of the RX medications are potentially addictive or habit-forming. The patient desires to continue the medication(s) in order to maximize therapeutic benefit. Every effort will be made to keep the quantities of such medications as low as possible.

* * *

February 13, 2003
SUBJECTIVE: Since the patient's last visit, the patient's condition continues. Activities impaired include: back. Pain is noted by patient in regions of back. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include more pain.

OBJECTIVE: Seated straight leg raising, SLR, R 5 degrees, SLR L 5 degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Cane.

ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued. Consideration of relative costs of medications has been made in selecting medications for treatment of injuries sustained in this industrial claim.

> PLAN: The patient has been advised that one or more of the RX medications are potentially addictive or habit-forming. The patient desires to continue the medication(s) in order to maximize therapeutic benefit. Every effort will be made to keep the quantities of such medications as low as possible. Employment status = PTD [permanent total disability].

253. In November 2004, the Percocet dose (10/325 mg) was changed from five times a day to six times a day. (St. Ex. 8 at 278)

254. In September 2005, the dose of Valium 10 mg was increased from three times per day to four times per day. In November 2005, the Valium 10 mg was increased to five times per day. (St. Ex. 8 at 279)

255. In April 2007, the Percocet (10/325 mg, six times daily) was changed to Magnacet 10/400 mg, six times daily, which maintained the dose of oxycodone at 60 mg per day but increased the dose of acetaminophen.

Dr. Cunningham's Opinion Regarding Physical Examinations – Patient 8

256. Dr. Cunningham testified that the physical examination documented by Dr. Lundeen on November 7, 1997, was not sufficient to meet the standard of care for the diagnosed conditions. Dr. Cunningham noted the lack of a sensory examination, range of motion for the back, the location of any tenderness in the low back, atrophy if any, and testing of reflexes. (Tr. at 415-416)

257. With respect to Dr. Lundeen's examination of Patient 8 on January 19, 2001, Dr. Cunningham also criticized the examination as documented. He testified that the lack of measurement of the atrophy was a violation of the standard of care. Further, Dr. Cunningham stated that none of the office-visit records document basic orthopedic tests such as supine straight leg raising, Faber's testing, the ability to stand on one's heels or toes, sensory examination, deep tendon reflexes, and/or supine straight leg raising. (Tr. at 417-418, St. Ex. 8 at 67; St. Ex. 30 at 67)

258. In addition, Dr. Cunningham criticized the examination findings made by Dr. Lundeen on October 5, 2001, noting that Dr. Lundeen had reported that Patient 8 was able to raise his right leg "zero degrees" and his left leg "zero degrees." Dr. Cunningham opined that, given the seated leg-raising used by Dr. Lundeen, this notation means that Patient 8 could not lift either heel from the floor. Dr. Cunningham testified that, if that were true, then the patient would be unable to walk, but Dr. Lundeen had stated that Patient 8 could walk, albeit with a cane. (St. Ex. 8 at 81, Tr. at 418-419)

Prescriptions Issues in 2008 - Patient 8

259. According to the Drug Utilization Chart in Patient 8's electronic records, Dr. Lundeen prescribed the following drugs for the patient in December 2007 through March 2008:

Date	Diagnosis	Drug	Strength	Qty/Freq
12/01/07	Lumbago	Oxy IR	5 mg	1 q4° (six x day)
12/01/07	Backache NOS	Lortab	10/500 mg	1 b.i.d.
12/01/07	Backache NOS	Magnacet	10/400mg	1 four x day
12/01/07	Lumbago	Lidoderm patch	5%	2 q.d.
12/01/07	Backache NOS	Colace	100 mg	1 t.i.d.
12/01/07	Backache NOS	Diazepam	10 mg	1 five x day
12/29/07	Backache NOS	Lortab	10/500 mg	1 b.i.d.
12/29/07	Lumbago	Lidoderm patch	5%	2 q.d.
12/29/07	Backache NOS	Diazepam	10 mg	1 five x day
12/29/07	Backache NOS	Colace	100 mg	1 t.i.d.
12/29/07	Backache NOS	Magnacet	10/400mg	1 four x day
12/29/07	Lumbago	Oxy IR	5 mg	1 q4°
1/19/08	Lumbago	Oxy IR	5 mg	1 q4°
1/19/08	Backache NOS	Colace	100 mg	1 t.i.d.
1/19/08	Backache NOS	Lortab	10/500 mg	1 b.i.d.
1/19/08	Backache NOS	Diazepam	10 mg	1 five x day
1/19/08	Backache NOS	Magnacet	10/400mg	1 four x day
1/19/08	Lumbago	Lidoderm patch	5%	2 q.d.
2/16/08	Lumbago	Lidoderm patch	5%	2 q.d.
2/16/08	Backache NOS	Diazepam	10 mg	1 five x day
2/16/08	Backache NOS	Magnacet	10/400mg	1 four x day
2/16/08	Backache NOS	Lortab	10/500 mg	1 b.i.d.
2/16/08	Backache NOS	Colace	100 mg	1 t.i.d.
2/16/08	Lumbago	Oxy IR	5 mg	1 q4°
3/15/08	Lumbago	OxyIR	5 mg	1 q4°
3/15/08	Lumbago	Lidoderm patch	5%	2 q.d.
3/15/08	Backache NOS	Lortab	10/500 mg	1 b.i.d.
3/15/08	Backache NOS	Magnacet	10/400 mg	1 four x day
3/15/08	Backache NOS	Colace	100 mg	1 t.i.d.
3/15/08	Backache NOS	Diazepam	10 mg	1 five x day
3/29/08	Lumbago	Deltasone	5 mg	1 q.d.[45]

(St. Ex. 8 at 282-283)

[45] Deltasone is a brand of prednisone, a corticosteroid. (Nat'l Library of Medicine, Nat'l Inst. of Health, at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000091>, accessed 10/28/11)

260. In a letter dated May 14, 2008, Dr. Lundeen responded to a medical opinion rendered by Dr. Mascarenhas on May 5, 2008, with regard to the prescriptions that Dr. Lundeen had been providing to Patient 8:

> As you aware [Patient 8] is under my care for treatment of injuries he sustained on October 28, 1977.
>
> The Bureau of Workers' Compensation has apparently terminated, or is in the process of, terminating payment of prescription medication based on a file review performed by Dr. Mascarenhas on May 5, 2008.
>
> First, Dr. Mascarenhas has not examined [Patient 8], his opinion's [sic] are based on a file review. Furthermore, Dr. Mascarenhas' review is not factually correct.
>
> Dr. Mascarenhas indicates that [Patient 8] "came under the care of James Lundeen on or about 2000". When in fact, [Patient 8] has been treating with this physician since August 2, 1993.
>
> It appears that Dr. Mascarenhas does not feel any treatment including medications are appropriate because [Patient 8] sustained "soft tissue injuries" which "generally resolve in a matter of several weeks".
>
> [Patient 8] has spinal injuries as allowed conditions in this claim. Spine pain is often very severe and debilitating, as is the case with this claimant. Apparently, Dr. Mascarenhas is not aware that in 1977, BWC did not require specific diagnoses, as "allowed conditions" were more general until 1991 when ICD codes were implemented. Therefore, sprain injuries of the spine in 1977 may well have been much more serious injuries to the spine. Which is obviously the case, since [Patient 8] has been receiving ongoing treatment for his conditions since the date of injury.
>
> In addition, I would like to point out that on March 20, 2008, the Bureau sent a letter to this physician ([Patient 8] faxed it to my office on May 12, 2008; copy attached) regarding the use of prescription medications. The Bureau apparently mailed this letter to: 5599 Pearl Road.
>
> I have not had an office on Pearl Road in Parma since 1996, and therefore, obviously never received this letter until [Patient 8] faxed it on May 12.
>
> RECENT EXAMINATION
>
> > **Subjective:** Since the last visit, the patient's condition continues without significant change. Pain level today = 10. Activities impaired include: back, legs. Office: WM. Pain is noted by patient in regions of injury. Employment status: PTD.

> **Objective:** Seated straight leg raising, SLR, R 5 degrees, SLR L 5 degrees, spasms present in lower back. Gait: cane. Flexion 25 degrees, extension 5 degrees, right lateral flexion 15 degrees and left lateral flexion 15 degrees.
>
> **Assessment:** No major change in medications prescribed.
>
> **Plan:** The next scheduled appointment with this examiner is in 4 weeks.
>
> SUMMARY
>
> As a result of the injuries sustained in this industrial accident and despite ongoing conservative treatment, [Patient 8] continues to have pain and symptoms in his lower back and legs.
>
> The medications prescribed:
> Lidoderm patch; Lortab, Magnacet and OxyIR are prescribed in combination for control of ongoing severe lower back pain.
> Diazepam is prescribed for control of muscles spasms in the lower back.
> Colace is prescribed to prevent constipation which is an unfortunate however common side effect of narcotic medications.
>
> Multiple narcotic medication use: Medications from this physician include one or more narcotic medications. The treatment rationale for a mixture of such medications is to titrate symptom control optimally with the least amount of stronger medication in conjunction with medication(s) in milder class(es). The goal is to control symptoms efficiently and with the safest medications which are effective for this patient's symptoms.
>
> Based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it is my opinion, that: the prescribed medications provide adequate relief of painful symptoms and allow the patient to perform his daily living activities. Furthermore, I maintain that [Patient 8]'s medications are medically necessary, effective and safe for his use.

(St. Ex. 8 at 14-15)

261. In a letter dated August 1, 2008, Dr. Lundeen again wrote in support of the medications he had prescribed for Patient 8:

> This correspondence concerns [Patient 8] who is under my care for treatment of injuries he sustained on October 28, 1977.
>
> Topic: prescription medications.
>
> As you are aware, the Hearing Officer was reluctant to order a blanket denial regarding all medications, however found that the prescriptions were excessive and not reasonable for the allowed conditions in this claim.

> Two (narcotic) prescriptions have been completely eliminated. Percocet (oxycodone/acetaminophen) which had been prescribed 5 times daily; and OxyIR (oxycodone) which had been prescribed every 4 hours as needed.
>
> I have attached a list of the medications currently prescribed to [Patient 8] for control of chronic pain and symptoms based on the allowed conditions in this claim.
> Magnacet 10/400 mg (oxycodone/acetaminophen) to take 5 times daily as needed for control of chronic low back pain.
> Lortab 10/500 mg (hydrocodone/bitartrate) to take twice daily as needed for control of chronic low back pain.
> Lidoderm patch (lidocaine 5%) to use 1 patch daily to help control chronic low back pain.
> Diazepam 10 mg to take 5 times daily as needed for control of low back spasms.
>
> SUMMARY
>
> As a result of the injuries sustained in this industrial accident and despite ongoing conservative treatment, [Patient 8] continues to have moderate to severe chronic pain in his low back and severe spasms.
>
> Based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it is my opinion, that: the currently prescribed medications provide adequate relief of painful symptoms and allow the patient to perform his daily living activities. Furthermore, I maintain that [Patient 8]'s medications are medically necessary, effective and safe for his use.

(St. Ex. 8 at 17-18)

262. On August 27, 2008, according to a notation by a staff member at Dr. Lundeen's office, an IME was performed by Dr. Michael A. Harris with regard to Patient 8's medications. Dr. Harris' report was described as containing the following recommendations:

> Dr. Michael A. Harris performed an IME on 8-27-08 and recommends that both short-acting opioids should be discontinued and replaced with 1 long-acting opioid such as Ultram ER, MS Contin, Opana ER or even Methadone if necessary. He also recommends a gradual wean from Diazepam as the present dose is excessive and unnecessary; he recommends Skelaxin or Flexeril. Dr. Harris also indicates trial of Neurontin or Lyrica may be helpful.

(St. Ex. 8 at 300)

263. In a letter dated December 8, 2008, Dr. Lundeen set forth his opinion regarding the prescription medications for Patient 8:

> DIAGNOSES: lumbago; disorders of sacrum; backache, nos.
>
> Topic: prescription medication.
>
> As you are aware, Dr. Michael A. Harris performed an IME on August 27, 2008.
>
> Dr. Harris indicates that ongoing use of opioid is a valid option in the treatment of severe chronic non-malignant pain.
>
> However, Dr. Harris further opines that the present opioid regimen is both inappropriate and excessive.
>
> I have been treating [Patient 8] since December 1996. I am well aware of his medical history.
>
> I have also tried to adjust [Patient 8]'s medications recently. Unfortunately, we have not been able to discontinue the two short acting opioid. [*sic*]
>
> RECENT EXAMINATION
>
> November 22, 2008
> **Subjective:** Since the last visit, the patient's condition continues without significant change. Pain level today = 8-10. Activities impaired include: back, legs, balance. Office: DM. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: PTD.
>
> **Objective:** Seated straight leg raising, SLR, R 5 degrees, SLR L 5 degrees, spasms present in lower back. Gait: cane. Admits to fecal urgency. Stronger lower extremity today: left leg. Flexion 25 degrees, extension 5 degrees, right lateral flexion 5 degrees and left lateral flexion 5 degrees.
>
> **Assessment:** No major change in medications prescribed.
>
> **Plan:** The next scheduled appointment with this examiner is in 4 weeks.
>
> SUMMARY
>
> Spine pain of this severity requires potent pain (often narcotic) medication and potent skeletal muscle relaxant medication to effectively control painful symptoms. Dr. Harris is not the treating physician, does not examine the claimant on a regular basis as I do and Dr. Harris, to my knowledge does not

> condone narcotic pain medication for treatment of chronic intractable benign pain, despite State Laws in Ohio which have clarified this issue.
>
> Based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it is my opinion, that: the prescribed medications provide adequate relief of painful symptoms and allow the patient to perform his daily living activities. Furthermore, I maintain that [Patient 8]'s medications are medically necessary, effective and safe for his use.

(St. Ex. 8 at 19-20)

2011 Prescription Drugs

264. On January 6, 2011, Dr. Lundeen listed the same diagnoses as listed since 1997. He stated as follows with regard to Patient 8's current status and his examination:

> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 10. Activities impaired include: back, legs. Office: DM. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications.
> Employment status: none. Income: PTD.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 10 degrees, SLR L 15 degrees, spasms present in lower back. Gait: cane. Flexion 25 degrees, extension 5 degrees, right lateral flexion 10 degrees and left lateral flexion 15 degrees.
>
> ASSESSMENT: Medication selection: PER, BWC, IME, report. [*sic*]
>
> PLAN: The next scheduled appointment with this examiner is in 4 weeks. Random drugs tests approximately twice a year. Medications from this physician include more than one scheduled narcotic medications in the strong DEA classification group 2. [Omitted: additional narcotic information] Use of multiple medications due to severity of symptoms and difficulty with dose titration with single drug from this category.

(St. Ex. 8 at 271, signatures omitted)

265. According to Dr. Lundeen's Drug Utilization Chart for Patient 8, the following drugs were prescribed in January 2011:

Date	Diagnosis	Drug	Strength	Qty/Freq	Total Daily Dose
1/06/11	Lumbago	Norco	10/325 mg	1 two x day	20 mg hydrocodone & 650 mg acetaminophen
1/06/11	Backache NOS	Diazepam	10 mg	1 five x day	50 mg diazepam (Valium)
1/06/11	Lumbago	Percocet	10/325 mg	2 five x day	100 mg oxycodone & 3,250 mg acetaminophen
1/06/11	Lumbago	Morphine	30 mg	1 three x day	90 mg morphine

(St. Ex. 8 at 286)

Dr. Cunningham's Testimony Regarding the Increased Dosage – Patient 8

266. Dr. Cunningham testified that Dr. Lundeen had not documented symptoms or conditions that would justify the increase in the dosages of medications `for Patient 8. He noted that the patient's diagnoses had not changed since 1997 and that there was not any significant change in objective examination findings over time. (Tr. at 416-418)

Dr. Cunningham's Written Report – Patient 8

267. Dr. Cunningham opined that Dr. Lundeen's treatment and care of Patient 8 constituted "multiple significant departures or failure from conformity to minimal standards of care of similar practitioners under the same or similar circumstances." He found "virtually no objective physical examination findings in Dr. Lundeen's records, including no description of height, weight, reflexes present or absent, sensation, ability to stand, sit and/or lie, or to walk on one's toes or heels." Dr. Cunningham stated that the prescriptions for Soma and/or the Valium/diazepam medications, along with the narcotic medications provided by Dr. Lundeen, were far outside treatment guidelines. Further, Dr. Cunningham stated that "the dramatically increased narcotic dosages" in recent years causes concern for narcotic dependency and/or addiction and/or tolerance. He opined that Patient 8 "should long ago have been referred to a physician skilled in the diagnosis and management of individuals with narcotic addiction, dependency and/or tolerance." (Tr. at 419-420, St. Ex. 30 at 68-70)

268. In his supplemental report, Dr. Cunningham noted that there were no new documents for Patient 8 in State's Exhibit 8A. (St. Ex. 30A at 6)

269. In addition, Dr. Cunningham opined that Dr. Lundeen had "failed to maintain the minimal standards applicable to the selection and administration of drugs." He concluded that there was a lack of objective evidence that Patient 8's medical status in regards to his low back and lower extremity symptoms changed in a significant way from 1997 to 2011. Further, Dr. Cunningham commented that, with regard to the narcotic therapy provided by Dr. Lundeen to Patient 8, "there are no random drug

screen tests within the record, and there is no objective evidence to support the increased total narcotic dosage in recent years are far and above what one would expect in the normal course of an individual who has self-limiting diagnoses, which long ago, on a peer-reviewed treatment basis, resolved." (St. Ex. 30 at 70-71)

270. With respect to whether Dr. Lundeen's treatment of Patient 8 complied with the Board's intractable pain rules, Ohio Admin. Code Sections 4731-21-01 through 06, Dr. Cunningham found that Dr. Lundeen's prescribing of increasing doses of narcotics did not comply. In addition to the opinions he had already stated regarding the narcotics prescribing, Dr. Cunningham noted that he had seen no evidence of a formal, signed "pain contract" within the record, and, if a contract was signed, then there was no evidence that the "pain contract" had been periodically reviewed, which, in Dr. Cunningham's opinion would be appropriate throughout the course of Dr. Lundeen's care of this patient.[46] Further, Dr. Cunningham relied on the lack of any urine drug-screening, random or otherwise, during the period of increased narcotic prescribing. (St. Ex. 30 at 71)

Dr. Lundeen's Written Defense – Patient 8

271. Among other things, Dr. Lundeen stated that Patient 8 is being managed for a heart transplant at "the VA hospital," which he said was managing all of the patient's internal-medicine issues and medications. Dr. Lundeen further asserted that the BWC "selected" the medications for Patient 8 two years previously after a series of hearings. Dr. Lundeen stated that the BWC, through an IME physician, had selected the regimen of Percocet, diazepam, morphine, and Norco. Dr. Lundeen further asserted that Patient 8 is now "without pain medications" because Dr. Lundeen cannot treat him due to the license suspension and that, as a result, the patient has regressed from a cane to a wheelchair because he can no longer walk without pain medications.[47] He further asserted, among other things, that the BWC authorized each prescription that he provided. (Resp. Ex. Z)

Patient 9

General Information

272. Patient 9, a female born in 1974, sustained an injury at work in May 2000 when a metal coffee machine fell two feet and struck her on the head, neck and left shoulder. She first saw Dr. Lundeen on June 29, 2000. His initial diagnosis was "920 Contusion face/scalp/neck." By September 2001, Dr. Lundeen's diagnoses, as well as the allowed

[46] Patient 8 is the one of the patients for whom there is no pain contract in the record.

[47] The Hearing Examiner notes that many of these assertions are not supported by evidence in the record, and the written position statement of Dr. Lundeen was not signed by Dr. Lundeen. Further, Dr. Lundeen did not appear at the hearing to make his representations under oath or subject to cross-examination.

conditions in the workers' compensation claim, were listed as "920. Contusion Face/Scalp/Nck" and "847.0 Sprain Of Neck." In September 2001, Dr. Lundeen proposed that the following diagnoses be added to the workers' compensation claim: "723.3 Cervicobrachial Syndrome, 805.2 Fx [Fracture] Dorsal Vertebra-Close, T-2 Level." As of December 2002, there were eight conditions diagnosed, which were the same as the allowed conditions in the workers' compensation claim, as set forth below. (E.g., Tr. at 6, 14, 22, 34, 45, 46) (The Hearing Examiner notes that Dr. Lundeen was involved in getting additional conditions recognized in the workers' compensation claim, and he would sometimes list the conditions currently allowed by the BWC as his formal "diagnoses" while indicating his belief that other conditions were present and making efforts to have those conditions allowed in the BWC claim.)

273. Medical records for Patient 9 were admitted as State's Exhibits 9 and 9A. Dr. Cunningham's initial written opinion is set forth at State's Ex. 30 at pages 72 to 80, and his supplemental opinion is set forth in State's Exhibit 30A, pages 7 and 14-15. His testimony regarding this patient is found at transcript pages including 421 to 430. Dr. Ross' opinion is set forth at Respondent's Exhibit A, pages 35 to 36, and Dr. Lundeen's written opinion is set forth in Respondent's Exhibit Z at page 16.

Patient 9's Treatment in 2000 and 2001

274. Dr. Lundeen's Drug Utilization Report for Patient 9 includes the following prescriptions in 2000 and 2001:

Date	Diagnosis	Drug	Strength	Qty/Freq	#
6/29/00	920. Contusion Face/Scalp/Nck	Vicodin ES	7.5/750mg	1 four x day	112
6/29/00	920. Contusion Face/Scalp/Nck	Soma	350 mg	1 at night	28
7/13/00	920. Contusion Face/Scalp/Nck	Soma	350 mg	1 four x day	100
7/13/00	920. Contusion Face/Scalp/Nck	Vicodin ES	7.5/750mg	1 four x day	100
7/27/00	806.21 T1-T6 Fx Cl /Com Cord Les[48]	Percocet	5/325 mg	1 four x day	32
8/15/00	806.21 T1-T6 Fx Cl /Com Cord Les	Percocet	5/325 mg	1 four x day	60
8/24/00	920. Contusion Face/Scalp/Nck	Vicodin ES	7.5/750mg	1 four x day	120
8/24/00	920. Contusion Face/Scalp/Nck	Soma	350 mg	1 four x day	120
8/24/00	806.21 T1-T6 Fx Cl /Com Cord Les	Percocet	5/325 mg	1 four x day	60
9/07/00	806.21 T1-T6 Fx Cl /Com Cord Les	Percocet	5/325 mg	1 four x day	56

[48] The ICD-9 code 806.21 identifies a closed fracture of the thoracic spine with lesion of the spinal cord. (E.g., <ICD9data.com> and <www.icd9.us/806.21>, accessed 10/31/11)

9/28/00	920.	Contusion Face/Scalp/Nck	Soma	350 mg	1 four x day	28
9/28/00	920.	Contusion Face/Scalp/Nck	Vicodin ES	7.5/750	1 four x day	28
9/28/00	920.	Contusion Face/Scalp/Nck	Percocet	5/325 mg	1 four x day	28

* * *

1/23/01	920.	Contusion Face/Scalp/Nck	Vicodin ES	7.5/750mg	1 four x day	80
1/23/01	920.	Contusion Face/Scalp/Nck	Xanax	0.50 mg	1 t.i.d.	90
1/23/01	920.	Contusion Face/Scalp/Nck	Soma	350 mg	1 four x day	80
1/23/01	920.	Contusion Face/Scalp/Nck	Percocet	5/325 mg	1 four x day	120
2/22/01	920.	Contusion Face/Scalp/Nck	Vicodin ES	7.5/750mg	1 four x day	84
2/22/01	920.	Contusion Face/Scalp/Nck	Soma	350 mg	1 four x day	84
2/22/01	920.	Contusion Face/Scalp/Nck	Percocet	5/325 mg	1 four x day	84
2/22/01	920.	Contusion Face/Scalp/Nck	Xanax	0.50 mg	1 t.i.d.	63
3/15/01	920.	Contusion Face/Scalp/Nck	Percocet	5/325 mg	1 four x day	60
3/15/01	920.	Contusion Face/Scalp/Nck	Vicodin ES	7.5/750 mg	1 four x day	60
3/15/01	920.	Contusion Face/Scalp/Nck	Xanax	0.50 mg	1 t.i.d.	45
3/15/01	920.	Contusion Face/Scalp/Nck	Soma	350 mg	1 four x day	60
3/30/01	920.	Contusion Face/Scalp/Nck	Percocet	5/325 mg	1 four x day	108
3/30/01	920.	Contusion Face/Scalp/Nck	Xanax	0.50 mg	1 T.I.D.	81
3/30/01	920.	Contusion Face/Scalp/Nck	Vicodin ES	7.5/750mg	1 four x day	108
3/30/01	920.	Contusion Face/Scalp/Nck	Soma	350 mg	1 four x day	108
3/30/01	920.	Contusion Face/Scalp/Nck	PhenerganVC	6.25/5cc	1 every 4 hrs	12 (3) (refills)

(St. Ex. 9 at 223)

275. In a letter dated February 11, 2001, Dr. Lundeen wrote a letter to the workers' compensation MCO regarding his treatment of Patient 9, starting in June 2000, as follows:

> This correspondence concerns [Patient 9] who is under my care for treatment of injuries she sustained on May 19, 2000. This medical report details the history, subjective complaints, objective examination findings, diagnoses, recommended treatment, as well as prognosis for [Patient 9]. * * *
>
> DIAGNOSES
> 920. Contusion Face/Scalp/Nck
>
> HISTORY OF INJURY
> [Patient 9] is a 26 year old female who presented herself to this office for expert medical care and advice for injuries she received on May 19, 2000.

This report is written to appeal the denial of authorization of the dynamic fluoroscope study of the cervical spine.

EXAMINATIONS

June 29, 2000
Subjective: *This patient is new to this medical practice.* She sustained injuries to her head, neck and left shoulder when a steel coffee pot fell about 2 feet and struck her head, neck and left shoulder. Neck, left shoulder movements, grips are affected. (Emphasis added)

Objective: Cervical spine range of motion: 50 degrees right lateral rotation, 35 degrees left lateral rotation, 30 degrees right lateral flexion, 30 degrees left lateral flexion, 40 degrees forward flexion and 30 degrees of neck extension; all movements are painful, flexion and extension result in vertigo. Motor strength determined by resistance testing: right upper extremity: C5 3+/5, C6 3+/5, C7 3+/5 and C8-T1 3+/5; left upper extremity: C5 3+/5, C6 3+/5, C7 3+/5 and C8-T1 3+/5. Grip in pounds right 15 and left 9. Evidence of surgery: none.

Assessment: The patient's diagnoses include the following: contusion head, probable HNP C5, bilateral cervical radiculopathy, vertigo.

Plan: A combination of Rx and Rx/controlled medication(s) is the current medication plan. The specific information is available in the patient's chart and/or computer account this SOAP note database. The use of controlled medication(s) is justified based on the patient's subjective and objective examination findings and is necessary in order for the patient to perform ADL's. Employment status: yes. C9 MRI of cervical spine.

July 13, 2000
Subjective: Since the patient's last visit, the patient's condition is neurologically stable at present. Activities impaired include neck, upper back, left arm adls. Pain is noted neck, upper back, left arm. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include T2 displaced vertebral compression fracture.

Objective: Cervical spine range of motion: 45 degrees right lateral rotation, 45 degrees left lateral rotation, 30 degrees right lateral flexion, 25 degrees left lateral flexion, 25 degrees forward flexion and 20 degrees of neck extension; most movements are painful. Grip in pounds right 30 and left 22. MRI revealed 50% or greater compression fracture with displacement, T2 vertebra.

Assessment: Based on her examination and MRI, I have recommended a consultation for surgery to the patient. I will make a referral to Dr. Michael Eppig. C9 form completed.

Plan: A combination of Rx and Rx/controlled medication(s) is the current medication plan. The specific information is available in the patient's chart and/or computer account this SOAP note database. The use of controlled medication(s) is justified based on the patient's subjective and objective examination findings and is necessary in order for the patient to perform ADL's. Employment status: TT. C9 completed.

July 27, 2000
Subjective: Since the patient's last visit, the patient's condition is worse, weaker grips, subjectively worse too. Activities impaired include neck movements, grips. Pain is noted upper back, neck, arms. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are less effective without adverse or intolerable side effects. New problems include weaker grips and more pain. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date.

Objective: Unable to move head in any plane. Grip right 15 pounds and left 8 pounds.

Assessment: Needs rigid collar.

Plan: The patient has been advised that one or more of the RX medications are potentially addictive or habit-forming. The patient desires to continue the medication(s) in order to maximize therapeutic benefit. Every effort will be made to keep the quantities of such medications as low as possible. Employment status = TT. Rx for rigid collar. Recheck 8/4/2000. No driving, may be driven.

August 15, 2000
Subjective: Since the patient's last visit, the patient's condition is ongoing. Activities impaired include neck, upper back, arms, left leg. Pain is noted spine, arms, left leg. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include none. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date.

Objective: Cervical spine range of motion: 25 degrees right lateral rotation, 25 degrees left lateral rotation, 20 degrees right lateral flexion, 15 degrees left lateral flexion, 10 degrees forward flexion and 10 degrees of neck extension; all movements are painful. Grip in pounds right 32 pounds and 10 pounds left.

Assessment: The patient has pain which is ongoing and is intense in severity. Sleep quality is adversely affected.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information} Employment status TT. To have additional tests and surgery.

August 24, 2000
Subjective: Since the patient's last visit, the patient's condition is ongoing, severe. Activities impaired include all adls. Pain is noted neck, upper back, arms. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include lightheaded, nausea. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date. MRI of cervical and thoracic reviewed. Patient encouraged to call Dr. Eppig for appointment as soon as available.

Objective: Cervical spine range of motion: 20 degrees right lateral rotation, 30 degrees left lateral rotation, 10 degrees right lateral flexion, 20 degrees left lateral flexion, 10 degrees forward flexion and 20 degrees of neck extension; most movements are painful; extension and lateral flexion cause vertigo. Grip in pounds right 25 (repeat 25) (prior visit 32) and left 8 (repeat 11) (prior visit 10).

Assessment: Needs to see Dr. Eppig at earliest available appointment. Must not work at all at this time.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information] Employment status TT. Recheck in 2 weeks. Wear cervical collar, rigid two piece collar. No physical exertion.

September 7, 2000
Subjective: Since the patient's last visit, the patient's condition is unremitting. Activities impaired include neck and upper back adls, grips. Pain is noted head, neck, arms. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New

problems include none. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date.

Objective: Cervical spine range of motion: 35 degrees right lateral rotation, 45 degrees left lateral rotation, 15 degrees right lateral flexion, 15 degrees left lateral flexion, 20 degrees forward flexion and 25 degrees of neck extension; most movements are painful; extension brings on vertigo. Motor strength determined by resistance testing: right upper extremity: C5 4/5, C6 3+/5, C7 3+/5 and C8-T1 3+/5; left upper extremity: C5 4/5, C6 3+/5, C7 3+/5 and C8-T1 3+/5. Grip in pounds right 22 and left 13.

Assessment: Need flexion/extension x-rays of cervical/thoracic spine.

Plan: A combination of Rx and Rx/controlled medication(s) is the current medication plan. The specific information is available in the patient's chart and/or computer account this SOAP note database. The use of controlled medication(s) is justified based on the patient's subjective and objective examination findings and is necessary in order for the patient to perform ADL's. Employment status: TT. C9 for additional testing.

September 28, 2000
Subjective: Since the patient's last visit, the patient's condition is ongoing. Activities impaired include neck, upper back, grips. Pain is noted neck and upper back. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include none. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date.

Objective: Cervical spine range of motion: 45 degrees right lateral rotation, 45 degrees left lateral rotation, 15 degrees right lateral flexion, 15 degrees left lateral flexion, 15 degrees forward flexion and 15 degrees of neck extension; movements are painful. Grip in pounds right 20 and left 12.

Assessment: The patient has pain which is ongoing and is intense in severity. Sleep quality is adversely affected.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information] Employment status TT. Tests next week.

October 5, 2000
Subjective: Since the patient's last visit, the patient's condition is unremitting. Activities impaired include neck stability, arm strength. Pain is noted neck and upper back, left arm. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include more pain in neck and left arm. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date.

Objective: Cervical spine range of motion: 35 degrees right lateral rotation, 35 degrees left lateral rotation, 15 degrees right lateral flexion, 10 degrees left lateral flexion, 15 degrees forward flexion and 20 degrees of neck extension; movements are painful. Grip in pounds right 15 and left 10; both grips very weak. Reports of neck and upper back x-rays were reported as normal; patient was not able to fully flex or extend her neck for these tests; I need to see the films and they may need to be retaken to get full flexion and extension.

Assessment: Not able to work. May begin physical therapy.

Plan: A combination of Rx and Rx/controlled medication(s) is the current medication plan. The specific information is available in the patient's chart and/or computer account this SOAP note database. The use of controlled medication(s) is justified based on the patient's subjective and objective examination findings and is necessary in order for the patient to perform ADL's. Employment status: TT.

November 6, 2000
Subjective: Since the patient's last visit, the patient's condition is ongoing, limited neck movements, vertigo, weak arms, pain in left leg. Activities impaired include neck movements, arm strength. Pain is noted neck, arms, left leg. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include none. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date.

Objective: Cervical spine range of motion: 40 degrees right lateral rotation, 45 degrees left lateral rotation, 15 degrees right lateral flexion, 15 degrees left

lateral flexion, 10 degrees forward flexion and 15 degrees of neck extension; all movements are painful; flexion or extension results in nausea/vertigo. Motor strength determined by resistance testing: right upper extremity: C5 4/5, C6 4/5, C7 4/5 and C8-T1 3+/5; left upper extremity: C5 3+/5, C6 3/5, C7 3/5 and C8-T1 3/5. Grip in pounds right 12 and left 5-7.

Assessment: Needs dynamic fluoroscopy study, obviously has myelopathy/radiculopathy in the absence of disc herniation.

Plan: A combination of Rx and Rx/controlled medication(s) is the current medication plan. The specific information is available in the patient's chart and/or computer account this SOAP note database. The use of controlled medication(s) is justified based on the patient's subjective and objective examination findings and is necessary in order for the patient to perform ADL's. Employment status: TT.

December 4, 2000
Subjective: Since the patient's last visit, the patient's condition continuous. Activities impaired include: neck and upper back movements, bilateral upper extremity strength, dizziness. Pain is noted by patient in regions of head, neck, arms. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include left ulnar nerve sensory and motor weakness (cervical nerve root level). Progress is noted in: movements of neck. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date. Employment status: TT. Needs neurology consultation.

Objective: Cervical spine range of motion: 50 degrees right lateral rotation, 50 degrees left lateral rotation, 20 degrees right lateral flexion, 20 degrees left lateral flexion, 35 degrees forward flexion and 15 degrees of neck extension; most movements are painful; flexion and extension are most painful and result in most nausea and dizziness. Grip in pounds right 12 and left 4. Reflexes absent in right upper extremity and minimal in left upper extremity.

Assessment: Needs neurology consult.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information] Employment status TT.

January 23, 2001
Subjective: Since the patient's last visit, the patient's condition is continuous. Activities impaired include: neck movements, upper back movements, arm

strength, sensory function in arms. Pain is noted by patient in regions of head, neck, arms. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include burn on left arm due to loss of sensory function, leaned against a heater at home and did not notice the intensity of the heat; this is over the medial epicondyle of her left elbow and left arm. Progress is noted in: none.

Objective: Cervical spine range of motion: 35 degrees right lateral rotation, 45 degrees left lateral rotation, 20 degrees right lateral flexion, 30 degrees left lateral flexion, 25 degrees forward flexion and 15 degrees of neck extension; movements are painful. Motor strength determined by resistance testing: right upper extremity: C5 3+/5, C6 3+/5, C7 3+/5 and C8-T1 3+/5; left upper extremity: C5 3+/5, C6 3+/5, C7 3/5 and C8-T1 3/5. Grip in pounds right 12 and left 7.

Assessment: Needs dynamic fluoroscopy test of the neck and upper thoracic spine to assess for instability of cervicothoracic spine and vertebrae.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information] Employment status TT.

SUMMARY
Substantial objective and subjective evidence of severe cervical spine trauma is present on serial examinations of the IW. Testing performed to date has not identified a structural lesion which can adequately account for the continuing impairment and disability. Intersegmental instability of the cervical-dorsal spine is currently the most probable cause of her abnormal orthopedic and neurological examination findings. The requested study is a motion picture x-ray examination of the neck and upper back. If the study reveals no significant instability, then aggressive physical therapy is clearly the direction of future treatment. However, if the study reveals significant intersegmental spinal instability, then internal fixation and mechanical stabilization of any/all loose vertebra/vertebrae will be medically necessary, appropriate and urgently required. The requested test should resolve this diagnostic enigma which has to date eluded localization.

(St. Ex. 9 at 14-21; emphasis added, signatures omitted)

Patient 9's Treatment in 2001

276. In a letter dated September 23, 2001, Dr. Lundeen wrote in support of adding further medical conditions to Patient 9's workers' compensation claim:

This correspondence concerns [Patient 9] who is under my care for treatment of injuries she sustained on May 19, 2000. This medical report details the history, subjective complaints, objective examination findings, diagnoses, recommended treatment, as well as prognosis for [Patient 9]. * * *

DIAGNOSES

Current Claim Allowances:
920. CONTUSION FACE/SCALP/NCK
847.0 SPRAIN OF NECK

Proposed Allowances:
723.3 CERVICOBRACHIAL SYNDROME
805.2 FX [FRACTURE] DORSAL VERTEBRA-CLOSE, T-2 LEVEL

HISTORY OF INJURY
[Patient 9] is a 27 year old female who presented herself to this office for expert medical care and advice for injuries she received on May 19, 2000.

EXAMINATIONS

[Omitted: progress notes already quoted above]

February 22, 2001
Subjective: Since the patient's last visit, the patient's condition worse, weaker grips. Activities impaired include: balance, strength, neck movements, anxiety and depression. Pain is noted by patient in regions of head, neck, upper back, arms. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include weaker grips, more anxious and depressed. Progress is noted in: none. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date. Employment status: TT.

Objective: Cervical spine range of motion: 45 degrees right lateral rotation, 45 degrees left lateral rotation, 25 degrees right lateral flexion, 15 degrees left lateral flexion, 15 degrees forward flexion and 15 degrees of neck extension; all movements are limited, stiff & painful. Grip in pounds on setting #3 of Jamar hand dynamometer right 5 and left 3; 1 pound each on setting #2. Obviously depressed and anxious over her injuries.

Assessment: Needs dynamic fluoroscopy to examine stability of cervicothoracic spine. Needs psych consult.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information] Employment status TT. Tests ordered dynamic fluoroscopy, C9 pending. Recheck in 2-4 weeks.

March 15, 2001
Subjective: Since the patient's last visit, the patient's condition unremitting. Activities impaired include: many adls. Pain is noted by patient in regions of head, neck, left arm and leg. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects.

Objective: Cervical spine range of motion: 40 degrees right lateral rotation, 50 degrees left lateral rotation, 20 degrees right lateral flexion, 20 degrees left lateral flexion, 15 degrees forward flexion and 15 degrees of neck extension; movements are painful. Grip in pounds right 20 and left 2; setting #2 Jamar hand dyno.

Assessment: test approved, dynamic fluoroscopy.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information] Employment status TT.

March 30, 2001
Subjective: Since the patient's last visit, the patient's condition is ongoing. Activities impaired include: neck and upper back movements, grips, balance. Pain is noted by patient in regions of neck, arms. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include none. Progress is noted in: none. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date. Employment status: TT. Attempting to schedule dynamic fluoroscopy.

Objective: Cervical spine range of motion: 35 degrees right lateral rotation, 25 degrees left lateral rotation, 5 degrees right lateral flexion, 5 degrees left lateral flexion, 15 degrees forward flexion and 5 degrees of neck extension; movements are painful. Grip in pounds right 10 and left 4.

Assessment: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information] Employment status TT.

April 26, 2001
Subjective: Since the patient's last visit, the patient's condition is ongoing. Activities impaired include: neck and upper back adls, grips. Pain is noted by patient in regions of head, neck, arms. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include none.

Objective: Cervical spine range of motion: 30 degrees right lateral rotation, 35 degrees left lateral rotation, 10 degrees right lateral flexion, 15 degrees left lateral flexion, 15 degrees forward flexion and 5 degrees of neck extension; all movements are painful. Grips 22 pounds right and zero pounds left.

Assessment: To see consultant soon.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information]

May 25, 2001
Subjective: Since the patient's last visit, the patient's condition is ongoing. Activities impaired include: neck and upper back ROM, grips, balance. Pain is noted by patient in regions of neck and upper back, radiates into arms, bladder urgency. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include bladder weaker.

Objective: Cervical spine range of motion: 30 degrees right lateral rotation, 45 degrees left lateral rotation, 25 degrees right lateral flexion, 25 degrees left lateral flexion, 10 degrees forward flexion and 30 degrees of neck extension; movements are painful and cause vertigo. Grip in pounds right 13 and left 2.

Assessment: Compression fracture confirmed recently on CT scan according to patient.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information] Employment status TT.

June 19, 2001
Subjective: Since the patient's last visit, the patient's condition is continuous. Activities impaired include: neck, arms, upper back adls and rom. Pain is noted by patient in regions of upper dorsal and lower cervical regions. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include none.

Objective: Cervical spine range of motion: 45 degrees right lateral rotation, 35 degrees left lateral rotation, 20 degrees right lateral flexion, 10 degrees left lateral flexion, 20 degrees forward flexion and 10 degrees of neck extension; each movement is painful. Grip in pounds right 10 and left 2.

Assessment: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued. Will need therapy and may need surgery.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information] Employment status unable to work.

July 26, 2001

Subjective: Since the patient's last visit, the patient's condition is unremitting. Activities impaired include: balance, grips, ROM. Pain is noted by patient in regions of head, neck, upper back, arms.

Objective: Cervical spine range of motion: 45 degrees right lateral rotation, 50 degrees left lateral rotation, 30 degrees right lateral flexion, 15 degrees left lateral flexion, 20 degrees forward flexion and 20 degrees of neck extension; all movements are painful. Grip in pounds right 16 and left 4. Pain neck and upper back.

Assessment: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued. Consideration of relative costs of medications has been made in selecting medications for treatment of injuries sustained in this industrial claim.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information] Employment status TT.

OPINION

Based on the mechanism of injury, the objective findings on numerous serial examinations, consultations and diagnostic testing and to a reasonable degree of medical certainty and probability, I opine that her claim should be further allowed for T-2 compression fracture and cervicobrachial syndrome. The mechanism of injury was being struck in the head, neck and left upper extremity with equipment which fell at work. The weight and sudden impact of the object which struck her without warning resulted in significant head, neck and thoracic injuries which have taken significant efforts of more than this examiner alone to elucidate with examinations, consultations and extensive testing.

(St. Ex. 9 at 22-32)

Patient 9's Treatment in 2002 – 2007

277. In a December 2002 letter regarding Patient 9's disability status, Dr. Lundeen stated in part:

SUMMARY
Do to [*sic*] her continuing neck and left shoulder pain, [Patient 9] was referred to Dr. Eubank in Columbus. Dr. Eubank recommended a repeat MRI scan of her neck due to poor quality of the prior study. Dr. Eubank then requested injection therapy which was denied for several months by BWC. Eventually the injection therapy was approved and patient has had several injections. She is scheduled for her next neck injection on 2/5/02 with Dr. Eubank's office. She has not reached maximum medical improvement despite a variety of appropriate and necessary medical treatment and therefore she remains temporarily totally disabled at this time.

(St. Ex. 9 at 34-35)

278. Dr. Lundeen's prescriptions for Patient 9 in 2002 and 2003 included the following:

1/14/02	Sprain Of Neck	Percocet	5/325 mg	1 q.i.d.
1/14/02	Contusion Face/Scalp/Nck	Vicodin ES	7.5/750 mg	1 t.i.d.
1/14/02	Contusion Face/Scalp/Nck	Xanax	0.50 mg	1 t.i.d.
1/14/02	Contusion Face/Scalp/Nck	Soma	350 mg	1 q.i.d.
1/14/02	Sprain Of Neck	Percocet	5/325 mg	1 q.i.d.

3/14/02	Sprain Of Neck	Neurontin	300 mg	1 q.i.d.
3/14/02	Contusion Face/Scalp/Nck	Soma	350 mg	1 q.i.d.
3/14/02	Cervicobrachial Syndrome	Percocet	5/325 mg	1 q.i.d.
3/14/02	Cervicobrachial Syndrome	Percocet	5/325 mg	1 q.i.d.
3/14/02	Personality Disorder Nos	Celexa[49]	20 mg	1 q.d.
3/14/02	Contusion Face/Scalp/Nck	Vicodin ES	7.5/750 mg	1 t.i.d.
3/14/02	Sprain Of Neck	Percocet	5/325 mg	1 q.i.d.
		* * *		
2/12/03	Contusion Face/Scalp/Nck	Soma	350 mg	1 q.i.d.
2/12/03	Contusion Face/Scalp/Nck	Vicodin ES	7.5/750 mg	1 t.i.d.
2/12/03	Sprain Of Neck	Percocet	5/325 mg	1 q.i.d.
2/12/03	Sprain Of Neck	Neurontin	300 mg	1 q.i.d.
2/12/03	Generalized Anxiety Disord	Buspar	10 mg	1 b.i.d.
2/12/03	Sprain Of Neck	Percocet[50]	5/325 mg	1 q.i.d.
2/12/03	Depress Psychosis-Severe	Zoloft	100 mg	1 b.i.d.
4/11/03	Contusion Face/Scalp/Nck	Vicodin ES	7.5/750mg	1 t.i.d.
4/11/03	Contusion Face/Scalp/Nck	Soma	350 mg	1 q.i.d.
4/11/03	Cervicobrachial Syndrome	Percocet	5/325 mg	1 q.i.d.
4/11/03	Sprain Of Neck	Percocet	5/325 mg	1 q.i.d.
4/11/03	Fx Dorsal Vertebra Close	Percocet[51]	5/325 mg	1 q.i.d.
4/11/03	Depress Psychosis Severe	Zoloft	100 mg	1 b.i.d.
4/11/03	Generalized Anxiety Disord	Xanax	0.50 mg	1 t.i.d.
4/11/03	Sprain Of Neck	Neurontin	300 mg	1 q.i.d.

(St. Ex. 9 at 224-225)

279. In October 2003, Dr. Lundeen wrote a letter to the BWC in support of the prescription medications he was writing for Patient 9. After setting forth a copy of his progress notes for several visits, Dr. Lundeen concluded as follows:

[49] In the progress notes for March 14, 2002, Dr. Lundeen reports no subjective complaints or objective findings with regard to the psychiatric condition. Under Assessment, he stated only: "Based on the patient's examination findings, history of injury and present complaints, the medications will be augmented with Celexa." (St. Ex. 9 at 90)

[50] This is not a typographical error; there were two prescriptions for Percocet listed in the Drug Utilization Report for February 12, 2003. (St. Ex. 9 at 225)

[51] The Drug Utilization Report lists three prescriptions for Percocet on April 11, 2003, one prescription for each of the three different conditions. (St. Ex. 9 at 225)

> As a result of the injuries sustained in this industrial accident and despite conservative treatment, [Patient 9] continues to have pain and symptoms in her neck, upper back and head.
>
> The medications prescribed:
> Zoloft 75 mg twice daily is prescribe[d] for depression/anxiety.
> Soma 350 mg 4 times daily is prescribe[d] for painful muscle spasms.
> Hydrocodone/Acetaminophen 7.5/750 twice daily and
> Percocet 5/325 mg 4 times daily is prescribed for moderate to severe neck pain.
>
> Based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it is my opinion, that: while the prescribed medications are not considered "life sustaining" they do provide adequate relief of painful symptoms and allow the patient to perform her daily living activities. Furthermore, I maintain that [Patient 9]'s medications are medically necessary, effective and safe for her use.

(St. Ex. 9 at 39-40)

280. In November 2003, Dr. Lundeen added Tenormin to treat the cervicobrachial syndrome, according to his Drug Utilization Report. (St. Ex. 9 at 225) In his progress notes for November 2003, Dr. Lundeen explained his reason for adding Tenormin:

> SUBJECTIVE: Since the patient's last visit, the patient's condition continues. Activities impaired include: neck, upper back, left arm, right arm. Pain is noted by patient in regions of headache, neck, left arm. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include PAT.[52] NKDA.
>
> OBJECTIVE: Cervical spine range of motion: 40 degrees right lateral rotation, 40 degrees left lateral rotation, 25 degrees right lateral flexion, 25 degrees left lateral flexion, 25 degrees forward flexion and 25 degrees of neck extension; movements are painful.
>
> ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued. Will add Tenormin to control PAT.
>
> PLAN: The patient has been advised that one or more of the RX medications are potentially addictive or habit-forming. The patient desires to continue the

[52] Dr. Cunningham suggests that "PAT" refers to paroxysmal atrial tachycardia. (St. Ex. 30 at 74)

> medication(s) in order to maximize therapeutic benefit. Every effort will be made to keep the quantities of such medications as low as possible. Employment status = TT.

(St. Ex. 9 at 104, signatures omitted)

281. In a June 2005 letter, Dr. Lundeen wrote to Patient 9's attorney in support of the patient's continued status of being temporarily disabled from returning to work:

> As a result of the injuries sustained in this claim and her ongoing pain and symptoms [Patient 9] has been unable to work since May 2000. Work conditioning 3 to five times per week for 8 weeks is medically necessary and appropriate. I have completed a C9 requesting the same.

(St. Ex. 9 at 36)

November 2008 – Patient 9

282. On November 14, 2008, Dr. Lundeen prescribed as follows for Patient 9, according to his Drug Utilization Report:

Date	Condition	Drug	Strength	Qty/Freq.
11/14/08 847.0	Sprain Of Neck	Doxycycline[53]	100 mg	1 b.i.d.
11/14/08 847.0	Sprain Of Neck	Percocet	5/325 mg	1 t.i.d.
11/14/08 920.	Contusion Face/Scalp/Nck	Soma	350 mg	1 q.i.d.
11/14/08 296.23	Depress Psychosis-Severe	Zoloft	100 mg	1 b.i.d.
11/14/08 920.	Contusion Face/Scalp/Nck	Xanax	2.00 mg	1 q.d.
11/14/08 723.3	Cervicobrachial Syndrome	Vicodin ES	7.5/750	1 five x day

(St. Ex. 9 at 228) In the Drug Utilization Report, Dr. Lundeen stated that all the prescriptions written on November 14, 2008, were prescribed to treat Patient 9 with regard to her 2000 BWC claim. (St. Ex. 9 at 228)

283. However, in his notes for Patient 9's visit on November 14, 2008, Dr. Lundeen did not explain why he had ordered a new medication, doxycycline, for the patient's neck sprain:

> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 9. Activities impaired include: neck, upper back and arm function. Office: GV. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially

[53] Doxycycline is a tetracycline antibiotic used to treat bacterial infections. Nat'l Libr. of Medicine, Nat'l Inst. of Health, at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000563>, accessed 11/1/11)

depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications.

OBJECTIVE: Cervical spine range of motion: 30 degrees right lateral rotation, 30 degrees left lateral rotation, 15 degrees right lateral flexion, 15 degrees left lateral flexion, 15 degrees forward flexion and 10 degrees of neck extension; neck movements are painful.

ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will remain unchanged.

PLAN: The next scheduled appointment with this examiner is in 4 weeks. Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2 and one or more in group 3. [Omitted: narcotic use information] More than one type of narcotic medication is utilized to adjust the pain control to optimal effect and minimize the use of the stronger type from group 2.

(St. Ex. 9 at 165-166, signatures omitted)

November 2009 – Patient 9

284. In his Drug Utilization Report, Dr. Lundeen listed the following medications as having been prescribed for Patient 9 on November 12, 2009:[54]

Date	Condition		Drug	Strength	Qty/Freq.
11/12/09	723.3	Cervicobrachial syndrome	Vicodin ES	7.5/750 mg	1 five x day
11/12/09	296.23	Depress Psychosis-severe	Zoloft	100 mg	1 b.i.d
11/12/09	920.	Contusion Face/Scalp/Nck	Soma	350 mg	1 q.i.d.
11/12/09	847.0	Sprain of Neck	Percocet	5/325mg	1 t.i.d.
11/12/09	920.	Contusion Face/Scalp/Nck	Xanax	2.00 mg	1 q.d.

(St. Ex. 9 at 229) Dr. Lundeen listed no other prescriptions for the month of November 2009. (St. Ex. 9 at 229)

285. With regard to Patient 9's visit on November 13, 2009, Dr. Lundeen provided two different sets of progress notes for Patient 9. In the first set of progress notes for this date, Dr. Lundeen diagnosed an infection of the urinary tract, but he made no mention of any complaint regarding urinary problems and provided no assessment regarding an infection:

[54]There are no progress notes for a November 12, 2009 visit. However, there are two separate sets of progress notes for November 13, 2009. (St. Ex. 9)

Diagnosis:

599.0 URIN TRACT INFECTION NOS

November 13, 2009
SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 8. Activities impaired include: neck, arms and grip strenght. [sic] Office: GV. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: none. .

OBJECTIVE: Cervical spine range of motion: 30 degrees right lateral rotation, 30 degrees left lateral rotation, 25 degrees right lateral flexion, 20 degrees left lateral flexion, 25 degrees forward flexion and 30 degrees of neck extension; movements are painful.

ASSESSMENT: No major change in medications prescribed.

PLAN: The next scheduled appointment with this examiner is in 4 weeks. [Omitted: narcotic use information]

(St. Ex. 9 at 45, signatures omitted)

286. In the second set of progress notes for the visit on November 13, 2009, Dr. Lundeen listed the diagnoses in the BWC claim, and provided a review of the condition of the cervical spine. (St. Ex. 191-192)

287. Although there is a diagnosis of UTI in the November 13, 2009 progress notes, and a report of an antibiotic prescribed on November 14, 2008, neither of the progress notes (November 2008 or November 2009) describe a urinary problem or an assessment of a urinary tract infection. (St. Exs. 9, 9A)

Prescription Drug Issues in 2010 – Patient 9

288. In a January 2010 letter, Dr. Lundeen again discussed Patient 9's medications:

Topic: prescription medications.

As a result of the injuries sustained in this industrial accident and despite conservative treatment, [Patient 9] continues to have pain and symptoms in her neck and upper back. The medications prescribed to treat the pain and symptoms related to the allowed conditions in this claim:
Zoloft is prescribed for control of depressive symptoms.

Vicodin ES and Percocet are prescribed in combination for control of ongoing moderate to severe neck and upper back pain.
Xanax is prescribed for control of anxiety.
Soma is prescribed for control of muscle spasms in her neck and upper back.

RECENT EXAMINATION

December 11, 2009
Subjective: Since the last visit, the patient's condition continues without significant change. Pain level today = 9. Activities impaired include: neck, upper back and arm function. Office: GV. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications.

Objective: Cervical spine range of motion: 30 degrees right lateral rotation, 30 degrees left lateral rotation, 15 degrees right lateral flexion, 20 degrees left lateral flexion, 15 degrees forward flexion and 10 degrees of neck extension; neck movements are painful.

Assessment: Based on the patient's examination findings, history of injury and present complaints, the medications will remain unchanged.

Plan: The next scheduled appointment with this examiner is in 4 weeks.

SUMMARY
[Patient 9] has ongoing moderate to severe neck and upper back pain and symptoms as a direct result of the injuries sustained in this claim. Multiple narcotic medication use: Medications from this physician include one or more narcotic medications. The treatment rationale for a mixture of such medications is to titrate symptom control optimally with the least amount of stronger medication in conjunction with medication(s) in milder class(es). The goal is to control symptoms efficiently and with the safest medications which are effective for this patient's symptoms. Based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it is my opinion, that: the prescribed medications provide adequate relief of painful symptoms and allow the patient to perform her daily living activities. Furthermore, I maintain that [Patient 9]'s medications are medically necessary, effective and safe for her use.

(St. Ex. 9 at 41-42)

289. In a letter dated February 16, 2010, Dr. Lundeen wrote a letter setting forth his disagreement with the BWC's order to cease payment for narcotic analgesics for Patient 9:

DIAGNOSES: sprain of neck; contusion; major depression; generalized anxiety disorder and personality disorder; T2 compression fracture; cervicobrachial syndrome; traumatic brain injury.

As you are aware, the Bureau has issued an Order advising they are no longer going to pay for narcotic analgesics based on a file review performed on January 8, 2010 by Dr. Ronald J. Bloomfield.

Dr. Bloomfield states "after reviewing the objective medical records in this claim file, it is my medical opinion narcotic analgesics have not been indicated in this claim form many years." I disagree with Dr. Bloomfield.

Dr. Bloomfield has not examined [Patient 9], his opinions are based on a limited file review. It appears from the report the only information Dr. Bloomfield "reviewed" was the office notes from this examiner. Dr. Bloomfield states "every office note is virtually identical to the previous note". Considering [Patient 9] has chronic pain in her neck and upper back with paresthesia's [sic], I am not sure exactly why Dr. Bloomfield would believe that her objective examination findings would markedly change from month to month.

A file review was performed on October 29, 2003 by Dr. Thomas Hospel who states *"I have reviewed all of Dr. Lundeen's notes and they support the ongoing symptoms related to the allowed conditions in the claim". Dr. Hospel further states "the chart supports the use of the following medications as reasonably related, appropriate and necessary for the treatment or control of symptoms of the allowed conditions: H3A narcotic analgesics; H2F anti anxiety drugs; H6H skeletal muscle relaxants; H2S (Zoloft); H4B anticonvulsants."* (Emphasis in original)

RECENT EXAMINATION
January 18, 2010
Subjective: Since the last visit, the patient's condition continues without significant change. Pain level today = 9. Activities impaired include: neck, upper back and arm function. Office: GV. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications.

Objective: Cervical spine range of motion: 20 degrees right lateral rotation, 20 degrees left lateral rotation, 15 degrees right lateral flexion, 20 degrees left lateral flexion, 15 degrees forward flexion and 10 degrees of neck extension; neck movements are painful.

> **Assessment:** Based on the patient's examination findings, history of injury and present complaints, the medications will remain unchanged.
>
> **Plan:** The next scheduled appointment with this examiner is in 4 weeks.
>
> SUMMARY
> Dr. Bloomfield has not examined [Patient 9]. His opinions regarding the necessity of medications was [*sic*] based on a limited file review and therefore his opinions should not be relied upon. As the examining physician, based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it remains my opinion, that: the prescribed medications provide adequate relief of painful symptoms and allow the patient to perform her daily living activities. Furthermore, I maintain that [Patient 9]'s medications are medically necessary, effective and safe for her use.

(St. Ex. 9 at 43-44)

290. On May 9, 2010, Dr. Lundeen provided an additional opinion letter in support of the prescription medications he had been prescribing for Patient 9:

> I have reviewed a copy of the hearing officers [sic] decision along with a copy of Dr. Bloomfield's report.
>
> I disagree with Dr. Bloomfield.
>
> [Omitted: list of diagnosed sprain, contusions, depression, anxiety, personality disorder, Cervicobrachial syndrome, fractured vertebrae, and brain injury]
>
> SUMMARY:
>
> [Patient 9] sustained an injury to her head and neck and suffers from pyschological [*sic*] disorders as a result of the industrial accident of May 19, 2000.
>
> Despite Dr. Bloomfield's limited file review, [Patient 9] requires ongoing narcotic analgesics based on the allowed conditions in this claim. Her pain is moderate to severe in nature and has been well documented since the date of injury.
>
> The medication I prescribe for [Patient 9] is necessary and medically appropriate for the allowed conditions in this claim.

(St. Ex. 9 at 2-3)

2010 and 2011: Most Recent Prescriptions for Patient 9

291. Dr. Lundeen's most recent prescriptions for Patient 9, as listed in his Drug Utilization Report, are as follows:

Date	Diagnosis	Drug	Strength	Qty/Freq
1/12/11	Contusion Face/Scalp/Nck	Xanax	2.00 mg	1 q.d.
1/12/11	Contusion Face/Scalp/Nck	Soma	350 mg	1 q.i.d.
1/12/11	Cervicobrachial Syndrome	Vicodin ES	7.5/750 mg	1 five x day
1/12/11	Sprain Of Neck	Percocet	5/325 mg	1 t.i.d.
1/12/11	Depress Psychosis-Severe	Zoloft	100 mg	1 b.i.d.
2/09/11	Contusion Face/Scalp/Nck	Xanax	2.00 mg	1 q.d.
2/09/11	Contusion Face/Scalp/Nck	Soma	350 mg	1 q.i.d.
2/09/11	Sprain Of Neck	Percocet	5/325 mg	1 t.i.d.
2/09/11	Cervicobrachial Syndrome	Vicodin ES	7.5/750 mg	1 five x day
2/09/11	Depress Psychosis-Severe	Zoloft	100 mg	1 b.i.d.
3/07/11	Contusion Face/Scalp/Nck	Xanax	2.00 mg	1 q.d.
3/07/11	Contusion Face/Scalp/Nck	Soma	350 mg	1 q.i.d.
3/07/11	Sprain Of Neck	Percocet	5/325 mg	1 t.i.d.
3/07/11	Cervicobrachial Syndrome	Vicodin ES	7.5/750 mg	1 five x day
3/07/11	Depress Psychosis-Severe	Zoloft	100 mg	1 b.i.d.

(St. Ex. 9 at 231)

Dr. Cunningham's Opinion: Dr. Lundeen's Examinations and Prescribing for Patient 9

292. Dr. Cunningham testified that a "contusion" is a bruise and generally takes about a month to heal, six weeks at the most. He opined that Dr. Lundeen's prescribing Vicodin and Soma for contusions for years after the incident violated the standard of care. (Tr. at 424-425)

293. Dr. Cunningham also criticized the prescriptions for the generalized anxiety disorder and the personality disorder, when the progress notes showed no evaluation or monitoring of those psychiatric conditions. (Tr. at 426-428; progress notes at St. Ex. 9 at 92-221; Drug Utilization Reports at St. Ex. 9 at 223-231)

294. In addition, Dr. Cunningham stated that the lack of a thorough neurological examination, given the head injury, was a violation of the standard of care. He also questioned Dr. Lundeen's opinion that Patient 9 suffered from myelopathy/radiculopathy when Dr. Lundeen had not done a neurological examination and mental status examination, and when the cervical MRI had shown

no evidence of neurologic compromise. Dr. Cunningham testified that an MRI would be a "much more accurate test" than a dynamic fluoroscopy study. (Tr. at 427-430)

295. Dr. Cunningham also opined that Dr. Lundeen's initial examination of the patient on July 29, 2000, failed to meet the standard of care. He noted that there was no testing of reflex or sensation. Further, he stated that he believes most physicians would do a range of motion for both shoulders when there is a neck injury, although he did not know whether the failure to test the range of both shoulders would constitute a violation of the standard of care. (Tr. at 421-423)[55]

296. In his written report, Dr. Cunningham provided a detailed review of the test results and consultations that Dr. Lundeen's staff had noted in the electronic medical records under the heading "Dump of Patient Data." Dr. Cunningham concluded among other things, with respect to Dr. Lundeen's treatment of Patient 9:

- that Dr. Lundeen's treatment and care constituted multiple significant departures or failures from conformity to minimal standards of care of similar practitioners under the same or similar circumstances;
- that Dr. Lundeen failed to meet the minimal standards acceptable to the selection and administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease; and
- that Dr. Lundeen's treatment of Patient 9 did not comply with the Board's intractable pain rules. Among other things, Dr. Cunningham found that the amounts of narcotics were not justified by the documentation in the patient's chart. Further, he found no random drug-screen records contained in the patient's records

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[55] Dr. Cunningham also criticized Dr. Lundeen for not documenting an examination with regard to the diagnosis of "fracture of the dorsal vertebra" and for performing no evaluation of the "depressive psychosis." (Tr. at 421-423; St. Ex. 9 at 46) However, the Hearing Examiner believes that those conditions were not yet diagnosed or made part of the BWC allowed conditions as of that date. See, e.g., St. Ex. 9 at 6, 14, 22. Therefore, the Hearing Examiner does not fault Dr. Lundeen for omitting discussion of the fracture or depressive psychosis in his notes on June 29, 2000.

As discussed above in footnote 9, the Hearing Examiner believes that there is a problem with Dr. Lundeen's electronic record-keeping system in that, when Dr. Lundeen printed out his electronic records in 2011, it appears that the field labeled "Diagnosis" in the S.O.A.P. notes appears to have been populated by the list of diagnoses currently in the computer rather than the diagnoses that were current on the date of the office visit, at least with respect to some of the patients' electronic records. *Compare,* for example, St. Ex. 9 at 6, 14, and 22 *with* St. Ex. 9 at 46 and 49; and *compare* St. Ex. 1 at 21, 191-192 *with* St. Ex. 1 at 39. The Hearing Examiner believes that Dr. Lundeen's letters provide more reliable documentation of the diagnoses at particular points in time.

The problem for a reviewer (such as a subsequent treating physician or a reviewer such as Dr. Cunningham) is that the electronically maintained S.O.A.P. notes for the office visit on June 29, 2000—as given to the Board for review—list eight diagnoses including the "fracture of the dorsal vertebra" and the "depressive psychosis" as being the diagnoses on June 29, 2000, and so Dr. Cunningham faulted Dr. Lundeen for not addressing those conditions. (St. Ex. 9 at 46)

> despite the increasing total narcotic and mood-altering dosages of medication without objective change in medical status.

In addition, Dr. Cunningham took issue with Dr. Lundeen's repeated statements that Patient 9 was having no adverse effects from the medications. Given the ever-increasing total narcotic dosage without objective change in medical status, Dr. Cunningham was concerned about narcotic dependency and/or tolerance, and he opined that Patient 9 required referral to a physician skilled in diagnosing and treating narcotic addiction/tolerance and dependence issues. (St. Ex. 30 at 75-80)

297. With regard to the additional documents that were provided to him after he had submitted his original report (St. Ex. 9A), Dr. Cunningham noted that the additional documents were duplicates of documents he had already reviewed. He testified that there was nothing in those documents that changed his original opinion. (Tr. at 430; St. Ex. 30A at 7)

Dr. Lundeen's Written Defense – Patient 9

298. As noted above, Dr. Lundeen did not appear at the hearing, but provided a written statement of his position and arguments. With regard to Patient 9, Dr. Lundeen stated that she is currently pregnant and not taking any pain medications. He noted that she had sustained severe injuries to her head, neck and upper back in 2000. He emphasized that "MRI and other major testing were done" and that a "neurosurgery consultation was obtained." (Resp. Ex. Z at 16) Dr. Lundeen further stated:

> Dr. Lundeen encouraged Patient 9 to work and she did get back to work in the past few years. She has difficulty with her adls due to her injuries. * * *
>
> * * *
>
> Dr. Lundeen's care of Patient 9 has been authorized by the Bureau of Worker's Compensation for each service, diagnosis, medication, and prescriptions provided. Dr. Lundeen's work has been subject to prospective, concurrent and retrospective peer review by case managers, nursing managers, and physician and medical directors, including the medical policy review committees at the Bureau of Workers Compensation. At all times Dr. Lundeen's care to Patient 9 was within or above the minimum standard of care; and, Dr. Lundeen's use of controlled substances for the management of chronic intractable pain were within the guidelines of the State Medical Board of Ohio, it's [sic] statutes and administrative rules.

(Resp. Ex. Z at 16)

Patient 10

General Information

299. Patient 10, a male born in 1976, sustained an industrial injury on February 15, 2006. He first saw Dr. Lundeen on February 28, 2006. The initial diagnosis was "846.0 Sprain Lumbosacral," according to a letter sent by Dr. Lundeen to the patient's attorney on August 24, 2006. Patient 10 continued to see Dr. Lundeen on a regular basis through March 8, 2011, the last visit documented. (St. Ex. 10 at 8-9, 19-144)

300. Medical records for Patient 10 were admitted as State's Exhibits 10 and 10A. Dr. Cunningham's initial written report is set forth in State's Exhibit 30, pages 81 to 86, and his supplemental report is set forth in State's Exhibit 30A, pages 7 and 14-15.
Dr. Cunningham's testimony regarding this patient is found at transcript pages beginning on page 430. Dr. Ross' opinion is set forth in Resp. Ex. A, page 36, and Dr. Lundeen's written opinion is set forth at Respondent's Exhibit Z, pages 16 to 17.

Patient 10's First Visit in February 2006

301. In his progress notes for Patient 10's first visit on February 28, 2006, Dr. Lundeen stated as follows:

> Diagnosis:[56]
> 722.10 LUMBAR DISC DISPLACEMENT
> 722.52 LUMB/LUMBOSAC DISC DEGEN
> 846.0 SPRAIN LUMBOSACRAL
> 722.83 POSTLAMINECT SYND-LUMBAR
> 724.02 SPINAL STENOSIS-LUMBAR
>
> February 28, 2006
> SUBJECTIVE: The patient seen today at Kenton, Ohio [office]. Employer when injured: * * *. Injured back at work. Right leg involved, bladder involved, erection involved. Left leg not very involved. No prior back condition.[57] Unable to work due to this injury.

[56] The same diagnoses are listed in each of the electronic progress notes. (St. Ex. 10 at 20-143) However, the electronic progress notes are not always the most reliable source of information regarding which conditions have been diagnosed (and allowed in workers' compensation claim) as of a specific date. (See footnotes 9 and 55 regarding discrepancies between the electronic progress notes stating the diagnoses and the letters and Drug Utilization Reports stating the diagnoses on specific dates.)

[57] It is not clear what is meant by this notation. One of the diagnoses is "722.83 Postlaminect Synd –Lumbar," which indicates that a laminectomy had previously been performed in the past and had failed. (St. Ex. 10 at 19)

> OBJECTIVE: Seated straight leg raising, SLR, R 15 degrees, SLR L 30 degrees, spasms present in lower back. Gait: slow, right leg drags. Stronger lower extremity left. Flexion 35 degrees, extension 15 degrees, right lateral flexion 15 degrees and left lateral flexion 25 degrees.
>
> ASSESSMENT: MRI and therapy needed. L5 disc probably involved.
>
> PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2. Patient to minimize use of such narcotic medication(s), to take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx narcotic medications. Patient understand [sic] potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency or addiction will be made. A moderate degree of dependency is normal and should be anticipated with the use of such narcotic medication(s). Beyond a normal reasonable degree of day to day dependency on such medications for ADL's, abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons. The next scheduled appointment with this examiner is in 2, 4 weeks.

(St. Ex. 10 at 19, signatures omitted)

302. Details regarding what actually happened to Patient 10, such as how he injured himself and what kind of care he had received following the accident, are not included in the progress notes for the first visit. However, information regarding Patient 10's injury is included in an August 2006 letter sent by Dr. Lundeen to Patient 10's attorney. In that August 2006 letter, in which he states the diagnosis as "846.0 Sprain Lumbosacral," Dr. Lundeen described the injury as follows:

> [Patient 10] is a 30 year old male who presented himself to this office for expert medical care and advice for injuries he received on February 15, 2006. A[t] that time he was moving/lifting a laser printer which weighed between 40-60 pounds, the printer was sitting on a shelf which broke, he tried to keep the printer from falling and felt pain in his lower back with pain radiation down into the right leg. Prior to this injury at work he was asymptomatic with regard to his lower back and denies prior low back injury or trauma.
>
> He sought treatment at Hardin Memorial Hospital Emergency Department where he was examined and treated conservatively with medication. No x-rays were performed.
>
> An MRI of the lumbar spine was performed on 3-8-06 which revealed: degenerative disc disease at L5-S1. Inferior L5 osteophytic overgrowth. There is

> bulging at this level with mild indentation of the ventral aspect of the thecal sac. There may be a small protrusion of disc material into the annulus fibrosis.
>
> He was referred to physical therapy and attended only 4 of 12 sessions due to increased pain.
>
> As conservative treatment failed, he was referred to Dr. Leo Clark for a surgical consultation. Dr. Clark noted weakness of gastrocnemius[58] and hamstrings and a depressed Achilles reflexes of the right lower extremity consistent with S1 radiculopathy. Dr. Clark reviewed the MRI films and notes the MRI showed a slightly small spinal canal with central ruptured disc and recommended lumbar microdiskectomy and posterior lumbar interbody fusion with hardware fixation using Spire hardware.

(St. Ex. 10 at 8-9)

303. The progress notes for the first visit in February 2006 do not document the actual treatment provided by Dr. Lundeen, such as any medications prescribed. (St. Ex. 10 at 19) However, the medications prescribed to Patient 10 are listed separately in the Drug Utilization Report. (St. Ex. 10 at 145-155) The report states that, on February 28, 2006, Dr. Lundeen prescribed the following medications to Patient 10, with no refills authorized:

Drug	Strength	Qty/Freq.	#
Percocet	10/650 mg	1 four times per day	112
Flexeril	10 mg	1 twice per day	56
Feldene	20 mg	1 once per day	28

(St. Ex. 10 at 145)

304. The documents in Patient 10's medical records include a patient-history form completed on February 28, 2006. Among other things, Patient 10 listed his medical history as including narcolepsy, sleep apnea, bipolar disorder, depression, and migraines. When asked to circle applicable items from a list of symptoms/conditions, Patient 10 circled the following: headaches, vision problems, chest pain, shortness of breath, and chronic fatigue. He indicated no use of alcohol or other mood-altering substances and stated that he had never used tobacco. (St. Ex. 10A at 99-119)

305. The medical records also include: records regarding emergency-department treatment, correspondence between Dr. Lundeen and insurance companies, correspondence with the BWC (some of which concerns patients other than Patient 10), correspondence with Patient 10's attorney, and communications with other physicians, including an MRI report

[58] The gastrocnemius muscle, with the soleus muscle, forms the "calf muscle" of the leg. (E.g., Univ. of No. Carolina Asheville, at <http://facstaff.unca.edu/cnicolay/BIO223/L18-bipedalism2.pdf>; Library of Congress, at <www.loc.gov/rr/scitech/mysteries/muscles.html>; accessed 11/6/11)

regarding a March 2006 study of the lumbar spine ordered by Dr. Lundeen. (St. Ex. 10A) The MRI report includes the following findings:

> There is relatively normal alignment of the lumbar vertebral bodies in the supine position. The vertebral marrow signal intensity is preserved at all levels. The conus medullaris terminates at T12-L1 which is within normal limits. There is no abnormal signal intensity in the cord terminus.
>
> There is facet fluid bilaterally at L5-S1, L4-5 and to a mild degree L3-4. Facet fluid may contribute to low back pain or referred symptoms and may be seen in patients who are asymptomatic. The segment-by-segment analysis reveals no disc herniation, no stenosis, no canal or nerve root compromise down to L5.[59]
>
> L5-S1: There is degenerative disc disease. There is inferior L5 osteophytic overgrowth. There is bulging at this level with a mild indentation on the ventral aspect of the thecal sac. There may be a small protrusion of disc material into the annulus fibrosus. There is no distinct nerve root deviation or dilatation.
>
> * * *
>
> 1. Facet fluid is seen in the lower three lumbar levels. This may be important in the proper clinical setting.
> 2. At L5-S1, there is mild degenerative disc disease and bulging of the annulus fibrosus. A small protrusion of disc material into the annulus fibrosus is possible.

(St. Ex. 10A at 43)

Dr. Cunningham's Opinions Regarding the Initial Examination and Treatment of Patient 10

306. Dr. Cunningham testified that the physical examination documented by Dr. Lundeen was not sufficient for the conditions diagnosed. He stated: "Again, there is no range of motion of the spine. There's no examination of the spine recorded. There are no reflexes. There's no sensation recorded." (Tr. at 431; St. Ex. 10 at 19)

307. When asked whether Flexeril was indicated for Patient 10's condition in 2006, Dr. Cunningham replied that the drug was indicated only if the most recent surgery had been performed just before the first visit in February 2006 when the Flexeril was prescribed. (Tr. at 431-432)

308. Dr. Cunningham testified that Dr. Lundeen's notes regarding the patient's first visit do not reflect the date of the patient's back surgery, and he opined that this omission is significant. He explained that a diagnosis of post-laminectomy syndrome means that there was a back

[59] Dr. Cunningham testified that spinal stenosis is a narrowing of the spinal canal, the narrowing of the center of a vertebra where the spinal cord and nerve roots are located. (Tr. at 431)

surgery that failed.[60] Dr. Cunningham testified that the date of the surgery is "important to know" and is "pretty basic information." Moreover, Dr. Cunningham testified that Dr. Lundeen did not document the vertebral level that was involved in the surgery. (Tr. at 432-433)

309. With respect to the section of Dr. Lundeen's April 2009 progress notes stating "Gait: right foot drop," Dr. Cunningham testified that it was not clear what had caused the condition. Dr. Cunningham stated that a foot drop means that the patient is unable to raise his or her foot up, pulling the toes upward toward the knee. The use of an ankle brace is necessary to enable the patient to walk properly. Dr. Cunningham testified that the condition of foot drop usually results from a complication following back surgery, although it can be caused by a pinching of the L5-S1 nerve root, although that is rare. (Tr. at 434-435; St. Ex. 10 at 97)

Description of Pain in the 2010-2011 Progress Notes

310. For the majority of Patient 10's visits, Dr. Lundeen usually documented Patient 10's pain level as a 9 or 10. However, in the months leading up to the March 2011 visit—during which Patient 10 was receiving the same or nearly the same amount of narcotic medication prescribed in March 2011—Dr. Lundeen documented Patient 10's pain level as "10+". (St. Ex. 10 at 127-155)

Patient 10's Last Visit in March 2011

311. According to the Drug Utilization Report for Patient 10, Dr. Lundeen prescribed the following drugs on March 7, 2011,[61] the last visit shown in the report:

Date	Diagnosis	Drug	Strength	Qty/Freq.
3/07/11	Lumbar Disc Displ	Magnacet	10/400mg	1 q4°
3/07/11	Lumbar Disc Displ	Dilaudid	4 mg	1 b.i.d.
3/07/11	Lumbar Disc Displ	Duragesic	100mcg/hr	1 q.o.d.
3/07/11	Lumbar Disc Displ	Xanax	0.25 mg	1 q.i.d.
3/07/11	Sprain Lumbosacral	Tofranil PM	75 mg	1 q.d.
3/07/11	Sprain Lumbosacral	Flexeril	10 mg	1 b.i.d.
3/07/11	Lumbar Disc Displ	Triavil[62]	4-25 mg	1 b.i.d.
3/07/11	Lumbar Disc Displ	Ambien CR	12.5 mg	1 h.s.
3/07/11	Sprain Lumbosacral	Feldene	20 mg	1 q.d.

(St. Ex. 10 at 155)

[60] The witness also explained that the diagnosis of "post-laminectomy syndrome" is used where the surgery was actually a laminectomy and also where it was a fusion, that the diagnosis can apply to either type of failed vertebral surgery. (Tr. at 432-433)

[61] The progress notes state that this visit took place on March 8, 2011. (St. Ex. 10 at 143)

[62] Dr. Cunningham noted that Triavil is an antidepressant and that some physicians prescribe antidepressants to chronic pain patients. Dr. Cunningham found this prescription to be within the standard of care. (Tr. at 435-436)

Dr. Cunningham's Further Opinions

312. Dr. Cunningham stated that the amount of narcotic medications prescribed to Patient 10 had increased "dramatically" from the patient's first visit in 2006. When asked if that was a result of Patient 10's developing a tolerance to the medication, Dr. Cunningham replied:

> Pain management physicians say that you should be able to manage chronic pain. You'll get the patient to a level of medication that covers their symptoms. And then that level should be pretty steady -- it shouldn't change very much over time. And that's their goal, the pain management * * * community.
>
> When you see the total dosages increase, it makes you concerned about whether or not some underlying structural or mechanical or medical thing is happening that's been missed; or, the other obvious thing is are they becoming dependent or tolerant or addicted, or are they diverting, is the other issue.

(Tr. at 437)

313. Dr. Cunningham further testified that there appeared to be no medical reason for the substantial increase in Patient 10's narcotic pain medication, at least none that was documented in the medical record. Further, Dr. Cunningham stated that there was no attempt on Dr. Lundeen's part to determine the reason for Patient 10's need for increasing doses of narcotic pain medication, and that this had violated the standard of care. (Tr. at 437-438)

314. Dr. Cunningham testified that the additional documents in State's Exhibit 10A, which the Board had received from the BWC, had not changed his opinions as stated in his initial report:

> I originally—my original report said that there weren't any—or there were very few pain contracts. But in my addendum report I said that there were pain contracts on most of the patients. Other than that, I don't—I have no change to my opinion.

(Tr. at 438-439)

Dr. Lundeen's Written Defense – Patient 10

315. In his written position statement, Dr. Lundeen offered the following:

> Patient 10 * * * is a 34-year-old white male who sustained a back injury at work and who had undergone FIVE major back surgeries for his injuries. After each surgery Patient 10 immediately developed severe epidural fibrosis. Patient 10 is at significant risk of suicide without close medical attention and supervision.

> Patient 10's right leg, bowel incontinence, bladder incontinence, and erectile dysfunction are involved in this case. His pain is at 10+ even when medicated with significant medications. His neurosurgeon is Dr. Clark in Toledo, Ohio.
>
> * * *
>
> Dr. Lundeen's care of Patient 10 has been authorized by the [BWC] for each service, diagnosis, medication and prescriptions (sic) provided. Dr. Lundeen's work has been subject to prospective, concurrent and retrospective peer review by case managers, nursing managers, and physicians and medical directors, including the medical policy review committees at the [BWC]. At all times Dr. Lundeen's care to Patient 10 was within or above the minimal standard of care; and, Dr. Lundeen's use of controlled substances for the management of chronic intractable pain were within the guidelines of the State Medical Board of Ohio, it's [sic] statutes and administrative rules.

(Resp. Ex. Z at 16-17, emphasis in original)

Patient 11

General Information

316. Patient 11, a male born in 1955, suffered an industrial injury on November 5, 1999, sustaining multiple injuries. He first saw Dr. Lundeen on April 28, 2009. He continued to see Dr. Lundeen on a regular basis through March 17, 2011, the last visit documented. (St. Ex. 11 at 3-4, 49-50)

317. Medical records for Patient 11 were admitted as State's Exhibits 11and 11A. Dr. Cunningham's initial written opinion is set forth at States Exhibit 30 at pages 87 to 93, and his supplemental report is set forth at States Exhibit 30A at pages 7 and 14-15. Dr. Cunningham's testimony regarding this patient is found in the hearing transcript starting at page 442. Dr. Ross' opinion is in Respondent's Exhibit A, pages 36-37, and Dr. Lundeen's written position statement is in Respondent's Exhibit Z, page 17.

First Visit in April 2009

318. In his progress notes for Patient 11's first visit on April 28, 2009, Dr. Lundeen documented the following:

> DIAGNOSIS
>
> 805.2 FX DORSAL VERTEBRA-CLOSE
> 808.2 FRACTURE OF PUBIS-CLOSE
> 814.00 FX CARPAL BONE NOS-CLOSE
> 823.00 FX UPPER END TIBIA-CLOSE
> 842.00 SPRAIN OF WRIST NOS

845.00 SPRAIN OF ANKLE NOS
846.0 SPRAIN LUMBOSACRAL
309.81 PROLONG POSTTRAUM STRESS

April 28, 2009
SUBJECTIVE: Pain level today = with meds 6. Activities impaired include: spine, ED, gait, balance, strength. Office: Springfield, Ohio (SP). Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. He has other physicians for other medical problems. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: none. Income: SSD, TT psych.

OBJECTIVE: Seated straight leg raising, SLR, R 10 degrees, SLR L 25 degrees, spasms present in lower back. Gait: slow. Flexion 25 degrees, extension 5 degrees, right lateral flexion 5 degrees and left lateral flexion 5 degrees. Multiple injuries, serious in nature, in this claim.

ASSESSMENT: No major change in medications prescribed. C9 for PT evaluation and 12 treatments. C9 for monthly TENS unit supplies.

PLAN: Medications from this physician include one or more scheduled narcotic medications in the moderate DEA classification group 3. Patient to minimize use of such narcotic medication(s), to take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx narcotic medications.
Patient understand [*sic*] potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency or addiction will be made. A moderate degree of dependency is normal and should be anticipated with the usage of such narcotic medication(s). Beyond a normal reasonable degree of day to day dependency on such medications for ADL's, abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons. The next scheduled appointment with this examiner is in 12 weeks or sooner if PATIENT approved.

(St. Ex. 11 at 3-4, signatures omitted)

319. No further information is included on the progress notes for April 28, 2009, such as how Patient 11 had been injured, and the actual treatment being provided, such as any specific medications prescribed. (St. Ex. 11 at 3-4)

320. Dr. Lundeen's "Drug Utilization Report" for Patient 11 states that he prescribed the following medications for Patient 11 at the first and second visits in 2009:

Date	Diagnosis	Drug	Strength	Qty/Freq.	#	Refills
4/28/09	Fx Dorsal Vertebra-Cl	Norco	10/325 mg	1 q.i.d.	112	2
4/28/09	Fx Dorsal Vertebra-Cl	Xanax	2.00 mg	1 q.i.d.	112	2
4/28/09	Fx Dorsal Vertebra-Cl	Lidoderm	Patch 5%	2 q.d.	60	2
4/28/09	Fx Dorsal Vertebra-Cl	Lyrica	75 mg	1 b.i.d.	56	2
5/19/09	Fx Dorsal Vertebra-CL	Dilaudid	8 mg	1 q.i.d.	120	0

(St. Ex. 11 at 51)

Testimony of Dr. Cunningham Regarding Patient 11's First Visit in April 2009

321. Dr. Cunningham testified that the physical examination documented by Dr. Lundeen for Patient 11 on April 28, 2009 "is very, very inadequate," given Patient 11's injuries. (Tr. at 446) Dr. Cunningham explained:

> [F]irst of all, there's an upper back injury, there's a pelvis injury, there's a wrist injury, there's a knee injury, there's an ankle injury, there's a low-back injury.
>
> The only thing that he reports that he examined was seated straight leg raising. He reported spasm in the lower back. He reported a slow gait. He reported range of motion of the spine, but not of the upper back, only of the lower back.
>
> And I don't think that there's enough documentation here to support the medications that he prescribed.
>
> * * *
>
> * * * [H]e doesn't even state which ankle or which wrist was injured in this record. He doesn't describe or note which knee is injured.
>
> He doesn't describe any physical examination findings in regard to any of those extremity diagnoses. And he does not mention the pubic fracture or the dorsal fracture in this exam. He doesn't examine any of those parts of the body.

(Tr. at 447-448)

322. In addition, Dr. Cunningham testified that the information included in the "Objective" section of the progress notes is "all basically subjective." (Tr. at 448-449) He further testified:

> The seated straight leg raising [as done in Dr. Lundeen's office] is voluntary on the part of the patient. And the range of motion that he's measuring is also voluntary on the part of the patient.

(Tr. at 448-449) When asked what he meant by "voluntary," Dr. Cunningham replied, "The patient is determining what the range of motion is, or what the straight leg raising is."

Moreover, Dr. Cunningham testified: "Objective is what you can measure, test, quantify. Subjective is what the patient tells you or shows you." (Tr. at 448-449)

Patient 11's Visit in May 2009

323. Dr. Lundeen's progress notes for Patient 11's second visit, on May 19, 2009, list the same diagnoses as on the first visit. (St. Ex. 11 at 5) Dr. Lundeen then reported the following:

> SUBJECTIVE: SP office. Since the last visit, the patient's condition is worse. Pain level today = 7-8. Activities impaired include: back adls. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. New problems include more pain, poor balance. Employment status: none. Income: SSD, VA pension.
>
> OBJECTIVE: Flexion 25 degrees. Seated straight leg raising, SLR, R 15 degrees, SLR L 10 degrees, very painful spasms present in mid and lower back. Extension 5 degrees, right lateral flexion 5 degrees and left lateral flexion 5 degrees. Gait slow. Stronger leg today: left leg.
>
> ASSESSMENT: Medication selection: Dilaudid 8 mg added to treat pain from fall due to his injuries.
>
> PLAN: The next scheduled appointment with this examiner is in 8-12 weeks. Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2 and one or more in group 3. [Omitted: narcotic information] More than one type of narcotic medication is utilized to adjust the pain control to optimal effect and minimize the use of the stronger type from group 2.

(St. Ex. 11 at 5-6, signatures omitted)

Additional Medical Records for Patient 11

324. Patient 11 had a very complex medical history when he came to Dr. Lundeen in 2009. In addition, Patient 11 then suffered additional injuries and underwent additional surgeries after he began seeing Dr. Lundeen. Patient 11's medical history includes the following information that was provided to Dr. Lundeen:

a) <u>1999: Patient 11's Industrial Injury</u>

Patient 11 stated that he had fallen from a 50-foot tower when the tower leg buckled. He was treated in the hospital for many weeks and had numerous MRIs,

X-rays, EEGs, and EMGs. He was treated from 1999 to 2009 in Springfield, Ohio, by various physicians who are listed in the medical records. (St. Ex. 11A at 3-4; St. Ex. 11 at 3-4, 65-102)

b) 2005-2006: Fall, Strokes, Seizures, Broken Bones, Surgeries, Eye Injury, Leg Wound

In 2005, Patient 11 fell down the stairs and broke his right clavicle. In 2005, he also suffered his first stroke and seizures, for which he was hospitalized at the VA medical center, according to his new-patient questionnaire provided to Dr. Lundeen in March 2009.

Patient 11 reported that, in 2006, he suffered more seizures and strokes, broke his lumbar spine, and underwent vertebroplasty surgery in April 2006 at Mercy Hospital. Patient 11 also reported that he had "put right eye out," broke his right leg, and "blew off" part of his right calf, which was treated with three skin-graft surgeries. (St. Ex. 11 at 65; St. Ex. 11A at 11)

c) March 28, 2009: New-Patient Questionnaires & Agreements

On March 28, 2009, Patient 11 completed the new-patient questionnaire and a health-history questionnaire, and also signed a medication contract before his first visit with Dr. Lundeen in April 2009. Patient 11 set forth a medical history including fibromyalgia, migraines, fractures, surgeries, blurry vision, double vision, blindness, psychiatric illnesses, strokes and seizures, and other conditions. Patient 11 reported his drug allergies (penicillin and liver intolerance to Depakote) and listed his current drugs and durable supplies including Phenobarbital, Seroquel, Zonisamide, Xanax, Cymbalta, hydrocodone, cyclobenzaprine [Flexeril], cetirizine [Zyrtec], ibuprofen, fluticasone propionate spray [Flonase], Fosamax, Lidoderm patches, Zomig [zolmitriptan], Imitrex, vitamin and mineral supplements, left knee brace, back support, and a TENS unit. (St. Ex. 11 at 65-102)

The progress notes for the first visit to Dr. Lundeen on April 28, 2009, were quoted above. (St. Ex. 11 at 3-4)

d) May 3, 2009: Another Fall

On May 3, 2009, Patient 11 fell and was treated at the hospital, according to a letter in Dr. Lundeen's files that Patient 11 wrote to Community Mercy Medical Center on September 24, 2009, in which Patient 11 referred to his "recent fall of 05/03/2009." (St. Ex. 11A at 11) In addition, Dr. Lundeen's staff recorded the following messages regarding the patient's May 2009 fall:

> 99-583624 X **15-May-2009** 11:35:31.91 COLEMANL
> Received a call from Jamie at Andreoff's [attorney's] office today, she indicates that [Patient 11] called their office yesterday and said that he

had fallen down some steps and fractured some ribs and while he was in the hospital, they had him on Dilaudid. He told Jamie that he was unable to get the Rx written by JEL for hydrocodone filled because BWC was not paying for it. He asked Jamie if she thought that JEL would "call in" some Dilaudid for him.

99-583624 X 15-May-2009 11:43:36.30 COLEMANL
Cont.> I told Jamie, that Dilaudid can not be called in, it was in a class of medications that under the law can not be phoned in.

290564616 **19-May-2009** 09:10:39.91 SCOTTJ
[Patient 11] just called and said he was in a terrific amount of pain. He talked to Jami and Andreoff's office and she told him Dr would be in SP today. He is asking if Dr Lundeen could see him today. Please advise.

290564616 **19-May-2009** 10:42:43.90 SCOTTJ
Called [Patient 11] back and told him I received a memo from Dr Lundeen for him to go to the emergency room. [Patient 11] said he did not want to go back to the hospital. The hospital put him on percocet every 4 hrs. He said he is not taking them because he [sic] aren't helping. He requested a script for duragesic patches saying he was on them before and they helped.

290564616 19-May-2009 10:44:38.62 SCOTTJ
[Patient 11] did say that Standard Pharmacy @ 937 325-2224 Fax 937 325-0422 said that if we fax them a precription [sic] and mail the hard copy, they would fill it.

(St. Ex. 11 at 54-55, emphasis added)

e) May 19, 2009: Visit to Dr. Lundeen. The progress notes, quoted above, include no mention of the hospital's administration of Dilaudid. Dr. Lundeen states that he is prescribing Dilaudid "to treat pain from fall due to his injuries." (St Ex. 11 at 5-6, 51)

f) Summer 2009 - Visits to Dr. Lundeen in June and July 2009

June 2009: In June 2009, Dr. Lundeen's staff reported the following messages from and regarding Patient 11:

99-583624 X 17-Jun-2009 13:32:00.38 COLEMANP
[Patient 11] called today and indicated he is in alot of pain [sic]. The Rx of Dilaudid written on 5-19-09 will run out tomorrow. His next appt. in SP is 7-21-09. Can he be seen in SP tomorrow to refill this medication? Please advise.

> 99-583624 X 19-Jun-2009 16:08:24.11 LUTZC
> Per your instructions: [Patient 11] is coming in at 12:00 in SP 6-24-09 due to
> his Dilaudid Rx has run out. Appt is not in the schedule because it was not available for me to get into.
>
> 99-583624 X 23-Jun-2009 15:49:44.45 WILSONL
> 6/16/09 Approval received for PT Consult and 12 PT sessions. MCO requested Medical notes and a letter of medical necessity for the ongoing authorization for Tens Supplies. Faxed medical documentation to MCO.

(St. Ex. 11 at 55-56) The progress notes for the June 24, 2009 visit do not mention these matters. (St. Ex. 11 at 7)

July 2009: It is noteworthy (for reasons that become evident below) that Dr. Lundeen stated in his progress notes for July 21, 2009, that Patient 11's next appointment was scheduled to be "*in 12 weeks*." The specific date scheduled was October 8, 2009. In addition, the Drug Utilization Report for July 21, 2009, states Dr. Lundeen prescribed enough Norco, Lidoderm, Xanax and Lyrica to last until/beyond October 13, 2009, and the supply of Dilaudid was listed as being enough to last until "8/18/09." However, although the report states that the "End Date" for Lyrica was "10/13/09," the number of capsules actually prescribed was, in fact, enough to last for only 28 days. (St. Ex. 11 at (St. Ex. 11 at 9, 51, 55-56)

g) Summer 2009 - Visit to Dr. Lundeen in August 2009 (St. Ex. 11 at 11, 51, 55)

In the electronic medical records, the following message to Dr. Lundeen is reported:

> 99-583624 X 12-Aug-2009 10:23:38.08 SCOTTJ
> [Patient 11] called about his Dilaudid which is only good to 8/18/09, his next appt to 8/18/09, his next appt is 10/08/09 in SP @ 3:30. Should I schedule him before 10/08/09. Please advise.

(St. Ex. 11 at 55) According to the Drug Utilization Report, Dr. Lundeen prescribed a 30-day supply of Dilaudid and a 28-day supply of Lyrica on August 18, 2009. In his progress notes for that date, Dr. Lundeen stated that Patient 11 was scheduled for the next visit "in four weeks." The date of an appointment in mid-September 2009, if any, is not in the record. (Tr. at 10-12, 51, 55-57)

h) September 9, 2009: Shoulder Pain, Visit to VA, & Talks with Lundeen Office

On September 9, 2009, Patient 11 visited the VA Medical Center in Dayton, Ohio, with complaints of "Bilateral shoulder pain from a recent fall." X-rays were taken of both shoulders. The radiologist found that the studies showed no acute fractures or

dislocations, but there was evidence of significant prior trauma on the right side and arthritic changes. (St. Ex. 11A at 15)

On September 9, 2009, Dr. Lundeen's staff recorded the following messages, according to Dr. Lundeen's electronic medical records:

> 99-583624 X 9-Sep-2009 14:06:13.45 LUTZC
> [Patient 11] called to check when his next appt was. I advised him it was 10-8-09. [Note: This appears to contradict the statement in the August 18, 2009 notes that an appointment had been scheduled in 4 weeks.] His Dilaudid Rx is good through 9-17-09. Can an earlier appt be made? The rest of his meds are good through 10-13-09. Please advise, thank you.
>
> 99-583624 X 9-Sep-2009 1 4:25:07.08 LUTZC
> Advised [Patient 11] he is to make the Dilaudid last until the next visit. He was none too happy about that. He states, Dr. Lundeen has never explained that. He takes them as they are prescribed. He said the Hydrocodone doesn't do anything more that straight Aspirin might do. He wants to discuss changes in his medications with Dr. Lundeen. Again, I advised him to do so on 10-8-09.

(St. Ex. 11 at 55)

i) <u>September 29, 2009: Patient Reported To Be In Withdrawal</u>
According to the electronic medical records, Patient 11 did not see Dr. Lundeen in four weeks pursuant to a scheduled appointment. Consequently, as of September 29, 2009, Patient 11's psychologist reported to Dr. Lundeen's office that Patient 11 had been in withdrawal for several days due to a lack of his prescription drugs. The documents reflect that there was a flurry of activity to get refills for Patient 11 before his October 8 appointment:

> 99-583624 X **29-Sep-2009** 13:01:10.61 SCOTTJ
> Received a letter from Dr Ward about [Patient 11]'s dilaudid. He said because [Patient 11] was not scheduled for a monthly appt, he went through (3) days of withdrawal. He said this man has severe injuries and cannot survive w/o pain medicine. He is asking if we can schedule monthly appts. Please advise.
>
> 99-583624 X 29-Sep-2009 13:03:25.97 SCOTTJ
> He has been seen on a monthly basis. We just had to cancell [sic] his Sept appt and could not get him in until Oct. [There is no reference to a cancelling and rescheduling in the patient data. Rather, the October 8 appointment appears to have been scheduled during the July 2009 appointment.]

> 99-583624 X 29-Sep-2009 14:42:14.90 SCOTTJ
> [Patient 11] called asking if he could get in to see Dr Lundeen before 10/8/09 in SP. He states he needs to talk to Dr Lundeen about a new pain medication. Can I schedule him for tomorrow 9/30/09. Please advise.

(St. Ex. 11 at 55-56)

On September 30, 2009, Patient 11 sent a letter to Dr. Lundeen's office by facsimile transmission, following a telephone discussion with Dr. Lundeen's staff. He stated, among other things, that

- he was currently using his last Duragesic patch;
- he was out of the 8 mg Dilaudid, which he said gave him relief for a couple hours;
- he wants Dr. Lundeen to switch his hydrocodone 10 mg to Percocet 10 mg [oxycodone] because the hydrocodone had "totally quit working" and he "might as well be taking aspirin";
- he had "significant excruciating chronic pain throughout [his] entire upper body particularly at the thoracic T7, T8, T9, Lumbar L1 through L5, ribs, shoulders, right pulbus [sic] & down the right leg, making it difficult to even get a good night's sleep";
- he intended to schedule his shoulder surgery as soon as possible after his consultation on October 15, but didn't know how long it would take to schedule that surgery; and
- if his prescriptions were provided as requested, he would be good for 30 days, and his appointment could be delayed to October 8.

(St. Ex. 11A at 3-5)

On October 1, 2009, an employee of Dr. Lundeen sent prescriptions for Dilaudid and Duragesic to the pharmacy for Patient 11:

> 290564616 1-Oct-2009 14:12:43.51 SEXTONS
> [Patient 11]'s Rx of Dilaudid 8mg 1 q.i.d PO Qty 30 with No refills and Rx of Duragesic 100mcg/hr 1 every 3 days Qty 5 with No refills have been faxed to CVS at 937-323-6687 and hard copies mailed to CVS at 1475 Upper Valley Pike, Springfield OH 45502. Spoke with Pharm April and have called [Patient 11] to let him know.

(St. Ex. 11 at 55-56)

j) October 8, 2009: Visit to Dr. Lundeen. The only statement in Dr. Lundeen's Assessment is: "Norco changed to Percore [sic]." (St. Ex. 11 at 13-14, 51) The drugs prescribed in October 2009, according to the Drug Utilization Report, were as follows:

Date	Drug	Strength	Qty/Freq.	#
10/01/09	Duragesic	100mcg/hr	1 every 3 days	5
10/01/09	Dilaudid	8 mg	1 q.i.d.	30
10/08/09	Dilaudid	8 mg	1 q.i.d.	108
10/08/09	Xanax	2.00 mg	1 q.i.d.	92
10/08/09	Percocet	10/325 mg	1 q.i.d.	112
10/08/09	Duragesic	100mcg/hr	1 every 3 days	10

(St. Ex. 11 at 51)

k) October 15, 2009: Consultation at the VA regarding Shoulder Pain.
Patient 11 provided to Dr. Lundeen a copy of his appointment confirmation for his orthopedic consultation about his shoulders on October 15, 2009, at the VA Medical Center in Dayton, Ohio. Patient 11 also provided the radiology report of his x-rays taken at the VA on September 9, 2009. (St. Ex. 11A at 3-15) The record does not reflect the results of the orthopedic consultation at the VA or whether it proceeded as scheduled.

l) October 25, 2009: Another Fall & Surgical Treatment by Dr. Thompson
On October 25, 2009, Patient 11 suffered another fall and sustained serious injuries. He underwent surgery on October 25, followed by additional surgery on November 3, 2009. He subsequently continued to treat with the orthopedic surgeon, Dr. Ian Thompson, through at least April 2010 in regard to his ongoing problems with shoulder pain. (St. Ex. 11A at 33-115) The treatment by the orthopedic surgeon with respect to this fall included the following:

October 25, 2009
Patient 11 fell and sustained the following injuries: a displaced, comminuted distal radius fracture, a fracture of the humerus, and fracture of the ulna. Surgery was performed on October 25, 2009, by Dr. Thompson: debridement and external fixation of the left wrist (with pins and hardware) to treat the distal radius fracture, as the wrist was too swollen for open reduction and internal fixation at that time. The surgery for open reduction and internal fixation of the radius and humerus was scheduled for the following week. On October 30, 2009, Dr. Thompson prescribed Opana ER (12-hour oxymorphone) for pain: 10 mg, quantity 10, no refills. (E.g., St. Ex. 11A at 33-39)

[November 2, 2009 visit to Dr. Lundeen. The progress notes are in St. Ex. 11 at 15-16. Again, Dr. Lundeen's only statement in his Assessment is "Norco changed to Percore."]

November 3, 2009
On November 3, 2009, the orthopedic surgeon performed the open reduction and internal fixation of the left humerus and left radius. The external fixation of the wrist was not removed at that time. (St. Ex. 11A at 39-43)

November 16 and 30, 2009
Patient 11 saw the surgeon for post-operative follow-up. The patient also complained of his persistent shoulder pain "due to falling down stairs." (St. Ex. 11A at 39-49)

December 2009
[December 1, 2009 visit to Dr. Lundeen. (St. Ex. 11 at 17-18)]
On December 17, 2009, Dr. Thompson removed the external-fixation hardware from Patient 11's left wrist, performed manipulation of the left shoulder to treat postoperative adhesive capsulitis, and did a subacromial injection of the right shoulder. A follow-up visit took place on December 30, 2010. Thereafter, Dr. Thompson treated Patient 11 primarily for the shoulder problems predating the October 2009 fall. (St. Ex. 11A at 51-55, 103-105)

m) December 23, 2009: Patient 11 visited Dr. Lundeen. Dr. Lundeen's notes regarding the visit are in St. Ex. 11 at 19-20, and the prescriptions are shown at St. Ex. 11 at 51.

n) January 1, 2010: Alprazolam Request
A pharmacy sent a Refill Authorization Request to Dr. Lundeen by fax on Jan 1, 2010, stating that Patient 11 wanted a refill of his Alprazolam. A handwritten note indicates that, on January 2, 2010, the request was denied because the patient had been given a new prescription on December 23, 2009. (St. Ex. 11 at 253–255)

o) January and February 2010: Patient 11 visited Dr. Lundeen on January 18 and February 15, 2010. Dr. Lundeen's notes regarding these visits are in St. Ex. 11 at 21-24.

p) February 22, 2010 – Further Treatment by Orthopedic Surgeon
On this date, Patient 11 saw Dr. Thompson, who again documented a lengthy examination and review of systems. The surgeon noted that the patient complained of "falls/injuries that occurred prior to this fall." The surgeon injected medication into the right shoulder subacromial space.[63]

q) March 2, 2010: MRI
On March 2, 2010, an MRI was done of the Right shoulder, per Dr. Thompson's order. It showed a full-thickness tear of the supraspinatus tendon, tendinopathy, glenohumeral joint effusion, synovitis, fluid build-up, bursitis, bone marrow edema, rotator cuff syndrome and possible impingement, etc. (St. Ex. 11A at 63-69) The MRI report is in Dr. Lundeen's file, but there is no transmission data showing when it was sent to him. (St. Ex. 11 at 257-259)

[63] The fax-transmitting information on the copies of Dr. Thompson's treatment notes indicates that they were sent to Dr. Lundeen's office in Plymouth, Ohio, on April 27, 2010. (St. Ex. 11A at 57-59; see, also, St. Ex. 11 at 1, one of many documents showing Dr. Lundeen's fax number)

r) April 12, 2010: Visit to the Orthopedic Surgeon
Patient 11 saw Dr. Thompson, who documented an extensive examination and review of systems (as usual), and he discussed the MRI findings with Patient 11. The current problems were identified as right shoulder pain, full-thickness rotator cuff tear with fluid and bursitis, severe tendinopathy with fraying, joint effusion with prominent debris consistent with synovitis, biceps tendinopathy, AC joint arthropathy with subacromial spurring, and right rotator cuff syndrome and impingement syndrome. Dr. Dr. Thompson notes reflect that he proposed arthroscopic shoulder surgery, discussing the uncertainties as to what might be found and discussing the types of repairs that would be performed depending on what was found. The risks of surgery were presented with information regarding the lengthy recovery and therapy following this kind of surgery. (St. Ex. 11A at 63-69)

s) April, May and June 2010: Patient 11 visited Dr. Lundeen on April 2, April 27, May 25, and June 22. Dr. Lundeen's notes regarding these visits are in St. Ex. 11 at 25-32.

t) July 2010 Messages to Dr. Lundeen
Dr. Lundeen's electronic medical records include the following notations in the Dump of Patient Data for July 2010:

> 290564616 22-Jul-2010 16:55:58.58 SEXTONS
> [Patient 11] thought his appt was today in SP. He was looking at last months [sic] appt. All his Rx's can't be called in. Please advise.
>
> 99-583624 X 23-Jul-2010 08:46:37.32 LUNDEENJ
> A regular prescription, control number 1328243, for Duragesic (fentanyl), 1 *e3Day #10 written by James E. Lundeen, Sr., M.D. on 7/20/10 for 0 refills has been cancelled because changed to qod.
>
> 99-583624 X 23-Jul-2010 08:47:51.88 LUNDEENJ
> Prescription for Dilaudid (hydromorphone) of July 20, 2010 has been marked for reprinting because a technical problem; the Rx didn't print.
>
> 99-583624 X 23-Jul-2010 08:47:57.24 LUNDEENJ
> Prescription for Percocet (oxycodone, acetaminophen) of July 20, 2010 has been marked for reprinting because a technical problem; the Rx didn't print.
>
> 290564616 29-Jul-2010 16:08:50.54 PERRYJ
> [Patient 11]'s MCO called and requested that a C-9 be submitted for an MRI * * *.

(St. Ex. 11 at 56-57)

u) August and September 2010: Patient 11 visited Dr. Lundeen on August 5 and September 2, 2010. Dr. Lundeen's notes for these visits are in St. Ex. 11 at 33-36). In the notes for the September 2010 visit, Dr. Lundeen mentions for the first time in his notes that Patient 11 is blind. In addition, in the progress notes for September 2010, Dr. Lundeen mentions for the first time that Patient 11 had injured his left upper extremity during the previous autumn:

> ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will remain unchanged. Injured upper extremities in November 2009.[64] Needs a Home Health Nurse for Med Management due to his blindness. He also needs a HHA Aid 2-4 hr a day. 7 days a week to help with ADL's food preparation [sic]. Due to his blindness he requires help with his meds. May need an automatic med dispenser.

(St. Ex. 11 at 35)

v) October 2010: Home Healthcare Visits
The medical records show that Patient 11 received care from Community Mercy Homecare starting on September 21, 2010, and ending on about October 7, 2010. The nurses stated in the discharge summary that the patient reported having fallen on August 30, 2010, and that the primary physician was Dr. Lundeen. Patient 11 received the following services: skilled nursing, occupational therapy, home health aide, and a social worker. (St. Ex. 11 at 235-247) The nurses listed the following medications for Patient 11 at the time of discharge:

- Percocet 10 mg/325, 1 every six hours (begin May 3, 2010);
- Fentanyl, 100 mcg patch, every two days (begin May 4, 2010);
- Lidocaine powder every 12 hours (begin June 7, 2010);
- Xanax 2 mg every six hours (prescription began May 4, 2010);
- Phenobarbital 30mg, tablets 3 at bedtime (prescription began May 3, 2010); *
- Soma 350 mg, once at bedtime (prescription began May 11, 2010; *
- Sumatriptan 50 mg, twice a day (began April 27, 2010);
- alendronate (Fosamax), ketoconazole shampoo (antifungal), lactulose, Flonase, ibuprofen, and several vitamins and minerals, with start dates in May through September 2010.

In addition, the nurses made notations that the patient was blind in one eye and had vision problems in the other eye, and one nurse noted that Patient 11 was "NOT HOMEBOUND, DRIVING." (St. Ex. 11 at 235-247; see, also, Tr. at 453-454.)

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[64] Although the ORIF took place in November, the fall itself, and the initial debridement and installation of internal fixation hardware, took place on October 25, 2009. (St. Ex. 11 at 33-43)

*The Soma and Phenobarbital are not shown on Dr. Lundeen's Drug Utilization Report for Patient 11. (St. Ex. 11 at 51-53)

w) January 13, 2011: Patient 11 visited Dr. Lundeen, whose notes are in St. Ex. 11 at 45-46.

x) February 9, 2011 – Alprazolam Runs Out Early
On this date, Patient 11's psychologist sent a letter by fax to Dr. Lundeen, stating that Patient 11 had presented with anxiety, depression, and PTSD symptoms. The psychologist stated that it appeared that the patient's prescription for alprazolam had run out early. He asked if the patient could see Dr. Lundeen earlier than the appointment scheduled for February 17. (St. Ex. 11 at 249)

y) February and March 2011: Patient 11 visited Dr. Lundeen on February 17 and March 17, 2011, according to Dr. Lundeen's progress notes. (St. Ex. 11 at 47-50) However, the Drug Utilization Report indicates that the March prescriptions were written on March 18, 2011. (St. Ex. 11 at 52-53)

Patient 11 Drug Utilization Report

325. Dr. Lundeen's electronic medical records show that he prescribed the following drugs to Patient 11 with regard to the 1999 industrial injury:

Rx Date	Drug & Number		Refill	Daily Dose
4/28/09	Norco 10/325 mg	112	2	40/1300 mg
	Lidoderm Patch 5%	60	2	2 patches
	Xanax 2 mg	112	2	8 mg
	Lyrica 75 mg	56	2	150 mg
5/19/09	**Dilaudid 8 mg**	**120**	0	32 mg [new]
6/24/09	**Dilaudid 8 mg**	**112**	0	32 mg
	Norco 10/325 mg	112	2	40/1300 mg
	Lidoderm Patch 5%	60	2	2 patches
	Xanax 2 mg	112	2	8 mg
	Lyrica 75 mg	56	2	150 mg
7/21/09[65]	**Dilaudid 8 mg**	**112**	0	32 mg
	Norco 10/325 mg	112	2	40/1300 mg
	Lidoderm Patch 5%	60	2	2 patches
	Xanax 2 mg	112	2	8 mg
	Lyrica 75 mg	56	2	150 mg
8/18/09	Dilaudid 8 mg	120	0	32 mg
	Lyrica 100 mg	56	0	200 mg [↑] [last]

[65] This July 2009 visit is the third visit in four months at which Dr. Lundeen issued prescriptions for a three-month supply for Norco, Lidoderm patch, Xanax, and Lyrica. (St. Ex. 11 at 51)

10/1/09	Dilaudid 8 mg	30	0	32 mg
	Duragesic 100 mcg/hr	5	0	1 patch every 3 days[66] [new]
10/8/09	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	10	0	1 patch every 3 days
	Percocet 10/325 mg	112	0	40/1300 mg [added]
	Xanax 2 mg	92	0	8 mg
11/2/09	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	10	0	1 patch every 3 days
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
12/1/09	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	10	0	1 patch every 3 days
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
	Enulose 10g/15ml	1	0	30 g
12/23/09	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	10	0	1 patch every 3 days
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
1/18/10	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	10	0	1 patch every 3 days
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
2/15/10	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	10	0	1 patch every 3 days
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
3/15/10	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	10	0	1 patch every 3 days
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
4/2/10	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	10	0	1 patch every 3 days
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg

[66] This dosage was later increased on 7/23/10 to one patch every other day, "q.o.d." What the increase means in terms of delivering fentanyl doses per day is unknown to the Hearing Examiner. According to the National Library of Medicine at the National Institutes of Health, a Duragesic (fentanyl) patch is usually applied every 72 hours. It unclear whether changing a patch after 48 hours would increase the daily dose that the patient receives or simply waste patches. See, "Fentanyl Transdermal" at <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000151>, accessed 11/5/11.

4/27/10	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	10	0	1 patch every 3 days
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
5/25/10	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	10	0	1 patch every 3 days
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
6/22/10	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	10	0	1 patch every 3 days
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
7/23/10	Duragesic 100 mcg/hr	15	0	1 patch every other day
8/5/10	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	15	0	1 patch every other day
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
9/2/10	Dilaudid 8 mg	108	0	32 mg
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
9/14/10	Duragesic 100 mcg/hr	15	0	1 patch every other day
10/1/10	Dilaudid 8 mg	108	0	32 mg
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
10/28/10	Dilaudid 8 mg	108	0	32 mg
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
10/29/10	Duragesic 100 mcg/hr	15	0	1 patch every other day
11/26/10	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	15	0	1 patch every other day
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
12/23/10	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	15	0	1 patch every other day
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg
1/13/11	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	15	0	1 patch every other day
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 2 mg	92	0	8 mg

2/17/11	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	15	0	1 patch every other day
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 1 mg	140	0	5 mg (↓)
3/18/11	Dilaudid 8 mg	108	0	32 mg
	Duragesic 100 mcg/hr	15	0	1 patch every other day
	Percocet 10/325 mg	112	0	40/1300 mg
	Xanax 1 mg	140	0	5 mg

(St. Ex. 11 at 51-53)

Testimony of Dr. Cunningham Regarding Prescriptions in April & May 2009

326. Dr. Cunningham testified that 8 milligrams of Dilaudid is a "large dose" of narcotics, equivalent to 32 milligrams of morphine, and the patient was taking that dose at a frequency of four times per day. Dr. Cunningham opined that Dr. Lundeen's documentation in the progress notes for May 2009 were not sufficient to justify adding Dilaudid: "[I]f he was having falls, Dilaudid would just sedate him more and make him more prone to falls." (Tr. at 450)

327. Dr. Cunningham observed that Dr. Lundeen continued Patient 11 on this dosage of Dilaudid through March 18, 2011.[67] (Tr. at 450-451; St. Ex. 11 at 52)

328. In addition, Dr. Cunningham testified that Dr. Lundeen had prescribed Xanax to Patient 11,[68] but did not document the patient's emotional or mental status in his progress note. Dr. Cunningham testified that a physician is supposed to document the reason for prescribing a medication, and that it violated the minimal standard of care for Dr. Lundeen to prescribe Xanax without assessing and monitoring the symptoms of the condition. (Tr. at 455-456)

Comparison of Medical Records Provided to Dr. Lundeen with His Office-Visit Notes

329. Dr. Lundeen's progress notes include little of the information in the medical records listed above. For example, Dr. Lundeen does not mention that the orthopedic surgeon had prescribed Opana to Patient 11 in October 2009. (St. Ex. 11, 11A, St. Ex. 11 at 7-

[67] The progress notes for the March 2011 visit are dated March 17, 2011. (St. Ex. 11 at 49-50)

[68] The questions were directed to the Xanax prescription on May 25, 2010, although Dr. Lundeen had prescribed Xanax to Patient 11 from the first visit. (St. Ex. 11 at 51-52; Tr. at 455-457) It appears that the State directed Dr. Cunningham to this date simply as an example of the prescribing. Similarly, for the diagnosis, the State directed the witness to Patient 11's first visit stating the diagnosis of posttraumatic stress, although all the office-visit notes list that diagnosis as well. (St. Ex. 1 at 291; Tr. at 455-456)

21) All of Dr. Lundeen's progress notes from that time period state that "[n]o other practitioner is currently prescribing pain medication(s) for this patient." (St. Ex. 11 at 7-21)

330. Dr. Cunningham testified that the type of injury to Patient 11's right shoulder usually requires surgical intervention. (Tr. at 459-460; St. Ex. 11A at 67) However, Dr. Cunningham observed that Dr. Lundeen's progress notes on April 2, 2010, and thereafter, include no mention of the patient's MRI or of any injury to Patient 11's shoulder. Further, Dr. Cunningham testified that there is no documentation of any assessment of Patient 11's shoulder. (Tr. at 460-461; St. Ex. 11 at 23-30)

331. Dr. Lundeen's records show that Patient 11 had been complaining of persistent shoulder pain from at least September 2009 and continuing through April 2010. In September 2009, Patient 11 had advised Dr. Lundeen that he was planning to have shoulder surgery after the VA completed its shoulder consultation on October 15, 2009. On April 27, 2010, Dr. Thompson transmitted his records to Dr. Lundeen. (St. Ex. 11A at 13-15, 39-49, 51-59) Dr. Cunningham opined that Dr. Lundeen received Dr. Thompson's notes on April 27, 2010. The documents show a transmission date of April 27, 2010, and the documents obviously were in Dr. Lundeen's files for Patient 11. (Tr. at 461-463; St. Ex. 11A at 29-69)

Testimony of Dr. Cunningham Regarding the Home Healthcare Report

332. For the period from May 2010 through October 2010, Dr. Lundeen's progress notes include the statement that "No other practitioner is currently prescribing pain medication(s) for this patient." However, the home healthcare reports show that the patient was taking Phenobarbital and Soma, which Dr. Lundeen was not prescribing for Patient 11, according to his Drug Utilization Report for Patient 11. Further, there is nothing in Patient 11's record to indicate that Dr. Lundeen had approved another practitioner's prescribing these medications to Patient 11. Dr. Cunningham emphasized that Patient 11 had signed a pain contract with Dr. Lundeen and was obliged to refrain from receiving medications from other providers unless Dr. Lundeen was aware of it. Dr. Cunningham commented unfavorably on Dr. Lundeen lack of monitoring of the patient's medications. (Tr. at 454-455; St. Ex. 11 at 29-39, 51-53)

333. Dr. Cunningham testified that, when a physician who is prescribing pain medication to a patient has knowledge that another practitioner is also prescribing for that patient, the physician should take action:

> I think the reasonable thing to do would be a statement in the record that says, "I counseled Mr. X to not take any—get any pain medications from other providers," and I think that would probably be sufficient.

> If he wanted to also write another note to the orthopedist and tell him to not to provide any extra medicine—but I don't think that that would be required. But I think he should admonish the patient not to jeopardize himself with overdosing himself with strong medications.

(Tr. at 471-472)

334. Dr. Cunningham testified that, especially with respect to the home health care record, Dr. Lundeen had "a very clear record that there are other medications being provided." Dr. Cunningham noted that those medications may have been perfectly legitimate; however, Dr. Lundeen, as a prescribing physician, "needs to know all the medications that the individual is on." Nevertheless, Dr. Cunningham testified that Dr. Lundeen did not document asking Patient 11 where the medications were coming from or what they were for, or that the patient had been advised that that violated his pain contract. Moreover, Dr. Cunningham testified that Dr. Lundeen did not document any urine drug screens for Patient 11. Finally, Dr. Cunningham testified that each of those was required once Dr. Lundeen received information that Patient 11 was receiving medication from outside sources. (Tr. at 474-475)

335. In addition, Dr. Cunningham testified that it was not until the progress notes for Patient 11's visit on September 2, 2010—more than one year after the patient's first visit—that Dr. Lundeen made a notation that Patient 11 was blind. Dr. Cunningham testified that this condition is significant for several reasons. One reason is that Dr. Lundeen was providing multiple medications to the patient, and, "if the patient's blind, you have to make sure that someone's helping him take the medications correctly, in the correct dose and the correct time." (Tr. at 456-457; St. Ex. 11 at 35)

Further, Dr. Cunningham observed that Dr. Lundeen's progress notes on September 2, 2010, do not state whether Patient 11 had recently become blind or had been blind during the entire time that Dr. Lundeen had been treating him. (Tr. at 457) Dr. Cunningham testified that the condition is significant regardless of whether the condition is new or an existing condition. He explained:

> [I]f it's a new condition, you wonder why—you know, why it occurred, what referral did he require, and did he see an ophthalmologist or whatever. If it's an old condition, longstanding condition, there's the concern about whether or not he can safely take his medications the way they are prescribed.

(Tr. at 458)

Dr. Lundeen's Written Defense – Patient 11

336. In his written defense, Dr. Lundeen stated in part:

> Patient 11 * * * sustained severe injuries, which resulted in SSD benefits following his injuries. Patient 11's psychologist * * * referred him for medical management of his pain and psych meds. Dr. Lundeen tried physical therapy and TENS unit in addition to his medication. Patient 11 fractured his pelvis, vertebrae, legs and sustained loss of much of his vision due to his injuries. He is not a candidate for voc rehab or surgery.
>
> * * *
>
> Dr. Ross is amazed how well managed Dr. Lundeen's has Patient 11 on moderate doses of four medications considering the horrific injuries the man sustained. [sic]

(Resp. Ex. Z at 17)

Patient 12

General Information

337. Patient 12, a male born in 1965, suffered an industrial injury on October 15, 2007. He first visited Dr. Lundeen on February 11, 2009, and Dr. Lundeen's diagnoses appear to be the same as the conditions allowed in the workers' compensation claim. Patient 12 continued to see Dr. Lundeen regularly through March 30, 2011, the last visit documented in the medical records submitted. (St. Ex. 12 at 14-67, St. Ex. 12A)

338. Medical records for Patient 12 were admitted as State's Exhibits 12 and 12A. Dr. Cunningham's initial written report is set forth at St. Ex. 30 at pages 94 to 98, and his supplemental report is set forth at St. Ex. 30A, pages 7 to 8 and 14 to 15. His testimony regarding this patient is found in the hearing transcript starting at page 442. Dr. Ross' opinion is set forth at Respondent's Exhibit at page 37, and Dr. Lundeen's written opinion is set forth at Respondent's Exhibit Z at 17 to 18.

Treatment in 2009

339. The following diagnoses are listed in Dr. Lundeen's progress notes for Patient 12's first visit on February 11, 2009, and are listed as well in all Dr. Lundeen's progress notes for Patient 12:

722.52	LUMB/LUMBOSAC DISC DEGEN
836.1	TEAR LAT MENISC KNEE – CUR
836.0	TEAR MED MENISC KNEE – CUR
847.0	SPRAIN OF NECK

847.2 SPRAIN LUMBAR REGION
873.42 OPEN WOUND OF FOREHEAD
920 CONTUSION FACE/SCALP/NCK
922.31 CONTUSION OF BACK

(St. Ex. 12 at 14-66) On February 11, 2009, Dr. Lundeen stated in his progress notes for Patient 12:

> SUBJECTIVE: Service location: Portsmouth, Ohio. The patient denies any difficulty with urination, defecation, urgency or incontinence of bladder or bowel. All bill adjudications will be made prospectively, not retrospectively. This patient is new to this medical practice. He sustained injuries at work when his truck was run off the road by another truck, his truck rolled over twice before it came to rest. Medical records are partially available on this date. A pain history booklet has been completed and reviewed by this physician today. NKDA. Right-handed.
>
> OBJECTIVE: The left knee is examined today. Flexion is maximum at 85 degrees of angulation. Extension deficit (degrees) is 30. Cane for balance. Lumbar movements limited and painful. Neck movements well below normal in all six directions of movement. Grip is weak in his hands.
>
> ASSESSMENT: Medication selection: Feldene, Voltaren Gel,[69] Percocet, Flexeril, Trazodone, Zanaflex.
>
> PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2. Patient to minimize use of such narcotic medication(s), to take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx narcotic medications. Patient understand [sic] potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency or addiction will be made. A moderate degree of dependency is normal and should be anticipated with the usage of such narcotic medication(s). Beyond a normal reasonable degree of day to day dependency on such medications for ADL's, abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons. The next scheduled appointment with this examiner is in 4 weeks.

(St. Ex. 12 at 14-15, signatures omitted)

340. Dr. Lundeen's Drug Utilization Report for Patient 12 reflects that he gave the following prescriptions to Patient 12 on February 11, 2009:

---

[69] Voltaren (diclofenac) gel is a topical NSAID used for osteoarthritis. (Novartis Consumer Health, Inc., "Voltaren Gel," at <www.voltarengel.com>, accessed 11/7/11)

- Percocet 10/650 mg one, four times per day (#112)
- Feldene 20 mg one per day (#28)
- Trazodone 100 mg one at bedtime (#28)
- Zanaflex 4 mg one, twice per day (#56)
- Flexeril 10 mg one, four times per day (#112)
- Voltaren Gel 1% topical, three times per day (#300)

(St. Ex. 12 at 68)

341. On April 8, 2009, Patient 12 visited Dr. Lundeen, who increased the dosage of Percocet, explaining as follows:

> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = near 10. Activities impaired include: back, legs, constipation. Office: PO. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: none. Income: none at present.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 5 degrees, SLR L 5 degrees, spasms present in lower back. Gait: cane. Admits to fecal urgency and incontinence. Flexion 25 degrees, extension 5 degrees, right lateral flexion 5 degrees and left lateral flexion 5 degrees.
>
> ASSESSMENT: No major change in medications prescribed. Colace added Percocet modified.
>
> PLAN: The next scheduled appointment with this examiner is in 4 weeks. [Omitted: narcotic use information]

(St. Ex. 12 at 18, signatures omitted)

342. According to his Drug Utilization Report, Dr. Lundeen prescribed the following drugs for Patient 12. (St. Ex. 12 at 68-69) All the drugs were listed as being prescribed to treat the conditions of lumbar/lumbosacral disc degeneration.

Date	Drug	Daily Dose	#
2/11/09	Percocet 10/650 mg	40/2600 mg	112
	Zanaflex 4 mg	8 mg	56
	Flexeril 10 mg #112	40 mg	112
	Feldene 20 mg #28	20 mg	28
	Trazodone 1 00 mg	100 mg	28
	Voltaren Gel 1%	3 times per day	
3/11/09	Percocet 10/650 mg	40/2600 mg	112
	Zanaflex 4 mg	8 mg	56
	Flexeril 10 mg	40 mg	112
	Feldene 20 mg	20 mg	28
	Trazodone 100 mg	100 mg	28
	Voltaren Gel 1%	3 times per day	
4/8/09	Percocet 10/325 mg	50/1625 mg [↑]	140
	Zanaflex 4 mg	8 mg	56
	Flexeril 10 mg	40 mg	112
	Feldene 20 mg	20 mg	28
	Trazodone 100 mg	100 mg	28
	Colace 100 mg	300 mg	84
	Voltaren Gel 1%	3 times per day	
5/6/09	Percocet 10/325 mg	50/1625 mg	140
	Opana ER 10 mg[70]	**20 mg** [new]	56
	Zanaflex 4 mg	8 mg	56
	Flexeril 10 mg	40 mg	112
	Feldene 20 mg	20 mg	28
	Trazodone 100 mg	100 mg	28
	Colace 100 mg	300 mg	84
	Voltaren Gel 1%	3 times per day	
6/3/09	Percocet 10/325 mg	50/1625 mg	140
	Opana ER 10 mg	20 mg	56
	Zanaflex 4 mg	8 mg	56
	Flexeril 10 mg	40 mg	112
	Feldene 20 mg	20 mg	28
	Trazodone 100 mg	100 mg	28
	Colace 100 mg	300 mg	84
	Voltaren Gel 1%	3 times per day	

[70] Opana is a Schedule II narcotic.

6/30/09	**Percocet** 10/325 mg	**60/1950 mg** [↑]	168
	Opana ER 10 mg	**30 mg** [↑]	84
	Zanaflex 4 mg	8 mg	56
	Flexeril 10 mg	40 mg	112
	Feldene 20 mg	20 mg	28
	Voltaren Gel 1%	3 times per day	
	Trazodone 100 mg	100 mg	28
	Colace 100 mg	300 mg	84
7/29/09	Percocet 10/325 mg	60/1950 mg	168
	Opana ER 10 mg	30 mg	84
	Zanaflex 4 mg	8 mg	56
	Flexeril 10 mg	40 mg	112
	Feldene 20 mg	20 mg	28
	Voltaren Gel 1%	3 times per day	
	Trazodone 100 mg	100 mg	28
	Colace 100 mg	300 mg	84
8/26/09	Percocet 10/325 mg	60/1950 mg	168
	Opana ER 10 mg	30 mg	84
	Zanaflex 4 mg	8 mg	56
	Flexeril 10 mg	40 mg	112
	Feldene 20 mg	20 mg	28
	Voltaren Gel 1%	3 times per day	
	Trazodone 100 mg	100 mg	28
	Colace 100 mg	300 mg	84
9/23/09	**Percocet 10/325 mg**	60/1950 mg	168
	Opana ER 10 mg	30 mg	84
	Avinza 45 mg	45 mg [one time]	28
	Zanaflex 4 mg	8 mg	56
	Flexeril 10 mg	40 mg	112
	Feldene 20 mg	20 mg	28
	Voltaren Gel 1%	3 times per day	
	Trazodone 100 mg	100 mg	28
	Colace 100 mg	300 mg	84

10/21/09	Percocet 10/325 mg	60/1950 mg	168
	Opana ER 10 mg	30 mg	84
	Zanaflex 4 mg	8 mg	56
	Flexeril 10 mg	40 mg	112
	Feldene 20 mg	20 mg	28
	Voltaren Gel 1%	3 times per day	300
	Trazodone 100 mg	100 mg	28
	Colace 100 mg	300 mg	84

(St. Ex. 12 at 68-69)

Continued Prescribing – Patient 12

343. Dr. Lundeen continued prescribing these medications for Patient 12 on a monthly basis through March 30, 2011. In addition, beginning on March 31, 2010, Dr. Lundeen added Triavil 4-25 mg, twice per day. On March 30, 2011, Dr. Lundeen added Cymbalta 30 mg, twice per day. (St. Ex. 12 at 69-72)

April 2009 – Issue Regarding Prescription Medications for Patient 12

344. In a letter dated April 10, 2009, Dr. Lundeen defended his prescribing. After providing copies of his progress notes for February and April 2009, he concluded:

> Topic: prescription medications.
>
> As a result of the injuries sustained in this industrial accident and despite ongoing conservative treatment, [Patient 12] continues to have pain and symptoms mainly in his lower back and left lower extremity.
>
> I have read the file review of Dr. Kennington dated 2-13-09 I disagree with Dr. Kennington's findings with regard to current medications. (Emphasis in original)
>
> * * *
>
> SUMMARY
> [Patient 12] has ongoing significant low back and left knee pain and symptoms as a direct result of the injuries sustained in this claim. Dr. Kennington has not examined [Patient 12]. His opinion's [*sic*] are based on a file review.
>
> The medications currently prescribed:
> Trazodone is prescribed to assist sleep which is restless due to ongoing low back and left knee pain and symptoms.
> Voltaren gel is prescribed to help control low back and left knee pain.

> Flexeril and Zanaflex are muscle relaxa, [*sic*] effective and safe for his use and are prescribed to control spasms in his lower back.
> Feldene is an NSAID.
> Percocet is a narcotic analgesic prescribed to help control low back and left knee pain.
> Colace is prescribed to help control bowels.
>
> Based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it is my opinion, that: the prescribed medications provide adequate relief of painful symptoms and allow the patient to perform his daily living activities. Furthermore, I maintain that [Patient 12]'s medications are medically necessary

(St. Ex. 12 at 9-11)

Dr. Cunningham's Opinions

345. Dr. Cunningham noted that Dr. Lundeen had prescribed both Flexeril and Zanaflex to Patient 12 on February 11, 2009. Dr. Cunningham testified that both Flexeril and Zanaflex are muscle relaxants, and he further testified that this prescribing violates the standard of care: "I think it's just double dosing, with the same pharmaceutical class. I've never seen someone on two muscle relaxants simultaneously in the thousands of charts of the patients I've seen over the years." (Tr. at 476-477; St. Ex. 12 at 68)

346. Dr. Cunningham further testified that Dr. Lundeen had prescribed Trazodone, a psychotropic medication, to Patient 12 on February 11, 2009, without documenting a diagnosis of a psychological condition, and without documenting any other reason for prescribing that medication. Dr. Cunningham testified that this prescribing had also violated the standard of care. (Tr. at 478-479)

347. In addition, Dr. Cunningham noted that, on April 8, 2009, Dr. Lundeen increased Patient 12's dose of Percocet from 10/650 mg four times per day to 10/325 mg five times per day. However, Dr. Cunningham noted that the progress notes for that visit does not show any change in the condition of the patient except that Dr. Lundeen "talks about fecal urgency and incontinence. But that wouldn't explain increasing the dosage of Percocet." (Tr. at 480-482; St. Ex. 12 at 18, 68)

348. Similarly, on June 30, 2009, Dr. Lundeen increased the frequency of Patient 12's dose of Percocet 10/325 from five times per day to every four hours (i.e., six times per day), thus raising Patient 12's daily dose of oxycodone from 50 to 60 milligrams. In his June 30, 2009 progress notes, Dr. Lundeen noted that the patient had reported "more pain," and he stated as follows: "Medication selection: pain medications increased in frequency to reduce pain." However, Dr. Cunningham criticized that Dr. Lundeen did not explain why Patient 12's pain had been increasing. Dr. Cunningham noted that Patient 12's straight leg raises had improved

to 25 on each side from 15 at the previous visit. Dr. Cunningham opined that Dr. Lundeen's failed to provide adequate documentation as to why he was increasing Patient 12's medication, and that this constituted a violation of the standard of care. (Tr. at 485-487; St. Ex. 12 at 24, 68)

349. Dr. Cunningham noted that the first statement under "Subjective" in the June 30, 2009 progress notes for Patient 12 is: "Since the last visit, the patient's condition is worse." However, in the remainder of the notes, Dr. Lundeen does not describe in what way the patient's condition is worse. Dr. Cunningham opined that this omission is a violation of the standard of care. (Tr. at 487-488; St. Ex. 12 at 24)

350. With respect to the issue of subjective information versus objective information, the following testimony was given by Dr. Lundeen:

> Q. When you talked about the difference between subjective examination and objective examination, why isn't it sufficient if the patient just says, "I have pain. I'm on these drugs and I still have pain"? Why can't the physician just take that and do nothing else, and prescribe them more medication?
>
> A. That's the dilemma. That's the whole issue with pain management. That's just the—If there's no objective change in status, the pain shouldn't be changing.
>
> Q. Okay.
>
> A. I mean, the medical status hasn't changed. You know, if it isn't changing, the level of pain should not be changing. You know, this is not a progressive disease like a malignancy, or something like that.
>
> Q. The conditions that this patient has aren't ones that should get worse over time?
>
> A. Yes.

(Tr. at 482-483)

351. Dr. Cunningham testified that there was in fact a pain contract signed by Patient 12 in the additional records provided to him for review. However, he stated that nothing he found in State's Exhibit 12A changed his opinion concerning Dr. Lundeen's care and treatment of Patient 12. (Tr. at 488; St. Ex. 30A) State's Exhibit 12A consists of additional records maintained by Dr. Lundeen for Patient 12, including hospital records, a new-patient questionnaire and medical history, and other documents. (St. Ex. 12A)

Dr. Lundeen's Written Defense – Patient 12

352. In his written defense, Dr. Lundeen stated in part:

> Patient 12 * * * sustained injuries as a truck driver. Patient 12's truck was run off the road by another truck driver. Patient 12's truck rolled over twice. He had a neurology consult in 2009.
>
> Patient 12 sustained injuries to his head, neck, back and knees. His hand grips are very weak from his head and neck injuries. Patient 12 uses a cane for balance. Patient 12 has been approved for SSD benefits as he is no longer employable and has no return to work potential from the myriad of severe injuries.

(Resp. Ex. Z at 17)

Patient 13

General Information

353. Patient 13, a female born in 1976, sprained her lower back muscles at work on February 13, 1997. On October 28, 1997, she first saw Dr. Lundeen. Her last visit to him, as documented in the hearing exhibits, occurred on December 22, 2010. (St. Ex. 13 at 12-73)

354. Medical records for Patient 13 were admitted as State's Exhibit 13. There were no additional records for Patient 13 submitted as an "A" exhibit. Dr. Cunningham's written report is set forth at State's Exhibit 30, pages 99 to 104. Dr. Cunningham did not provide a supplemental report with regard to Patient 13 because there were no additional medical records provided for Patient 13. Dr. Cunningham's testimony regarding this patient is found in the hearing transcript starting at page 488. Dr. Ross' opinion is set forth at Respondent's Exhibit A, pages 37 to 38, and Dr. Lundeen's position is set forth at Respondent's Exhibit Z, page 18.

First Examination in October 1997 – Patient 13

355. At the patient's first visit on October 28, 1997, Dr. Lundeen documented a diagnosis of "846.0 Sprain Lumbosacral." He further noted:

> SUBJECTIVE: This patient is new to my medical practice and has transferred his/her care from Roy Johnson, MD, of Shelby, Ohio. Dr. Johnson is not currently practicing medicine in Ohio. Medical records will be requested at this time; a medical records release form will be/has been signed by the patient. Since the patient was last seen by Dr. Johnson, he/she states that the condition(s) is/are same. No other practitioner will be prescribing medications except this physician. No new injury, surgery, surgery or medical illness has occurred during the interval of transfer from Dr. Johnson to me. Medication usage has

been reviewed. A pain history booklet has been completed by the patient and reviewed by me. Other important medical history includes: none.

OBJECTIVE: SLR R 20 degrees, SLR L 30 degrees, spasms present in lower back. Gait list to left. Stronger lower extremity left. Motor function of R leg is 3/3+ out of 5. Motor function of the L leg is 3+/4- out of 5.

ASSESSMENT: The patient has pain which is chronic in nature and is very severe in severity. A good understanding of the patient's conditions, medical history, and important facts are integrated into the current treatment plan.

PLAN: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. Minimize use of narcotic medication, take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx controlled/narcotic medications. Patient understand [sic] potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency will be made. A moderate degree of dependency is normal and should be anticipated with the use of such controlled/narcotic medication(s). Beyond a normal reasonable degree of day to day dependency on such medications for ADL's, abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons. Employment status temporary total.

(St. Ex. 13 at 12, signatures omitted)

356. On October 28, 1997, according to Dr. Lundeen's Drug Utilization Report, Dr. Lundeen prescribed the following medications to Patient 13:

- Axocet[71] 50/650mg one tablet, three times per day (#65, 3 refills)
- Darvocet N-100mg one tablet, twice per day (#43, 3 refills)
- Soma 350 mg one tablet, three times per day (#65, 3 refills)

(St. Ex. 13 at 74)

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[71] The combination of acetaminophen and **butalbital** (a barbiturate sedative) has brand names including **Axocet** and **Phrenilin**. The combination has the brand name **Fioricet** when caffeine is added. All are categorized as Schedule III substances by the DEA, except Fioricet (although Fioricet is controlled by some states due to its addictive potential). Although Fiorinal (aspirin/butalbital/caffeine) is a Schedule III drug, Fioricet is not scheduled by the DEA.

See, e.g., The Mayo Clinic, "Butalbital and Acetaminophen Combination," at <www.mayoclinic.com/health/drug-information/DR602261; MDinfo, "Acetaminophen and Butalbital," at <www.mdinfo.com/drug/ 2417/Axocet>; Drug Information Online, "Axocet," at <www.drugs.com/cdi/axocet.html>; "Fiorinal," at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000027>; Mass. Medical Society, at <www.massmed.org/AM/Template.cfm?Section=Home6&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=5751; accessed 10/28/11.)

Dr. Cunningham testified that Axocet is "similar to" Percocet, a schedule II drug. (Tr. at 490) Given that the DEA has placed the two drugs in different schedules of risk, the Hearing Examiner did not find that testimony by Dr. Cunningham to be persuasive.

357. Dr. Lundeen's October 1997 progress notes do not describe the manner in which Patient 13 was injured. However, in a January 1998 letter to an attorney, Dr. Lundeen wrote that Patient 13 was working as a cashier when she reached over the conveyor line to lift a large bag of cat litter, and felt a "sharp pain and burning in her back." She was seen at a hospital emergency department and then treated by Dr. Johnson. (St. Ex. 13 at 4)

Medication Chart – January 1998 through October 2001

358. Dr. Lundeen changed Patient 13's medications as follows, according to his Drug Utilization Report:

Date	Condition	Drug	Strength	Qty/Freq.	#	Refills
1/29/98	sprain lumbosacral	Darvocet N	100 none	1 b.i.d.	60	0
	sprain lumbosacral	Axocet	50/650 mg	1 t.i.d.	90	0
	sprain lumbosacral	Soma	350 mg	1 t.i.d.	90	0
	sprain lumbosacral	Sinequan	50 mg	1 h.s.	30	0
2/28/98	sprain lumbosacral	Tylenol	325 mg	1 t.i.d.	100	0
11/03/98[72]	sprain lumbosacral	Axocet	50/650 mg	1 t.i.d.	84	0
	sprain lumbosacral	Darvocet N	100 none	1 b.i.d.	56	0
	sprain lumbosacral	Soma	350 mg	1 t.i.d.	84	0
	sprain lumbosacral	Sinequan	50 mg	1 h.s.	28	0
12/01/98	sprain lumbosacral	Sinequan	50 mg	1 h.s.	28	0
	sprain lumbosacral	Soma	350 mg	1 t.i.d.	84	0
	sprain lumbosacral	**Axocet**	50/650mg	1 t.i.d.	84	0
	sprain lumbosacral	**Darvocet**	N-100	1 b.i.d.	56	0
12/29/98	sprain lumbosacral	**Vicodin ES**	7.5/750mg	1 t.i.d.	42	2
2/09/99	sprain lumbosacral	Vicodin ES	7.5/750mg	1 t.i.d.	93	2
5/13/99	sprain lumbosacral	Pamelor[73]	25 mg	1 h.s.	34	1
	sprain lumbosacral	Vicodin ES	7.5/750mg	1 t.i.d.	102	1
7/20/99	sprain lumbosacral	Soma	350 mg	1 t.i.d.	77	2
	sprain lumbosacral	Vicodin ES	7.5/750mg	1 t.i.d.	77	2
10/05/99	sprain lumbosacral	Soma	350 mg	1 t.i.d.	98	2
	sprain lumbosacral	Vicodin ES	7.5/750mg	1 t.i.d.	98	2

[72] Dr. Lundeen explained that Patient 13 was pregnant in 1998 and that her treatment was put on hold until the baby was born. (St. Ex. 13 at 8)

[73] Pamelor (nortriptyline) is a tricyclic antidepressant. (Nat'l Libr. Med., Nat'l Inst. of Health, "nortriptyline," at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000732>, accessed 11/13/11)

1/14/00	lumb/lumbosac disc degen[74]	**Fioricet**	50/325/40	1 a.m.	90	2
	sprain lumbosacral	Vicodin ES	7.5/750mg	1 t.i.d.	90	2
4/11/00	sprain lumbosacral	Soma	350 mg	1 t.i.d.	90	2
	lumb/lumbosac disc degen	Fioricet	50/325/40	1 a.m.	30	2
	sprain lumbosacral	Vicodin ES	7.5/750mg	1 t.i.d.	90	2
6/29/00	sprain lumbosacral	Soma	350 mg	1 t.i.d.	80	2
	lumb/lumbosac disc degen	Vicodin ES	7.5/750mg	1 t.i.d.	100	2
	lumb/lumbosac disc degen	Fioricet	50/325/40	1 a.m.	27	2
9/26/00	lumb/lumbosac disc degen	Vicodin ES	7.5/750mg	1 t.i.d.	100	2
	lumb/lumbosac disc degen	Soma	350 mg	1 t.i.d.	100	2
1/18/01	lumb/lumbosac disc degen	Vicodin ES	7.5/750mg	1 q.i.d.	113	2
	lumb/lumbosac disc degen	Oxycontin	20 mg	1 t.i.d.	90	0
4/13/01	lumb/lumbosac disc degen	Vicodin ES	7.5/750mg	1 q.i.d.	120	2
	lumb/lumbosac disc degen	Oxycontin	20 mg	1 t.i.d.	90	0
7/12/01	lumb/lumbosac disc degen	Percocet	5/325 mg	1 t.i.d.	90	0
	lumb/lumbosac disc degen	Vicodin ES	7.5/750mg	1 q.i.d.	123	2
10/16/01	lumb/lumbosac disc degen	Vicodin ES	7.5/750mg	1 q.i.d.	112	2
	lumb/lumbosac disc degen	Percocet	5/325 mg	1 t.i.d.	90	0

(St. Ex. 14 at 74)

Prescribing of Soma

359. Dr. Lundeen continued to prescribe Soma to Patient 13 through September 26, 2000, and then there was a long period when he did not prescribe Soma. On June 26, 2004, Dr. Lundeen began prescribing Soma for Patient 13 again, and the prescriptions for Soma continued through December 2010, the patient's last visit.[75] (St. Ex. 13 at 74-75)

360. However, Dr. Lundeen's progress notes for the June 2004 visit say nothing about resuming Soma to treat Patient 13:

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[74] The diagnoses changed on this date, and Dr. Lundeen listed a new date of injury. He also ceased to list the workers' compensation claim number in the progress notes. (St. Ex. 13 at 74)

[75] In his testimony Dr. Cunningham stated that Dr. Lundeen had resumed prescribing Soma on May 1, 2004, which contradicts the Drug Utilization Report and for which there is no evidence. In addition, Dr. Cunningham criticized the fact that Dr. Lundeen's progress notes for *May 1, 2004*, do not explain a new injury or other reason for restarting Soma on that date, and he testified that this omission constituted a violation of the standard of care. (Tr. at 491-494; St. Ex. 13 at 50)

SUBJECTIVE: This patient is seen today at Mansfield, Ohio. Since the last visit, the patient's condition continues. Activities impaired include: back, legs, bladder. Pain is noted by patient in regions of back, legs. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include none. Progress is noted in: full bladder control with Tofranil -- no pads needed.

OBJECTIVE: Seated straight leg raising, SLR, R 35 degrees, SLR L 35 degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles.

ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will be continued.

PLAN: The patient has been advised that one or more of the RX medications are potentially addictive or habit-forming. The patient desires to continue the medication(s) in order to maximize therapeutic benefit. Every effort will be made to keep the quantities of such medications as low as possible. Employment status = none.

(St. Ex. 52, 75, signatures omitted)

January 2000 – Change of Diagnoses, New Date of Injury, etc.

361. After the visit on October 5, 1999, Patient 12's next visit to Dr. Lundeen was on January 14, 2000. In the progress notes for October 5, 1999, Dr. Lundeen stated a diagnosis of "846.0 SPRAIN LUMBOSACRAL," as he had in all his progress notes since first seeing Patient 13 in 1997. However, at the next visit on January 14, 2000, the diagnoses changed, as did information in the heading of the progress notes. (St. Ex. 13 at 29-31)

362. Dr. Lundeen's progress notes for January 14, 2000, no longer include the workers' compensation claim number. There is a new date of injury stated: January 1, 2000. (St. Ex. 13 at 31) Although the list of diagnoses changed, the subsequent notes of subjective and objective reports do not discuss the new diagnoses and new date of injury:

722.52 LUMB/LUMBOSAC DISC DEGEN
846.0 SPRAIN LUMBOSACRAL
382.9 OTITIS MEDIA NOS
354.0 CARPAL TUNNEL SYNDROME

> January 14, 2000
> SUBJECTIVE: Since the patient's last visit, the patient's condition is ongoing. Activities impaired include back movements. Pain is noted back. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include none. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 30 degrees, SLR L 30 degrees, spasms present in lower back.
>
> ASSESSMENT: The patient has pain which is ongoing and is intense in severity. Sleep quality is adversely affected.
>
> PLAN: A combination of Rx and Rx/controlled medication(s) is the current medication plan. The specific information is available in the patient's chart and/or computer account * * *. * * * Employment status: none.

(St. Ex. 13 at 31; signatures omitted, emphasis added)

363. In addition, on January 14, 2000, Dr. Lundeen provided a letter to Patient 3 stating: "You may attend the Police Academy without physical restriction." (St. Ex. 13 at 2)

364. After the visit in January 2000, the same four diagnoses appear in the progress notes through 2010 (the last visit documented), with one exception. (St. Ex. 13 at 31-72)

> There is a set of progress notes signed and dated on October 19, 2009. These notes include the following information: that the date of injury was in February 1997, that there is a single diagnosis of "846.0 Sprain Lumbosacral," that the claim number is the workers' compensation claim number, and that the visit took place on April 25, 2008, despite the fact that the notes were signed and dated in October 2009. There is no explanation in the progress notes to help understand these anomalies. In fact, at the beginning of these progress notes, Dr. Lundeen states: "Since the last visit, the patient's condition ongoing." (St. Ex. 13 at 30)

Messages in Patient 13's Electronic Medical Records

365. In the electronic medical records, in the Dump of Patient Data, messages were noted, including the following:

> MA00011401S 16-Oct-2008 10:57:19.35 COLEMANL
> [Patient 13] called yesterday to schedule an appt. She called back today and indicates that ***she is out of her medications.*** I told her according to the computer she should have enough medication to last her until 10-22-08. ***Nothing will be called in.***
>
> 300700049 10-Feb-2009 08:55:14.17 COLEMANL
> Financial watch flag changed to 1 (Patient discharged by Doctor/stop treat).
>
> 300700049 11-Feb-2009 14:17:39.28 COLEMANL
> Spoke to [Patient 13; and another woman] was conferenced. [Patient 13] knows why she was terminated, was advised that whenever we receive those types of calls, we have to terminate the patient because we can not prove if the information is true or false.
>
> 300700049 11-Jan-2010 14:17:47.82 SEXTONS
> Financial watch flag changed to N (No problem; flag is clear.)
>
> 300700049 11-Jan-2010 14:18:01.41 SEXTONS
> ***Drug watch flag changed to N (No problem; flag is clear.)***

(St. Ex. 13 at 80, emphasis added) The Hearing Examiner found no further information regarding this termination.

December 2006 – Patient 13

366. In his progress notes dated December 7, 2006, Dr. Lundeen stated:

> SUBJECTIVE: Mansfield office. Since the last visit, the patient's condition continues without significant change. Pain level today = 7. Activities impaired include: back, legs, depressed, attempted left wrist slashing due to [man]'s threatening behavior. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 20 degrees, SLR L 30 degrees, spasms present in lower back. Gait: list to left. Flexion 35 degrees, extension 15 degrees, right lateral flexion 15 degrees and left lateral flexion 15 degrees.
>
> ASSESSMENT: No major change in medications prescribed. Effexor for depression. No definite suicide planned now.

> PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2 and one or more in group 3. [omitted: narcotic use information] The next scheduled appointment with this examiner is in 12 weeks.

(St. Ex. 13 at 68)

367. The prescriptions issued by Dr. Lundeen on December 7, 2006, consist of the following, according to Dr. Lundeen's Drug Utilization Report:

Date	Diagnosis	Drug	Strength	Qty/Freq.
12/07/06	lumb/lumbosac disc degen	Soma	350 mg	1 b.i.d.
12/07/06	lumb/lumbosac disc degen	Lidoderm	patch 5%	1 q.d.
12/07/06	lumb/lumbosac disc degen	Percocet	5/325 mg	1 q.d.
12/07/06	lumb/lumbosac disc degen	Tofranil	25 mg	1 t.i.d.
12/07/06	lumb/lumbosac disc degen	Vicodin ES	7.5/750 mg	1 five x daily

(St. Ex. 13 at 76)

Prescriptions in 2010

368. Patient 13 visited Dr. Lundeen three times in 2010, according to the electronic medical records. The prescriptions (all listed as treating lumbar/lumbosacral disc degeneration), were as follows:

Date	Drug	Strength	Freq.	#	Refills
1/15/10	Vicodin ES	7.5/750mg	1 five x daily	150	5
1/15/10	Percocet	5/325 mg	1 q.d.	28	0
1/15/10	Soma	350 mg	1 b.i.d.	60	5
1/15/10	Tofranil	25 mg	1 t.i.d.	90	5
6/24/10	Lidoderm	patch 5%	1 q.d.	30	5
6/24/10	Vicodin ES	7.5/750mg	1 five x daily	150	5
6/24/10	Soma	350 mg	1 b.i.d.	60	5
6/24/10	Percocet	5/325 mg	1 q.d.	35	0
6/24/10	Tofranil	25 mg	1 t.i.d.	90	5
12/22/10	Percocet	5/325 mg	1 q.d.	35	0
12/22/10	Soma	350 mg	1 b.i.d.	60	5
12/22/10	Vicodin ES	7.5/750mg	1 five x daily	150	5
12/22/10	Tofranil	25 mg	1 t.i.d.	90	5

(St. Ex. 13 at 77)

Dr. Cunningham's Opinions – Patient 13

369. Dr. Cunningham testified that, in his opinion, the examination documented by Dr. Lundeen on Patient 13's first visit on October 28, 1997 was not an adequate examination:

> [H]e didn't measure the legs for atrophy. He didn't do reflex. He didn't test for sensation. He did not do a range of motion of the back. He doesn't have any indication that he examined the back, except that he says [s]he has spasms in the lower back. Doesn't say whether or not [she]'s had surgery * * *.

(Tr. at 490)

370. In addition, Dr. Cunningham opined that the physical examination as documented in October 1997 did not support Dr. Lundeen's prescription for Soma, a muscle relaxant. Dr. Cunningham testified that "[m]uscle relaxants are for acute pain situations" and that Patient 13's injury had occurred six months earlier. Dr. Cunningham stated the period of effectiveness for muscle relaxants lasts only about three months. (Tr. at 491-492)

371. Dr. Cunningham noted that Dr. Lundeen, as of January 7, 2004, was prescribing both Percocet 5/325 mg, once per day, and Vicodin ES 7.5/750, five times per day. Dr. Cunningham testified that this means the patient was taking 325 mg of acetaminophen in the Percocet plus 3750 mg of acetaminophen in the Vicodin ES (750 x 5 = 3750), for a total of 4,075 mg of acetaminophen per day. Dr. Cunningham testified that this exceeds the maximum recommended daily dosage for acetaminophen. Moreover, Dr. Cunningham testified that Dr. Lundeen maintained Patient 13 on that dosage level for nearly six years, through December 2010. (Tr. at 497-498; St. Ex. 13 at 75)

372. Dr. Cunningham testified that prescribing in excess of the maximum recommended dosage of acetaminophen, and failing to order blood tests to check Patient 13's liver function during the time he prescribed those doses of acetaminophen, constituted a violation of the standard of care. (Tr. at 498)

373. Further, Dr. Cunningham observed that Dr. Lundeen, in his December 7, 2006 progress notes for Patient 13, reported in the "Subjective" section that the patient had attempted suicide, and, reported in his "Assessment" section as follows: "No major change in medications prescribed. Effexor for depression. No definite suicide planned now." (St. Ex. 13 at 68)

374. Dr. Cunningham testified that he had initially interpreted the progress notes as indicating that Dr. Lundeen was going to prescribe Effexor for Patient 13's depression. However, Dr. Cunningham noted that Dr. Lundeen's Drug Utilization Report includes no prescriptions for Effexor. (Tr. at 500-501; St. Ex. 13 at 76-77) Dr. Cunningham testified:

> If you look in [Dr. Lundeen's] listing of medications, the Effexor is not in there. I would assume that if she had attempted suicide, someone gave her Effexor; maybe the emergency room physician or somebody. But – or maybe she was seeing a psychiatrist. * * * Well, since he identified the Effexor, he must have felt that it was okay. So I think –the only problem – you know, he just doesn't -- like in this situation, a couple of words or a phrase would take a lot of confusion out of his records.

(Tr. at 501-502)

375. Dr. Cunningham also testified with regard to Dr. Lundeen's notes regarding Patient 13's suicide attempt:

> Q. Do you see where the patient attempted to slash her left wrist?
>
> A. Yes.
>
> Q. Is there any indication he referred her for a psych consultation?
>
> A. No.
>
> Q. Did he perform one himself?
>
> A. Well, I think the violation is it – if the person had attempted suicide and was seeing a psychiatrist, he should have recorded that, that she was seeing -- was under psychiatric care. I mean, he should have recorded it one way or the other, I would think.
>
> * * *
>
> Q. Did he prescribe any -- either prescribe any kind of medication for this issue, or indicate that she would be receiving treatment anywhere else for the psychological issue?
>
> A. No.

(Tr. at 498-499)

376. However, Dr. Cunningham acknowledged that Dr. Lundeen's notation that the patient was not planning any "definite suicide" does indicate that Dr. Lundeen had discussed with Patient 13 her current risk of harming herself. (St. Ex. 13 at 501)

377. One of the medications being prescribed to Patient 13 at the time of the December 2006 visit was Tofranil, and Dr. Cunningham was asked whether Tofranil is an antidepressant. He answered: "Tofranil is the bladder medicine he gives out. You're thinking Trazodone. Trazodone—I misspoke earlier—is an antidepressant."[76] (Tr. at 499)

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[76] As set forth above, Tofranil is a tricyclic antidepressant that is also used to treat incontinence and bedwetting. [See footnote 10, above) Trazadone is also an antidepressant. (Nat'l Libr. of Med., "Trazadone," at <www.ncbi. nlm.nih.gov/pub med health/

378. In addition, with regard to Dr. Lundeen's examinations of the patient, Dr. Cunningham testified that there is no indication that Dr. Lundeen had performed a Faber's test on Patient 13. Dr. Cunningham explained that a Faber's test is an examination for hip joint problems. Sometimes, with patients complaining of pain in the buttock or hip area, "the pain may actually be coming from the hip rather than the low back." Dr. Cunningham testified: "I think if you're going to examine somebody for low-back pain, [Faber's test] should have been done. Very easy to do, takes just a second." However, Dr. Cunningham testified that there is no documentation that Dr. Lundeen performed a Faber's test on Patient 13. (Tr. at 507-508)

379. Dr. Cunningham noted that the "Dump of Patient Data" for Patient 13 includes a message dated October 16, 2008, which states:

> [Patient 13] called yesterday to schedule an appt. She called back today and indicates that she is out of her medications. I told her according to the computer she should have enough medication to last her until 10-22-08. Nothing will be called in.

(St. Ex. 13 at 80)

380. Dr. Cunningham testified that Patient 13's request for an early refill of her medications was a "red flag." He also commented on messages in Dr. Lundeen's records regarding the patient's termination in February 2009. (St. Ex. 13 at 80; Tr. at 503-504)

> Q. [T]here's a note dated 16 October 2008 * * * that indicates the patient called and said she was out of her medications? * * * And whoever entered this said, "I told her, her medications should last until October 22nd."
>
> A. Yes.
>
> Q. Is that a possible indication of drug seeking or addiction?
>
> A. Yes.
>
> Q. And why is that?
>
> A. Well, when you sign a pain contract, you [agree to] take the medications as prescribed. It's one of the first things that you agree to. And it's just a – what, in medicine, we call a red flag. It's something worrisome that she is either diverting or taking medications – not taking the medications in the correct dosage as prescribed.
>
> Q. After that call came in, in October, is there any indication that he discussed that issue with her to remind her she needs to take the medications as prescribed?

PMH0000530>, accessed 11/9/11) Dr. Lundeen, in his October 22, 2002 progress notes, stated that he had prescribed Tofranil to Patient 13 for bladder control. (St. Ex. 13 at 43)

A. No.

Q. Or that he conducted drug screens on her?

A. No.

Q. Or did a pill count?

A. No.

Q. And in your opinion, would the standard of care require him to do those types of things?

A. You at least have to consider them. I think he should have at least recorded, "I talked to this individual," so forth and so on.

Q. * * * February 11th, 2009. Do you see that note?

A. * * * Yes, he did terminate her.

Q. Does it say why?

A. "Was advised that whenever we receive those types of calls we have to terminate the patient because we cannot prove that the information is true or false." And I have no idea what the call -- what the content of the call was.

Q. But prior to that he hadn't taken any action in response to her using her medications early? Prior to terminating her for whatever reason, he hadn't taken any actions in response to her losing[77] her medications?

A. No.

(Tr. at 502-504)

381. Dr. Cunningham testified that, with the increase in narcotics prescribed to Patient 13, Dr. Lundeen should have considered possible addiction. Dr. Cunningham further testified that Dr. Lundeen had violated the standard of care in failing to address that issue with the patient and continuing to increase her narcotic medications. (Tr. at 510)

382. With respect to the addition of Vicodin ES (which started on December 29, 1998), and the prescribing of Vicodin ES, Soma, and Fioricet (as of January 14, 2000), Dr. Cunningham testified that it appeared that Dr. Lundeen had discontinued the Axocet and started Vicodin instead. Dr. Cunningham further testified that Dr. Lundeen added Fioricet to the regimen, which he testified is a combination of acetaminophen and phenobarbital.[78] (Tr. at 493-494; St. Ex. 13 at 74)

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[77] The line of questioning had focused on Patient 13's "using" her medications, not "losing" them, and the Hearing Examiner found no report of lost medications. This word is either a mistake by the speaker or the court reporter.

[78] The Hearing Examiner did not find this portion of Dr. Cunningham's testimony to be convincing for several reasons. First, all the consulted sources were uniform in stating that Fioricet is a combination of *butalbital,* acetaminophen and *caffeine.* Although both phenobarbital and butalbital are barbiturates, it appears that butalbital is a short- to intermediate-

383. However, with respect to the addition of Vicodin ES and the addition of Fioricet, Dr. Cunningham testified as if these medication changes had taken place on *January 29, 1998.* He testified at length about the progress notes on January 29, 1998, with respect to these medication changes. (Tr. at 494-496; St. Ex. 13 at 14)

Written Position of Dr. Lundeen

384. In his written defense, Dr. Lundeen stated in part:

> Patient 13 * * * is a 35-year-old female who sustained a work related lower back injury in 1997 at Kroger's. Patient 13's allowed condition does not reflect the true extent of her injuries; she has disc injuries and was allowed only a sprain lumbosacral condition. Patient 13's right leg has severe sciatica. Dr. Lundeen first saw Patient 13 in 1997 when her other physician, Dr. Roy Johnson, closed his practice. Patient 13 was on Temporary Total disability when Dr. Lundeen first saw her. Patient 13 has bowel and bladder leakage problems associated with her back injury and perhaps due to her multiple childbirths. Dr. Lundeen ceased medications when Patient 13 was pregnant each time. Dr. Lundeen tried to get an MRI from Kroger's for her. Dr. Johnson sent her for epidural injections, which did not reduce pain.
>
> * * *
>
> Patient 13 is raising five sons and is not employed. She was last seen on December 2010.

(Resp. Ex. Z at 18)

Patient 14

General Information

385. Patient 14, a male born in 1972, sustained an industrial accident on January 6, 2007. He first saw Dr. Lundeen on May 28, 2008. Before he saw Dr. Lundeen as a patient, Dr. Lundeen

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acting drug while phenobarbital is long-acting. In addition, considering the sequence of medication changes (quoted above), it appears more likely that Fioricet was substituted for Axocet (as they are similar in composition and were the two weaker medications) and that the Vicodin ES was substituted for the Darvocet N, because those were the two stronger drugs.

(See, e.g., Nat'l Library of Medicine, "Phenobarbital," at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000542>; "butalbital," at DORLAND'S MEDICAL DICTIONARY (Elsevier 2007), available at <http://medical-dictionary.thefreedictionary.com/butalbital>; The Mayo Clinic, "Butalbital and Acetaminophen Combination," at <www.mayoclinic.com/health/drug-information/DR6 02261; "Fioricet—Acetaminophen, Butalbital, and Caffeine," at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000016>; MDinfo, "Acetaminophen and Butalbital," at <www.mdinfo.com/drug/2417/Axocet>; Drug Information Online, "Axocet," at <www.drugs.com/cdi/axocet.html>; "Fioricet," at <www.rxlist.com/fioricet-drug.htm>; WebMD "Axocet," at <www.webmd.com/drugs /drug- 15346-Axocet+Oral.aspx?drugid=153 46& drugname=Axocet+Oral&source=1>, and "Darvocet N-100," at <www.accessdata.fda.gov/drugsatfdadocs/label/2009/Darvocet-N_July2009.pdf>; accessed 11/7/11. See, also, *Controlled Substances Schedules,* above, at pages 15-18)

examined him to provide an extensive report of impairment, including a discussion of medical history, dated April 4, 2008. Patient 14 continued seeing Dr. Lundeen on a regular basis through February 23, 2011, the last visit documented in State's Exhibit 14. (St. Ex. 14 at 3-5, 28-100)

386. Patient 14 completed a patient-information questionnaire including a medical history, and signed a medication contract and other documents, on April 5, 2008. (St. Ex. 14A at 273-279, 393-411)

387. Medical records for Patient 14 were admitted as State's Exhibits 14 and 14A. Dr. Cunningham's initial written report is set forth at State's Exhibit 30 at pages 105 to 110, and his supplemental report is set forth at State's Exhibit 30A at pages 8-9 and 14-15. Dr. Cunningham's testimony regarding this patient is found in the hearing transcript starting at page 511. Dr. Ross' report is set forth at Respondent's Exhibit A at page 38, and Dr. Lundeen's written defense is set forth at Respondent's Exhibit Z at pages 18 to19.

April 2008

388. Before Patient 14 began seeing Dr. Lundeen as his treating physician, Dr. Lundeen performed an examination with regard to the issue of permanent partial impairment due to the industrial injuries. In a letter dated April 4, 2008, Dr. Lundeen provided an extended report to Patient 14's attorney regarding the issue of percentage of disability. He reviewed the mechanism of injury, the post-injury treatment including surgery, allergies, range of motion of the left knee and hip, x-ray studies, orthopedic support for the knee, general medical history, work/social history, and so forth. (St. Ex. 14 at 3-5)

389. At Patient 14's first visit on May 28, 2008, Dr. Lundeen documented the following:

> 726.5 ENTHESOPATHY OF HIP [79]
> 836.0 TEAR MED MENISC KNEE – CUR
> 836.1 TEAR LAT MENISC KNEE – CUR
> 847.2 SPRAIN LUMBAR REGION [80]
>
> May 28, 2008
> SUBJECTIVE: New treating patient Claim allowed for left hip and left knee. Pain in lower back, left hip, left knee. Weak left leg. Overactive bladder and bowel, mild left foot drop, erectile dysfunction. Working light duty, but lack of work last four days. They told him to stay away until after this exam.

[79] The Hearing Examiner did not find this portion of Dr. Cunningham's testimony to be convincing. [79] In a letter dated June 25, 2008, Dr. Lundeen described this condition as "left hip bursitis." (St. Ex. 14 at 14)

[80] On the last documented visit, Dr. Lundeen documented the same diagnoses. (St. Ex. 14 at 30-99)

> OBJECTIVE: The right knee is examined today. Flexion is maximum at 90 degrees of angulation. Extension deficit (degrees) is 30. Weak left leg muscles, L4, L5 and S1. Seated straight leg raising, SLR, R 45 degrees, SLR L 10 degrees, very painful left-sided spasms present in lower back. Gait: list to right. Stronger lower extremity right. Flexion 35 degrees, extension 5 degrees, right lateral flexion 20 degrees and left lateral flexion 10 degrees. Very tender muscles of left lower extremity.
>
> ASSESSMENT: needs MRI of lower back and emg/ncv of both legs. Highly probable disc displacements of L4-L5 and L5-S1 both towards the left side of the spine.
>
> PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2. [Omitted: narcotic use information] The next scheduled appointment with this examine is in 4 weeks. C9 for MRI of lumbosacral spine and emg/ncv of both lower extremities.

(St. Ex. 14 at 28, signatures omitted)

390. Dr. Lundeen's Drug Utilization report indicates that he prescribed the following medications to Patient 14 on May 28, 2008:

- Lidoderm Patch 5%, one per day
- Percocet 10/650 mg, one tablet four times per day

(St. Ex. 14 at 101)

391. Dr. Cunningham commented that, on May 28, 2008, Dr. Lundeen documented an examination of Patient 14's right knee, but not of the left knee, which is the knee that was diagnosed. When asked if that violated the standard of care, Dr. Cunningham replied:

> [L]et me put it this way: The right—the word "right" might be a typographical error, and we've all done that, including me. And it may be perfectly innocent.
>
> But the knee examination that he reports is very minimal. The only thing he reports is range of motion and weakness of the leg.

(Tr. at 511-512)

392. Dr. Cunningham further testified: "He doesn't report whether or not the knee is unstable, whether it has arthritic change, whether it's swollen, whether it's inflamed, whether it's—whether it's had surgery." Dr. Cunningham testified that that had violated the standard of care. (Tr. at 513)

393. Dr. Cunningham testified that Dr. Lundeen did not document any examination of the patient's hip during the May 28, 2008 visit. (Tr. at 513-514)

394. Dr. Cunningham noted that Dr. Lundeen had prescribed Percocet and Lidoderm Patch for Patient 14's knee. Dr. Cunningham testified that he has no problem with the prescription for Percocet; however, the Lidoderm patch was not appropriate treatment for a meniscus tear: "The only thing it's going to do is cause the skin to be a little numb, where the patch is. It doesn't have anything to do with the internal workings of the knee, the ligaments, and the cartilage, and so forth." (Tr. at 514; St. Ex. 14 at 101)

June 2008

395. At the second visit on June 18, 2008, Dr. Lundeen added Opana, a schedule II narcotic, to Patient 14's medications, stating that it was to treat Patient 14's hip. However, Dr. Cunningham noted that no examination of Patient 14's hip was documented that day. Dr. Cunningham acknowledged that June 18 was a follow-up visit, and acknowledged that the level of detail does not need to be as great as for the initial visit. However, because Dr. Lundeen added medication to treat Patient 14's hip, "there should have been an examination and a little description of why the new medication was being added." Finally, Dr. Cunningham testified that this had violated the standard of care. (Tr. at 515-516; St. Ex. 14 at 30, 101)

396. Additionally, Dr. Lundeen's progress notes for June 18, 2008, do not mention adding Opana to Patient 14's medications. In fact, under "Assessment," Dr. Lundeen stated: "No major change in medications prescribed." (St. Ex. 14 at 30)

November 2008

397. On November 7, 2008, Dr. Lundeen continued to prescribe Percocet for Patient 14's knee, and he prescribed Dilaudid 4mg, three times per day, for Patient 14's hip. Dr. Lundeen discontinued Opana. (St. Ex. 14 at 101)

398. Dr. Cunningham noted that there was no mention of adding Dilaudid to treat Patient 14's hip pain. Dr. Cunningham testified that Dr. Lundeen in fact had documented that there was "[n]o major change in the medications prescribed." Dr. Cunningham further testified that, in his opinion, adding Dilaudid was a major change. In addition, Dr. Cunningham testified that there was nothing documented in the examination that indicated a need for Dilaudid. Moreover, when asked if that had violated the standard of care, Dr. Cunningham replied: "If he hasn't examined it, I would say yes. I mean, the person might have very significant hip pain and significant arthritis, which can be very painful, but there's no record of that." (Tr. at 517-518; St. Ex. 14 at 39)

Prescribing Through March 2011

399. Dr. Cunningham noted that Dr. Lundeen had continued to prescribe Percocet and Dilaudid to Patient 14 through March 24, 2011, the last visit documented in the chart, and that there was no examination of the hip in any of the progress notes. Finally, Dr. Cunningham opined that Dr. Lundeen had violated the standard of care by continuing to prescribe Percocet and Dilaudid to Patient 14 based on the documentation he provided. (Tr. at 518-5191 St. Ex. 14 at 101-102)

Dr. Lundeen's Written Defense - Patient 14

400. In his written defense, Dr. Lundeen included the following:

> Patient 14 is a 38-year-old * * * who sustained back, hip and knee injuries at work as a plumber at [company name omitted]. Patient 14 was off of work from his injuries when Dr. Lundeen first saw him in 2008. Patient 14's back symptoms included pain, left foot drop, overactive bladder and bowel as well as erectile dysfunction. An MRI and bilateral lower extremity EMG/ncv tests were requested.
>
> Dr. Lundeen encouraged Patient 14 to participate in voc rehab and job search with physical restrictions. He is compliant and is seeking employment within his limitations.

(Resp. Ex. Z at 18-19)

Patient 15

General Information

401. Patient 15, a female born in 1964, reported a history of an injury on January 1, 2009. The earliest prescriptions listed by Dr. Lundeen in his Drug Utilization Report were written on August 19, 2009. The earliest electronic progress notes are also dated August 19, 2009, although Dr. Lundeen stated in those notes that Patient 15 was an established patient. (St. Ex. 15 at 2-3, 46) In another location within the computerized records, the "date first seen" is stated as July 13, 2009, which appears to have involved review of new-patient information such as a patient-information questionnaire and medication contract dated July 12, 2009, along with ordering lab tests. For example, there are lab results for a drug abuse panel on a specimen collected on July 17, 2009. (St. Ex. 15A at 11, 33, 51, 55-61, 73-81)

402. Patient 15 continued to see Dr. Lundeen on a regular basis through March 30, 2011. (St. Ex. 15 at 4-45)

403. Patient 15 was one of two patients of Dr. Lundeen who appeared as witnesses during the hearing. Her testimony, which starts on page 557 of the hearing transcript, is discussed below.

404. Medical records for Patient 15 were admitted as State's Exhibits 15 and 15A. Dr. Cunningham's initial written report is set forth at State's Exhibit 30, pages 111 to116, and his supplemental report is set forth at State's Exhibit 30A at 9 and 14-15. Dr. Cunningham's testimony regarding this patient is found in the hearing transcript starting at page 519. Dr. Ross' report is set forth at Respondent's Exhibit A at page 38, and Dr. Lundeen's written defense is set forth at Respondent's Exhibit Z at page 19.

Dr. Lundeen's Progress Notes for August 2009 – Patient 15

405. In the progress notes for Patient 15's visit on August 19, 2009, Dr. Lundeen noted that Patient 15 had been injured on January 1, 2009, but he did not describe the injury. His notes state:

> 401.1 BENIGN HYPERTENSION[81]
> 491.2 OBSTRUCT CHR [chronic] BRONCHITIS
> 311 DEPRESSIVE DISORDER NEC
> 300.02 GENERALIZED ANXIETY DIS
> 726.10 ROTATOR CUFF SYND NOS[82]
>
> August 19, 2009
> SUBJECTIVE: Pain level today = 7. Activities impaired include: right shoulder. Office: WU. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from the medications. Employment status: none. Income: SSI. Increase Vicodin to 4x day.
>
> OBJECTIVE: The right shoulder is examined today. Flexion is 135 degrees, extension is 35 degrees, abduction is 90 degrees, adduction is 70 degrees, internal rotation with the elbow abducted at or near shoulder level is 90 degrees, external rotation with the elbow abducted at or near shoulder level is 15 degrees. Grip decreased.
>
> ASSESSMENT: No major change in medications prescribed.

---

[81] Dr. Cunningham testified that "benign hypertension" is "plain, old, garden variety high blood pressure," whereas malignant hypertension is where the patient is "having end organ damage, like kidney or brain." (Tr. at 520)

[82] Dr. Lundeen's progress notes continue to list the same diagnoses through Patient 15's last documented visit. (St. Ex. 14 at 4-44)

PLAN: The next scheduled appointment with this examiner is in 4 weeks.
[Omitted: narcotic information]

(St. Ex. 15 at 2, signatures omitted)

406. The Drug Utilization Report indicates that Dr. Lundeen issued the following prescriptions to Patient 15:

- Tenormin: 25 mg, twice per day, for hypertension (#58, no refills)
- Vicodin: 5/500 mg, 4 times per day, for rotator cuff syndrome (#116, no refills)

(St. Ex. 15 at 46)

Undated Notes in the Medical Records – Patient 15

407. Dr. Lundeen's records include handwritten notes on a form, which appear to record an intake interview and may document Patient 15's initial visit to Dr. Lundeen in July 2009. The following notations are included:

- Current medications: Vicodin ("out 2 days"), Clonazepam, Benicar,[83] Singulair, ProAir, Symbicort, and Alb. HHN [probably Albuterol Hand Held Nebulizer].
- Blood pressure of 116/60, pulse of 84, respirations of 12-14, and a "stated" weight of 154 pounds. No height was documented.
- Checkmarks indicating that HEENT, neck, lungs, heart, abdomen, back, extremities, neurological, and skin were normal, with a doctor's name written next to "skin."
- Notes that the patient had an angiogram two years ago, said to be "fine," and that the patient is a smoker.
- A "Plan" listing the following diagnoses: 401.1 HTN; 491.20 COPD; 311 Depression; 300.02 Anxiety; "?Torn (R) Rotator cuff"; "726.10?"; 715.9, and "[illegible] etiology (R) femur Dx 2000."[84]
- The planned follow-up includes: "√ records from Q-s Pharmacy"; "labs CBC, CMP, A1c, LP, TSH, tox," etc.
- The plan also includes continuing the "current care" for the HTN, COPD, Depression, and Anxiety, and "7/23/09 Atenolol [Tenormin] 25 mg QD x 14 d, √ BP dly" and "Vicodin 5/500 PO QD #14 RFØ B@WU."
- There is additional information, possibly another prescription, that is illegible because the page was partially cut off by the copier or scanner. The document appears to include Dr. Lundeen's signature. (St. Ex. 15A at 33)

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[83] Benicar (olmesartan) is used to treat high blood pressure. (Nat'l Libr. Med., *<www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000215>*, accessed 11/11/11.)

[84] HEENT means "Head, ears, eyes, nose, throat." HTN is hypertension, COPD is chronic obstructive pulmonary disease, and "726.10" is an ICD-9 code that refers to "Disorders of bursae and tendons in shoulder region unspecified."

408. Dr. Lundeen's medical records for Patient 15 also include 2007 records from Dr. David Herr regarding Patient 15's concerns regarding her right femur and both shoulders. (St. Ex. 15A at 37-49)

Patient 15 Medication Chart

409. According to Dr. Lundeen's Drug Utilization Report, he prescribed the following for Patient 15:

Rx Date	Dx	Medication	Strength (#)	Daily Dose
8/19/09	hnp	Tenormin	25 mg (#58)	50 mg
	r.cuff	Vicodin	5/500 mg (#116)	20/2000 mg
9/17/09	hnp	Tenormin	25 mg (#58)	50 mg
	r.cuff	**methadone**	**5 mg** (#112)	20 mg
10/15/09	hnp	Tenormin	25 mg (#58)	50 mg
	r.cuff	methadone	5 mg (#112)	20 mg
11/12/09[85]	r.cuff	**Vicodin HP**	10/660 mg (#112)	40/2640 mg
	hnp	Tenormin	25 mg (#58)	50 mg
12/10/09	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	hnp	Tenormin	25 mg (#28)	25 mg (↓)
	hnp	**HCTZ**	25 mg (#28)	25 mg
	hnp	**Prinivil**	10 mg (#28)	10 mg
12/30/09	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	r.cuff	**methadone**	**5 mg** (#116)	20 mg
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg
2/3/10	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	r.cuff	**Percocet**	**5/325** mg (#56)	10/650 mg
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg
3/3/10	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	r.cuff	Percocet	5/325 mg (#56)	10/650 mg
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg

[85] Dr. Lundeen's progress notes for this date include: "Blood pressure 156/74 mmHg. Pulse 72. Respirations 16 per minute. SpO2 98%. Heart RRR. Lungs CTA. Edema." (St. Ex. 15 at 8)

3/31/10[86]	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	r.cuff	Percocet	5/325 mg (#56)	10/650 mg
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg
	bronchitis	Keflex	500 mg (#40) 1 refill	2000 mg
4/28/10[87]	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	r.cuff	Percocet	5/325 mg (#56)	10/650 mg
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg
5/26/10	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	r.cuff	Percocet	5/325 mg (#56)	10/650 mg
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg
6/23/10	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	r.cuff	Percocet	5/325 mg (#56)	10/650 mg
	r.cuff	**Dilaudid**	8 mg (#87)	24 mg
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg
7/22/10	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	r.cuff	Percocet	5/325 mg (#56)	10/650 mg
	r.cuff	Dilaudid	8 mg (#84)	24 mg
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg
8/19/10	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	r.cuff	Percocet	5/325 mg (#56)	10/650 mg
	r.cuff	Dilaudid	8 mg (#84)	24 mg
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg

[86] Dr. Lundeen's notes for this date include the following: "Obtains controlled drugs from Psychiatrist. Allergic to Sulfa drugs." (St. Ex. 15 at 18)

[87] Dr. Lundeen's notes for this date include the following: "Pressure 106/65 mmHg. Pulse 54. Respirations 12 per minute. Heart RRR." (St. Ex. 15 at 20)

9/16/10	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	r.cuff	Percocet	5/325 mg (#56)	10/650 mg
	r.cuff	Dilaudid	8 mg (#84)	24 mg
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg
10/8/10	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	r.cuff	Percocet	5/325 mg (#56)	10/650 mg
	r.cuff	Dilaudid	8 mg (#84)	24 mg
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg
11/10/10	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	r.cuff	Percocet	5/325 mg (#56)	10/650 mg
	r.cuff	Dilaudid	8 mg (#84)	24 mg
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg
12/8/10	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	r.cuff	Percocet	5/325 mg (#56)	10/650 mg
	r.cuff	**Dilaudid** [last]	8 mg (#84)	24 mg
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg
1/5/11	r.cuff	**Neurontin**	600 mg (#112)	2400 mg
	r.cuff	**Percocet**	5/325 mg (#56)	10/650 mg
	r.cuff	**Norco**	7.5/325 mg (#168)	45/1950 mg
	bronchitis	**Ventolin**	none (1) 5 refills	2, 4 x per day
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg
2/4/11	r.cuff	Neurontin	600 mg (#112)	2400 mg
	r.cuff	Percocet	5/325 mg (#56)	10/650 mg
	r.cuff	Norco	7.5/325mg (#168)	45/1950 mg
	bronchitis	Ventolin	none 5 refills	2, 4 x per day
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg

3/2/11	r.cuff	Neurontin	600 mg (#112)	2400 mg
	r.cuff	Percocet	5/325 mg (#56)	10/650 mg
	r.cuff	**Vicodin HP**	10/660 mg (#112)	40/2640 mg
	bronchitis	Ventolin	none 5 refills	2, 4 x per day
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg
3/30/11	r.cuff	Neurontin	600 mg (#112)	2400 mg
	r.cuff	Percocet	5/325 mg (#56)	10/650 mg
	r.cuff	Vicodin HP	10/660 mg (#112)	40/2640 mg
	anxiety	**Klonopin**	1 mg (#56)	2 mg
	bronchitis	Ventolin	none 5 refills[88]	2, 4 x per day
	hnp	Tenormin	25 mg (#28)	25 mg
	hnp	HCTZ	25 mg (#28)	25 mg
	hnp	Prinivil	10 mg (#28)	10 mg
	depression	**Cymbalta** [new]	60 mg (#28)	60 mg
	depression	**Lamictal** [new]	100 mg (#28)	100 mg

(St. Ex. 15 at 46-48)

410. Dr. Lundeen often documented, "Current medication: Atolenol [*sic*]"or a similar statement, despite the fact that he also prescribed numerous other medications to Patient 15. (St. Ex. 15 at 20, 22, 24, 26, 28, 30, 32, 34, 36, 38)

Dr. Cunningham's Testimony – Patient 15

411. Dr. Cunningham criticized Dr. Lundeen's treatment of the patient's hypertension. He testified that, when treating a patient for hypertension, the evaluations must include, among other things, measuring the patient's blood pressure. Dr. Cunningham noted that Dr. Lundeen had documented a blood-pressure reading on the initial visit, but failed to document any follow-up readings on subsequent visits.[89] Dr. Cunningham opined that a blood-pressure reading should have been taken at every visit because, if a physician is providing blood-pressure medication and the patient is coming in for refills, the physician needs to know whether the blood pressure is under control. Dr. Cunningham testified that it violated the standard of care for Dr. Lundeen to prescribe blood pressure medication to Patient 15 without checking her blood pressure at every visit. (Tr. at 522-525; St. Ex. 15 at 46-48)

[88] This is Patient 15's fourth prescription for Ventolin with five refills in four months. (St. Ex. 15 at 48)

[89] Dr. Lundeen recorded a blood-pressure reading in his progress notes on November 12, 2009 (156/74) and April 28, 2010 (106/65). (St. Ex. 15 at 8, 20)

412. Dr. Cunningham further testified that Dr. Lundeen should have listened to Patient 15's heart and lungs, at least every six months approximately, while treating her for hypertension. (Tr. at 524, 526)

413. In addition, Dr. Cunningham testified that Dr. Lundeen should have recorded Patient 15's weight approximately every six months; however, no weight was recorded except for her first visit. Dr. Cunningham testified that this, too, had violated the standard of care. (Tr. at 526)

414. With respect to Dr. Lundeen's switching of Patient 15's medications—such as putting her on methadone, and then on Vicodin, and then back to methadone or a stronger formulation of Vicodin, and so forth—Dr. Cunningham stated that Dr. Lundeen did not explain his reasons for these changes. Dr. Cunningham testified, for example, that it violated the standard of care for Dr. Lundeen to add methadone for Patient 15's without setting forth his reason. (Tr. at 530-533; St. Ex. 15 at 4, 46)

415. As another example, Dr. Lundeen discontinued methadone in November 2009 and prescribed the stronger Vicodin HP tablet (10/660 mg) four times per day. Dr. Cunningham indicated that a physician might reasonably change the medication due to a report of undesirable side effects, but he faulted Dr. Lundeen for failing to document a reason for the change. (Tr. at 532-534; St. Ex. 15 at 8, 46)

416. With respect to the addition of Percocet 5/325 mg (twice per day) in February 2010 while also continuing the Vicodin HP, Dr. Cunningham noted that, despite the fact that Dr. Lundeen changed the medication, his progress notes for that visit state that "the medications will remain unchanged." Dr. Cunningham opined that this violated the standard of care: "If you're going to change medicine, you need to document it." (Tr. at 535; St. Ex. 15 at 14, 46) In addition, Dr. Cunningham observed that Dr. Lundeen had not documented his reason for the change in medication. Although Dr. Lundeen had noted that Patient 15 needed a referral to an oncologist, Dr. Cunningham found this statement to lack sufficient information: "So that may be what her—is explaining some of her pain, but it is not otherwise discussed. I don't know any more than that." (Tr. at 535-536; St. Ex. 15 at 14-15)

417. In addition, Dr. Cunningham opined that Dr. Lundeen's increase in Patient 15's narcotics on June 23, 2010, was "a dramatic increase in narcotics." Dr. Cunningham noted that Dr. Lundeen had added Dilaudid 8 mg, three times per day, while continuing to prescribe Percocet and Vicodin HP. Moreover, Dr. Cunningham noted Dr. Lundeen did not mention Dilaudid in his progress notes for that visit and documented no objective change in Patient 15's status. Dr. Cunningham opined that this violated the standard of care. (Tr. at 536-537; St. Ex. 15 at 24, 46)

418. Dr. Cunningham also focused on the medications that Dr. Lundeen prescribed in December 2010 and January 2011 to treat Patient 15's rotator cuff syndrome, which were as follows:

Date	Drug	Strength	Qty/Freq.
12/8/10	Vicodin HP	10/660 mg	1 q.i.d.
	Percocet	5/325 mg	1 b.i.d.
	Dilaudid [last]	8 mg	1 t.i.d.
1/5/11	Neurontin [new]	600 mg	1 q.i.d.
	Percocet	5/325 mg	1 b.i.d.
	Norco	7.5/325 mg	1 6 x day
	Ventolin [new]	none (5 refills)	2 q.i.d.

(St. Ex. 15 at 47) Dr. Cunningham testified that Neurontin is used to treat neuropathic pain, relating to pinched nerves, radicular pain, and peripheral nerve conditions. He opined that it is not an appropriate medication to treat rotator cuff syndrome "unless she's got a—something like a suprascapular neuritis, scapular nerve entrapment, no." Dr. Cunningham stated that Dr. Lundeen failed to "document why he gave that to her for shoulder pain." (Tr. at 537-538; St. Ex. 15 at 38, 47)

419. Dr. Cunningham also observed that Dr. Lundeen had discontinued Vicodin HP and Dilaudid, and substituted Norco, without providing an explanation in the patient's notes for the visit on January 5, 2011. This created a decrease in the amount of narcotic analgesics for Patient 15. Dr. Cunningham testified that Dr. Lundeen did not document any reason for doing that. Dr. Cunningham further testified that, when medication is decreased, a reason needs to be documented in the medical record: "Did he decrease it because she was feeling overmedicated, or was she drowsy, that sort of thing; or, was she having an adverse reaction * * * or whatever." Instead, Dr. Lundeen documented in the January 5, 2011 progress notes as follows:

> Based on the patient's examination findings, history of injury and present complaints, *the medications will remain unchanged.*

(St. Ex. 15 at 38, emphasis added) Dr. Cunningham opined that this violated the standard of care. (Tr. at 538-539)

420. In addition, Dr. Cunningham observed that Dr. Lundeen, in his progress notes dated March 2, 2011, stated that he would change Patient 15's medication "to Norco 10 mg to reduce pain." (St. Ex. 15 at 42) However, Dr. Cunningham noted that Patient 15's pain level was unchanged from the previous two months, and there was no significant change in examination findings. Also, Dr. Cunningham noted that Dr. Lundeen actually prescribed Vicodin HP 10/660 mg four times per day rather than Norco. (Dr. Cunningham acknowledged that he does not know whether Dr. Lundeen uses Vicodin and Norco interchangeably, as they both contain hydrocodone.) (Tr. at 539-541)

421. Dr. Cunningham also focused on Dr. Lundeen's prescribing and progress notes on March 30, 2011. He stated that Dr. Lundeen prescribed Cymbalta, 60 mg per day, and Lamictal, 100 mg

per day, to treat the depressive disorder, and also prescribed Klonopin, 1 mg twice per day, to treat the anxiety disorder. (Tr. at 541-543; St. Ex. 15 at 44, 48)

However, Dr. Cunningham commented that, in the progress notes dated March 30, 2011, Dr. Lundeen mentioned nothing about Cymbalta or Lamictal, and did not document any examination concerning the patient's depression or mental status. Moreover, Dr. Lundeen stated in the notes that Patient 15 was receiving "Klonopin from Psych doctor," despite the fact that he also started prescribing Klonopin for the patient on that day. Furthermore, Dr. Cunningham stated that Dr. Lundeen did not explain why he began prescribing Lamictal when the psychiatrist was prescribing Klonopin. In addition, Dr. Cunningham testified that Dr. Lundeen should have explained why he was prescribing psychiatric medications, and he should have taken a psychiatric history and determined what her psychiatric symptoms were. Finally, Dr. Cunningham testified that it violated the standard of care for Dr. Lundeen to prescribe antidepressants to Patient 15 without assessing her depression. (Tr. at 541-543; St. Ex. 15 at 44, 48)

Testimony of Patient 15

422. Patient 15 testified that she had first started seeing Dr. Lundeen at his office in West Union, Ohio, approximately two years ago, primarily for problems with her right rotator cuff and a tumor on her right femur. She noted that a receptionist and a nurse had worked at that location. (Tr. at 557-558)

423. Patient 15 testified that she had completed a patient history form at her first visit and "told him everything," including that she had hypertension. When asked what type of examination Dr. Lundeen had performed at her first visit, Patient 15 replied, "None." She further testified that one of his assistants had taken a urine sample and that she was "told to bring an MRI, which was a very old MRI." She testified that blood work was done at the second visit. She denied that anyone in the office took her blood pressure.[90] (Tr. at 558-559, 566-567)

424. Patient 15 testified that she had seen Dr. Lundeen every 28 days following her first visit, and that her fiancé, Patient 22, also a patient of Dr. Lundeen's, accompanied her to her visits. Patient 15 noted that Dr. Lundeen had conducted both their appointments while they were in the same room together. However, Patient 15 testified that she had had no objection to being seen along with Patient 22. (Tr. at 559-560, 586-587)

425. Patient 15 testified that the office where Dr. Lundeen had seen her and Patient 22 was "a little office with boxes stacked everywhere." She further testified that there had been a desk, but no examination table, and that she sat in a chair during her appointment. (Tr. at 560)

[90] This conflicts with Dr. Lundeen's progress notes, which indicate that her blood pressure had been taken at her initial visit as well as her visits on November 12, 2009, and April 28, 2010. (St. Ex. 15 at 8, 20; St. Ex. 15A at 33)

426. Patient 15 testified that, at first, Dr. Lundeen had prescribed "Vicodin 10 and Methadone, which had put her in the hospital last January [2010]." When asked what put her in the hospital, Patient 15 replied, "It was, I guess, where I wasn't—I was overdosing on the Vicodin and the Methadone. I was having back-to-back convulsions and not realizing it, and I was just totally out of my mind." Patient 15 further testified that she had told Dr. Lundeen about that, and that he told her to take less.[91] (Tr. at 560-561)

427. Patient 15 stated that, after the West Union office closed, she began seeing Dr. Lundeen in his Portsmouth office. She testified that Dr. Lundeen then began prescribing her "Vicodin 10, Percocet 5s, and Tramadol."[92] (Tr. at 561-562)

428. Patient 15 testified that, after starting to visit Dr. Lundeen at the Portsmouth office, she had developed a painful lump on her left wrist. She asked Dr. Lundeen about this condition, but, according to Patient 15, he did not perform any examination. She stated that he was sitting in a swivel chair facing his computer, and he swung around and glanced at her wrist while she held her arm out, and he then turned back to his computer and prescribed "Dilaudid No. 8s" for her. Patient 15 testified that Dr. Lundeen "didn't touch it [her wrist], look at it, or anything, he just turned back around and started writing out a prescription." (Tr. at 561-562)

429. With respect to Patient 15's rotator cuff issue, Patient 15 testified that Dr. Lundeen's examination of her shoulder had simply been to see how far she could raise her arm. (Tr. at 563)

430. With respect to her high blood pressure, Patient 15 testified:

> A. [O]n my blood pressure, in West Union he had written me out three different blood pressure medications, and * * * Julie, the one nurse, she had said that Dr. Lundeen said just to adjust myself to them until I felt better, because I was having low blood pressure, high blood pressure.
>
> So I stopped taking them, and I told him that. And he continued to write the prescriptions, but the only one I would take was the Atenolol, because that made my blood pressure level.
>
> Q. How did you know when your blood pressure was going up and down?

[91] The records reflect that Dr. Lundeen issued prescriptions for both Vicodin HP (10/660 mg four times per day) and methadone (5 mg four times per day) on December 30, 2009. (St. Ex. 15 at 46)

[92] Dr. Lundeen's records do not support Patient 15's statement that he prescribed tramadol for her. (St. Ex. 15 at 46-48)

A. My head would hurt, and the back of my neck would hurt. And then when my blood pressure would drop, I would get chills and just real weak. My vision would get blurry.

(Tr. at 563)

431. Patient 15 testified that, when Dr. Lundeen prescribed Dilaudid for her, she did not question him or tell him she did not want them because she had been "very addicted" at that time. (Tr. at 564) Patient 15 further testified:

> My tolerance was so high that, you know, any drug, you know, we [Patient 15 and Patient 22] never objected to it or anything.
>
> And once I started taking Dilaudids with the Percocet and the Vicodins, I nodded out at the wheel and I hit a house head-on.

(Tr. at 565)

432. Patient 15 further testified that Patient 22 had overdosed on medication and that he was receiving more medication than she was.[93] (Tr. at 565-566)

433. Patient 15 testified that Dr. Lundeen never asked her if she was taking her medication as directed. Patient 15 further testified that Dr. Lundeen never performed a pill count or urine test other than the urine test performed in connection with her first visit. (Tr. at 566)

Patient 15 acknowledged that she never told Dr. Lundeen that she was not taking her medication properly: "To be honest, I was—you know, I was addicted, and I wouldn't want to mention that." (Tr. at 567)

434. Patient 15 testified that Dr. Lundeen usually asked for her pain level, and that she would usually say "seven or eight, or something like that." (Tr. at 567)

435. Patient 15 testified that, when she and Patient 22 visited Dr. Lundeen, the office visit for both of them would usually take "about five minutes, maybe six total." (Tr. at 567) She also stated:

> But most of our visits in his office was where he was talking about—he had went to Maui and had proposed to his secretary, which is the one you spoke with when you called. I believe her name was [name omitted].
>
> And then he would show us pictures on his cell phone of a NASCAR driver woman he had been dating.

[93] Patient 22 also testified during the hearing and described his overdose. (See below.)

> And at one point in time, this was in West Union, he was complaining about his Blackberry cell phone had broke and— "But no problem, I'll get me a new one." And he put his—the broken one in the drawer. When me and my fiancé went back, he had swirled back in his chair and said, "You can call me a legal drug dealer," and he had the broke one and the new one in his hand.

(Tr. at 567-568)

436. Patient 15 testified that, during the time that she was a patient of Dr. Lundeen, she was charged with and pleaded guilty to two felony charges of aggravated possession of drugs. Patient 15 indicated that she had been sentenced to a fine of about $2,000 and two years of incarceration, which was stayed subject to two years of community control including a two-year suspension of her driver's license, weekly drug testing, and 100 hours of community service. Patient 15 further testified that she now sees a drug counselor and attends "three meetings a week." (Tr. at 568-569)

437. Patient 15 testified that she does not recall seeing a scale, blood pressure cuff, or stethoscope at Dr. Lundeen's Portsmouth office. Patient 15 further testified that Dr. Lundeen was by himself at that office, with no nurse or receptionist. (Tr. at 566, 570)

Patient 15 - Cross-Examination

438. When confronted with Dr. Lundeen's progress notes dated November 12, 2009, indicating a blood pressure reading of 156/74, Patient 15 testified that she could not "recall any of the girls taking a blood pressure." She acknowledged that it could have happened, but that she does not recall it happening. (Tr. at 572-573)

439. Patient 15 testified that, at Dr. Lundeen's West Union office, Dr. Lundeen's assistant Julie had usually taken her pulse, respirations, oxygen saturation, and listened to her lungs. (Tr. at 573-575)

440. When asked if she recalls Dr. Lundeen's or an assistant's taking her blood pressure at her April 2010 visit, Patient 15 replied: "No, I don't. I was far out there on drugs." (Tr. at 575)

441. Patient 15 acknowledged that she had abused the medication that Dr. Lundeen prescribed. (Tr. at 576) She further conceded that she had signed a pain contract with Dr. Lundeen, whereupon the following exchange took place:

> Q. [By Mr. Graff] And did you tell him you violated it [the pain contract]?
>
> A. [By Patient 15] No, I didn't. Sir, when you're addicted on drugs, you don't want to say or do anything that's going to maybe stop you from getting your medication.

Q. So you lied?

A. No, I didn't lie.

Q. What do you mean you didn't lie?

A. Of course I lied.

MS. BOCKBRADER: Objection, badgering.

THE EXAMINER: Overruled.

THE WITNESS: I wasn't asked.

BY MR. GRAFF: You lied. You told him in your pain contact you were going to do what you were going to do?

A. Well, he never asked. And he didn't care nothing about his patients, so why should I care to be honest? I mean, he was more concerned with the money than anything, and his trips to Maui and Hawaii and all this and that. He didn't care about his patients.

Q. He seemed to have seen you every 28 days to take care of you.

A. No, he didn't take care of me, sir. He seen me every 28 days to get money for the payments, medical card that the State paid for, and to give me my narcotics.

Q. So * * * he took care of you every 28 days and you gave him a Medicaid card?

A. No. He harmed me more than anything. My life today is still not functional.

Q. Well, that's right. You do have a criminal record, don't you?

A. Yes, I do. Thanks to Dr. Lundeen, I now have two felonies on me.

Q. Well, now, they weren't the drugs from Dr. Lundeen that you got arrested for?

A. But they were. I wish I had brought my Court papers. Yes, sir, they were. They were both from Dr. Lundeen.

Q. No. The possession of them were for drugs that were not yours appropriately.

A. No. You may be looking at Patient 22's record, because mine—that's—that's the only medication I got, was from Dr. Lundeen.

Q. Well, you said you went out—when you ran out of pills you went out and bought them.

A. No, I did not say that. I did not say that. I was asked if I was taking—if I would run out of my medicine earlier, and I said yes.

Q. So where were you getting the drugs?

A. From Dr. Lundeen, is where I was getting them. Why are you being rough on me for? I mean, I'm the victim here. And that's exactly the way I feel.

Because once you get addicted and your tolerance gets so high, and then you're given more and more and more, you're not going to stop.

You're not going to stop until you're arrested or you're in your grave. Just like me hitting the house head-on, me and my fiancé both could have been killed. But by the grace of God, it's my belief, that we weren't, we were spared. Excuse me.

Q. Did you tell Dr. Lundeen about the accident?

A. No, I did not.

Q. How is he supposed to know if you don't tell him?

A. He did not care. He gave me Dilaudid No. 8, sir—I'm sorry for raising my voice—because I had a knot on my arm. And I was only concerned because when you touched it, it was tender. "Oh, we can fix that. You're getting Percs and Vicodin, so we'll give you this."

I mean, Dilaudid 8, I hear that's worse than an epidural that a woman has received when she goes in to have a baby.

I mean, you know, we lost our home, we lost everything. And I'm still not back on track. I still have withdrawals. And every day of my life is a life of pure hell. I have to fight it and fight it and fight it.

(Tr. at 576-580)

Patient 15 on Re-Direct Examination

442. Patient 15 testified as to why Dr. Lundeen had prescribed Cymbalta, Lamictal, and Klonopin on March 30, 2011. She testified that, while she and Patient 22 were in the examination room, Dr. Lundeen overheard her telling Patient 22 of her concern about getting to her psychiatrist appointment in time. She further testified:

> Dr. Lundeen, he turned and he asked me what was I being prescribed there, and I told him my Cymbalta, Lamictal, and my Klonopin, and he said, "Well, I can take care of that right now."
>
> So he wrote them prescriptions as well. And they had went to—I believe they was at Fitzger's pharmacist, and when I went to pick them up—which caused

> me to lose my psychiatrist, because that would have been a third appointment missed.
>
> So I was dismissed from [the psychiatrist], and then I wasn't allowed to pick up my medication because Dr. Lundeen had lost his license temporarily.

(Tr. at 591-592)

443. Patient 15 further testified that Dr. Lundeen did not ask her what conditions her psychiatrist had prescribed those medications for, nor did he question her about her symptoms or mental issues. (Tr. at 592)

Dr. Lundeen's Written Defense – Patient 15

444. In his written defense, Dr. Lundeen stated in part:

> Patient 15 * * * is a 46-year-old white female whose prior physician * * * abandoned her and his medical practice in West Union, Ohio in 2009. With Dr. Lundeen's physician assistant, Dr. Lundeen evaluated and treated Patient 15 without compensation from 2009 to 2011. Both the physician assistant and Dr. Lundeen encouraged the Patient 15 to seek the care of an internist for management of her internal medicine conditions. Patient 15's conditions include a shoulder injury for which pain medication is required. Patient 15's internal medicine conditions under treatment include hypertension, COPD, depressive disorder and generalized anxiety. Her anxiety is most likely due to her underlying COPD and difficulty breathing. Patient 15 is encouraged to monitor her blood pressure at home and review readings with Dr. Lundeen in the office. Patient 15 was instructed how to titrate her blood pressure meds to keep her blood pressure in range; she has multiple blood pressure meds including HCTZ, Tenormin and prinivil [sic].
>
> * * *
>
> At all times Dr. Lundeen's care to Patient 15 was within or above the minimum standard of care; and, Dr. Lundeen's use of controlled substances for the management of chronic intractable pain were within the guidelines of the State Medical Board of Ohio, it's [sic] statutes and administrative rules.

(Resp. Ex. Z at 19)

Patient 16

445. Patient 16, a female born in 1962, suffered an industrial injury on July 1, 1995. She first saw Dr. Lundeen on November 15, 2006, and his diagnoses appear to be the same as the conditions

allowed in the workers' compensation claim. Patient 16 continued seeing Dr. Lundeen through March 18, 2011. (St. Ex. 16 at 9-61; St. Ex. 16A)

446. Medical records for Patient 16 were admitted as State's Exhibits 16 and 16A. Dr. Cunningham's initial written report is set forth at State's Exhibit 30 at page 117 to 121, and his supplemental report is set forth at State's Exhibit 30A, pages 9-10 and 14-15. Dr. Cunningham's testimony regarding this patient is in the hearing transcript starting at page 972. Dr. Ross' report is set forth at Respondent's Exhibit A, pages 38 to 39, and Dr. Lundeen's written defense is set forth at Respondent's Exhibit Z at page 20.

Patient 16's First Visit – November 2006

447. In his progress notes for Patient 16's first visit on November 15, 2006, Dr. Lundeen documented the following:

> Diagnosis:
> 847.2 SPRAIN LUMBAR REGION
> 296.23 DEPRESS PSYCHOSIS – SEVERE
> 300.21 AGORAPHOBIA WITH PANIC[94]
>
> **November 15, 2006**
> SUBJECTIVE: Service location: Portsmouth, Ohio. New patient, referred by Dr. Medlin for medication for pain and to treat her allowed conditions. On TT for psych allowances, Dr. Medlin. Current medications: Percocet 10/325, Soma 350, Xanax 1 mg. NKDA. No serious medical illness/condition.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 5 degrees, SLR L 5 degrees, spasms present in lower back. Gait: even. Flexion 30 degrees, extension 5 degrees, right lateral flexion 25 degrees and left lateral flexion 25 degrees.
>
> ASSESSMENT: No major change in medications prescribed. Has urinary frequency.
>
> PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2 and one or more in group 3. The patient is to minimize use of such narcotic medication(s), to take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx narcotic medications. Patient understand [sic] potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency or addiction will be made. A moderate degree of dependency is normal and should be anticipated with the usage of such narcotic medication(s). Beyond a normal reasonable degree of

[94] Dr. Lundeen's progress notes through Patient 16's visit in March 2011 list the same diagnoses. (St. Ex. 16 at 9-61)

> day to day dependency on such medications for ADL's, abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons. More than one type of narcotic medication is utilized to adjust the pain control to optimal effect and minimize the use of the stronger type from group 2. Percocet for breakthrough pain only. Call for next appointment.

(St. Ex. 16 at 9, signatures omitted)

448. Dr. Lundeen's initial progress notes do not describe Patient 16's injury. However, in a letter dated February 16, 2008, Dr. Lundeen wrote that Patient 16 had been working at a medical center bathing a patient who became combative, causing her to slip and twist her back. An MRI ordered by a prior physician had shown some bulging disks. (St. Ex. 16 at 2) In addition, Dr. Lundeen's medical records include new-patient questionnaires regarding Patient 16's medical history, prior treatment and medications, current pain, and so forth. His file also includes records from prior treating physicians as well as Patient 16's medication contract. (St. Ex. 16A at 49-141)

449. According to Dr. Lundeen's Drug Utilization Report, Dr. Lundeen prescribed the following medications to Patient 13 on November 15, 2006:

- Percocet 10/325, three times per day (#90, no refills)
- Soma 350 mg, three times per day (#84, five refills)
- Lorcet 10/650 mg, five times per day (#140, five refills)
- Xanax 1 mg, twice per day. (#56, five refills)

(St. Ex. 13 at 74)

450. According to Dr. Cunningham, Dr. Lundeen's initial examination of Patient 16 on November 15, 2006, fell below the minimal standard of care. He stated:

> The physical examination was purely on a subjective basis. It was seated straight leg raising with a description of an even gait and range of motion of the low back. There were no reflexes or sensory exam recorded; there was no supine straight leg raising; no [Faber's] testing; and no other routine orthopedic tests performed for individuals with complaints of low back pain.

(St. Ex. 30 at 117)

451. Dr. Cunningham elaborated that all of the examination findings documented by Dr. Lundeen were "voluntary on the part of the patient" and that none of the findings recorded were objective or measurable, such as reflexes, sensation, or atrophy. (Tr. at 975-97 Dr. Cunningham also testified that Faber's test is a test for hip joint abnormalities. He further testified that a patient being seen for low-back pain should have that test during the early phase of treatment. (Tr. at 976)

Patient 16's Second Visit – March 2007

452. Patient 16 next visited Dr. Lundeen on March 21, 2007. Dr. Lundeen recorded the following under the headings Subjective, Objective, and Assessment:

> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 4 with meds. Activities impaired include: back, legs, psych conditions, bladder urgency. Office: PO. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: none. Income: TT psych.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 10 degrees, SLR L 10 degrees, spasms present in lower back. Gait: even, slow. Stronger lower extremity today: right leg. Flexion 35 degrees, extension 5 degrees, right lateral flexion 15 degrees and left lateral flexion 15 degrees.
>
> ASSESSMENT: Medication selection: Wellbutrin 75 mg x2 per day added for treatment of anxiety.

(St. Ex. 16 at 10, signatures omitted)

453. According to Dr. Cunningham, Dr. Lundeen's statement that Wellbutrin was being added for the treatment of anxiety was not a sufficient examination to justify his prescribing of Wellbutrin:

> He doesn't describe any change in status in regards to this individual's diagnoses of depressive psychosis or agoraphobia with panic to justify adding the medication Wellbutrin.

(Tr. at 977-978) Dr. Cunningham further testified that Dr. Lundeen needed to interview the patient, and to compare her current psychiatric status with her prior psychiatric status. Dr. Cunningham opined that Dr. Lundeen's failure to do so fell below the minimal standard of care. (Tr. at 977-978)

December 2007 - Reviewer's Comments on Patient 16

454. In December 2007, Robert F. Shadel, M.D., reported his analysis of Patient 16's medical conditions, accepting the physical findings of the examining physicians. Among other things, Dr. Shadel noted that Patient 16 had sustained a lumbar sprain in 1995 and has also been treated for psychiatric conditions. He further noted that it had been reported

that Patient 16 is obese. Dr. Shadel stated that the MRI in 2006 showed degenerative changes in the lumbar spine with very mild annular and disc bulging at L4-5 without any focal disc herniation and bony degenerative changes in the vertebral bodies and facet joints. Further, he stated that examinations "have reported no focal neurological deficits" in Patient 16's legs. Dr. Shadel also commented that the "exams of Dr. Lundeen since 11/15/06 have documented no subjective complaints of any neurologic or radicular nature, and no objective physical findings of any neurologic deficit."[95] (St. Ex. 16 at 21-23, 41)

455. In a February 2008 letter, Dr. Lundeen set forth his disagreement with Dr. Shadel's analysis and conclusions. (St. Ex. 16 at 2-3)

Increase of Xanax Prescription – Patient 16

456. On August 26, 2009, Dr. Lundeen prescribed, among other things, Xanax 1 mg, to be taken four times per day. This was an increase in the frequency of taking 1 mg of Xanax, from three times per day as prescribed at the previous visit on June 29, 2009. The only notations regarding the patient's emotional/mental status in Dr. Lundeen's progress notes for the August 26, 2009 visit were as follows, under Subjective: "Activities impaired include: back, legs, anxiety panice [sic]." The Objective findings dealt only with the back. Under Assessment, the only statement was: "Increan Xamax to 4x day [*sic*]." (St. Ex. 16 at 37, 64)

457. Dr. Cunningham testified that there was no documentation of any reason for this increase in Xanax. He noted that Dr. Lundeen did not document any change in Patient 16's psychiatric condition. Dr. Cunningham opined that this violated the minimal standard of care. (Tr. at 978-St. Ex. 16 at 37, 64)

June 2009 – Patient 16

458. On June 29, 2009, Dr. Lundeen added Ventolin to Patient 16's medications.[96] (St. Ex. 16 at 64)

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[95] The Hearing Examiner comprehends the limited nature of the issue presented to Dr. Shadel with respect to whether an additional condition should be allowed in the workers' compensation claim, as causally related to the 1995 incident. Nonetheless, some of Dr. Shadel's observations are general in nature. The lack of certain types of neurologic or radicular findings has relevance to the patient's pain and appropriate medications.

[96] Ventolin is a brand of albuterol, a bronchodilator used to treat "difficulty breathing and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease." (Nat'l Libr. of Med., at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH000 0355>; MedLine Plus, at <www.nlm.nih.gov/medlineplus/druginfo/meds/a682145.html>, accessed 11/10/11.) Ventolin comes in an aerosol form that can be inhaled, whereas the tablets come in doses of 2 mg, 4 mg and 8 mg. Because Dr. Lundeen did not list a dosage of milligrams under "Strength" but stated "None," the Hearing Examiner believes that the stated dose of " 2 q.i.d." probably refers to two sprays from an inhaler, four times per day.

459. However, Dr. Lundeen's progress notes for the patient's visit on June 29, 2009, make no mention of breathing problems or chest tightness, or of adding Ventolin to the drug regimen:

> SUBJECTIVE: Since the last visit, *the patient's condition continues without significant change*. Pain level today = 7. Activities impaired include: back, legs. Office: PO. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: none.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 5 degrees, SLR L 10 degrees, spasms present in lower back. Gait: slow. Flexion 35 degrees, extension 5 degrees, right lateral flexion 10 degrees and left lateral flexion 10 degrees.
>
> ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, *the medications will remain unchanged.*
>
> PLAN: The next scheduled appointment with this examiner is in 8 weeks. [Omitted: general information about narcotic use]

(St. Ex. 16 at 35; signatures omitted, emphasis added)

460. According to the Drug Utilization Report, the Ventolin was prescribed to treat "Agoraphobia With Panic." However, at Patient 16's next visit on August 26, 2009, Dr. Lundeen prescribed Ventolin to treat "Sprain Lumbar Region." (St. Ex. 16 at 64-66) Subsequently, Dr. Lundeen regularly prescribed Ventolin to Patient 16 for "Sprain Lumbar Region," continuing through the patient's visit in December 2010. The prescriptions listed for February 3, 2010, are typical:

Condition	Drug	Strength	Qty/Freq.
Sprain lumbar region	Percocet	10/325 mg	1 q.i.d.
Sprain lumbar region	Lorcet	10/650 mg	1 five x day
Sprain lumbar region	Soma	350 mg	1 t.i.d.
Sprain lumbar region	Ventolin	none	2 q.i.d.
Agoraphobia with panic	Wellbutrin	75 mg	1 b.i.d.
Agoraphobia with panic	Xanax	1.00 mg	1 q.i.d.
Depress psychosis-severe	Trazodone	50 mg	1 b.i.d.

(St. Ex. 16 at 64-66)

461. Dr. Cunningham testified that Ventolin is a pulmonary drug. He further testified that prescribing Ventolin in the absence of pulmonary findings fell below the minimal standard of care. (Tr. at 980-981)

Prescribing Soma for Patient 16

462. Throughout his treatment of Patient 16, from November 2006 through March 2011, Dr. Lundeen prescribed Soma to Patient 16 for the lumbar sprain that took place on July 1, 1995. Dr. Cunningham testified that Soma is a muscle relaxant, and that no muscle relaxant is believed to be therapeutic for more than about a three-month period. Dr. Cunningham opined that Dr. Lundeen's prescribing of Soma to Patient 16 for over four years fell below the minimal standard of care. (Tr. at 981-982; St. Ex. 16 at 63-66)

March 2011

463. In his progress notes for Patient 16's visit on March 18, 2011, Dr. Lundeen recorded the following information under the heading "Objective":

> Seated straight leg raising, SLR, R zero degrees, SLR L zero degrees, severe intense spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: slow, labored. Flexion 30 degrees, extension 10 degrees, right lateral flexion 10 degrees and left lateral flexion 10 degrees.

(St. Ex. 16 at 61, emphasis added)

464. Dr. Cunningham testified that, when the gait was described as slow and labored, that nonetheless meant that the patient was independently ambulatory. He further testified that, when straight-leg raising is performed in a seated position, a result "of zero degrees means that you cannot raise your heel off of the floor." He further explained that, if the patient's "straight-leg raising on both legs was zero," then the "individual would not have been able to be independently ambulatory." He added: "It's physically impossible." (Tr. at 982-983)

Prescriptions for Wellbutrin and Xanax

465. Dr. Cunningham testified that, because Dr. Lundeen was prescribing Wellbutrin and Xanax to Patient 16, he should have been evaluating the patient with respect to her psychiatric conditions, throughout her care.[97] However, Dr. Cunningham testified that there is nothing

[97] The Hearing Examiner did not find evidence that Dr. Lundeen was receiving information from a treating psychologist or therapist regarding the patient's ongoing mental/emotional status. Although Dr. Lundeen mentioned a referring psychologist in the first progress notes for the initial visit in 2006, the Hearing Examiner found no further references to the psychologist's care in Dr. Lundeen's progress notes, or references to communications with any other treating therapist or counselor regarding Patient 16. (St. Ex. 16 at 1-72) The only other mention of the

in Dr. Lundeen's medical records to indicate that he had done so. Dr. Cunningham opined that this fell below the minimal standard of care. (Tr. at 983)

Lack of Referral – Patient 16

466. Dr. Cunningham testified that there is nothing documented in the medical record to indicate that Dr. Lundeen referred Patient 16 to a specialist to address the underlying cause of her pain. Dr. Cunningham further testified that Dr. Lundeen did not attempt any other treatment for Patient 16's pain other than narcotic medications. Moreover, Dr. Cunningham testified that Dr. Lundeen increased the dosages of Patient 16's medications without documenting any rationale. Dr. Cunningham opined that this conduct violated the standard of care. (Tr. at 984-985)

Dr. Lundeen's Written Defense – Patient 16

467. In his written defense, Dr. Lundeen stated in part:

> Patient 16 * * * is a 48-year-old female who has work-related back injuries from 1995 with claim allowances of sprain, depressive psychosis and agoraphobia with panic. The sprain allowance belies the true extent of her lower back injury. Dr. Medlin, Patient 16's psychologist, referred her to Dr. Lundeen for medications in 2006. Patient 16 has urinary control issues from her severely injured lower back. When Dr. Lundeen's license was suspended, Dr. Lundeen attempted to secure a psychiatrist to treat Patient 16 psych conditions for which she is very reliant on her medications of Xanax, Lexapro, and wellbutrin [sic]. Due to her sprain allowance, Patient 16 is unable to receive injections, therapy or back surgery[;] palliative care with pain medication is all that she is afforded under BWC. In 2007, she had an MRI with Dr. Yen; L4/5 disc injury.

(Resp. Ex. Z at 20)

Patient 17

General Information

468. Patient 17, a male born in 1954, sustained an industrial injury to his lower back in September 1994 when he was lifting a concrete panel. Dr. Lundeen's electronic business records indicate that, on March 30, 1996, Patient 17 was a new patient who received an extended examination with respect to "847.2." However, the Hearing Examiner found no medical records describing that visit: there are no progress notes or prescription list for the patient's visit in March 1996. (St. Ex. 17 at 259, 272; St. Ex. 17 at 1-612; St. Ex. 17A)

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referring psychologist appeared to be a request that the psychologist filed in late 2010 for approval of sessions in December 2010 through June 2011, which was approved. (St. Ex. 15A at 5; St. Exs. 16 & 16A)

469. Dr. Lundeen's electronic business records also reflect that Patient 17 was examined regarding "847.2" on the following dates in 1996: April 11, April 27, May 25, July 20, September 16, and November 12. Dr. Lundeen provided a letter report to the patient's attorney in June 2006. Further, the electronic business records reflect that Patient 17 received examinations for various conditions on the following dates in 1997: January 7, February 4, April 1, May 27, July 1, August 28, October 21, and December 13. (St. Ex. 17 at 2-3, 259, 272-273)

470. There are no prescriptions listed in the Drug Utilization Report until January 1997. There are no dated progress notes until the visit on August 28, 1997. (St. Ex. 17 at 238, 274)

471. The last visit was on March 24, 2011. (St. Ex. 17 at 236, 237, 256)

472. Medical records for Patient 17 were admitted as State's Exhibits 17 and 17A. Dr. Cunningham's initial written report is set forth at State's Exhibit 30 at pages 122 to 129, and his supplemental report is set forth at State's Exhibit 30A at pages 10 and 14-15. Dr. Cunningham's testimony regarding this patient is found in the hearing transcript beginning at page 985. Dr. Ross' opinion is set forth at Respondent's Exhibit A at page 39, and Dr. Lundeen's written defense is set forth at Respondent's Exhibit Z at pages 20 to 21.

June 1996 Letter – Patient 17

473. In the letter to the patient's attorney dated June 20, 1996, Dr. Lundeen described Patient 17's status and recommended that the BWC claim be amended to add an additional condition:

> As you are aware, [Patient 17] has been treating with this physician for injuries sustained as the result of an industrial accident in the course of his employment. This claim has been recognized for sprain of the lumbar region. [Patient 17] was initially evaluated at a local hospital, and then followed up with Dr. Manthey. An MRI was obtained by Dr. Manthey which revealed degenerative changes, and protrusions at levels L4-5 and L5-S1.
>
> Recently Dr. Jeffrey Blood performed an examination at the request of the Bureau. In Dr. Bloods [sic] report, he states that several studies over the years have demonstrated that individuals with no back pain symptoms whatsoever have abnormal MRI studies 25 percent of the time. He also sates [sic] that it in [sic] not that unusual to find slight protrusions or desiccation's [sic] of discs in individuals who are asymptomatic[;] therefore it is his opinion that it would not be appropriate to add [an] allowance to a claim for something that is essentially a degenerative condition. [Patient 17] sustained an injury to his lower back in this work related injury, and was a symptomatic prior to this injury[;] therefore if a degenerative condition proceeded this injury, it was definitely aggravated as a result of this injury.

> At the present time, [Patient 17] is not able to perform his former position. He continues to complain of lower back pain that is increased with prolonged sitting/standing. Recent examination reveals limited lumbar range of motion. Straight leg raising 5-15 degrees bilaterally on repeated attempts while seated. Reduced strength bilaterally lower extremities grade 3+/5. Severe tenderness to palpation over the lumbar paraspinal muscles.
>
> Based on the history, mechanism of injury, available medical evidence and clinical findings (both subjective and objective), it is my opinion, with a reasonable degree of medical certainty that: [Patient 17] sustained and injury to his lumbar spine in this industrial accident. This accident exacerbated pre-existing conditions. The injuries sustained in this accident (exacerbation of pre-existing degenerative discs/protrusions at L4-5 and L5-S1) should be amended into the claim allowance.
>
> [Patient 17] has refused surgery at this time. He may benefit from a pain and stress management program as well as job retraining.

(St. Ex. 17 at 2-3)

Prescription Medication Chart – Patient 17

474. Dr. Lundeen prescribed the following medications to Patient 17 from January 1997 through December 1998, according to the Drug Utilization Report:

Date	Condition	Drug	Strength	Qty/Freq	#	Refills
1/07/97	sprain lumbar	Soma	350 mg	1 t.i.d.	42	1
1/07/97	sprain lumbar	Ultram	50 mg	1 b.i.d.	28	1
1/07/97	sprain lumbar	Valium	5 mg	1 b.i.d.	27	1
1/07/97	sprain lumbar	Vicodin ES	7.5/750mg	1 t.i.d.	42	1
2/04/97	sprain lumbar	Valium	5 mg	1 b.i.d.	56	1
2/04/97	sprain lumbar	Vicodin ES	7.5/750mg	1 t.i.d.	84	1
2/04/97	sprain lumbar	Ultram	50 mg	1 b.i.d.	56	1
2/04/97	sprain lumbar	Soma	350 mg	1 t.i.d.	84	1
4/01/97	lumb/lumbsac disc degen	Vicodin ES	7.5/750mg	1 t.i.d.	42	3
4/01/97	sprain lumbar	Soma	350 mg	1 t.i.d.	42	3
4/01/97	lumb/lumbsac disc degen	Oxycontin	20 mg	1 a.m.	30	0
5/27/97	lumb/lumbsac disc degen	Percocet	5/325	1 t.i.d.	90	0
5/27/97	sprain lumbar	Soma	350 mg	1 t.i.d.	90	0

7/01/97	sprain lumbar	Soma	350 mg	1 t.i.d.	87	1
7/01/97	lumb/lumbsac disc degen	Vicodin ES	7.5/750	1 q.i.d.	116	1
8/28/97	cellulitis of arm	Duricef	500 mg	1 b.i.d.	20	0
8/28/97	lumb/lumbsac disc degen	Vicodin ES	7.5/750 mg	1 q.i.d.	112	1
8/28/97	lumb/lumbsac disc degen	Valium	10 mg	1 h.s.	28	1
8/28/97	sprain lumbar	Soma	350 mg	1 t.i.d.	84	1
10/21/97	lumb/lumbsac disc degen	Valium	10 mg	1 h.s.	13	3
10/21/97	lumb/lumbsac disc degen	Vicodin ES	7.5/750	1 q.i.d.	51	3
10/21/97	sprain lumbar	Soma	350 mg	1 t.i.d.	38	3
12/13/97	lumb/lumbsac disc degen	Valium	10 mg	b.i.d.	55	1
12/13/97	lumb/lumbsac disc degen	Vicodin ES	7.5/750 mg	1 q.i.d.	112	1
12/13/97	sprain lumbar	Soma	350 mg	1 t.i.d.	84	1
2/07/98	lumb/lumbsac disc degen	Vicodin ES	7.5/750 mg	1 q.i.d.	126	1
2/07/98	lumb/lumbsac disc degen	Valium	10 mg	1 b.i.d.	63	1
2/07/98	sprain lumbar	Soma	350 mg	1 t.i.d.	95	1
4/11/98	sprain lumbar	Soma	350 mg	1 t.i.d.	81	1
4/11/98	lumb/lumbsac disc degen	Vicodin ES	7.5/750 mg	1 q.i.d.	108	1
4/11/98	lumb/lumbsac disc degen	Valium	10 mg	1 b.i.d.	54	1
6/04/98	sprain lumbar region	Soma	350 mg	1 t.i.d.	95	1
6/04/98	lumb/lumbsac disc degen	Valium	10 mg	1 b.i.d.	63	1
6/04/98	lumb/lumbsac disc degen	Vicodin ES	7.5/750	1 q.i.d.	126	1
6/23/98	lumb/lumbsac disc degen	Percocet	5/325 mg	1 t.i.d.	90	0
8/06/98	lumb/lumbsac disc degen	Vicodin ES	7.5/750 mg	1 q.i.d.	136	1
8/06/98	lumb/lumbsac disc degen	Percocet	5/325 mg	1 t.i.d.	90	0
8/06/98	sprain lumbar region	Soma	350 mg	1 t.i.d.	102	1
8/06/98	lumb/lumbsac disc degen	Valium	10 mg	1 b.i.d.	68	1
10/13/98	dislocat vertebra nos-cl	Valium	10 mg	1 b.i.d.	56	1
10/13/98	dislocat vertebra nos-cl	Vicodin	ES 7.5/750	1 q.i.d.	112	1
10/13/98	sprain lumbar region	Soma	350 mg	1 t.i.d.	84	1
10/13/98	dislocat vertebra nos-cl	Percocet	5/325	1 b.i.d.	60	0

12/08/98	dislocat vertebra nos-cl	Percocet	5/325 mg	1 b.i.d.	60	0
12/08/98	dislocat vertebra nos-cl	Vicodin ES	7.5/750 mg	1 q.i.d.	120	0
12/08/98	dislocat vertebra nos-cl	Valium	10 mg	1 b.i.d.	60	0
12/08/98	sprain lumbar region	Soma	350 mg	1 t.i.d.	90	0

(St. Ex. 17 at 237-238)

August 1997 to August 1998 – Patient 17

475. In his progress notes for Patient 17's visit on August 28, 1997, Dr. Lundeen identified the date of injury as September 30, 1994, and stated the following:

> Diagnosis:
> 847.2 SPRAIN LUMBAR REGION
> 722.52 LUMB/LUMBOSAC DISC DEGEN
> 682.3 CELLULITIS OF ARM
> 466.0 ACUTE BRONCHITIS
>
> **August 28, 1997**
> SUBJECTIVE: Since the patient's last visit, the patient's condition is worse; *cellulitis in left axilla.* Activities impaired include use of back, legs and left arm. Pain is noted left axilla. No other practitioner is currently prescribing medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or untolerable [sic] side effects. *No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination.* Refer to the patient's records for the date of the last examination and Rx's written on that date.
>
> OBJECTIVE: SLR R 20 degrees, SLR L 20 degrees, spasms present in lower back. Gait slow. Station (balance) ok usually. Stronger lower extremity R. Motor function of R leg is grade 4 out of 5. Motor function of the L leg is grade 3- out of 5.
>
> ASSESSMENT: Chronic pain in back and legs. New left axillary cellulitis. Duricef for cellulitis.
>
> PLAN: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: information regarding narcotic use.] Employment status not [sic].

(St. Ex. 17 at 274; emphasis added, signatures omitted)

476. In the progress notes for October 21, 1997, Dr. Lundeen again identified a date of injury in September 1994 and listed the same diagnoses as listed for the August 1997 visit. He then stated as follows:

> SUBJECTIVE: Since the patient's last visit, the patient's condition is worse. Activities impaired include lower back and legs. Pain is noted groin, back, legs. No other practitioner is currently prescribing medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or untolerable [sic] side effects. New problems include none. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date.
>
> OBJECTIVE: SLR R 10 degrees, SLR L 30 degrees, spasms present in lower back. Gait slow. Station (balance) mild disorder. Stronger lower extremity left. Motor function of R leg is grade 3/3+ out of 5. Motor function of the L leg is grade 4-/4 out of 5.
>
> ASSESSMENT: The patient has pain which is chronic in nature and is intense in severity. *A good understanding of the patient's conditions, medical history and other important facts are integrated into the current treatment plan.*
>
> PLAN: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotics information] Employment status none.

(St. Ex. 17 at 276)

Changes in Diagnoses for Patient 17

477. Until August 8, 1998, Dr. Lundeen treated Patient 17 for the same diagnoses arising from the injury on September 30, 1994:

847.2	SPRAIN LUMBAR REGION
722.52	LUMB/LUMBOSAC DISC DEGEN
682.3	CELLULITIS OF ARM
466.0	ACUTE BRONCHITIS

(St. Ex. 17 at 274-287)

478. However, starting in October 13, 1998, and continuing through March 24, 2011,[98] Dr. Lundeen treated Patient 17 regarding an injury that had occurred much earlier, on January 22, 1981:

[98] There were a few exceptions when Dr. Lundeen prescribed for acute bronchitis. (St. Ex. 17 at 242-244)

722.10 LUMBAR DISC DISPLACEMENT
839.40 DISLOCAT VERTEBRA NOS-CL
729.5 PAIN IN LIMB
847.2 SPRAIN LUMBAR REGION

(St. Ex. 17 at 11-236)

Treatment in August 2000 – Patient 17

479. An MRI report dated June 30, 2000, includes the following impressions: "Very mild apophyseal joint disease with ligamentum flavum hypertrophy[99] noted at the level of L3-4 without evidence of spinal stenosis or lateral foraminal stenosis," and "No evidence of herniated disc." (St. Ex. 17 at 442)

480. On August 7, 2000, Dr. Lundeen issued the following prescriptions to Patient 17:

Condition	*Medication*	*#*	*Daily Dose*
Dislocat vertebra nos-cl	Percocet 5/325 mg	(60)	10/650 mg
Dislocat vertebra nos-cl	Vicodin ES 7.5/750 mg	(118)	30/3000 mg
Dislocat vertebra nos-cl	Valium 10 mg	(59)	20 mg
Sprain lumbar	Soma 350 mg	(89)	1050 mg
Lumbar disc displacemnt	Celebrex 100 mg	(59)	200 mg

(St. Ex. 17 at 240)

481. Dr. Cunningham characterized the MRI as "the gold standard test for imaging of the spine." He testified that "the MRI findings showed a rather benign condition," namely, arthritis, and the MRI revealed no significant abnormalities. Further, Patient 17 was in his mid-40s, and Dr. Cunningham testified that most people develop some arthritis in their backs as they age. Dr. Cunningham further testified that Dr. Lundeen did not include arthritis among Patient 17's diagnoses and did not document anything about the MRI report in his August 7, 2000 progress note, which was the patient's first visit following the MRI. Moreover, Dr. Cunningham testified that the MRI results do not support the prescriptions issued to Patient 17 on August 7, 2000, except for the Celebrex prescription, which was appropriate for the arthritis noted in the MRI. (Tr. at 988-990)

482. In the "Objective" section of the August 7, 2000, progress note, Dr. Lundeen documented the following:

[99] Dr. Cunningham testified that this refers to "enlargement of one of the ligaments at the low back." (Tr. at 986-987)

> Seated straight leg raising, SLR, R 35 degrees, SLR L 5 degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Gait: list to right leg.

(St. Ex. 17 at 30)

483. Dr. Cunningham criticized the examination documented by Dr. Lundeen on August 7, 2000, because it was "all subjectively based" and included no objective measures. Further, although Dr. Lundeen stated that there was some atrophy, there is no indication that he had measured the thighs or calves; Dr. Cunningham testified that a physician must measure the area and cannot simply rely on a personal visualization. (Tr. at 990-991)

2010 Message from Pharmacy

484. Dr. Lundeen's Dump of Patient Data for Patient 17 includes a message on July 2, 2010, regarding a telephone call from a pharmacy, notifying Dr. Lundeen that the pharmacy had mistakenly given the patient 75 mcg patches of Duragesic (fentanyl) instead of 25 mcg patches, and the pharmacy was unable to reach the patient. (St. Ex. 17 at 265) A subsequent message states that the pharmacy had reached Patient 17 and asked him to return the incorrect patches, but he did not return them until six hours later, at which point he had knowingly used one of the 75mcg Duragesic patches. (St. Ex. 17 at 265-266)

    Dr. Cunningham opined that a physician prescribing regular narcotics to a patient should have found this information alarming because "the patient obviously knew that he was inappropriately taking an increased dose of Duragesic." Dr. Cunningham noted that there was no indication that Dr. Lundeen had addressed this matter with Patient 17, and he opined that this had violated the standard of care. (Tr. at 996-997) Dr. Cunningham further testified that "most physicians would probably" write the patient a letter, probably certified mail, and would also talk with the patient about how the use of the patch was inappropriate and remind them of the pain contract, "and probably ask" the patient to sign a new pain contract "and also get a drug screen on him." However, Dr. Cunningham indicated that he would probably not discharge the patient if this was a first offense. (Tr. at 997- 998)

485. Dr. Lundeen's progress notes for Patient 17's visit on July 16, 2010, includes no mention of the information received from the pharmacy, despite the fact that it states, as do all of his progress notes, "Every effort to monitor usage and note early signs of abnormal dependency or addiction will be made" and that "abnormal manifestations [of dependency] will be addressed should they become apparent to this examiner or to other concerned persons." (St. Ex. 17 at 218)

Prescriptions in December 2003 and January 2004 – Patient 17

486. Dr. Lundeen prescribed as follows for Patient 17, according to his electronic medical records:

Date	Diagnosis	Drug	Strength	Qty/Freq.	#
12/11/03	lumbar disc displacemnt	Percocet	5/325	1 t.i.d.	90
12/11/03	dislocat vertebra nos-cl	Percocet[100]	5/325	1 t.i.d.	90
12/11/03	dislocat vertebra nos-cl	Vicodin ES	7.5/750	1 q.i.d.	120
12/11/03	dislocat vertebra nos-cl	Valium	10 mg	1 b.i.d.	60
12/11/03	sprain lumbar	Soma	350 mg	1 t.i.d.	90
12/11/03	lumbar disc displacemnt	Celebrex	100 mg	1 b.i.d.	60
12/11/03	dislocat vertebra nos-cl	Colace	100 mg	1 b.i.d.	60
12/11/03	dislocat vertebra nos-cl	Tofranil PM	75 mg	1 q.d.	30
12/11/03	acute bronchitis	Amoxicillin	500 mg	1 t.i.d.	30
12/11/03	lumbar disc displacemnt	Quinine	260 mg	1 q.o.d.	15
1/31/04	dislocat vertebra nos-cl	Percocet	5/325 mg	1 t.i.d.	84
1/31/04	dislocat vertebra nos-cl	Diazepam[101]	10 mg	1 b.i.d.	56
1/31/04	dislocat vertebra nos-cl	Colace	100 mg	1 b.i.d.	56
1/31/04	lumbar disc displacemnt	Ditropan	5 mg	1 h.s.	28
1/31/04	lumbar disc displacemnt	Celebrex	100 mg	1 b.i.d.	56
1/31/04	sprain lumbar	Soma	350 mg	1 t.i.d.	84
1/31/04	dislocat vertebra nos-cl	Hydrocodone/ acetaminophen	7.5/750 mg	1 t.i.d.	84

(St. Ex. 17 at 242-243)

487. In his progress notes for January 31, 2004, Dr. Lundeen reported that Patient 17 was suffering from bladder urgency, which was disturbing his sleep. Under the Objective notes, Dr. Lundeen reported the following: degrees of straight-leg raising, spasms in the lower back, tenderness and atrophy of calf muscles and thigh muscles, and a slow gait. Dr. Lundeen stated that quinine and Tofranil would be discontinued for the urinary frequency and that he would try Ditropan instead. (St. Ex. 17 at 65) In the February 2004 notes, Dr. Lundeen stated that both Tofranil PM and Ditropan had failed to control the patient's bladder urgency, and so he was going to try Detrol for the patient. (St. Ex. 17 at 66) In the February 2004 notes, Dr. Lundeen reported that there had been some progress with the Detrol. (St. Ex. 17 at 67)

[100] The Drug Utilization Report shows one Percocet prescription for the lumbar disc displacement, and another Percocet prescription for the dislocated vertebra.

[101] Valium is a brand name for diazepam, as noted above.

Last Visit – Patient 17

488. Dr. Lundeen's Drug Utilization Report indicates that on March 24, 2011, he prescribed the following medications to Patient 17:

Condition	*Medication*	*Strength - #*	*Daily Dose*
lumbar disc displacemnt	Duragesic patch	25 mcg/hr (15)	600 mcg
dislocat vertebra nos-cl	Percocet	5/325 mg (90)	15/975 mg
dislocat vertebra nos-cl	Hydrocodone/ acetaminophen	7.5/750 (120)	30/3000 mg
dislocat vertebra nos-cl	Diazepam	10 mg (60)	20 mg
sprain lumbar	Soma	350 mg (90)	1050 mg
dislocat vertebra nos-cl	Motrin	600 mg (120)	2400 mg
dislocat vertebra nos-cl	Colace	100 mg (90)	300 mg
lumbar disc displacemnt	Cialis	20 mg (10)	20 mg

(St. Ex. 17 at 256)

489. Dr. Cunningham testified that the medical records do not support the prescriptions Dr. Lundeen issued to Patient 17 on March 24, 2011. He explained:

> Well, again, the Soma's not supported. The—He's not being treated for any psychiatric difficulties; consequently, no mood-altering drugs, such as diazepam, Valium, is supported. There's no diagnosis compatible with arthritis that would support prescription-strength Motrin.
>
> This individual is being maintained on three different narcotics at the same time; Duragesic, hydrocodone, and Percocet. And these records don't support those heavy doses of narcotics for these diagnoses, in my opinion.

(Tr. at 1000-1001)

Dr. Lundeen's Written Defense – Patient 17

490. In his written defense, Dr. Lundeen stated in part:

> Patient 17 * * * is a 56-year-old white male who sustained lumbar disc and vertebral trauma at work in 1981 while performing construction work. Dr. Lundeen first saw Patient 17 in 1998 [sic] and BWC has provided resources for his care and treatment continuously since. Patient 17 is on SSD as he demonstrated no return to work potential when evaluated by Social Security physicians and Dr. Lundeen. Patient 17 has had TENS units,

epidural injections and MRI testing. His back injury is so severe that he has erectile dysfunction and neurogenic bowel.

* * *

Patient 17 has no potential for rehab or return to work in any capacity.

(Resp. Ex. Z at 20)

Patient 18

General Information

491. Patient 18, a female born in 1977, first visited Dr. Lundeen on March 31, 2009, regarding an industrial injury sustained on November 5, 2007. She continued to see Dr. Lundeen regularly through at least March 17, 2011. (St. Ex. 18 at 2-58)

492. Medical records for Patient 18 were admitted as State's Exhibits 18 and 18A. Dr. Cunningham's initial written report is set forth at State's Exhibit 30 at pages 130 to 134, and his supplemental report is set forth at State's Exhibit 30A at 10 and 14-15. Dr. Cunningham's testimony regarding this patient is found in the hearing transcript starting at page 1001. Dr. Ross' opinion is set forth at Respondent's Exhibit A at pages 39 to 40, and Dr. Lundeen's written opinion is set forth at Respondent's Exhibit Z at page 21.

First Visit in March 2009

493. In his progress notes for Patient 18's first visit on March 31, 2009, Dr. Lundeen stated:

Diagnosis:

920 CONTUSION FACE/SCALP/NCK
922.31 Contusion of Back [sic]
923.00 CONTUSION SHOULDER REG [102]

March 31, 2009
SUBJECTIVE: Pain level today = nearly 10. Activities impaired include: neck, back, right shoulder/arm. Has had surgery for right shoulder in this claim (4/21/08). Office: Springfield. Dr. Andorfer is retiring. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: yes, 40 hours per week, no written restrictions.

[102] Dr. Lundeen's progress notes for all of Patient 18's subsequent visits reflect these same diagnoses. (St. Ex. 18 at 6-58)

> OBJECTIVE: The right shoulder is examined today. Flexion is 70 degrees, extension in 25 degrees, abduction is 40 degrees, adduction is 35 degrees, internal rotation with the elbow abducted at or near shoulder level is 90 degrees, external rotation with the elbow abducted at or near shoulder level is -45 degrees. Grip weak. Cervical spine range of motion: 40 degrees right lateral rotation, 40 degrees left lateral rotation, 10 degrees right lateral flexion, 40 degrees left lateral flexion, 40 degrees forward flexion and 20 degrees of neck extension; neck movements are painful.
>
> ASSESSMENT: No major change in medications prescribed. Norflex for muscle relaxer. Opana for pain control at night. Lortab for pain control during the day. Needs PT evaluation and 12 treatments including but not limited to intermittent cervical traction.
>
> PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2 and one or more in group 3. {Omitted: narcotic use information] The next scheduled appointment with this examiner is in 4 weeks. C9 for PT evaluation and 12 treatments.

(St. Ex. 18 at 4-5, electronic signatures omitted)

494. At Patient 18's first visit on March 31, 2009, Dr. Lundeen prescribed the following:

- Opana ER 5 mg, one at bedtime (#28, no refills)
- Lortab 10/500 mg, five times per day (#140, no refills)
- Norflex 100 mg, three times per day (#84 no refills)

(St. Ex. 18 at 60)

495. Dr. Cunningham testified that contusions are bruises, which last "[d]ays, six weeks at most." (Tr. at 1001-1002) In his written report, Dr. Cunningham stated in part:

> It must be emphasized that contusions, which are the only diagnoses for which the Ohio BWC has allowed this claim, were self-limiting conditions. The peer reviewed treatment guidelines, whether it is the ODG or the Occupational Medicine Practice Guidelines along with others, do not support that contusion injuries require active medical care for more than 3-4 months after the date of injury.
>
> This date of injury was on 11/05/07, and this individual did not require any active medical care in regards to this injury as of 03/05/08, at the latest, according to the peer reviewed treatment guidelines. Consequently, this

> individual did not require any active medical care in regards to this Ohio BWC claim long prior to first visiting Dr. Lundeen on 03/31/09.
>
> On 03/31/09, Dr. Lundeen stated, "Pain level today = nearly 10. Activities impaired include: neck, back, right shoulder/arm. She had surgery for her right shoulder in this claim (4/21/08)", without stating what procedure was performed. For some inexplicable reason, Dr. Lundeen then stated, "No other practitioner is currently prescribing pain medication(s) for this patient. The medication is/are usually effective. No adverse or intolerable side effects from medications. Employment status: yes, 40 hours per week, no written restrictions". Dr. Lundeen does not report what medications this individual was then currently on, and Dr. Lundeen had not begun to treat her until 03/31/09. This series of sentences is just an example of "boiler plate" electronic medical records. In the "assessment" section of this report, he states, "No major change in medications prescribed". What were her prior medications? He goes on to state, "Norflex for muscle relaxer, Opana for pain control at night. Lortab for pain control during the day. Needs PT evaluation and 12 treatments including but not limited to intermittent cervical traction". All of this for a set of conditions that, according to the peer-reviewed literature, had long ago resolved. Dr. Lundeen reports range of motion for the right shoulder; he describes her grip as weak; cervical spine range of motion was also reported; and he stated that she had pain on range of motion of the neck and her grip was weak. There are no other physical examination findings, such as pulses, height, body weight, reflexes, sensation, impingement signs, Spurling's test and the like.

(St. Ex. 30 at 130)

496. Moreover, Dr. Cunningham testified that, because contusions are self-limiting and would have resolved long before Dr. Lundeen first saw Patient 18, "there has to be something else going on with the shoulder that's * * * not specified." Dr. Cunningham further testified that physicians do not perform surgery on shoulders for contusions. Dr. Cunningham opined that Dr. Lundeen's lack of documentation regarding Patient 18's condition violated the standard of care. (Tr. at 1002-1003)

497. Dr. Cunningham testified that Dr. Lundeen did not perform an adequate physical examination, particularly in light of the fact that he treated her for a contusion but the patient had had shoulder surgery. (Tr. at 1003)

498. The Drug Utilization Report indicates that Dr. Lundeen prescribed the following medications to Patient 18:

Date	Condition	Medication	Strength & Number	Daily Dose
3/31/09	contusion face/sclp/nck	Opana ER	5 mg #28	5 mg
	contusion face/sclp/nck	Lortab	10/500 mg #140	50/2500 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
4/28/09	contusion face/sclp/nck	Opana ER	5 mg #28	5 mg (last)
	contusion face/sclp/nck	**Avinza** (added)	30 mg #23	30 mg (new)
	contusion face/sclp/nck	Vicodin HP	10/660 mg #115	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
5/21/09	contusion face/sclp/nck	Avinza	30 mg #28	30 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
6/18/09	contusion face/sclp/nck	Avinza	30 mg #28	30 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
7/16/09	contusion face/sclp/nck	Avinza	30 mg #28	30 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
8/13/09	contusion face/sclp/nck	Avinza	30 mg #28	30 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
9/10/09	contusion face/sclp/nck	Avinza	30 mg #28	30 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
10/8/09	contusion face/sclp/nck	Avinza	30 mg #28	30 mg (last)
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
11/2/09	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg (new)
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
12/1/09	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
12/23/09	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg

1/18/10	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
2/15/10	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza	45 mg #28	45 mg (new)
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
3/15/10	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza	45 mg #28	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
4/8/10[103]	contusion face/sclp/nck	Dilaudid	8 mg #7	8 mg
	contusion shoulder reg	Avinza	45 mg #7	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #35	50/3300 mg
	Contusion of back	Norflex	100 mg #7	100 mg (↓)
4/15/10	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza	45 mg #28	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg (↑)
5/11/10	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza	45 mg #28	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
6/10/10	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza	45 mg #28	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
7/8/10	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza	45 mg #28	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
8/5/10	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza	45 mg #28	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg

[103] These prescriptions were all written for a one-week supply. (St. Ex. 18 at 60)

9/2/10	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza	45 mg #28	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
9/29/10	contusion face/sclp/nck	Duragesic	patch 75 mcg/hr #15	1800 mcg
9/30/10	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza	45 mg #28	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
10/28/10	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza 45	mg #28	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
10/29/10	contusion face/sclp/nck	Duragesic	patch 75 mcg/hr #15	1800 mcg
11/26/10	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza	45 mg #28	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Duragesic	75 mcg/hr #15	1800 mcg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
12/23/10	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza	45 mg #28	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Duragesic	75 mcg/hr #15	1800 mcg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
1/13/11	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza	45 mg #28	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Duragesic	75 mcg/hr #15	1800 mcg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg
2/17/11	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza	45 mg #28	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Duragesic	75 mcg/hr #15	1800 mcg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg

3/18/11	contusion face/sclp/nck	Dilaudid	8 mg #28	8 mg
	contusion shoulder reg	Avinza	45 mg #28	45 mg
	contusion face/sclp/nck	Vicodin HP	10/660 mg #140	50/3300 mg
	contusion face/sclp/nck	Duragesic	75 mcg/hr #15	1800 mcg
	contusion face/sclp/nck	Norflex	100 mg #84	300 mg

(St. Ex. 18 at 60-62)

Report from the Ohio Automated Rx Reporting System – Patient 18

499. Dr. Lundeen's records include an OARRS report for the period from June 1, 2009, through June 10, 2010. The report shows that Patient 18 received the following prescriptions from other providers in addition to those received from Dr. Lundeen:[104]

OARRS:

Rx Date	Drug	Qty.	Prescriber
6/11/09	Tramadol 50 mg	90	Dr. A***
	Hydrocodone/APAP 7.5/325 mg	60	Dr. A***
3/12/10	Hydrocodone/APAP 5/500 mg	15	Dr. M****
3/16/10	Hydrocodone/APAP 5/500 mg	15	Dr. M****
3/22/10	Hydrocodone/APAP 5/500 mg	15	Dr. M****
3/24/10	Hydrocodone/APAP 5/500 mg	4	Dr. S**** (DDS)
3/29/10	Hydrocodone/APAP 5/500 mg	15	Dr. M****

(St. Ex. 18 at 109-111)

500. Dr. Cunningham testified that Dr. Lundeen did not document anything regarding Patient 18 receiving narcotic medication from other practitioners, other than the same recitations that he included in all of his progress notes, that "'[n]o other practitioner is currently prescribing pain medication(s) for this patient.'" Dr. Cunningham opined that it had violated the standard of care for Dr. Lundeen to fail to address the information that Patient 18 was receiving narcotics from other practitioners. (Tr. at 1005-1007)

[104] No refills were authorized for any of the prescriptions. (St. Ex. 18 at 89-90) The abbreviation APAP stands for acetaminophen.

501. In Dr. Lundeen's Dump of Patient Data for Patient 18, a message dated June 5, 2009, states:

> FYI: [Patient 18] went to the ER last night as she is still having pain. They gave her a pain injection and a steroid injection but has no relief today. She is asking, is there anything else to do. Please advise, thank you.

(St. Ex. 18 at 64)

502. With respect to this June 5, 2009 call from Patient 18, Dr. Cunningham testified that the call should have been of concern to Dr. Lundeen. When asked why, Dr. Cunningham replied:

> Well, first of all, Dr. Lundeen should have explained it. Maybe [s]he went to the ER because [s]he had something else causing h[er] pain and needed treatment for it. It doesn't say what—what—why the person went to the ER, other—other than pain. And if this were a second episode, the—I would—would think that he would discuss the pain contract, renegotiate the pain contract.

(Tr. at 1007-1008) Dr. Cunningham added that he would have instituted random drug screening on Patient 18, based on her violation of her pain contract. (Tr. at 1008)

503. Dr. Cunningham testified that, as of September 2010, Dr. Lundeen was prescribing the following medications to Patient 18 at each visit:

- Avinza
- Dilaudid
- Duragesic
- Vicodin HP
- Norflex

(Tr. at 1009) Dr. Cunningham noted that Dr. Lundeen continued Patient 18 on those medications through her last visit in March 2011. (Tr. at 1009) Dr. Cunningham opined that the examination findings documented by Dr. Lundeen did not justify the huge doses of narcotics:

> I mean, there's no physical—looks like there's no physical examination that says whether or not this individual has an impingement syndrome of the shoulder present or absent, which is very important, and this individual is being treated for neck difficulties. The diagnoses are all self-limiting contusions, but this individual is being maintained on huge doses of narcotics. And I—I don't find any physical examination findings in Dr. Lundeen's records to support all these narcotics.

(Tr. at 1010-1011)

Dr. Lundeen's Written Defense – Patient 18

504. In his written defense, Dr. Lundeen stated in part regarding his care and treatment of Patient 18:

> Patient 18 * * * is a 34-year-old white female, single mom, working with severe neck and right shoulder injuries sustained in 2007. Patient 18's claim allowances are appallingly insufficient (contusion head/neck; contusion back; contusion shoulder) and belie the true extent of her injuries. Patient 18 has severe neck and right shoulder injuries and can't get a surgery for her shoulder or an MRI for her neck. Patient 18 has had injections from pain specialists without success. Patient 18['s] medications permit her to work and support her children; she works 50-60 hours per week effectively on her medication regimen.

(Resp. Ex. Z at 21)

Patient 19

General Information

505. Patient 19, a female born in 1985, first saw Dr. Lundeen on June 9, 2010. She stated in her new-patient questionnaire that she was injured in a "4-wheeler wreck" in "2000" that caused her to be "in ICU 18 days, hospitalized 21 days." Dr. Lundeen listed the date of injury as January 1, 2000, in his progress notes. (St. Ex. 19 at 2-3, St. Ex. 19A at 13)

506. In his Drug Utilization Report, Dr. Lundeen states that he prescribed for Patient 19 on eleven dates, and his list of appointments identifies twelve visits. However, Dr. Lundeen's electronic medical records include only three progress notes, for June 9, 2010, July 6, 2010, and March 18, 2011. (St. Ex. 19 at 2-8)

507. Dr. Lundeen's records for Patient 19 include a health questionnaire filled out by the patient. The information includes a medical and family history, as well as a description of her injury and treatment history. Patient 19 also signed a medication contract. (St. Ex. 19A at 13-19)

508. Medical records for Patient 19 were admitted as State's Exhibits 19 and 19A. Dr. Cunningham's initial written report is set forth in State's Exhibit 30 at pages 135 to 139, and his supplemental report is in State's Exhibit 30A at pages 10 and 14-15. Dr. Cunningham's testimony regarding this patient starts at page 1012 of the hearing transcript. Dr. Ross' opinion is in Respondent's Exhibit A, pages 40 to 41, and Dr. Lundeen's written opinion is in Respondent's Exhibit Z, pages 21 to 22.

Patient 19's Chart of Prescriptions from Dr. Lundeen

509. In his Drug Utilization Report, Dr. Lundeen listed the following medications that he prescribed for Patient 19:

Date	Diagnosis	Drug	Strength	Qty/Freq.	#
6/09/10	crushing inj lower leg	Percocet	10/325 mg	1 q.i.d.	112
6/09/10	crushing inj lower leg	Dilaudid	4 mg	1 q.i.d.	112
7/06/10	crushing inj lower leg	Dilaudid	4 mg	1 q.i.d.	112
7/06/10	crushing inj lower leg	Percocet	10/325 mg	1 q.i.d.	112
8/03/10	crushing inj lower leg	Percocet	10/325 mg	1 q.i.d.	112
8/03/10	crushing inj lower leg	Dilaudid	4 mg	1 q.i.d.	112
8/03/10	crushing inj lower leg	Xanax	1.00 mg	1 t.i.d.	84
8/31/10	crushing inj lower leg	Dilaudid	4 mg	1 q.i.d.	112
8/31/10	crushing inj lower leg	Percocet	10/325 mg	1 q.i.d.	112
8/31/10	crushing inj lower leg	Xanax	1.00 mg	1 t.i.d.	84
9/28/10	crushing inj lower leg	Percocet	10/325 mg	1 q.i.d.	112
9/28/10	crushing inj lower leg	Dilaudid	4 mg	1 q.i.d.	112
9/28/10	crushing inj lower leg	Opana ER	20 mg	1 q.d.	28
9/28/10	crushing inj lower leg	Xanax	1.00 mg	1 t.i.d.	84
10/26/10	crushing inj lower leg	Dilaudid	4 mg	1 q.i.d.	112
10/26/10	crushing inj lower leg	Percocet	10/325 mg	1 q.i.d.	112
10/26/10	crushing inj lower leg	Xanax	1.00 mg	1 t.i.d.	84
10/26/10	crushing inj lower leg	Opana ER	20 mg	1 q.d.	28
11/23/10	crushing inj lower leg	Xanax	1.00 mg	1 t.i.d.	84
11/23/10	crushing inj lower leg	Percocet	10/325 mg	1 q.i.d.	112
11/23/10	crushing inj lower leg	Dilaudid	4 mg	1 q.i.d.	112
11/23/10	fx dorsal vertebr-open	Opana ER	10 mg	1 b.i.d.	56
12/24/10	injury leg vessel nos	Opana ER	20 mg	1 q.d.	26
12/24/10	crushing inj lower leg	Xanax	1.00 mg	1 t.i.d.	84
12/24/10	crushing inj lower leg	Percocet	10/325 mg	1 q.i.d.	112
12/24/10	crushing inj lower leg	Dilaudid	4 mg	1 q.i.d.	112
1/19/11	crushing inj lower leg	Percocet	10/325 mg	1 q.i.d.	112
1/19/11	crushing inj lower leg	Xanax	1.00 mg	1 t.i.d.	84
1/19/11	injury leg vessel nos	Opana ER	20 mg	1 q.d.	28
1/19/11	crushing inj lower leg	Dilaudid	4 mg	1 q.i.d.	112

2/16/11	crushing inj lower leg	Percocet	10/325 mg	1 q.i.d.	112
2/16/11	crushing inj lower leg	Xanax	1.00 mg	1 t.i.d.	84
2/16/11	crushing inj lower leg	Dilaudid	4 mg	1 q.i.d.	112
2/16/11	injury leg vessel nos	Opana ER	20 mg	1 q.d.	28
3/18/11	crushing inj lower leg	Percocet	10/325 mg	1 q.i.d.	112
3/18/11	crushing inj lower leg	Dilaudid	4 mg	1 q.i.d.	112
3/18/11	crushing inj lower leg	Xanax	1.00 mg	1 t.i.d.	84
3/18/11	injury leg vessel nos	Opana ER	20 mg	1 q.d.	28

(St. Ex. 19 at 7)

Patient 19's First Examination by Dr. Lundeen – June 2010

510. Dr. Lundeen stated in his progress notes for Patient 19's visit on June 9, 2010:

> Diagnosis:
>
> 904.8 INJURY LEG VESSEL NOS
> 928.10 CRUSHING INJ LOWER LEG
> 805.3 FX DORSAL VERTEBRA – OPEN
>
> June 9, 2010
> SUBJECTIVE: Service location: Portsmouth, Ohio. Employment status: not employed. Disabled, unable to work. The patient requests continuation of COX-2 medication and is aware of potential cardiovascular harm from this class of medications.[105] This patient is new to this medical practice. Patient sustained crushing injuries to her right leg and ankle, with major tissue loss, fusion of right ankle, removal of calf muscle on right leg, and right leg repaired patella. Medical records available on this date. A pain history booklet has been completed and reviewed by this physician today. The patient is not receiving controlled or narcotic medication from any physician outside of this medical practice at this time.
>
> OBJECTIVE: * [sic: no text, only an asterisk and the electronic signature][106]

[105]COX-2 inhibitors (including Celebrex and Vioxx) are a subclass of NSAIDS. There have been warnings at various times that certain NSAIDS, especially selective COX-2 inhibitors, increase the risk of serious cardiovascular events and other problems. (See, generally, FDA, at <www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformation forpatientsandproviders/ucm103420.htm>; Nat'l Libr. Medicine, "Risks and benefits of COX-2 inhibitors vs non-selective NSAIDs," at <www.ncbi.nlm.nih.gov/pubmed/17255138>; accessed 11/12/11.)

[106] There is no accompanying text or footnoted text to which an asterisk might be expected to lead. (St. Ex. 19 at 2)

> ASSESSMENT: Based on the examination findings, history of injury, and present complaints, the medications will be as follows: Percocet 10/325, and Dilaudid 4 mg.
>
> PLAN: The next scheduled appointment with this examiner is in 4 weeks. Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2. [Omitted: narcotic use information]

(St. Ex. 19 at 2, signatures omitted)

Patient 19's Second Visit – July 2010

511. Dr. Lundeen's progress notes for the patient's next visit on July 6, 2010, are nearly identical to the notes for the patient's first visit. The "Subjective" section even repeats the statement that Patient 19 is "new to this medical practice." (St. Ex. 19 at 3) The only differences are:

- In the "Objective" section, the phrase "TS 10-10-10" appears rather than the asterisk, and there is with no other text.
- In the "Assessment" section, Dr. Lundeen stated that the medications "will be modified" to Percocet 10/326 and Dilaudid 4 mg. However, those were already the medications prescribed, the same as prescribed at the first visit.

(St. Ex. 19 at 2-3)

512. Dr. Lundeen's progress notes for Patient 19's last visit on March 18, 2011, state in part:

> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 8 of 10. Activities impaired include: back, legs, gait. Office: PO. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: none. SSI.
>
> OBJECTIVE: Seated straight leg raining, SLR, R 40 degrees, SLR L 45 degrees, spasms present in lower back. Spasms, tenderness and atrophy in posterior calf muscles. Spasms, tenderness and atrophy in posterior thigh muscles. Spasms, tenderness and atrophy in anterior thigh muscles. Stronger lower extremity left leg. Motor function of R leg is grade 3+ out of 5 in L4, grade 3+ out of 5 in L5 and grade 3+ out of 5 in S1. Motor function of the L leg is grade 4 out of 5 in L4, grade 4 out of 5 in L5 and grade 4 out of 5 in S1.

> ASSESSMENT: No change in medications prescribed.
>
> PLAN: The next scheduled appointment with this examiner is in 4 weeks. Random drug tests approximately twice a year.[107] Medications from this physician include more than one scheduled narcotic medications in the strong DEA classification group 2. [Omitted: additional narcotic information] Paid $80.00 on account today.

(St. Ex. 19 at 5-6, signatures omitted)

Dr. Cunningham's Opinion – Patient 19

513. When asked if Dr. Lundeen's initial examination of Patient 19 was sufficient to justify the prescriptions written for Percocet and Dilaudid, Dr. Cunningham stated:

> Not in my opinion. He's treating this individual for a crush injury of the leg, and he doesn't describe it, * * * you know, did [s]he have broken bones, inappropriate healing, ulcer formation, varicose veins, limitation of motion. None—none of that is described. And he doesn't have any examination in regards to the spine, and—and his record states that he's treating this individual for a—a remote fracture of the upper back.

(Tr. at 1014) Dr. Cunningham also noted that there were no physical-examination findings documented in the July 6, 2010, progress note. (Tr. at 1016)

514. Dr. Cunningham further opined that the examination documented by Dr. Lundeen on March 18, 2011, had been insufficient:

> Again, he does not characterize the crush injury that this individual was being—of the leg that this individual was being treated for. He talks about the low back. He doesn't talk about the upper back. So I'd say the physical examination doesn't reflect the diagnosis for which he's treating this individual.

(Tr. at 1017)

515. Dr. Cunningham testified that he could find nothing in the medical record to justify Dr. Lundeen prescribing Percocet, Dilaudid, Opana ER, and Xanax to Patient 19. (Tr. at 1018-1019)

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[107] No drug-testing results are included in State's Exhibit 19 or State's Exhibit 19A. (However, Dr. Lundeen's statement appears to reflect an intention. It is noted that Dr. Lundeen's offices were raided in March 2011 and his medical license was summarily suspended in May 2011.)

Dr. Lundeen's Written Defense – Patient 19

516. Dr. Lundeen's written defense included the following:

> Patient 19 * * * is a 26-year-old white female who sustained a crushing injury to her right lower extremity and compression fracture of dorsal vertebrae. Patient 19 has had a fusion of her right ankle and repair of her right patellar tendon from these injuries sustained. She is on SSI for her source of income. Due to the fusion of her right ankle and her limited education, Patient 19 has limited voc rehab potential without furthering her education substantially.
>
> * * *
>
> Dr. Ross commented favorably about the severity of Patient 19's injury and her need for such medication control of pain.

(Resp. Ex. Z at 22)

Patient 20

General Information

517. Patient 20, a male born in 1965, was first seen by Dr. Lundeen on February 18, 1998, with regard to an industrial injury in January 1997. Dr. Lundeen saw Patient 20 on a regular basis through August 2002. As of November 2002, however, Patient 20's care was provided by Francis E. Picklow, M. D., with whom Dr. Lundeen practiced in Cleveland, Ohio. Subsequently, in June 2008, Dr. Lundeen resumed his care of Patient 20, and continued to see Patient 20 on a regular basis through April 28, 2011. (St. Ex. 20 at 48, 96-98)

518. Medical records for Patient 20 were admitted as State's Exhibits 20 and 20A. Dr. Cunningham's initial written report is in State's Exhibit 30 at pages 140-157, and his supplemental report is in State's Exhibit 30A at pages 10 and 14-15. His testimony regarding the patient is found in the hearing transcript starting at page 1020. Dr. Ross' opinion is set forth at Respondent's Exhibit A at page 41, and Dr. Lundeen's written opinion is set forth at Respondent's Exhibit Z at 22.

Treatment Beginning in February 1998 – Patient 20

519. From February 18, 1998, through September 25, 2000, Dr. Lundeen treated Patient 20 for the following diagnoses:

724.02	SPINAL STENOSIS – LUMBAR
847.2	SPRAIN LUMBAR REGION
846.0	SPRAIN LUMBOSACRAL

(St. Ex. 20 at 48-79. See, also, St. Ex. 20 at 96-98)

520. In a letter to Patient 20's attorney dated September 11, 1998, Dr. Lundeen reported in part:

> **HISTORY OF INJURY**
> [Patient 20] is a 33 year old male who presented himself to this office for expert medical care and advice for injuries he received on January 4, 1997.
>
> **EXAMINATIONS**
>
> **February 18, 1998**
> **Subjective:** This patient is new to my medical practice and has transferred his care from George Smirnoff, MD, of Cleveland, Ohio. Dr. Smirnoff is not currently prescribing controlled medications for pain control to any patient. Dr. Smirnoff referred the patient to me for evaluation and treatment. Medical records will be requested at this time; a medical records release form will be/has been signed by the patient. Since the patient was last seen by Dr. Smirnoff, he states that his condition is worse without medications for the past 10 days. No other practitioner will be prescribing medications except this physician. No new injury, surgery or medical illness has occurred during the interval of transfer from Dr. Smirnoff to me. Medication usage has been reviewed. A pain history booklet has been completed by the patient and has reviewed by this physician. Other important medical history includes: hypertension.
>
> **Objective:** Gait: antalgic. Station: mild imbalance. Transfers in and out of a chair: uses hands. Transfers on and off of examination table: uses hands. Standing forward flexion: 40 degrees. Standing extension: 5 degrees. Standing right lateral flexion: 20 degrees. Standing left lateral flexion: 10 degrees. Motor: right lower extremity: thigh abduction 4/5, knee extension 4/5, knee flexion 4/5, dorsiflexion of foot 4/5; left lower extremity: thigh abduction 4+/5, knee extension 4+/5, knee flexion 4/5, dorsiflexion of foot 4/5. Sitting SLR R 10-15 degrees. Sitting SLR L 45-60 degrees. *BP 160/100 due to increased pain due to being out of medication for 10 days.* (Emphasis added)
>
> **Assessment:** The patient has pain which is chronic in nature and is very intense in severity. A good understanding of the patient's conditions, medical history and other important facts are integrated into the current treatment plan. Date of report: this examination date. Date of last examination: date of this report. ICD codes and descriptions: refer to demographics printout. Any reason(s) recovery has been delayed: extent of injuries; has four displaced discs. PHYSICAL CAPACITIES: standing at one time 10 minutes; standing total in 8 hour period 4 hours; sitting at one time 30 minutes; sitting total in 8 hour period 4 hours; lifting (pounds): frequently 0-5; occasionally 10; maximum (rarely) 20; kneeling impaired; bending impaired; climbing steps very impaired; exposure to unprotected heights must avoid; working around moving machinery should avoid; operating a motor vehicle

or tow motor: can't drive more than 30-45 minutes; exposure to extremes of weather conditions impaired due to back and right leg pain increases. Need for vocational rehabilitation very good idea. Objective findings: see section in this note labeled Objective. Other findings increased blood pressure. Treatment plan: frequency of treatments: none approved at this time; frequency of MD examinations 2 weeks to review records and MRI films; need to obtain these from St Vincent Charity Hospital. Factors that are unrelated to the work related condition but are impacting recovery none. [Omitted: Dr. Lundeen's explanation about his electronic signatures and contact information.]

Plan: Current medications: Percocet and Valium from Dr. Smirnoff. Exercises encouraged. Appointment in computer. Minimize use of narcotic medication, take only for uncontrolled pain symptoms. [Omitted: additional information regarding narcotic use.] Employment status none, laid off. Has had extensive diagnostic testing, physical therapy and spinal injections. Four additional disc allowances have been approved recently at BWC hearings.

March 11, 1998
Subjective: Since the patient's last visit, the patient's condition is severe. Activities impaired include all adls. Pain is noted back and legs. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include none today. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date. REVIEW OF MRI REVEALS FRANK HERNIATION AT L4-5 and some problems above and below that level. (Emphasis in original)

Objective: Seated SLR R 20 degrees, SLR L 40 degrees, severe spasms present in lower back. Gait list to left. Station (balance) impaired. Stronger lower extremity left. Weak right leg; HNP at L4-5 affects right leg more severely than left.

Assessment: The patient has pain which is chronic in nature and is severe in severity. A good understanding of the patient's conditions, medical history and other important facts are integrated into the current treatment plan.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information] Employment status none. REFER TO DEPARTMENT OF NEUROSURGERY AT THE CLEVELAND CLINIC REGARDING L4-5 DISC HERNIATION. (Capitalization in original)

March 25, 1998
Subjective: Since the patient's last visit, the patient's condition is very intense. Activities impaired include stand, walk, lift, carry, climb, run, sleep. Pain is noted right leg and lower back. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include none. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date.

Objective: Seated SLR R 10 degrees, SLR L 35 degrees, very intense spasms present in lower back. Gait list to left. Station (balance) mild imbalance. Stronger lower extremity left. Motor function of R leg is grade 3 out of 5 in L4 and grade 3 out of 5 in L5. Motor function of the L leg is grade 4 out of 5 in L4 and grade 4 out of 5 in L5.

Assessment: The patient has pain which is chronic in nature and is very intense in severity. A good understanding of the patient's conditions, medical history and other important facts are integrated into the current treatment plan.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information] Medication reduced from CII to CIII; the surgeon at Cleveland Clinic does not recommend surgery on the disc itself at this time.

* * *

August 10, 1998
Subjective: Since the patient's last visit, the patient's condition is same. Activities impaired include sit, stand, bend, lift. Pain is noted back. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are ineffective without adverse or intolerable side effects. New problems include increased pain.

Objective: Seated SLR R 45 degrees, SLR L 35 degrees, moderate spasms present in lower back. Gait even.

Assessment: The patient has pain which is chronic in nature and is intense in severity. A good understanding of the patient's conditions, medical history and other important facts are integrated into the current treatment plan.

Plan: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information] Employment status none.

SUMMARY
[Patient 20] was involved in a work related accident on 1-4-97 when he was lifting a 55 gallon drum. The patient indicates that initially the pain was localized in the low back. He received conservative treatment with a local chiropractor. He developed right lower extremity pain about two weeks after the injury, while treating with the chiropractor. Follow up treatment has consisted of physical therapy, epidural blocks and medications. An MRI was performed on April 17, 1997 which revealed disc herniation at L4-5 and disc bulges at L2-3 and L3-4. This herniation was clinically confirmed and significant. A lumbar laminectomy was performed in May of this year. [Patient 20] sustained an injury to his lower back in this industrial accident. There was immediate onset of severe lumbar pain and symptoms. The MRI study confirmed the presence of a herniated disc at L4-5.

Based on the history, mechanism of injury, available medical evidence and clinical findings (both subjective and objective), it is my opinion, with a reasonable degree of medical certainty, that:

- [Patient 20] sustained an injury to his lumbar spine in this industrial accident
- This accident was the direct cause of the injuries sustained
- The injuries sustained in this industrial accident(herniated disc at L4-5, bulging discs at L2-3, L3-4), should be amended into the claim allowance. The previously recognized/accepted condition(s) of lumbosacral sprain, sprain lumbar region. [*sic*] Based on his rate and extent of progress since first examined, I rate his prognosis as guarded.

(St. Ex. 20 at 3-9)

Overview of Treatment Beginning December 2000 – Patient 20

521. Starting on December 5, 2000, and continuing through December 1, 2001, Dr. Lundeen treated Patient 20 for the following diagnoses:

722.52	LUMB/LUMBOSAC DISC DEGEN
722.4	CERVICAL DISC DEGEN
401.9	HYPERTENSION NOS
724.02	SPINAL STENOSIS – LUMBAR
847.2	SPRAIN LUMBAR REGION

(St. Ex. 20 at 10-17, 97) In addition, Dr. Lundeen's care for these conditions resumed in January 2010 and continued through March 2011. (St. Ex. 20 at 18-46)

522. Dr. Lundeen stated as follows in the first progress note involving these diagnoses:[108]

> **December 5, 2000**
> SUBJECTIVE: *Since the patient's last visit, the patient's condition ongoing.* Activities impaired include: neck and back movements. Pain is noted by patient in regions of neck and back. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. *New problems include neck and back are more painful.* Progress is noted in: none. *No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination.* Refer to the patient's records for the date of the last examination and Rx's written on that date. Employment status: none. (Emphasis added)
>
> OBJECTIVE: Cervical spine range of motion: 35 degrees right lateral rotation, 25 degrees left lateral rotation, 5 degrees right lateral flexion, 15 degrees left lateral flexion, 15 degrees forward flexion and 15 degrees of neck extension; all movements are painful.
>
> ASSESSMENT: The patient's pain is ongoing and is generally intense in severity. Sleep quality is adversely affected. Weather conditions adversely affect pain level.
>
> PLAN: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information]

(St. Ex. 20 at 10-11, signatures omitted)

Overview of Treatment for Conditions Including Acute Bronchitis – Patient 20

523. Beginning in 2002, Dr. Lundeen treated Patient 20 for a group of conditions that included acute bronchitis:

724.02	SPINAL STENOSIS – LUMBAR
847.2	SPRAIN LUMBAR REGION
846.0	SPRAIN LUMBOSACRAL
466.0	ACUTE BRONCHITIS

(St. Ex. 20 at 80-83) In his March 25, 2002, progress note, Dr. Lundeen made no mention of the change in the patient's diagnoses. In fact, he stated, "Since the patient's last visit, the patient's conditions have not changed." (St. Ex. 20 at 80)

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[108] These diagnoses are stated under a new claim number that does not appear to be a BWC claim number. (See St. Ex. 20 at 78) (Although the Hearing Examiner had noted the changes in the claim number, the Hearing Examiner recognizes that the patient's care is the focus in this matter involving minimal standards and prescribing choices, not the identity of the payer.)

Overview of Resumption of Treatment by Dr. Lundeen – Patient 20

524. As noted above, Patient 20 was treated for several years by Dr. Picklow. When Dr. Lundeen resumed care of Patient 20, it appears he began treating him again in July 2008, according to the progress notes. Dr. Lundeen treated Patient 20 for the following diagnoses:

724.02	SPINAL STENOSIS – LUMBAR
847.2	SPRAIN LUMBAR REGION
846.0	SPRAIN LUMBOSACRAL
466.0	ACUTE BRONCHITIS

(St. Ex. 20 at 84-90, Tr. at 96)

525. Beginning on January 16, 2010, and continuing through the last visit on March 3, 2011, Dr. Lundeen treated Patient 20 for the following conditions:

722.52	LUMB/LUMBOSAC DISC DEGEN
722.4	CERVICAL DISC DEGEN
401.9	HYPERTENSION NOS
724.02	SPINAL STENOSIS – LUMBAR
847.2	SPRAIN LUMBAR REGION

(St. Ex. 20 at 18-46) In his January 16, 2010 progress note, Dr. Lundeen made no mention of the change in the patient's diagnoses, stating that, "Since the last visit, the patient's condition continues without significant change." (St. Ex. 20 at 18)

2001 – Treatment of Patient 20's Hypertension

526. In his progress notes dated March 10, 2001, Dr. Lundeen included among the diagnoses "HYPERTENSION NOS." Under the "Subjective" section, Dr. Lundeen stated:

> SUBJECTIVE: Since the patient's last visit, the patient's condition is ongoing. Activities impaired include: neck movements. Pain is noted by patient in regions of neck. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are effective without adverse or intolerable side effects. New problems include none. Progress is noted in: none. No new trauma or surgical event has occurred since the prior examination. No new medical illness has manifested itself since the prior examination. Refer to the patient's records for the date of the last examination and Rx's written on that date. Employment status: none. SSD for ***aneurysms,*** aslo ***left eye blind, CVA's***. [spelling *sic*, emphasis added][109]

[109] A "CVA" is a "cerebrovascular accident" or stroke. MedlinePlus Online Medical Dictionary, at <*www.merriam-webster.com/medlineplus/cva*> and <*http://www.merriam-webster.com/medlineplus/cerebrovascular%20accident*>; accessed 10/26/11)

> OBJECTIVE: Cervical spine range of motion: 45 degrees right lateral rotation, 45 degrees left lateral rotation, 25 degrees right lateral flexion, 25 degrees left lateral flexion, 50 degrees forward flexion and 25 degrees of neck extension; movements are painful.
>
> ASSESSMENT: The patient's pain is ongoing and is generally intense in severity. Sleep quality is adversely affected. Weather conditions adversely affect pain level.
>
> PLAN: Current medications: refer to computer and/or patient chart. Exercises encouraged. Appointment in computer. [Omitted: narcotic use information] Employment status none.

(St. Ex. 20 at 12, signatures omitted)

527. Dr. Cunningham criticized the lack of documentation of the patient's blood pressure, given the diagnosis of hypertension and the history of CVAs. Dr. Cunningham testified that hypertension, especially uncontrolled hypertension, is a significant risk factor for stroke. Dr. Cunningham noted that Dr. Lundeen had prescribed Catapres to Patient 20, which is a blood-pressure medication, but that Dr. Lundeen documented only one blood-pressure reading during his entire course of treating Patient 20.[110] Dr. Cunningham testified that that had violated the standard of care, and that the standard of care requires that the patient's blood pressure be taken at every visit. Moreover, Dr. Cunningham testified that Dr. Lundeen needed to also periodically monitor Patient 20's weight, as well as perform blood tests to check kidney function, which can be affected by hypertension, and electrolytes, which can be affected by antihypertensive medications. (Tr. at 1021-1024)

    Dr. Cunningham testified that, in patients who have suffered from stroke, the physician should document "cerebral symptoms," such as dizziness, lightheadedness, or loss of memory. Dr. Cunningham testified that Dr. Lundeen's medical record does not reflect that he had examined Patient 20 for such symptoms, which violated the standard of care. (Tr. at 1024)

[110] During Patient 20's initial visit on February 18, 1998, Dr. Lundeen documented Patient 20's blood pressure as 160/100 "due to increased pain due to being out of medication for ten days." St. Ex. 20 at 48)

Additional Opinions Stated by Dr. Cunningham

528. In the Dump of Patient Data, a message dated May 28, 1998, states:

> Patient called here today, states that he had recent surgery and he has been having increased pain, and he has been doubling up on his medication and therefore has run out. He is scheduled for Saturday at LR, he was advised that he should only take meds as directed and he would have to wait until Saturday to see [Dr. Lundeen].

(St. Ex. 20 at 98)

529. Dr. Cunningham testified that Dr. Lundeen should have documented what type of surgery Patient 20 had undergone and whether the surgeon had provided Patient 20 with medication. (Tr. at 1025-1026)

530. Further, in the Dump of Patient Data, an entry dated June 8, 1998, states:

> Patient called. Stated he was involved in an MVA this past Thursday night. He was tested following the accident, as they suspected that he was driving while intoxicated; no charges filed against him, according to the patient. His car was impounded; medications in the car. Wants us to write new rx's. Told him we do not replace medications. I told him to get me a copy of the police report and that I would review, but no promises.

(St. Ex. 20 at 98)

531. Dr. Cunningham testified that, based on the facts stated in this message, he would be concerned that the patient was overmedicated. Dr. Cunningham further testified that, taking the May 28 and June 8 notes together, he would be concerned about drug-seeking and would address the pain contract with Patient 20 and institute random drug screening. Dr. Cunningham testified that he also would have informed the patient in writing that violation of the pain contract would not be tolerated. Moreover, Dr. Cunningham testified that Patient 20 needed to be referred to an addictionologist. Finally, Dr. Cunningham testified that Dr. Lundeen's failure to address any of those issues fell below the minimal standard of care. (Tr. at 1027-1028)

Chart of Prescriptions for Patient 20: 2008 - 2011

532. After resuming the care of Patient 20 in June 2008, Dr. Lundeen issued the following prescriptions to Patient 20:

Rx Date	Medication	Daily Dose	Refill	Condition
6/21/08	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Catapres-TTS-2 patch	every 7 days	0	spinal stenosis – lumbar
7/19/08	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar
8/16/08	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar
9/13/08	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar
10/11/08	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Phenergan VC w/ Codeine [new]	6x per day	1[111]	spinal stenosis – lumbar
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar
11/8/08	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar
12/6/08	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Phenergan VC 6.25/5cc	6x per day	3	sprain lumbar region
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar
1/3/09	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar
1/31/09	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Phenergan VC w/ Codeine	6x per day	3	acute bronchitis
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar

[111] In the Dump of Patient Data, two of the notations state that the Phenergan VC with Codeine was being dispensed in 8-ounce bottles. (St. Ex. 20 at 100)

2/28/09	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Phenergan VC w/ Codeine	6x per day	3	acute bronchitis
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar
3/28/09	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Phenergan VC w/ Codeine	6x per day	3	acute bronchitis
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar
4/25/09	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Phenergan VC w/ Codeine	6x per day	3	acute bronchitis
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar
5/23/09	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Phenergan VC w/ Codeine	6x per day	3	acute bronchitis
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar
6/20/09	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Phenergan VC w/ Codeine	6x per day	3	acute bronchitis
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar
7/18/09	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Phenergan VC w/ Codeine	6x per day	3	acute bronchitis
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar
	Doxycycline 100 mg	200 mg	1	spinal stenosis – lumbar
8/15/09	Vicodin HP 10/660 mg	50/3300	5	spinal stenosis – lumbar
	Diazepam 10 mg	40 mg	5	spinal stenosis – lumbar
	Catapres-TTS-2	every 7 days	5	spinal stenosis – lumbar
1/16/10	Percocet 10/650 mg	60/3900 mg	0	sprain lumbar region
	Diazepam 10 mg	40 mg	0	spinal stenosis – lumbar
	Phenergan VC w/ Codeine	6x per day	3	acute bronchitis
	Catapres-TTS-2	every 7 days	0	spinal stenosis – lumbar

2/13/10	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
	Diazepam 10 mg	40 mg	2	spinal stenosis – lumbar
	Catapres-TTS-2	every 7 days	0	hypertension NOS
3/15/10	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
3/29/10	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
	Phenergan VC w/ Codeine	6x per day	5	lumb/lumbosac disc degen
4/26/10	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
	Valium 10 mg	40 mg	0	lumb/lumbosac disc degen
	Phenergan VC w/ Codeine	6x per day	5	lumb/lumbosac disc degen
5/8/10	Catapres-TTS-2	every 7 days	0	hypertension NOS
5/24/10	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
	Phenergan VC w/ Codeine	6x per day	5	lumb/lumbosac disc degen
6/21/10	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
	Valium 10 mg	40 mg	0	lumb/lumbosac disc degen
	Catapres-TTS-2	every 7 days	0	hypertension NOS
7/19/10	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
	Valium 10 mg	40 mg	0	lumb/lumbosac disc degen
	Phenergan VC w/ Codeine	6x per day	5	lumb/lumbosac disc degen
8/16/10	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
	Valium 10 mg	40 mg	0	lumb/lumbosac disc degen
	Phenergan VC w/ Codeine	6x per day	5	lumb/lumbosac disc degen
	Catapres-TTS-2	every 7 days	0	hypertension NOS
9/13/10	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
	Valium 10 mg	40 mg	0	lumb/lumbosac disc degen
	Phenergan VC w/ Codeine	6x per day	5	lumb/lumbosac disc degen
	Catapres-TTS-2	every 7 days	0	hypertension NOS
10/8/10	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
	Valium 10 mg	40 mg	0	lumb/lumbosac disc degen
	Phenergan VC w/ Codeine	6x per day	5	lumb/lumbosac disc degen
	Catapres-TTS-2	every 7 days	0	hypertension NOS
11/12/10	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
	Valium 10 mg	40 mg	0	lumb/lumbosac disc degen
	Phenergan VC w/ Codeine	6x per day	5	lumb/lumbosac disc degen
	Catapres-TTS-2	every 7 days	0	hypertension NOS

12/9/10	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
	Valium 10 mg	40 mg	0	lumb/lumbosac disc degen
	Phenergan VC w/ Codeine	6x per day	5	lumb/lumbosac disc degen
	Catapres-TTS-2	every 7 days	0	hypertension NOS
1/6/11	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
	Valium 10 mg	40 mg	0	lumb/lumbosac disc degen
	Phenergan VC w/ Codeine	6x per day	5	lumb/lumbosac disc degen
	Catapres-TTS-2	every 7 days	0	hypertension NOS
2/3/11	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
	Valium 10 mg	40 mg	0	lumb/lumbosac disc degen
	Phenergan VC w/ Codeine	6x per day	5	lumb/lumbosac disc degen
	Catapres-TTS-2	every 7 days	0	hypertension NOS
3/3/11	Percocet 10/650 mg	60/3900 mg	0	lumb/lumbosac disc degen
	Valium 10 mg	40 mg	0	lumb/lumbosac disc degen
	Phenergan VC w/ Codeine	6x per day	5	lumb/lumbosac disc degen
	Catapres-TTS-2	every 7 days	0	hypertension NOS

(St. Ex. 20 at 93-95)

Prescriptions for Phenergan VC with Codeine

533. Between March 29, 2010, and March 3, 2011, Dr. Lundeen issued twelve prescriptions for Phenergan VC with Codeine, providing a total of 60 refills. (St. Ex. 20 at 93-95)

534. On March 14, 2009, the following messages were recorded with regard to Patient 20:

> Tim Williams pharmacist [at phone number] called today, he is concerned about [Patient 20] who has been a long time customer at his pharmacy. He indicates that [Patient 20] has had 7 Rx for 8 oz of Phenergan with codeine filled in the last six weeks. He thinks this is an excessive amount of Phenergan with codeine and is worried about [Patient 20]. Advise if any action is needed, thanks. [March 14, 2009]
>
> Response from JEL [Dr. Lundeen] to prior memo: leave out the codeine next time. I will call the pharmacist Mr. Williams who will be back in on Monday.

(St. Ex. 20 at 100) In addition, the following message was recorded on May 26, 2009:

> Back in March we received a call from Tim Williams the pharmacist with regard to [Patient 20] and his phenergan VC with codeine * * *. Your instruction at that time was to leave out the codeine. On May 23,

> you wrote * * * the Rx with codeine? Do you want codeine or not, please advise, thanks.

(St. Ex. 20 at 100)

535. Dr. Cunningham testified that the pharmacist was correct that the amount of Phenergan VC with Codeine was excessive. Moreover, Dr. Cunningham noted that Dr. Lundeen continued to prescribe the medication with codeine *after* being notified of the problem. (Tr. at 1029-1030)

536. Dr. Cunningham commented that, most of the time, Dr. Lundeen prescribed the Phenergan VC with Codeine to Patient 20 for low back issues, and that this medication is not an appropriate choice for spinal stenosis or for lumbar/lumbosacral disc degeneration: "It's a pulmonary drug. Has nothing to do with the low back." However, Dr. Cunningham also noted that, for a period of time—January 2009 through January 2010—Dr. Lundeen prescribed Phenergan VC with Codeine for acute bronchitis. Dr. Cunningham testified that acute bronchitis is a short-term illness, which does not support prescribing Phenergan VC with Codeine for such a long period of time. Dr. Cunningham testified that prescribing Phenergan VC with Codeine for an excessive period of time for acute bronchitis, based on the documentation in the progress notes, violated the standard of care. (Tr. at 1030-1032; St. Ex. 20 at 93-95)

Dr. Lundeen's Written Defense - Patient 20

537. In his written defense, Dr. Lundeen stated in part:

> Patient 20 * * * is a 46-year-old * * * male who has sustained injuries in 1997 to his back which resulted in back surgery in 1998; work-related, claim settled.[112] Patient 20 has tried injections since sustaining his injury without success. Patient 20 had brain surgery for aneurysms and had more aneurysms and must avoid straining or coughing and has a need for cough syrup with codeine. Dr. Picklow treated Patient 20 for years while Dr. Picklow worked for Dr. Lundeen. Dr. Picklow treated him with OxyContin. Dr. Picklow died 2-3 years ago and Dr. Lundeen resumed the charity care, which the doctors provided Patient 20 for nearly 10 years. Patient 20 now has Medicare coverage. Patient 20 monitors his blood pressure closely since he had brain aneurysms.* * *
>
> * * * Dr. Lundeen's care of Patient 20 has been authorized by the Bureau of Worker's Compensation for each service, diagnosis, medication, and prescription provided. Dr. Lundeen's work has been subject to prospective, concurrent and retrospective peer review by case managers, nursing managers, and physician and medical directors, including the medical policy review committees at the Bureau of Workers Compensation. At all times Dr. Lundeen's care to Patient 20 was within

[112]The fact that the industrial claim was settled explains why the claim number and diagnoses changed. The patient would be expected to pay for his treatment from the settlement proceeds.

> or above the minimum standard of care; and, Dr. Lundeen's use of controlled substances for the management of chronic intractable pain were within the guidelines of the State Medical Board of Ohio, it's [sic] statutes and administrative rules.

(Resp. Ex. Z at 22)

Patient 21

General Information

538. Patient 21, a male born in 1971, injured his back while working as a police office in October 2001, making an arrest of a resisting suspect. He first visited Dr. Lundeen for treatment on November 9, 2007. However, prior to that visit, Patient 21was examined by Dr. Lundeen for an impairment-rating report, and Dr. Lundeen provided an extensive report of medical history and physical capacity. Patient 21 also completed new-patient forms including a medical history. Patient 21 indicated that he had undergone a laminectomy in March 2001 and disc replacement at three levels in 2005. He also stated that he suffered from arthritis, hypertension, and irritable bowel syndrome. Moreover, Patient 21 stated that he had "hip & leg pain due to hip being out of socket." Patient 21 also signed a pain contract in September 2007. Patient 21 continued to see Dr. Lundeen on a regular basis through March 2011. (St. Ex. 21 at 3-6, 20-109, St. Ex. 21A at 1-13, 23)

539. Medical records for Patient 21 were admitted as State's Exhibits 21 and 21A. Dr. Cunningham's initial written opinions are set forth at State's Exhibit 30 at pages 148-152, and his supplemental report is set forth at State's Exhibit 30A at 11 and 14-15. His testimony regarding this patient is in the transcript starting at page 1033. Dr. Ross' opinions[113] are set forth at Respondent's Exhibit A at pages 41-42, and Dr. Lundeen's written opinion is set forth at Respondent's Exhibit Z at pages 22-23.

Patient 21's First Examination by Dr. Lundeen – November 9, 2007

540. In his progress notes for Patient 21's first visit on November 9, 2007, Dr. Lundeen stated the following diagnoses for Patient 21, which appear to be the same as the allowed conditions in Patient 21's workers' compensation claim. (St. Ex. 21 at 14, 20-30) Dr. Lundeen stated these diagnoses in his progress notes throughout his care of Patient 21:

> 722.2 DISC DISPLACEMENT NOS
> 724.8 OTHER BACK SYMPTOMS
> 722.52 LUMB/LUMBOSAC DISC DEGEN
> 724.4 LUMBOSACRAL NEURITIS NOS
> 726.5 ENTHESOPATHY OF HIP
> 726.5 ENTHESOPATHY OF HIP [sic: listed twice]

[113] There is no Patient 21 listed in Dr. Ross' report. However, there are *two* Patient 22s, with different initials. It appears that the first "Patient 22" is meant to refer to Patient 21. (Resp. Ex. A at 41-42)

300.00 ANXIETY STATE NOS
846.0 SPRAIN LUMBOSACRAL

(St. Ex. 21 at 20-107)

541. With regard to Patient 21's visit November 9, 2007, Dr. Lundeen explained his findings and the treatment plan as follows:

> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 5 with meds. Activities impaired include: back, legs. Office: New Haven, Ohio. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medication from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: yes.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 10 degrees, SLR L 5 degrees, severe spasms present in lower back. Gait: slow. Stronger lower extremity right. Flexion 30 degrees, extension 5 degrees, right lateral flexion 15 degrees and left lateral flexion 10 degrees.
>
> ASSESSMENT: No major change in medications prescribed.
>
> PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2. [Omitted: narcotic use information] The next scheduled appointment with this examiner is in 4 weeks.

(St. Ex. 21 at 20-21, signatures omitted)

542. According to the Drug Utilization Report, Dr. Lundeen prescribed the following drugs on November 9, 2007:

- OxyIR 5 mg, four tablets per day, to treat the disc displacement
- Neurontin[114] 300 mg, eight tablets per day, to treat the disc displacement
- Ambien 10 mg, one tablet per day, to treat the disc degeneration

(St. Ex. 21 at 109)

[114] Dr. Cunningham testified that Neurontin is an anti-epileptic medication that is also used for patients who have irritation of the spinal nerve root. (Tr. at 1035)

543. Dr. Cunningham testified that the initial examination of Patient 21 documented by Dr. Lundeen did not justify prescribing OxyIR and Ambien. He further testified that Dr. Lundeen's initial examination violated the standard of care: "[F]irst of all, there's no examination of the hip. And, second of all, the physical examination in regards to the low back was minimal and again all subjective, without any objective findings." Dr. Cunningham further testified that "on subsequent visits you don't have to be as detailed, but you do need to document why—if there's any change in status. Physical exam and objective status in regards to the patient's illnesses—or diagnoses, I should say." (Tr. at 1035-1037)

March 2008 – Toradol Prescription for Patient 21

544. Dr. Lundeen's records show that, on March 21, 2008, he wrote a prescription for Toradol, 10 mg, 1 tablet to be taken every other day. (St. Ex. 21 at 109) Dr. Cunningham testified that Toradol is an NSAID that is used to treat acute pain and that the FDA has explicitly stated that Toradol is not to be used for chronic pain. Further, in the progress notes for that date, Dr. Lundeen said nothing about adding Toradol. In fact, Dr. Lundeen made only one statement in his assessment: "No change in medications prescribed." (St. Ex. 21 at 30) Dr. Cunningham opined that prescribing Toradol based on the documentation provided by Dr. Lundeen constituted a violation of the standard of care. (Tr. at 1037-1039)

Dr. Lundeen's Findings Regarding Straight-Leg Raising

545. Dr. Cunningham further criticized Dr. Lundeen's findings regarding straight-leg raising. He noted, for example, that Dr. Lundeen's findings in the "Objective" section of his progress notes dated March 23, 2011, include the following: "Seated straight leg raising, SLR R 10 degrees, SLR L zero degrees * * *. Gait: list to right." (St. Ex. 21 at 107) Dr. Cunningham testified that "if you have zero degrees straight-leg raising, the means you can't raise your heel off the floor." Dr. Cunningham further testified that, if that were true, Patient 21 would not have been able to walk independently, which contradicts the finding concerning Patient 21's gait. (Tr. at 1039-1040)

Prescribing Changes n January 2011

546. According to Dr. Lundeen's Drug Utilization Report, he changed Patient 21's prescriptions on January 26, 2011, as follows:

12/29/10	Disc displacemnt NOS	OxyIR	5 mg	1 6 x day	(#168)
12/29/10	Disc displacemnt NOS	Percocet	10/325 mg	2 4 x day	(#224)
12/29/10	Disc displacemnt NOS	Vimovo[115]	500/20 mg	1 1 x day	(#28)

[115] Vimovo tablets are a combination of an NSAID, naproxen, and a gastric medication, esomeprazole, to prevent stomach upset from the NSAID. E.g., FDA, "Vimovo Medication Guide," at www.fda.gov/downloads/Drugs/DrugSafety/UCM 213832.pdf; "Vimovo," at <www.drugs.com/vimovo.html>, accessed 11/13/11.

1/26/11	Disc displacemnt NOS	Percocet	10/325 mg	2	4 x day	(#224)
1/26/11	Disc displacemnt NOS	OxyIR	5 mg	1	6 x day	(#168)
1/26/11	Anxiety state NOS	Lexapro[116]	20 mg	1	2 x day	(# 56)

547. In his progress notes for the visit on January 26, 2011, Dr. Lundeen explained as follows as to why he was discontinuing the Vimovo and adding the Lexapro:

> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 8. Activities impaired include: lower back, spine. Office: PC. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: none. Left leg weaker.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 30 degrees, SLR L 10 degrees, spasms present in lower back. Gait: list to right. Stronger lower extremity right. Flexion 35-40 degrees, extension 20 degrees, right lateral flexion 15 degrees and left lateral flexion 5 degrees.
>
> ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will be modified as follows: Add Vimovo for pain [sic: same as stated on 12/29/10]. Tens Unit Supplies good for 8-31-10 to 3-3-11.
>
> PLAN: The next scheduled appointment with this examiner is in 4 weeks. Random drugs tests approximately twice a year. [Omitted: narcotic use information] Tens Unit Supplies is good for 8-31-10 till 3-3-11.

(St. Ex. 21 at 103-104, signatures omitted)

548. With regard to the Lexapro for Patient 21, Dr. Cunningham testified that Dr. Lundeen had indicated in the drug chart that it was prescribed to treat anxiety. However, Dr. Cunningham stated that there was no indication in the patient's chart that Dr. Lundeen had conducted an examination regarding the patient's anxiety symptoms. Dr. Cunningham testified that this constituted a violation of the standard of care. (Tr. at 1041)

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[116] Lexapro (escitalopram) is a selective serotonin reuptake inhibitor used to treat depression and generalized anxiety disorder. (Nat'l Libr. of Medicine, Nat'l Inst. of Health, at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000214>, accessed 11/14/11)

Narcotics Dosing in March 2011 – Patient 21

549. According to Dr. Lundeen's Drug Utilization Report, he prescribed the following drugs for Patient 21 on March 23, 2011:

- OxyIR 5 mg, 6 tablets per day
- Percocet 10/325 mg, 8 tablets per day
- Lexapro 20 mg, 2 tablets per day

(St. Ex. 21 at 111)

550. Dr. Cunningham stated that Dr. Lundeen's prescribing of controlled substances increased dramatically over the course of his treatment of Patient 21, which was little more than three years. By the patient's last visit on March 23, 2011, Dr. Lundeen was prescribing doses of OxyIR and Percocet that, if taken as prescribed, meant that Patient 21 was getting a total dose of 110 mg of oxycodone per day. In contrast, the total dose of oxycodone prescribed in November 2007 was 20 mg per day. Dr. Cunningham testified that there was no justification in the medical record for this increase in dosage. He testified that there was no documentation that Patient 21 had any objective change in his health status to support such an increase. (Tr. at 1041-1042; St. Ex. 21 at 109, 111; St. Ex. 30 at 149)

551. Dr. Cunningham further opined:

> Either Dr. Lundeen should have ordered diagnostic tests regarding the underlying conditions for which he was treating to justify—which showed changes which justified the increase in medication; or this patient should have been referred to someone, to a specialist, regarding the underlying conditions for further evaluation * * *.

(Tr. at 1044)

552. Further, Dr. Cunningham opined that Patient 21 should have been referred to an addictionologist. (Tr. at 1044) He explained:

> This individual's increasing dosages of narcotic analgesics over time are clear indications that he has the potential for narcotic dependency and/or addiction and/or tolerance. In my medical opinion, this individual required referral to a physician skilled in narcotic addition/tolerance/dependence issues. There is no mention in these records of this individual having any adverse effects from the medications; however, his total narcotic dosage continued to increase over and above what one would expect in the normal course in the chronic management of low back and lower extremity symptoms in the late postoperative period without objective change in medical status.

(St. Ex. 30 at 151)

Neurontin – Patient 21

553. Dr. Cunningham also opined that Neurontin was not justified in the early visits because the medical record did not indicate that Patient 21 had radicular symptoms or had had a low-back surgery to justify that medication. (Tr. at 1035-1036) However, State's Exhibit 20 includes a letter from Dr. Lundeen detailing the patient's surgical history, and State's Exhibit 21A, which was made available to Dr. Cunningham by August 2011, contains substantial information regarding Patient 21's radiculopathy and low-back surgery. (St. Ex. 21A at 1-3, 5, 19, 23, 42-43, 77-79, 81-85)

Dr. Lundeen's Written Defense – Patient 21

554. In his written defense, Dr. Lundeen stated in part:

> Patient 21 * * * is a 39-year-old white male who is obese[117] and has severe back and hip injury conditions allowed in his BWC claim. Patient 21 is not a surgical candidate due to his weight and due to his anxiety condition. Patient 21 uses a TENS unit and pain medication to control pain in his multiple regions of severe injury. He has 8 or more significant claim allowances.
>
> * * *
>
> * * * Dr. Lundeen's care of Patient 21 has been authorized by the Bureau of Worker's Compensation for each service, diagnosis, medication, and prescriptions provided. Dr. Lundeen's work has been subject to prospective, concurrent and retrospective peer review by case managers, nursing managers, and physician and medical directors, including the medical policy review committees at the Bureau of Workers Compensation. At all times Dr. Lundeen's care to Patient 21 was within or above the minimum standard of care; and, Dr. Lundeen's use of controlled substances for the management of chronic intractable pain were within the guidelines of the State Medical Board of Ohio, it's [sic] statutes and administrative rules.

(Resp. Ex. Z at 22-23)

Patient 22

555. Patient 22 is a male born in 1966. Dr. Lundeen's records indicate that Dr. Lundeen first examined Patient 22 on August 19, 2009. Before that, a staff member in Dr. Lundeen's office, J. Ramsey, took a history and examined Patient 22 on July 21, 2009. Patient 22

[117] One of Dr. Cunningham's criticisms was that Dr. Lundeen failed to document height, weight and blood pressure in the progress notes for Patient 21. (St. Ex. 30 at 150-151)

signed a medication contract on July 10, 2009. Patient 22 saw Dr. Lundeen on a regular basis until March 30, 2011. (St. Ex. 22 at 4-45, 49; St. Ex. 22A at 53, 71-79)

556. Patient 22 testified during the Board hearing in the present administrative matter. (Tr. at vol. IV, pages 595-619) Dr. Cunningham's initial written report regarding Patient 22 is in State's Exhibit 30 at pages 153-157, His supplemental report is in State's Exhibit 30A at pages 11-12 and 14-15. Dr. Cunningham's testimony is found in the hearing transcript starting at page 1045. Dr. Ross' opinion is set forth at Respondent's Exhibit A at 42,[118] and Dr. Lundeen's written opinion is set forth at Respondent's Exhibit Z at page 23.

July 2009 Intake Visit

557. On July 21, 2009, Patient 22 completed a new-patient questionnaire and stated that he had no known drug allergies. He stated his current medications:

- Atenolol 25 mg, two tablets per day
- Cymbalta 60 mg per day from "SMH"
- Zantac from SMH
- Xanax 1 mg three times per day from SMH
- Percocet and Neurontin (with a notation that these had been stopped by previous physician when patient decided to go on disability)
- Ultram #40 as needed for pain

(St. Ex. 22A at 45)

558. On July 21, 2009, Ms. Ramsey recorded Patient 22's blood pressure as 152/96. The stated weight was 180 pounds. Ms. Ramsey noted that the patient's left wrist was swollen and was painful with range of motion.[119] (St. Ex. 22A at 45) Ms. Ramsey's notes regarding the patient's history include the following:

> HTN – pt has not been taking Atenolol but not covered til 9/1/09
> Cervical fusion – 1 yr C5-C6 – s/p mvc93[120]
> DJD – multilevel neck
> (L) ACL tear – Scopy 99 – needs repaired
> (R) knee Baker cyst/torn cart.
> Injury (L) wrist – swelling sprain/contusion / R/O fx [rule out fracture] – x-ray ordered pending carpal tunnel (L) wrist

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[118] Although Dr. Ross discussed two different Patient 22s in his report, the first discussion addresses Patient 21, and the second one actually addresses Patient 22, based on the patients' initials provided.

[119] Patient 22's medical records show a diagnostic study regarding a possible chip fracture of the wrist. There was also a knee injury in May 2009. (E.g., St. Ex. 22A at 17, 43, 61-63)

[120] This note probably means Status/Post Motor Vehicle Collision in 1993. There is another notation on the same page that states "MVC – 93."

(St. Ex. 22A at 45) Other plans, as noted by Ms. Ramsey, included retrieving "notes from pharmacy & Dr. Quraishi's office," and getting lab tests consisting of CBC, CMP, LP, TSH, and UA Tox. The patient was to return in one month. (St. Ex. 22A at 45)

559. An orthopedic consultation was arranged with Dr. Roberts, to take place on August 13, 2009. (St. Ex. 22A at 51)

Patient 22 – August 19, 2009

560. Dr. Lundeen stated as follows in his progress notes for Patient 22's visit on August 19, 2009:

> Diagnosis:
>
> | | |
> |---|---|
> | 401.1 | BENIGN HYPERTENSION |
> | 715.00 | GENERAL OSTEOARTHRITIS |
> | 722.4 | CERVICAL DISC DEGEN |
> | 300.00 | ANXIETY STATE NOS[121] |
>
> August 19, 2009
> SUBJECTIVE: Pain level today = 8+. Activities impaired include: back, neck, knees, left arm. Office: West Union (WU). Pain is noted in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: none. Income: SSD.
>
> OBJECTIVE: Cervical spine range of motion: 50 degrees right lateral rotation, 35 degrees left lateral rotation, 30 degrees right lateral flexion, 35 degrees left lateral flexion, 50 degrees forward flexion and 80 degrees of neck extension; movements are painful.
>
> ASSESSMENT: No major change in medications prescribed, except resume Percocet.
>
> PLAN: The next scheduled appointment with this examiner is in 4 weeks. [Omitted: narcotic use information] Missed ortho appt.

(St. Ex. 22 at 4, signatures omitted)

[121] Dr. Lundeen stated the same diagnoses throughout his treatment of Patient 22. (St. Ex. 22 at 4-44)

561. On August 19, 2009, Dr. Lundeen prescribed: Percocet 10/325 mg, one tablet four times per day (#116); Tenormin 50 mg, one tablet daily (#29); and Neurontin 300 mg, two tablets per day (#58) (St. Ex. 22 at 46)

562. With respect to Patient 22's visit on August 19, 2009, Dr. Cunningham testified that Dr. Lundeen did not document an adequate physical examination for the conditions diagnosed. He further testified:

> [T]here's no height, there's no weight, there's no blood pressure. He was treating this individual for hypertension. There's no description of what—his prior difficulties with his arthritis, what joints were involved in the arthritis, or joint. There's no discussion as to what kind of diagnostic testing he had had or had not had in regards to these diagnoses, such as regards to the neck; had he had an MRI, or a CAT scan, or an EMG, or had he had surgery or injections, physical therapy. There's no mention one way or the other in regards to these diagnoses. [122]

(Tr. at 1046)

563. A handwritten note in Patient 22's file includes these statements:

> -- Missed appt with ortho
>
> -- Must continue counseling counseling! We won't write for Xanax or Cymbalta.

(St. Ex. 22A at 35) (Emphasis in original)

Patient 22 Medication Chart

Date	Condition	Drug - Strength (Number)	Daily Dose
8/19/09	hypertension	Tenormin 50 mg (#29)	50 mg
	cervical disc degen	Percocet 10/325 mg (#116)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#58)	600 mg
9/17/09	hypertension	Tenormin 50 mg (#29)	50 mg
	cervical disc degen	Percocet 10/325 mg (#116)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#58)	600 mg
10/15/09	hypertension	Tenormin 50 mg (#29)	50 mg
	cervical disc degen	Percocet 10/325 mg (#116)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#58)	600 mg

[122] The Hearing Examiner notes, however, that a medical history was in the medical records for Patient 22 at that point, including some information regarding prior surgeries, etc., as described above. In addition, a blood pressure had been noted in July 2009 as well as a stated weight and height.

11/12/09	hypertension	Tenormin 25 mg (#28)	25 mg (↓)
	cervical disc degen	Percocet 10/325 mg (#116)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#58)	600 mg
12/10/09	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#116)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#58)	600 mg
12/30/09[123]	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#116)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#58)	600 mg
	cervical disc degen	Dilaudid 4 mg (#56) [new]	8 mg
	anxiety	Xanax 1 mg (#112) [new]	4 mg
	anxiety	Cymbalta 60 mg (#56) [new]	120 mg
2/3/10[124]	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#116)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#58)	600 mg
	anxiety	Xanax 1 mg (#112)	4 mg
	anxiety	Cymbalta 60 mg (#56)	120 mg
3/3/10	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#108	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#54)	600 mg
	cervical disc degen	Dilaudid 4 mg (#112)	16 mg (↑)
	anxiety	Xanax 1 mg (#112)	4 mg
	anxiety	Cymbalta 60 mg (#56)	120 mg
3/31/10	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#112)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#112)	1200 mg (↑)
	cervical disc degen	Dilaudid 4 mg (#140)	20 mg (↑)
	anxiety	Xanax 1 mg (#112)	4 mg
	anxiety	Cymbalta 60 mg (#56)	120 mg

[123] Patient 22's suicide attempt had occurred eleven days earlier on December 19, 2009. (St. Ex. 22A at 9-15)
[124] According to the Drug Utilization Report, Dilaudid was not prescribed at this visit. (St. Ex. 22 at 47)

4/28/10	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#112)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#112)	1200 mg
	cervical disc degen	Dilaudid 4 mg (#140)	20 mg
	anxiety	Xanax 1 mg (#112)	4 mg
	anxiety	Cymbalta 60 mg (#56)	120 mg
5/26/10	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#112)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#112)	1200 mg
	cervical disc degen	Dilaudid 4 mg (#140)	20 mg
	anxiety	Xanax 1 mg (#112)	4 mg
	anxiety	Cymbalta 60 mg (#56)	120 mg
6/23/10	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#112)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#112)	1200 mg
	cervical disc degen	Dilaudid 4 mg (#140)	20 mg
	anxiety	Xanax 1 mg (#112)	4 mg
	anxiety	Cymbalta 60 mg (#56)	120 mg
7/22/10	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#112)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#112)	1200 mg
	cervical disc degen	Dilaudid 4 mg (#140)	20 mg
	anxiety	**Xanax** 1 mg (#112)	4 mg (last rx)
	anxiety	Cymbalta 60 mg (#56)	120 mg
8/18/10	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#112)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#112)	1200 mg
	cervical disc degen	Dilaudid 4 mg (#140)	20 mg
	anxiety	**Klonopin 2 mg** (#112)	8 mg
	anxiety	Cymbalta 60 mg (#56)	120 mg
9/16/10	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#112)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#112)	1200 mg
	cervical disc degen	Dilaudid 4 mg (#140)	20 mg
	anxiety	Klonopin 2 mg (#112)	8 mg
	anxiety	Cymbalta 60 mg (#56)	120 mg

10/08/10	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#112)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#112)	1200 mg
	cervical disc degen	Dilaudid 4 mg (#140)	20 mg
	anxiety	Klonopin 2 mg (#112)	8 mg
	anxiety	Cymbalta 60 mg (#56)	120 mg
11/10/10	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#112)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#112)	1200 mg
	cervical disc degen	Dilaudid 4 mg (#140)	20 mg
	anxiety	Klonopin 2 mg (#112)	8 mg
	anxiety	Cymbalta 60 mg (#56)	120 mg
12/08/10	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#112)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#112)	1200 mg
	cervical disc degen	Dilaudid 4 mg (#140)	20 mg
	anxiety	Klonopin 2 mg (#112)	8 mg
	anxiety	Cymbalta 60 mg (#56)	120 mg
1/5/11	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#112)	40/1300 mg
	cervical disc degen	Neurontin 300 mg (#112)	1200 mg
	cervical disc degen	Dilaudid 4 mg (#140)	20 mg
	anxiety	Klonopin 2 mg (#112)	8 mg
	anxiety	Cymbalta 60 mg (#56)	120 mg
2/4/11	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#112)	40/1300 mg
	cervical disc degen	Neurontin 400 mg (#112)	1600 mg (↑)
	cervical disc degen	Dilaudid 4 mg (#140)	20 mg
	anxiety	Klonopin 2 mg (#112)	8 mg
	anxiety	Cymbalta 60 mg (#56)	120 mg
3/2/11	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#112)	40/1300 mg
	cervical disc degen	Neurontin 400 mg (#112)	1600 mg
	cervical disc degen	Dilaudid 4 mg (#140)	20 mg
	anxiety	Klonopin 2 mg (#112)	8 mg
	anxiety	Cymbalta 60 mg (#56)	120 mg

3/30/11	hypertension	Tenormin 25 mg (#28)	25 mg
	cervical disc degen	Percocet 10/325 mg (#112)	40/1300 mg
	cervical disc degen	Neurontin 400 mg (#112)	1600 mg
	cervical disc degen	Dilaudid 4 mg (#140)	20 mg
	anxiety	Klonopin 1 mg (#112)	4 mg (↓)
	anxiety	Cymbalta 60 mg (#56)	120 mg

(St. Ex. 22 at 46-48, emphasis added)

Patient 22 – Treatment for Hypertension

564. In the progress notes for Patient 22's visits in August, September, and October 2009, the only objective findings are in regard to cervical-spine ranges of motion. (St. Ex. 22 at 4-7)

565. On November 12, 2009, Dr. Lundeen documented the following examination findings in addition to cervical spine ranges of motion: "BP 130/80, P 65 [pulse], SpO2 98% [oxygen saturation], Lungs CTA [clear to auscultation], Heart RRR [regular rate & rhythm]." His assessment was: "Decrease beta blocker, HR too slow." At this visit, Dr. Lundeen reduced the dose of Tenormin from 50 mg per day to 25 mg. (St. Ex. 22 at 9, 46)

566. On December 10, 2009, the progress notes set forth the following findings in addition to cervical-spine findings: "Blood pressure 118/68 mmHg. Pulse 57. Respirations 12 per minute. Weight 175 pounds. Pre surgery left wrist reduction from injury." (St. Ex. 22 at 11) The medications were unchanged from November 2009. (St. Ex. 22 at 46)

567. Another set of vital signs was handwritten on a marked-up draft of the November 2009 progress notes: "130/80, lungs CTA, SpO2 98%, Heart RRR, P–65, Ext Ø edema." However, there is no date written with these notations. (St. Ex. 22A at 23)

568. Dr. Cunningham noted that Dr. Lundeen recorded no blood pressure for subsequent visits through March 30, 2011. Dr. Cunningham testified that Dr. Lundeen should have taken a blood pressure reading at every visit and taken the patient's weight at least every two or three months. Dr. Cunningham testified that most physicians take a weight at every visit. Further, Dr. Cunningham testified that blood work should have been done about every three months to monitor Patient 22's electrolytes and kidney function. Moreover, Dr. Cunningham testified that Dr. Lundeen should have obtained a baseline EKG and subsequent EKGs annually, or at the very least a baseline EKG. In addition, Dr. Cunningham commented that the blood pressure in December 2009 was lower than it had been in November 2009 and that the pulse was even slower at 57, but Dr. Lundeen made no comment in the progress notes regarding the Tenormin dose. (St. Ex. 22 at 9, 11, 13-44, 46; St. Ex. 30 at 153; Tr. at 1048-1049)

New Medications Added

569. On December 30, 2009, Dr. Lundeen added Dilaudid (4 mg, twice per day) for the cervical spine condition, Xanax (1 mg, four times per day) for anxiety, and Cymbalta (60 mg, two in the morning) for anxiety. (St. Ex. 22 at 46) However, the progress notes for that date state that there was no significant change in the patient's condition, and no complaints are reported relating to anxiety or emotional distress. The objective examination relates only to the cervical spine. (St. Ex. 22 at 13)

Patient 22's Suicide Attempt

570. Records from the Adams County Regional Medical Center, in Seaman, Ohio, state that on December 19, 2009, an EMS vehicle brought Patient 22 to the emergency department following an attempted suicide. The records include:

> Patient presents with symptoms of depression. Expresses suicidal ideation. Has definite suicidal thoughts and has a plan. * * *
>
> Cut his right wrist with a kitchen knife ***since he did not have his medication – stated at that moment he wanted to kill himself.*** He has a 4cm laceration self induced. ***Patient admits he took someone's methadone several days ago.***

(St. Ex. 22A at 9, emphasis added)

571. The medical center identified Dr. Lundeen as Patient 22's "PMD," which may mean primary doctor. (St. Ex. 22A at 9)

572. In Dr. Lundeen's file, someone has written the following note on the copy of the ER report: "Suicide attempt – taking [Patient 15's] meds." (St. Ex. 22A at 9)

573. Dr. Lundeen's progress notes for Patient 22's next visit on December 30, 2009, do not mention the December 19, 2009 visit to the ER. In fact, Dr. Lundeen stated: "Since the last visit, the patient's condition continues without significant change." However, on December 30, 2009, Dr. Lundeen prescribed Percocet, Neurontin, and Tenormin as before, and added prescriptions for Dilaudid 4 mg (twice per day), Xanax 1 mg (four times per day), Cymbalta 60 mg (two tablets each morning). In addition, although Dr. Lundeen's December 30, 2009 notes state "Add Xanax, Cymbalta," there is no mention of the Dilaudid prescription. (St. Ex. 22 at 13, 46)

574. Dr. Cunningham testified that he concludes from the emergency room report of the attempted suicide that "it's pretty obvious" that Patient 22 had become "addicted." Dr. Cunningham further testified that the standard of care required Dr. Lundeen either to evaluate the patient's psychological status himself or refer Patient 22 to a psychiatrist following the suicide attempt. (Tr. at 1057-1061)

575. Dr. Cunningham testified that Patient 22's drug-seeking behavior was not addressed by Dr. Lundeen, nor was Patient 22's suicide attempt. Dr. Cunningham found Patient 22's increasing narcotic medication over the course of Dr. Lundeen's treatment to be below the standard of care. Dr. Cunningham opined that Dr. Lundeen's records do not reflect changes in the patient's condition to justify the increase in medications. (Tr. at 1060-1061)

576. Dr. Cunningham also noted that, on August 19, 2010, Dr. Lundeen prescribed Klonopin/clonazepam (2 mg, four times per day) for the patient's anxiety. Dr. Cunningham testified that there is no documentation that Dr. Lundeen evaluated Patient 22's psychiatric status prior to prescribing the Klonopin. Dr. Cunningham testified that Dr. Lundeen should have documented the psychiatric symptoms, their severity, what the causes appeared to be, and how the symptoms were affecting the patient's daily life. He testified that Dr. Lundeen continued to prescribe Klonopin and Cymbalta for anxiety without reflecting the patient's psychiatric status.[125] (Tr. at 1051-1053; St. Ex. 22 at 47)

Testimony of Patient 22

577. Patient 22 testified that he had been a patient of Dr. Lundeen, and that Patient 15 is his fiancée. He stated that their first visit to Dr. Lundeen was in West Union and that thereafter they saw him at his Portsmouth office, where they had appointments together. (Tr. at 595-598)

578. Patient 22 testified that, at his first visit with Dr. Lundeen, his MRIs were brought in, and his blood pressure was taken, as well as other vital signs. He stated that blood work was done and a drug screen. Patient 22 further testified that Dr. Lundeen asked to see how far Patient 22 could turn his head and asked about his pain level. (Tr. at 596-597)

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[125] Although Dr. Lundeen does not discuss it in his progress notes, it appear that Patient 22 received some treatment at Shawnee Mental Health Center, according to messages in the Dump of Patient Data, for example:

> **14-Dec-2009** 14:12:35.39
> [Patient 22] called and said Julie was to call in Zanax [*sic*] and symbota [*sic*] to Blakes Pharm.in WU @ 937 544 2451. Has this been done? Please advise.
>
> *O09071308M **18-Dec-2009** 16:03:10.07 COLEMANL
> I just got off the phone with Mr. and Mrs. [Patient 22]. They state that Julie [of Lundeen office] was going to call in Xanax and Cymbalta to Blakes pharmacy in WU at * * *. Julie called here yesterday and spoke to Cheryl, Julie said that she was waiting on a fax from Shawnee (however, they have not faxed anything here). I asked Mrs. [Patient 22] to call Shawnee and have them fax whatever they need to 1099.
>
> *O09071308M **31-Dec-2009** 09:40:25.31 COLEMANL
> in the stuff that JEL brought to MD today are progress notes from David Helm, M.D. at Shawnee Mental Health Center.

(St. Ex. 22 at 49-50)

579. Patient 22 testified that Dr. Lundeen's examination room in Portsmouth was small and that he sat in a chair, and Dr. Lundeen sat in a chair, at his desk with a computer. He testified that Dr. Lundeen never got up to examine him, and there was no examination table. Patient 22 testified that visits lasted long enough for him to sit down, turn his head, and tell his pain level, while Dr. Lundeen was typing his prescription. Patient 22 testified that Dr. Lundeen liked to chat about his vacation and then the prescriptions would print and Dr. Lundeen would cut them apart. Dr. Lundeen would tell him to call the next person in.[126] (Tr. at 597-599, 603)

580. Patient 22 testified that Dr. Lundeen worked by himself at the Portsmouth office and did not have a nurse. (Tr. at 599, 603)

581. Patient 22 testified that, every month, he used up all of his medications before they were due to be refilled. Patient 22 testified that he told Dr. Lundeen that he was out of medication on one occasion and that Dr. Lundeen prescribed Demerol for him.[127] (Tr. at 600, 606-607)

582. Patient 22 testified that Dr. Lundeen never had him submit to a urine screen after the first visit, and that Dr. Lundeen never performed a pill count. (Tr. at 601)

583. Patient 22 testified that he had recently pleaded guilty to and been convicted of aggravated possession of drugs. He described his sentence: "I'm doing six months in Star [Star Community Justice Center in Franklin Furnace, Ohio] right now. And I got a year. If I don't complete Star, I got to go to the penitentiary. Two years' probation, a thousand dollars fine, and 40 hours community service." He testified that he is not in a "lock-down cell." He explained that he gets drug counseling/treatment. There are meetings for Narcotics Anonymous and Recoveries Anonymous. In addition, he goes to different classes every week, such as classes for relationships, anger management, changed thinking, and so forth. He obtained a pass to testify at the Board hearing. (Tr. at 601-602)

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[126] Dr. Cunningham testified that, if the patient's visits to Dr. Lundeen consisted of asking him to move his neck and asking his pain level, then Dr. Lundeen's examinations were not sufficient to justify the medications prescribed to Patient 22, and that the prescribing upon such an examination constitutes a violation of the standard of care. (Tr. at 1061)

[127] The Dump of Patient Data includes the following messages:

*O09071308M 3-Mar-2010 11:52:52.52 LUNDEENJ
A regular prescription, control number 1314630, for Demerol (meperidine), 1 b.i.d. #56 written by James E. Lundeen, Sr., M.D. on 2/03/10 for 0 refills has been cancelled because changed to two more Dilaudids.

*O09071308M 3-Mar-2010 11:53:13.96 LUNDEENJ
A regular prescription, control number 1314468, for Dilaudid (hydromorphone), 1 b.i.d. #56 written by James E. Lundeen, Sr., M.D. on 2/03/10 for 0 refills has been cancelled because increased to 4x day.

(St. Ex. 22 at 50)

584. Patient 22 testified that he knows what a blood-pressure cuff is, and he never saw one at Dr. Lundeen's Portsmouth office, and that he was never weighed at that office. He also testified that when his fiancée, Patient 15, saw Dr. Lundeen when her wrist was broken, Dr. Lundeen "made a smart remark to quit using handcuffs, a sexual remark." (Tr. at 603-604

Patient 22 Cross-Examination

585. Patient 22 testified that Dr. Lundeen and his staff took his blood pressure on only one occasion. When asked why Dr. Lundeen had reported more than one blood pressure in his charts, Patient 22 replied that he could not explain that. He did not recall any others. (Tr. at 604-606)

586. Patient 22 said that he had told Dr. Lundeen that he had "run short" of his medication. He stated that he had been abusing the prescriptions from Dr. Lundeen every month. Patient 22 described his arrest in detail. He admitted that he had been criminally buying prescriptions drugs on the street. He indicated that, when he was arrested, he had some of the narcotics from Dr. Lundeen in an unmarked bottle. He explained that the containers that the pharmacy used to dispense his narcotics were very large, six to eight inches tall--a bottle for 140 Dilaudid, another for 116 Percocet 10s, another for 116 Klonipins, and another for the Neurontin—and so he had placed some of each medication in a smaller bottle to carry with him. Nonetheless, he admitted that he had pleaded guilty to the crime of aggravated possession, and that he had also been arrested "back in March [2011] for Vidodins." (Tr. at 606-609)

587. Patient 22 admitted that he had overdosed on his medications after his last visit to Dr. Lundeen's office in March 2011. He stated that the sheriff's office took away his medications, and that, when he was released from jail, he had bought some Vicodin "on the street." (Tr. at 610)

588. Patient 22 described the treatment he received at Shawnee Mental Health Center, and the medications he was provided there. He testified regarding the discussions as to where he would get his prescriptions for his mental-health needs, from Dr. Lundeen or Shawnee. He acknowledged that Dr. Lundeen had wanted him to get a form or release from Shawnee with regard to medication. (Tr. at 599-600, 605-606)

589. Patient 22 testified that, when he was seen by Dr. Lundeen at Dr. Lundeen's West Union office, he had been seen alone. When he was seen in Dr. Lundeen's Portsmouth office, he was seen along with Patient 15. Patient 22 further testified that he had had no objection when Dr. Lundeen suggested it as a convenience, because they had come to the office together. (Tr. at 613-614)

590. Patient 22 acknowledged that he had had an auto accident that resulted from his abuse of medication. Patient 22 testified that he did not tell Dr. Lundeen about that accident,

although he should have. Patient 22 further testified that he had withheld a lot of information from Dr. Lundeen that Dr. Lundeen should have known about. Moreover, Patient 22 testified that he regularly violated his drug contract with Dr. Lundeen. However, Patient 22 denied that he had lied to Dr. Lundeen, because he stated that Dr. Lundeen had not asked him. Patient 22 denied that he had withheld information. He testified: "He wouldn't give me the time to talk. I tried to talk before. He said, 'Wait, wait, wait. Let me get this. Call the next patient in. I'm going to take a smoke break.'" (Tr. at 615-616)

591. Patient 22 also testified on cross-examination:

Q Now, during the time you were arrested you had an interview with investigators for the State Medical Board; isn't that correct?

A. Yes, when I was incarcerated.

Q. So that was during the time you were in jail?

A. Yes.

Q. What did they promise you for the interview?

A. Nothing.

Q. Why did you do it?

A. Because they asked me.

Q. Well, they also asked you to plead guilty and you did that too, right?

A. Yes.

Q. Is it part of your program to —

A. The way I see it, sir, Dr. Lundeen, like he told me, is a legal drug dealer, when he held up his two Blackberry phones.

Q. So when he made a joke, you decided to take that joke seriously; is that right?

A. Well, he called me a drug dealer because I went out and bought pills.

Q. Well, you are a drug dealer.

A. And I'm illegal and he's legal?

MS. BOCKBRADER: Objection, badgering.

THE EXAMINER: Overruled.

Q. So you were mad at him, and you wanted to get back; is that right?

A. No, not mad. My pancreas is ate up.

Q. So you were mad and you wanted to get back at him, and so you decided to go see what you could do to be a snitch?

A. I'm not a snitch.

Q. Well, sir, it seems that way, sir?

A. You can say what you want. I'm not mad one bit. I'm doing my time. * * *

(Tr. at 611-612)

Dr. Lundeen's Written Defense– Patient 22

592. In his written defense, Dr. Lundeen stated in part:

> Patient 22 * * * is a 45-year-old white male who has hypertension, neck injuries to discs and vertebra and anxiety. Patient 22's former physician * * * abandoned his practice in 2009 and Patient 22 has been worked up by my physician assistant[128] and has been treated by Dr. Lundeen without compensation since mid 2009. Patient 22 and his fiancée, Patient 15, who is also treated for hypertension, monitor their blood pressure at home and report their results to this physician at their examinations. Patient 22 might benefit from injections or surgery, but authorization for the same was precluded as Dr. Lundeen was unable to get contracted with his insurance carrier until the past few visits. Patient 22 has not been seen since March 2011, prior to the suspension of Dr. Lundeen's medical license and Dr. Lundeen understand [sic] that Patient 22 is incarcerated.

(Resp. Ex. Z at 23)

Patient 23

General Information

593. Patient 23, a male born in 1980, sustained an industrial injury on October 7, 2004, and commenced care with Dr. Lundeen on February 26, 2009. Dr. Lundeen's diagnoses appear to be the same as the conditions allowed in the workers' compensation claim. Patient 23 continued to see Dr. Lundeen on a regular basis through January 18, 2010. (St. Ex. 22 at 16-40)

594. Medical records for Patient 23 were admitted as State's Exhibits 23 and 23A. Dr. Cunningham's initial written report is set forth in State's Exhibit 30 at pages 158 to 163, and

[128] Dr. Lundeen's statement thus clarifies that it was not Dr. Lundeen who performed the examination of Patient 22 in July 2009, described above.

his supplemental opinion is set forth at State's Exhibit 30A at pages 12 and 14-15. His testimony regarding this patient starts at page 1062 of the hearing transcript. Dr. Ross' opinion is in Respondent's Exhibit A at page 43, and Dr. Lundeen's written defense is in Respondent's Exhibit Z at pages 23 to 24.

Patient 23's First Visit to Dr. Lundeen

595. In 2006, before Patient 23 became a patient of Dr. Lundeen, Dr. Lundeen examined Patient 23 to provide an IME report on the issue of permanent partial impairment, and Dr. Lundeen's report sets forth medical history, work history, ranges of motion, and other information. (St. Ex. 23 at 3-5)

596. On February 24, 2009, Patient 23 completed a new patient form, including a medical history, and he signed a medication contract and other forms. (St. Ex. 23A at 169-199)

597. In his progress notes for Patient 23's initial visit, Dr. Lundeen stated:

> 841.9 SPRAIN ELBOW/FOREARM NOS
> 842.00 SPRAIN OF WRIST NOS
> 337.21 Rflx symp dist, up limb
> 296.30 RECURR DEPR PSYCHOS – UNSP[129]
>
> February 26, 2009
> SUBJECTIVE: New treating patient with regional pain syndrome (RSD) in right upper extremity. Horrific pain in neck, chestwall, right arm, right shoulder, upper back and headaches. Terrific muscle spasms in neck, shoulder, chest and right arm. This injury occurred during strenuous physical exertion with right arm and whole body weight to "stone or polish" a die. Right-handed. Unable to work and not yet MMI. Needs testing of right wrist and neck.
>
> OBJECTIVE: The right shoulder is examined today. Flexion is 90-95 degrees, extension is 50 degrees, abduction is 90 degrees, adduction is 35 degrees, internal rotation with the elbow abducted at or near shoulder level is 90 degrees, external rotation with the elbow abducted at or near shoulder level is -30 degrees. The right elbow is examined today. Extension deficit is 0 degrees, flexion is maximum at 135 degrees of angulation, supination is 50-60 degrees and pronation is 40 degrees. The right wrist is examined today. Flexion is 45 degrees, extension 45 degrees, ulnar deviation 20 degrees and radial deviation 20 degrees. Grip 14 pounds right, 96 left hand. The ulnar styloid is very tender to palpation; the anatomical snuffbox is

[129] Dr. Lundeen continued to list these diagnoses for each visit through Patient 23's last visit in January 2010. (St. Ex. 23 at 18-40)

extremely tender to palpation. C-Spine: range of motion: 30 degrees right lateral rotation, 30 degrees left lateral rotation, 30 degrees right lateral flexion, 30 degrees left lateral flexion, 50 degrees forward flexion and 55 degrees of neck extension; movements are all slow and very painful. Motor strength: right upper extremity: C5 3+/5, C6 3+/5. C7 3/5 and C8-T1 2/5; left upper extremity: C5 5/5, C6 5/5, C7 5/5, and C8-T1 5/5. Vascular: normal. Evidence of neck surgery: none.

ASSESSMENT: Medication selection: Duragesic patch and Methadone for pain control; Dalmane for sleep; K-dur potassium supplement for muscle cramps; Flexeril for muscle spasms. I want to order x-rays of his neck (7 views), x-rays of his right wrist (attention first row of carpal bones), 3-phase bone scan skeletal survey and will submit a C9 for testing. He wants to be fixed so that he can work and raise his family.

PLAN: The next scheduled appointment with this examiner is in 2 weeks. Medications from this physician include more than one scheduled narcotic medications in the strong DEA classification group 2. Patient to minimize use of such narcotic medication(s), to take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx narcotic medications. Patient understand [sic] potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency or addiction will be made. A moderate degree of dependency is normal and should be anticipated with the usage of such narcotic medication(s). Beyond a normal reasonable degree of day to day dependency on such medications for ADL's, abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons. Use of multiple medications due to severity of symptoms and difficulty with dose titration with single drug from this category.

(St. Ex. 23 at 16-17, signatures omitted)

598. At the February 26, 2009, visit, Dr. Lundeen prescribed the following medications:

- methadone 10 mg, two tablets four times per day
- Duragesic patch 75 mcg/hr, one every three days
- Flexeril 10 mg, four times per day
- Dalmane 30 mg, one at bedtime
- K-Dur 20 mEq (potassium), one in the morning

(St. Ex. 23 at 42)

599. Dr. Cunningham described reflex sympathetic dystrophy [RSD]:

> [S]ome people have an injury to an extremity, or after surgery, or after an invasive procedure rarely, but occasionally after an injection or something like that, they can develop what is called reflex sympathetic dystrophy, which is pain generated by the autonomic * * * nervous system. And it is usually treated with injection therapy and medication; occasionally, it will require a spinal cord stimulator.

(Tr. at 1063)

600. When asked if Dr. Lundeen's examination had been sufficient with regard to the diagnosis of RSD, Dr. Cunningham replied:

> The examination is actually more than * * * Dr. Lundeen usually reports, but he does not talk about the cardinal signs of reflex sympathetic dystrophy, which are color change of the skin, whether the skin is warm or cold, whether it's moist or dry, whether there are changes in the fingernails, whether there—there is atrophy of the muscles; and whether the patient has what's called allodynia, * * * which is exquisite pain to the touch, tenderness to touch. Those are the cardinal signs for reflex sympathetic dystrophy. * * * None of them are specifically discussed.

(Tr. at 1063-1064) Dr. Cunningham further testified that Dr. Lundeen's medical record for Patient 23's first visit included no discussion of treatment for RSD by another practitioner. Dr. Cunningham opined that that had violated the standard of care. (Tr. at 1064)

601. Dr. Cunningham testified that none of Dr. Lundeen's progress notes for Patient 23's subsequent visits reflect the cardinal signs of RSD. (Tr. at 1064-1065)

602. For example, Dr. Cunningham testified that Dr. Lundeen's "Objective" note in the March 12, 2009 progress notes reflects an examination of the shoulder and the elbow, which was fine, but Dr. Lundeen did not address the patient's primary difficulty, RSD. (Tr. at 1067)

Patient 23's Prescription Medications

603. During the course of treating Patient 23, Dr. Lundeen issued the following prescriptions to treat the patient's RSD:

Date	*Medication*	*Daily Dose*
2/26/09	Duragesic 75 mcg/hr (#5)	1800 mcg
	methadone 10 mg (#112)	80 mg
	Dalmane 30 mg (#14)	30 mg
	Flexeril 10 mg (#56)	40 mg (last)
	K-Dur 20 mEq (#14)	20 mEq
3/12/09	Duragesic 75 mcg/hr (#10)	1800 mcg
	methadone 10 mg (#224)	80 mg
	Dalmane 30 mg (#28)	30 mg
	Valium 10 mg (#84)	30 mg
	Qualaquin 324 mg (#14)	162 mg
4/9/09	Duragesic 75 mcg/hr (#10)	1800 mcg
	methadone 10 mg (#224)	80 mg
	Dalmane 30 mg (#28)	30 mg
	Valium 10 mg (#84)	30 mg
	Qualaquin 324 mg (#14)	162 mg
	Lexapro 20 mg (#28)[130]	20 mg
5/7/09	Duragesic 75 mcg/hr (#10)	1800 mcg
	methadone 10 mg (#224)	80 mg
	Dalmane 30 mg (#28)	30 mg
	Valium 10 mg (#84)	30 mg
	Qualaquin 324 mg (#14)	162 mg
6/8/09	Duragesic 75 mcg/hr (#10)	1800 mcg
	methadone 10 mg (#224)	80 mg
	Dalmane 30 mg (#28)	30 mg (last)
	Valium 10 mg (#84)	30 mg
	Qualaquin 324 mg (#14)	162 mg
7/6/09	Duragesic 75 mcg/hr (#10)	1800 mcg
	methadone 10 mg (#360)	120 mg (↑)
	Valium 10 mg (#120)	40 mg (↑)
	Qualaquin 324 mg (#15)	162 mg
	K-Dur 20 mEq (#30)	20 mEq
8/5/09	Duragesic 75 mcg/hr (#10)	1800 mcg
	methadone 10 mg (#360)	120 mg
	Valium 10 mg #120	40 mg

[130] On this date, Dr. Lundeen stated that the Lexapro was prescribed to treat "296.30 RECURR DEPR PSYCHOS – UNSP." On all other dates, Dr. Lundeen stated that the Lexapro was prescribed for the RSD.

	Qualaquin 324 mg #15	162 mg
	K-Dur 20 mEq #30	20 mEq
9/2/09	**Duragesic 50 mcg/hr (#10)**	1200 mcg (↓)
	methadone 10 mg (#224)	80 mg (↓)
	Percocet 10/325 (#112)	40/1300 mg
	Valium 10 mg #120	40 mg
	Qualaquin 324 mg #15	162 mg
	K-Dur 20 mEq #30	20 mEq
9/30/09	Duragesic 50 mcg/hr (#10)	1200 mcg
	methadone 10 mg (#224)	80 mg
	Percocet 10/325 (#112)	40/1300 mg
	Valium 10 mg #120	40 mg
	Qualaquin 324 mg #15	162 mg
	K-Dur 20 mEq #30	20 mEq
	Lexapro 20 mg (#28)	20 mg
	Nexium 40 mg (#28)	40 mg
10/28/09	Duragesic 50 mcg/hr (#10)	1200 mcg
	methadone 10 mg (#224)	80 mg
	Percocet 10/325 (#112)	40/1300 mg
	Valium 10 mg #120	40 mg
	Qualaquin 324 mg #15	162 mg
	K-Dur 20 mEq #30	20 mEq
	Lexapro 20 mg (#28)	20 mg
	Nexium 40 mg (#28)	40 mg
11/25/09	Duragesic 50 mcg/hr (#10)	1200 mcg
	methadone 10 mg (#224)	80 mg
	Percocet 10/325 (#112)	40/1300 mg
	Valium 10 mg #120	40 mg
	Qualaquin 324 mg #15	162 mg
	K-Dur 20 mEq #30	20 mEq
	Lexapro 20 mg (#28)	20 mg
	Nexium 40 mg (#28)	40 mg
12/23/09	Duragesic 50 mcg/hr (#10)	1200 mcg
	methadone 10 mg (#224)	80 mg
	Percocet 10/325 (#112)	40/1300 mg
	Valium 10 mg (#120)	40 mg
	Qualaquin 324 mg (#15)	162 mg
	K-Dur 20 mEq (#30)	20 mEq
	Lexapro 20 mg (#28)	20 mg

	Nexium 40 mg (#28)	40 mg
1/18/10	Duragesic 50 mcg/hr (#10)	1200 mcg
	methadone 10 mg (#224)	80 mg
	Percocet 10/325 (#112)	40/1300 mg
	Valium 10 mg (#120)	40 mg
	Qualaquin 324 mg (#15)	162 mg
	K-Dur 20 mEq (#30)	20 mEq
	Lexapro 20 mg (#28)	20 mg
	Nexium 40 mg (#28)	40 mg

(St. Ex. 23 at 42-43, emphasis added)

Discussion Regarding Progress Notes Regarding Medication Changes

604. Dr. Lundeen's progress note for Patient 23's visit on March 12, 2009, states under the "Assessment" heading: "No major change in medications prescribed. Valium is added to control spasms. Quinine added to control tetanic spasms. BWC refused to pay for potassium." (St. Ex. 23 at 18)

605. With respect to the addition of Valium, Dr. Cunningham testified that Dr. Lundeen's progress note does not identify where the patient's spasms were located. He assumed it was in the patient's arm. However, Dr. Cunningham testified that spasms are not generally associated with RSD, and that RSD is not a muscle-tissue problem. Moreover, Dr. Cunningham testified that, if presented with an RSD patient who was suffering from spasms, he would look for a cause of the spasms. (Tr. at 1066)

606. Dr. Cunningham testified that Valium is used to treat anxiety, and is not an appropriate prescription for RSD. Dr. Cunningham further testified that Valium is not an appropriate medication for pain. (Tr. at 1069)

607. Dr. Cunningham further testified that tetanic spasms are caused by "[l]ow calcium, tetany." Dr. Cunningham testified that the diagnosis of tetany requires a blood test to obtain the patient's calcium value, and that he found no documentation of such a test. (Tr. at 1066-1067)

608. Dr. Cunningham testified that Qualaquin is quinine. Dr. Cunningham further testified that, other than treating malaria, the only other use he is aware of for quinine is to treat nighttime leg cramps. Moreover, Dr. Cunningham testified that prescribing that to Patient 23 for "tetanic spasms" without documenting the presence of such spasms, and without documenting a calcium level, fell below the minimal standard of care. (Tr. at 1068-1069, 1071-1072)

609. Dr. Cunningham testified that Lexapro is used to treat psychiatric conditions, and that Patient 23 did not have a psychiatric diagnosis. [The Hearing Examiner notes, however, that one of the patient's diagnoses listed was "296.30 Recurr Depr Psychos – Unsp." However,

Dr. Lundeen routinely stated that he was prescribing the Lexapro for the RSD.] Dr. Cunningham further testified that there is no documentation in Dr. Lundeen's medical record for Patient 23 that he had evaluated Patient 23's psychiatric status. Moreover, Dr. Cunningham testified that prescribing Lexapro without documenting why it was being utilized violated the standard of care. (Tr. at 1069-1071)

610. Dr. Cunningham also found the use of K-Dur, a potassium supplement, to be inappropriate for muscle cramps. (Tr. at 1070-1071)

611. Dr. Cunningham testified that Duragesic, Percocet, and methadone are appropriate medications for treating RSD. Dr. Cunningham noted that the total narcotic dose for Patient 23 increased somewhat from the time Dr. Lundeen started treating him in February 2009 until Dr. Lundeen stopped treating him. In addition, Dr. Cunningham noted that Dr. Lundeen had added Percocet at one point and reduced the Duragesic. (Tr. at 1070-1073)

Dr. Cunningham found no documentation of the reason for this change: "[H]e doesn't say why he reduced the Duragesic and why he added the Percocet. There may be a legitimate reason for it, but he doesn't document it." Dr. Cunningham testified that, because Percocet and Duragesic are controlled substances, Dr. Lundeen's failure to document the reason for the changes violated the standard of care. (Tr. at 1073)

Dr. Lundeen's Written Defense – Patient 23

612. In his written defense, Dr. Lundeen stated in part:

> Patient 23 * * * is a 30-year-old white male who was terminated from Dr. Lundeen's practice for a firearms violation for which he was arrested. Patient 23 has RSD, which is a very debilitating and very painful condition in his right upper extremity, chest wall, and neck. Patient 23 was unable to work due to his injuries that are well reflected in his claim's allowances. Patient 23 tried stellate ganglion blocks without success. A trial period of a spinal cord stimulator has been requested. Occasionally, Patient 23 had medication left over at the end of the month; he took only what he needed and tried to avoid taking pain medication.
>
> Patient 23 was terminated as a patient in January 2010 for felony charge related to firearms.
>
> * * * Valium, potassium and quinine were employed to control extreme muscle spasms in neck, chest and right upper extremity.
>
> * * * Dr. Lundeen's care of Patient 23 has been authorized by the Bureau of Worker's Compensation for each service, diagnosis, medication, and prescriptions provided. Dr. Lundeen's work has been subject to prospective, concurrent and

> retrospective peer review by case managers, nursing managers, and physician and medical directors, including the medical policy review committees at the Bureau of Workers Compensation. At all times Dr. Lundeen's care to Patient 23 was within or above the minimum standard of care; and, Dr. Lundeen's use of controlled substances for the management of chronic intractable pain were within the guidelines of the State Medical Board of Ohio, it's statutes and administrative rules.

(Resp. Ex. Z at 23-24)

Patient 24

General Information

613. Patient 24, a male born in 1973, sustained an industrial injury on June 10, 2004, when a steel beam fell off a forklift and landed on his right foot. Patient 24 first visited Dr. Lundeen on March 12, 2007, with respect to foot injuries. Patient 24 continued to see Dr. Lundeen regularly through at least March 17, 2011. (St. Ex. 24 at 14-116)

614. Medical records for Patient 24 were admitted as State's Exhibits 24 and 24 A. Dr. Cunningham's initial written report opinion is set forth at pages 164 to 168 of State's Exhibit 30, and his supplemental opinion is set forth at pages 12-13 and 14-15 of State's Exhibit 30A. Dr. Cunningham's testimony regarding this patient begins at page 1074 of the hearing transcript. Dr. Ross' opinion is set forth at Respondent's Exhibit A at page 43 to 44, and Dr. Lundeen's written defense is set forth at Respondent's Exhibit Z at 24.

Patient 24's First Visit to Dr. Lundeen – March 2007

615. On January 17, 2007, Patient 24 completed new patient forms, including a medical history, and he signed a medication contract. (St. Ex. 24A at 17-35, 133-135, 205) Dr. Lundeen's records for Patient 24 include the hospital records regarding the patient's treatment immediately following the injury. (St. Ex. 24A at 89-117)

616. Before becoming a patient of Dr. Lundeen, Patient 23 was examined by Dr. Lundeen for an IME report on the issue of his permanent partial impairment. In that report, Dr. Lundeen discussed Patient 23's medical history, work history, functional capacity, and other information. In addition, an extensive report regarding impairment was provided in October 2009. (St. Ex. 23 at 3-9)

617. In his progress notes for Patient 24's initial visit on March 12, 2007, Dr. Lundeen reported:

> Diagnosis:
> 928.20 CRUSHING INJURY FOOT
> 892.0 OPEN WOUND OF FOOT

825.30 FX FOOT BONE NOS-OPEN
825.25 FX METATARSAL-CLOSED
825.25 FX METATARSAL-CLOSED
825.25 FX METATARSAL-CLOSED
826.0 FX PHALANX- FOOT-CLOSED
826.0 FX PHALANX- FOOT-CLOSED[131]

March 12, 2007
SUBJECTIVE: Service location: Springfield, Ohio. This patient is new to this medical practice. He sustained injuries to his right foot with a crushing injury which nearly amputated his right forefoot. Medical records are partially available on this date. A pain history booklet has been completed and reviewed by this physician today. Has severe pain even at rest, worsened by weightbearing.

OBJECTIVE: The right ankle is examined today. Dorsiflexion 25 degrees, plantarflexion 25 degrees, inversion 15 degrees and eversion 15 degrees. Hyperpigmented scars and bony deformation of right forefoot due to crushing injury by structural steel.

ASSESSMENT: Medication selection: Lyrica for burning pain contro[l], Magnacet for sharp pain control.

PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2. Patient to minimize use of such narcotic medication(s), to take only for uncontrolled pain symptoms. Patient aware of abuse potential of the Rx narcotic medications. Patient understand potential risks and elects to accept such medications in order to effectively control painful symptoms. Every effort to monitor usage and note early signs of abnormal dependency or addiction will be made. A moderate degree of dependency is normal and should be anticipated with the usage of such narcotic medication(s). Beyond a normal reasonable degree of day to day dependency on such medications for ADL's, abnormal manifestations will be addressed should they become apparent to this examiner or to other concerned persons. The next scheduled appointment with this examiner is in 4 weeks.

(St. Ex. 24 at 14, signatures omitted)

[131] Dr. Lundeen continued to document these diagnoses through Patient 24's last visit on March 17, 2011. (St. Ex. 24 at 16-116)

618. At the March 12, 2007 visit, Dr. Lundeen prescribed:

- Magnacet 10/400 mg, one tablet four times per day (#124)
- Lyrica 150 mg #124 with instructions to take one tablet four times per day.

(St. Ex. 24 at 118)

Medication Changes

619. On May 10, 2007, Dr. Lundeen increased the dose of Magnacet 10/400 mg to five times per day. The Lyrica dosage was maintained throughout the course of treatment. (St. Ex. 24 at 118-122)

620. On June 7, 2007, he added Restoril 22.5 mg at bedtime, and on July 5, 2007, he added Pamelor 10 mg per day. (St. Ex. 24 at 118)

621. On November 20, 2009, Dr. Lundeen prescribed a 30-day supply of Magnacet. On November 25, 2009, Dr. Lundeen did not see Patient 24, but prescribed a six-day supply of Percocet 10/325 mg, to be taken five times per day. On December 1, 2009, Dr. Lundeen saw the patient and discontinued the Magnacet, which was a reduction in the amount of acetaminophen per day from 2,000 mg to 1,625 mg. (St. Ex. 24 at 120)

Date	Drug	Strength	Qty/Freq.	#
11/02/09	Pamelor	10 mg	1 q.d.	30
11/02/09	Magnacet	10/400mg	1 five x day	**150**
11/02/09	Lyrica	150 mg	1 q.i.d.	120
11/02/09	Restoril	22.5 mg	1 h.s.	30
11/25/09	Percocet	10/325 mg	1 five x day	**30**
12/01/09	Percocet	10/325 mg	1 five x day	110
12/01/09	Pamelor	10 mg	1 q.d.	21
12/01/09	Lyrica	150 mg	1 q.i.d.	84
12/01/09	Restoril	22.5 mg	1 h.s.	21
12/23/09	Lyrica	150 mg	1 q.i.d.	84
12/23/09	Pamelor	10 mg	1 q.d.	21
12/23/09	Percocet	10/325 mg	1 five x day	110
12/23/09	Restoril	22.5 mg	1 h.s.	21

(St. Ex. 24 at 118-119)

622. The Hearing Examiner could not find any progress notes for November 25, 2009, and no other notes regarding the prescription on November 25, 2009. The only notation that was found, close to the date of the prescription, was a message as follows:

> 04-361828 X 24-Nov-2009 13:55:21.45 COLEMANL
> Stacy: [Patient 24] would like you to call him at [telephone number], or at the other number you have for him (he said you would know what it was), thanks.

(St. Ex. 24 at 126)

623. The progress notes on December 1, 2009, do not mention the change of medication. (St. Ex. 24 at 84, 120)

624. At Patient 24's last visit on March 22, 2011, Dr. Lundeen prescribed:

- Percocet 10/325 mg (#14) five times per day,
- Lyrica 150 mg (#112) four times per day
- Restoril 22.5 mg (#28) one at bedtime
- Pamelor 10 mg (#28) one per day.

(St. Ex. 24 at 122)

Physical Therapy Evaluation – Patient 24

625. Dr. Lundeen's records include a physical therapy evaluation in February 2009 by a physical therapist who worked in Dr. Lundeen's office. (St. Ex. 24A at 191-201)

Letters to the BWC Regarding Prescription Medications

626. In letters dated September 9, 2008, and again on July 7, 2009, Dr. Lundeen wrote to the BWC in support of his prescribing of medications for Patient 24. (St. Ex. 24 at 10-13) In the 2009 letter, Dr. Lundeen stated:

> Topic: prescription medications.
>
> As a result of the injuries sustained in this industrial accident and despite conservative treatment, [Patient 24] continues to have pain and symptoms in his right foot.
>
> The medications prescribed to treat the pain and symptoms related to the allowed conditions in this claim:
> Pamelor and Restoril are prescribed in combination to assist sleep. [Patient 24]does not sleep well due to pain and symptoms in his right foot.
> Magnacet is prescribed to control ongoing right foot pain.
> Lyrica is prescribed to control nerve pain due to this injury.

> [Omitted: progress notes regarding patient's visit on May 19, 2009]
>
> SUMMARY
>
> [Patient 24] has ongoing right foot/ankle pain and symptoms as a direct result of the injuries sustained in this claim.
>
> Multiple narcotic medication use: Medications from this physician include one or more narcotic medications. The treatment rationale for a mixture of such medications is to titrate symptom control optimally with the least amount of stronger medication in conjunction with medication(s) in milder class(es). The goal is to control symptoms efficiently and with the safest medications which are effective for this patient's symptoms.
>
> Based on a reasonable degree of medical certainty, based on the mechanism of injury, and the available medical documentation, it is my opinion, that: the prescribed medications provide adequate relief of painful symptoms and allow the patient to perform his daily living activities. Furthermore, I maintain that [Patient 24] medications are medically necessary, effective and safe for his use.

(St. Ex. 24 at 12-13)

Dr. Cunningham's Opinions

627. Dr. Cunningham opined that Dr. Lundeen's progress note for Patient 24's initial visit on March 12, 2007, did not sufficiently document the condition of Patient 24's right foot. Dr. Cunningham testified that Dr. Lundeen did not indicate whether Patient 24 had had surgery or post-surgical complications, or whether he used crutches, a cane, special shoes, or orthotics. Dr. Lundeen did not indicate whether Patient 24 had trouble with leg or foot ulcers that didn't heal. Further, he did not indicate what impairments Patient 24 may have suffered as a result of his injury, such as problems climbing stairs. In addition, Dr. Cunningham testified that Dr. Lundeen described only the range of motion and strength of the right ankle, and described the foot only as having "scars and bony deformation of (the) right forefoot due to crushing injury by structural steel." Accordingly, Dr. Cunningham opined that Dr. Lundeen's March 12, 2007, progress note was insufficient for an initial visit. (Tr. at 1075-1077)

628. Dr. Cunningham testified that Dr. Lundeen should have performed a complete examination of Patient 24's right lower extremity at his initial visit, and that such an examination was not documented. Dr. Cunningham explained that the documentation for subsequent visits need not be as detailed, but he stated that, if there is a change in the treatment, the reason for the change must be documented. (Tr. at 1077-1078)

629. In his progress notes dated April 15, 2010, Dr. Lundeen listed the diagnoses relating to the foot injuries, but stated an examination relating only to the right wrist. (St. Ex. 24 at 94)

630. In his progress notes dates June 22, 2010, visit, Dr. Lundeen again listed the diagnoses relating to the foot injuries, and again documented only an examination of the right wrist. (St. Ex. 24 at 96) Dr. Cunningham commented on the lack of any examination of the injured foot or ankle. (Tr. at 1089-1080)

631. Dr. Cunningham noted that Dr. Lundeen added Pamelor to Patient 24's regimen on July 5, 2007. However, the progress notes include no mention of a new medication being prescribed. (Tr. at 1080-1081; St. Ex. 24 at 22, 118)

632. Similarly, Dr. Lundeen had added Restoril to Patient 24's regimen on June 5, 2007, but his progress notes do not reflect any change in Patient 24's medication. [132] (St. Ex. 24 at 20, 118)

Dr. Lundeen's Written Defense – Patient 24

633. In his written defense, Dr. Lundeen stated in part:

> Patient 24 * * * is a 37-year-old white male who sustained a crushing injury of his right foot in 2004 working at a steel fabricating company. Injections did not help. Surgery was discouraged by surgeon due to the complex nature of the multiple fractures of the forefoot. Education limits his potential for voc rehab and job placement.
>
> * * *
>
> * * * Dr. Lundeen's care of Patient 24 has been authorized by the Bureau of Worker's Compensation for each service, diagnosis, medication, and prescriptions provided. Dr. Lundeen's work has been subject to prospective, concurrent and retrospective peer review by case managers, nursing managers, and physician and medical directors, including the medical policy review committees at the Bureau of Workers Compensation. At all times Dr. Lundeen's care to Patient 24 was within or above the minimum standard of care; and, Dr. Lundeen's use of controlled substances for the management of chronic intractable pain were within the guidelines of the State Medical Board of Ohio, it's [sic] statutes and administrative rules.

(Resp. Ex. Z at 24)

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[132] Dr. Cunningham testified that both Restoril and Pamelor are sleeping medications (Tr. at 1080-1081), but Pamelor is a brand name for nortriptyline, a tricyclic antidepressant. (Nat'l Libr. Med., Nat'l Inst. of Health, "nortriptyline," at <www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000732>, accessed 11/13/11)

Patient 25

General Information

634. Patient 25, a female born in 1972, sustained an industrial injury to her low back in May 2006 as a result of lifting 50-pound bags for several hours. Dr. Lundeen's records indicate that Patient 25 first visited him for treatment on August 11, 2006. His diagnosis at that time was "sprain lumbar region," which was the same condition allowed in the workers' compensation claim. (St. Ex. 25 at 6, 10, 83, 89)

635. Medical records for Patient 25 were admitted as State's Exhibits 25 and 25A. Dr. Cunningham's initial written opinion is set forth in State's Exhibit 30, pages 169 to 173, and his supplemental opinion is set forth in State's Exhibit 30A, pages 13 to 15. Dr. Cunningham's testimony regarding Patient 25 is found in the transcript starting at page 1090. Dr. Ross' opinion is set forth in Respondent's Exhibit A, page 43, and Dr. Lundeen's written opinion is set forth in Respondent's Exhibit Z, page 25.

Overview of Prescriptions in 2006 and 2007 - Patient 25

636. According to Dr. Lundeen's Drug Utilization Chart for Patient 25, the prescriptions provided to her in 2006 and 2007 included the following:

Date	Diagnosis	Drug	Strength	Qty/Freq	Daily Dose
8/11/06	sprain lumbar	Lorcet	10/650 mg	1 five x day	
8/11/06	sprain lumbar	Xanax	1.00 mg	1 b.i.d.	
10/06/06	sprain lumbar	Lorcet	10/650 mg	1 five x day	(50 hydrocodone/3,250 acetamin)
10/06/06	sprain lumbar	Percocet	5/325 mg	1 h.s.	(5 oxycodone/325 acetamin)
10/06/06	sprain lumbar	Xanax	1.00 mg	1 b.i.d.	
10/06/06	sprain lumbar	Lunesta	2 mg	1 h.s.	
10/31/06	sprain lumbar	**Xanax**	**1.00 mg**	**1 t.i.d.**	
10/31/06	sprain lumbar	Lunesta	2 mg	1 h.s.	
10/31/06	sprain lumbar	Lorcet	10/650 mg	1 five x day	
10/31/06	sprain lumbar	Percocet	5/325	1 h.s.	
			* * *		
1/02/07	sprain lumbar	Xanax	1.00 mg	1 t.i.d.	
1/02/07	sprain lumbar	Lorcet	10/650 mg	1 five x day	
1/02/07	sprain lumbar	Percocet	5/325	1 h.s.	
3/02/07	sprain lumbar	Restoril	22.5 mg	1 h.s.	
3/02/07	sprain lumbar	Lorcet	10/650 mg	1 five x day	(50 hydrocodone/3,250 acetamin)
3/02/07	sprain lumbar	**Percocet**	**5/325 mg**	**1 b.i.d.**	(10 oxycodone/650 acetamin)
3/02/07	sprain lumbar	Xanax	1.00 mg	1 t.i.d.	

4/24/07	sprain lumbar	Restoril	22.5 mg	1 h.s.	
4/24/07	sprain lumbar	Lorcet	10/650 mg	1 five x day	(50 hydrocodone/3,250 acetam)
4/24/07	sprain lumbar	**Percocet**	**5/325 mg**	**1 q.i.d.**	(20 oxycodone/ 1,300 acetamin)
4/24/07	sprain lumbar	Lidoderm	patch 5%	1 q.d.	
4/24/07	sprain lumbar	Xanax	1.00 mg	1 t.i.d.	
			* * *		
8/14/07	sprain lumbar	Lidoderm	patch 5%	1 q.d.	
8/14/07	sprain lumbar	Lorcet	10/650 mg	1 five x day	(50 hydrocodone/3,250 acetam)
8/14/07	sprain lumbar	Percocet	5/325 mg	1 q.i.d.	(20 oxycodone/ 1,300 acetamin)
8/14/07	sprain lumbar	Restoril	22.5 mg	1 h.s.	
8/14/07	sprain lumbar	Xanax	1.00 mg	1 t.i.d.	
10/05/07	sprain lumbar	Lorcet	10/650 mg	1 five x day	(50 hydrocodone/3,250 acetam)
10/05/07	sprain lumbar	Percocet	5/325 mg	1 q.i.d.	(20 oxycodone/ 1,300 acetamin)
10/05/07	sprain lumbar	Xanax	1.00 mg	1 t.i.d.	
10/05/07	sprain lumbar	Restoril	22.5 mg	1 h.s.	
11/02/07	sprain lumbar	Lorcet	10/650 mg	1 five x day	(50 hydrocodone/3,250 acetam)
11/02/07	sprain lumbar	Percocet	5/325 mg	1 q.i.d.	(20 oxycodone/ 1,300 acetamin)
11/02/07	sprain lumbar	Xanax	1.00 mg	1 t.i.d.	
11/02/07	sprain lumbar	Lidoderm	patch 5%	1 q.d.	
11/02/07	sprain lumbar	Restoril	22.5 mg	1 h.s.	
11/26/07	sprain lumbar	Lorcet	10/650 mg	1 five x day	(50 hydrocodone/3,250 acetam)
11/26/07	sprain lumbar	Percocet	5/325 mg	1 q.i.d.	(20 oxycodone/ 1,300 acetamin)
11/26/07	sprain lumbar	Xanax	1.00 mg	1 t.i.d.	
11/26/07	sprain lumbar	Restoril	22.5 mg	1 h.s.	

(St. Ex. 25 at 83-84, emphasis added)

Patient 25's First Visit in August 2006 - Dr. Lundeen's Notes

637. On August 11, 2006, Dr. Lundeen set forth the following in his notes regarding Patient 25:

> Diagnosis:
> 847.2 SPRAIN LUMBAR REGION
>
> **August 11, 2006**
> SUBJECTIVE: The patient is seen today at Kenton, Ohio. [Employer's name omitted] History of injury: lifting 50 pound bags. Services needed today: initial exam, review of records, treatment plan. She is told to take only her medications for treatment of her pain and symptoms. Copy of this note to patient today.

> OBJECTIVE: Seated straight leg raising, SLR, R 45 degrees, SLR L 25 degrees, left-sided spasms present in lower back. Gait: list to right. Stronger lower extremity right. Flexion 35 degrees, extension 15 degrees, right lateral flexion 15 degrees and left lateral flexion 15 degrees.
>
> ASSESSMENT: No major change in medications prescribed. Was on Vicodin, but this upset her stomach with nausea.
>
> PLAN: Medications from this physician include one or more scheduled narcotic medications in the moderate DEA classification group 3. [Omitted: use of scheduled narcotic medication] The next scheduled appointment with this examiner is in 8 weeks. Working full time, in pain. Pain level today is 6 of 10.

(St. Ex. 25 at 6, signatures omitted)

638. On October 6, 2006, the patient's second visit, Dr. Lundeen added Percocet and Lunesta to the prescription medications, which he explained as follows:

> October 6, 2006
> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 5-6. Activities impaired include: back, legs, sleep. Office: Kenton. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: yes.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 45 degrees, SLR L 25 degrees, spasms present in lower back. Gait: list to right. Stronger lower extremity right. Flexion 35 degrees, extension 5 degrees, right lateral flexion 25 degrees and left lateral flexion 15 degrees.
>
> ASSESSMENT: No major change in medications prescribed. Percocet for pain relief at night. Lunesta for sleep.
>
> PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2 and one or more in group 3. [Omitted: use of scheduled narcotic medication] More than one type of narcotic medication is utilized to adjust the pain control to optimal effect and minimize the use of the stronger type from group 2. The next scheduled appointment with this examiner is in 3-4 weeks. C9 for physical therapy for one month.

(St. Ex. 25 at 11)

Patient 25's Initial Visits in August & October 2006 - Dr.Cunningham's Opinion

639. Dr. Cunningham opined that the examinations documented by Dr. Lundeen for Patient 25's first two visits is inadequate to support the prescriptions for narcotics and Xanax. (Tr. at 1091-1093)

Further Visits in 2006 and 2007 – Patient 25

640. On October 31, 2006, the patient's third visit, Dr. Lundeen increased the dose of Xanax from 2 mg per day to 3 mg per day (St. Ex. 25 at 83), but he did not address this increase in his notes:

> October 31, 2006
> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 6. Activities impaired include: back, left leg, urinary frequency. Office: Kenton. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: Yes.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 35 degrees, SLR L 25 degrees, spasms present in lower back. Gait: list to right. Flexion 35 degrees, extension 5 degrees, right lateral flexion 15 degrees and left lateral flexion 10 degrees.
>
> ASSESSMENT: No major change in medications prescribed.
>
> PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2 and one or more in group 3. [Omitted: use of scheduled narcotic medication] More than one type of narcotic medication is utilized to adjust the pain control to optimal effect and minimize the use of the stronger type from group 2. The next scheduled appointment with this examiner is in 4 weeks.

(St. Ex. 25 at 13, signatures omitted)

641. On January 2, 2007, the patient's fifth visit, Dr. Lundeen eliminated the prescription for Lunesta, according to his drug chart for Patient 25. (St. Ex. 25 at 83). However, Dr. Lundeen did not explain why. He stated simply that there were "no major changes in medications prescribed." (St. Ex. 25 at 15)

642. When Patient 25 visited on January 30, 2007, the narcotic medications and Xanax stayed the same: Lorcet 10/650, five times per day; Percocet 5/325 at bedtime, and Xanax 1 mg, three times per day. However, a prescription for Restoril was added, 22.5 mg at bedtime. (St. Ex. 25 at

83-84) However, Dr. Lundeen's notes for January 30, 2007, make no mention of the addition of Restoril:

> **January 30, 2007**
> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 8. Activities impaired include: back and legs. Office: Kenton. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: college student Human and Social Services.
>
> OBJECTIVE: Seated straight leg raising, SLR R 5 degrees, SLR L 5 degrees, spasms present in lower back. Gait: even. Flexion 25 degrees, extension 15 degrees, right lateral flexion 15 degrees and left lateral flexion 15 degrees.
>
> ASSESSMENT: *No change in medications prescribed.*
>
> PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2 and one or more in group 3. [Omitted: narcotic use information] The next scheduled appointment with this examiner is in 4 weeks.

(St. Ex. 25 at 15, signatures omitted)

643. On March 2, 2007, Dr. Lundeen doubled the dose of Percocet (oxycodone/acetaminophen), from 5/325 mg per day to 10/650 mg per day, which he explained in his notes as follows:

> March 2, 2007
> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. *Pain level today = 6.* Activities impaired include: back, legs. Office: Kenton. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: student.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 45 degrees, SLR L 25 degrees, spasms present in lower back. Gait: even. Flexion 45 degrees, extension 15 degrees, right lateral flexion 15 degrees and left lateral flexion 5 degrees.
>
> ASSESSMENT: *No major change in medications prescribed.*
>
> PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2 and one or more in group 3.

[Omitted: narcotic use information] The next scheduled appointment with this examiner is in 8 weeks.

(St. Ex. 25 at 17, 83; signatures omitted, emphasis added)

644. At the next visit, on April 24, 2007, the Percocet prescription was doubled again, which not only doubled the potent narcotic but also yielded very high doses of acetaminophen. A prescription for Lidoderm patches was also added:

Date	Drug	Strength	Qty/Freq	Daily Dose
4/24/07	Lorcet	10/650 mg	1 five x day	= (50 hydrocodone/3,250 acetamin)
4/24/07	Percocet	5/325 mg	1 q.i.d.	= (20 oxycodone/ 1,300 acetamin)
4/24/07	Lidoderm	patch 5%	1 q.d.	Total daily acetaminophen = 4,550
4/24/07	Xanax	1.00 mg	1 t.i.d.	
4/24/07	Restoril	22.5 mg	1 h.s.	

(St. Ex. 25 at 83)

645. With respect to Patient 25's visit on April 24, 2007, Dr. Cunningham opined that it was below the standard of care to prescribe acetaminophen in excess of the recommended maximum dose.

646. Further, Dr. Cunningham noted that these doses of Lorcet and Percocet, above the maximum recommended level, continued into 2011. (Tr. at 1093-1095, 1097;)

647. On November 16, 2007, Dr. Lundeen provided an opinion regarding Patient 25's percentage of impairment. He discussed the nature of the injury, diagnostic studies, prior treatment, the patient's educational level, problems with sleep, disease history, medication allergies, ranges of motion, and other information. (St. Ex. 25 at 3-4)

February 2008 - Pharmacist's Concern Regarding Amount of Acetaminophen

648. On February 21, Dr. Lundeen prescribed the following drugs for Patient 25, according to the Drug Utilization Report:

Date	Diagnosis	Drug	Strength	Qty/Freq	Daily Dose
2/21/08	sprain lumbar	Percocet	5/325	1 q.i.d.	20/1300
2/21/08	sprain lumbar	Lorcet	10/650 mg	1 five x day	50/3250
2/21/08	sprain lumbar	Lidoderm	patch 5%	1 q.d.	
2/21/08	sprain lumbar	Xanax	1.00 mg	1 t.i.d.	

(St. Ex. 25 at 84)

649. On February 21, 2008, a pharmacist called Dr. Lundeen's office to ask about the prescriptions for Lorcet and Percocet. The pharmacist was concerned because the amount of

acetaminophen of the two prescriptions together was above the daily recommended maximum dose of acetaminophen.[133] The pharmacist explained that it was the first time that Patient 25 had brought prescriptions to them and asked that Dr. Lundeen contact the pharmacy. (St. Ex. 25 at 89)

650. At Patient 25's next visits, Dr. Lundeen again prescribed the same amounts of Lorcet and Percocet, according to his Drug Utilization Report:

3/20/08	sprain lumbar	Percocet	5/325 mg	1 q.i.d.	20/1300
3/20/08	sprain lumbar	Lorcet	10/650 mg	1 five x day	50/3250
3/20/08	sprain lumbar	Lidoderm	patch 5%	1 q.d.	
3/20/08	sprain lumbar	Xanax	1.00 mg	1 t.i.d.	
6/05/08	sprain lumbar	Percocet	5/325 mg	1 q.i.d.	20/1300
6/05/08	sprain lumbar	Lorcet	10/650 mg	1 five x day	50/3250
6/05/08	sprain lumbar	Lidoderm	patch 5%	1 q.d.	
6/05/08	sprain lumbar	Xanax	1.00 mg	1 t.i.d.	

(St. Ex. 25 at 84; Tr. at 1097)

651. Dr. Lundeen's notes for Patient 25's next visit on March 20, 2008 make no mention of any problem with the fact that the total acetaminophen dosage he was prescribing was higher than the recommended daily maximum dose of that drug:

> **March 20, 2008**
> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 8. Activities impaired include: back, left leg, bladder, left drop foot. Office: PO. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: none.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 35 degrees, SLR L 15 degrees, spasms present in lower back. Gait: list to right. Flexion 35 degrees, extension 5 degrees, right lateral flexion 25 degrees and left lateral flexion 15 degrees.
>
> ASSESSMENT: No major change in medications prescribed.

[133] Dr. Cunningham testified that the maximum recommended dose of acetaminophen (Tylenol) is 4,000 milligrams per day. He stated that high doses of acetaminophen pose a risk of liver or kidney damage, and that, if a physician believes that he or she must prescribe doses at, or close to, the maximum for a period of time, then the physician order some blood work to test the liver function, in order to meet the standard of care. (Tr. at 375, 497-498)

> PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2 and one or more in group 3. [Omitted: narcotic use information] The next scheduled appointment with this examiner is in 4 weeks.

(St. Ex. 25 at 28) Similarly, Dr. Lundeen's notes for the following visit in June 2008 include no discussion of the dosage level of acetaminophen. (St. Ex. 25 at 29)

December 2010 Letter to the BWC Regarding Patient 25's Prescription Medications

652. In a letter dated December 21, 2010, Dr. Lundeen discussed Patient 25's prescriptions as follows:

> This correspondence concerns [Patient 25] who is under my care for treatment of injuries which occurred on May 11, 2006.
>
> DIAGNOSIS: 847.2 Sprain Lumbar Region
>
> TOPIC: PRESCRIPTION MEDICATION
>
> This office treats [Patient 25] for the allowed conditions in this claim and prescribes the following medications: Ambien, Lorcet, Percocet, and Xanax.
>
> EXAMINATION:
> December 8, 2010
> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. *Pain level today = 3*. Activities impaired include: back. Pain is noted by patient in regions of injury.
>
> OBJECTIVE: Seated straight leg raising, SLR, R 40 degrees, SLR L 50 degrees, spasms present in lower back. Gait: even. Flexion 45 degrees, extension 5 degrees, right lateral flexion 20 degrees and left lateral flexion 20 degrees.
>
> ASSESSMENT: Based on the patient's examination findings, history of injury and present complaints, the medications will be modified as follows: *Change to 10mg Percocet.*
>
> PLAN: The next scheduled appointment with this examiner is in 4 weeks.
>
> SUMMARY:
> [Patient 25] sustained an injury to her back in this industrial accident on May 11, 2006.
>
> [Patient 25] requires ongoing Non-Barbiturate Sedative, Serotonin-Nonrepineph Reup Inhi [sic], and Narcotic Analgesics based on the allowed conditions in this claim. Her pain is moderate to severe in nature and has been well documented

since the date of injury. The medications I prescribe for [Patient 25] are necessary and appropriate for the allowed conditions in the claim.

(St. Ex. 25 at 8-9, emphasis added)

653. In 2011, Dr. Lundeen prescribed the following drugs for Patient 25 for the diagnosis of "sprain lumbar region," according to Dr. Lundeen's Drug Utilization Report:

Date	Drug	Strength	Qty/Freq.	Daily Dose
1/05/11	Xanax	1.00 mg	1 t.i.d.	
1/05/11	Ambien	10 mg	1 h.s.	
1/05/11	Percocet	10/325 mg	1 q.i.d.	= 40 oxycodone/1300 acetaminophen
1/05/11	Lorcet	10/650 mg	1 five x day	= 50 hydrocodone/3250 acetaminoph = 4550 acetaminoph
2/04/11	Xanax	1.00 mg	1 t.i.d.	
2/04/11	Ambien	10 mg	1 h.s.	
2/04/11	Percocet	10/325 mg	1 q.i.d.	= 40 oxycodone/1300 acetaminophen
2/04/11	Lorcet	10/650 mg	1 five x day	= 50 hydrocodone/3250 acetaminoph = 4550 acetaminoph
3/02/11	Xanax	1.00 mg	1 t.i.d.	
3/02/11	Percocet	10/325 mg	1 q.i.d.	40 oxycodone/1300 acetaminophen
3/02/11	Lorcet	10/650 mg	1 five x day	50 hydrocodone/3250 acetaminoph
3/02/11	Ambien	10 mg	1 h.s.	
3/30/11	Xanax	1.00 mg	1 t.i.d.	
3/30/11	Percocet	10/325 mg	1 q.i.d.	40 oxycodone/1300 acetaminophen
3/30/11	Lorcet	10/650 mg	1 five x day	50 hydrocodone/3250 acetaminoph
3/30/11	Ambien	10 mg	1 h.s.	

(St. Ex. 25 at 87)

Dr. Cunningham's Opinions

654. Dr. Cunningham testified that he saw no justification in the medical records to justify prescribing acetaminophen in excess of the recommended daily maximum. In addition, he stated that the standard of care requires that, if a physician believes that a patient does need more than 4 grams (4,000 milligrams) of acetaminophen per day, then the physician should monitor the patient's liver function. He opined that Dr. Lundeen's failure to monitor Patient 25's liver function violated the standard of care. (Tr. at 1098)

655. Dr. Cunningham also criticized Dr. Lundeen's medical records for not including documentation of the patient's height, weight, blood pressure, and allergies. (Tr. at 1102; St. Ex. 30 at 169)

Dr. Lundeen's Written Defense – Patient 25

656. With regard to Patient 25, Dr. Lundeen stated in his written position:

> Patient 25 [patient identifying information omitted] injured her back while lifting 50-pound bags in a factory in 2006. Patient 25's allowed condition of sprain lumbar spine belies her true disc injury with left leg sciatica. Due to Patient 25's condition allowance, it has not been possible to obtain surgery or injections.
>
> Patient 25's most recent BWC allowed medications: Norco 10 mg 5x; Xanax 1 mg 3x; Ambien 10 mg hs; Motrin 800mg 2x. This is a modest amount of medication for her back and left leg sciatica pain treatment, which impairs all back adls [activities of daily living] and her sleep.
>
> Dr. Lundeen's saw Patient 25 on each of the dates of service indicated in Dr. Lundeen's records. Dr. Lundeen's care of Patient 25 has been authorized by the Bureau of Worker's Compensation for each service, diagnosis, medication, and prescriptions provided. Dr. Lundeen's work has been subject to prospective, concurrent and retrospective peer review by case managers, nursing managers, and physician and medical directors, including the medical policy review committees at the Bureau of Workers Compensation. At all times Dr. Lundeen's care to Patient 25 was within or above the minimum standard of care; and, Dr. Lundeen's use of controlled substances for the management of chronic intractable pain were within the guidelines of the State Medical Board of Ohio, it's statutes and administrative rules.

(Resp. Ex. Z at 25)

Patient 26

General Information

657. Patient 26, a male born in 1965, sustained a work-related injury in 2005 to his right shoulder, right arm, and neck. He stated that he had been working in a 12-foot hole and there was no backhoe to get him out, and some other workers pulled him out by one arm and he felt something pop. His first visit to Dr. Lundeen was in March 2009. (St. Ex. 26 at 5, 59, 62; St. Ex. 26A at 75)

658. Medical records for Patient 26 were admitted as State's Exhibits 26 and 26A. Dr. Cunningham's initial written opinion is set forth at State's Exhibit 30 at pages174 to 177, and his supplemental opinion is set forth at State's Exhibit 30A, pages 13-14 and 14-15. His testimony regarding this patient starts at page 11-5 of the hearing transcript. Dr. Ross' opinion is set forth in

Respondent's Exhibit A at page 43, and Dr. Lundeen's written opinion is set forth in Respondent's Exhibit Z at page 25.

First Examination by Dr. Lundeen – March 26, 2009

659. Prior to his first visit, Patient 26 completed new patient forms, including medical history and allergies, and he signed a medication contract. The records also include information from prior treating physicians. (St. Ex. 26A; St. Ex. 26A at 73-105)

660. Dr. Lundeen stated as follows in his progress notes for Patient 26's initial visit on March 26, 2009:

Diagnosis:

722.0 CERVICAL DISC DISPLACMNT
726.10 ROTATOR CUFF SYND NOS
727.62 BICEPS TENDON RUPTURE
840.4 SPRAIN ROTATOR CUFF
840.6 SPRAIN SUPRASPINATUS
840.9 SPRAIN SHOULDER/ARM NOS
792.2 ABN[ORMAL] FINDINGS-SEMEN
723.4 BRACHIAL NEURITIS NOS

March 26, 2009
SUBJECTIVE: Pain level today = 7. Activities impaired include: right shoulder and neck. Office: Springfield, Ohio. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: none. Income: TT. Needs C84 completed.

OBJECTIVE: The right shoulder is examined today. Flexion is 70 degrees, extension is 35 degrees, abduction is 90 degrees, adduction is 40 degrees, internal rotation with the elbow abducted at or near shoulder level is 90 degrees, external rotation with the elbow abducted at or near shoulder level is -70 degrees. Cervical spine range of motion: 35 degrees right lateral rotation, 35 degrees left lateral rotation, 35 degrees right lateral flexion, 25 degrees left lateral flexion, 35 degrees forward flexion and 35 degrees of neck extension; most movements are very painful. Weak in right arm and grip.

ASSESSMENT: Medication selection: similar to prior with substitution for Oxycontin with Percocet.

PLAN: Medications from this physician include one or more scheduled narcotic medications in the strong DEA classification group 2. [Omitted: narcotic use information] The next scheduled appointment with this examiner is in 4 weeks.

Approved for right shoulder surgery, Dr. Kevin Paley. Dayton Orthopedic Center. C9 for PT evaluation and 12 treatments.

(St. Ex. 26 at 5-6, signatures omitted)

661. Dr. Lundeen prescribed the following for Patient 26 during the initial visit in March 2009:

- Diazepam 10 mg, 1 at bedtime (#28), for Rotator Cuff Syndrome
- Percocet 10/325 mg, 2 tablets four times per day (#224), for cervical disk displacement
- Soma 350 mg, twice per day (#56), for "sprain shoulder/arm NOS"

(St. Ex. 26 at 59)

Dr. Cunningham's Opinions on the Initial Visit – Patient 26

662. Dr. Cunningham testified that the brachial plexus is a network of nerves in the arm, originating near the neck and shoulder, and a person can develop inflammation or irritation of those structures. He testified that, on an initial visit with respect to brachial neuritis, the standard of care requires the physician to conduct a sensory examination, check the reflexes, check for the presence or absence of atrophy, and conduct muscle-strength testing. (Tr. at 1106)

663. Dr. Cunningham opined that Dr. Lundeen's examination of Patient 26 at the initial visit was not sufficient for brachial neuritis, or for the other diagnoses that Dr. Lundeen listed. He stated that Dr. Lundeen reported only the range of motion of the shoulder and did not address whether there was instability, deformity, loss of muscle strength, and whether or not the patient had impingement syndrome, which makes it very painful for the patient to raise his arm above the shoulder level. (Tr. at 1106-1108)

664. Dr. Cunningham also testified that Soma was not an appropriate medication for Patient 26 in March 2009, several years after his injury. He reiterated that the use of this muscle relaxant more than three months after the injury is not indicated. (Tr. at 1108)

665. Dr. Cunningham further opined that diazepam, which is Valium, is not an appropriate medication for rotator cuff syndrome, which is a mechanical problem not amenable to an antianxiety agent. (Tr. at 1109)

666. With respect to the Percocet to treat cervical disc displacement, Dr. Cunningham opined that the only thing Dr. Lundeen reported regarding the neck was range of motion, and that, in and of itself, does not support Percocet, a Schedule II narcotic. (Tr. at 1109)

The Second Visit in April 2009 – Patient 26

667. On April 23, 2009, Dr. Lundeen added Dilaudid, prescribing as follows:

> Diazepam 10 mg, 1 at bedtime, for rotator cuff syndrome
> Percocet 10/325 mg, 2 tablets 4 times per day, for cervical disc displacement
> Dilaudid, 4 mg at bedtime, for the cervical disc displacement
> Soma 350 mg, twice per day, for the shoulder/arm sprain

(St. Ex. 26 at 59) Dr. Lundeen explained the addition of Dilaudid as follows:

> SUBJECTIVE: Since the last visit, the patient's condition continues without significant change. Pain level today = 7. Activities impaired include: neck, right shoulder/arm. Office: SP. Pain is noted by patient in regions of injury. No other practitioner is currently prescribing pain medication(s) for this patient. The patient's medications from the prior Rx's is/are essentially depleted. The medications is/are usually effective. No adverse or intolerable side effects from medications. Employment status: TT for injuries in this claim.
>
> OBJECTIVE: The right shoulder is examined today. Flexion is 90 degrees, extension is 30 degrees, abduction is 70 degrees, adduction is 30 degrees, internal rotation with the elbow abducted at or near shoulder level is 90 degrees, external rotation with the elbow abducted at or near shoulder level is -70 degrees.
>
> ASSESSMENT: No major change in medications prescribed. Dilaudid added to control pain during the night.
>
> PLAN: The next scheduled appointment with this examiner is in 4 weeks. [Omitted: narcotic use information] C9 for PT evaluation and 12 treatments.

(St. Ex. 26 at 7-8)

668. Dr. Cunningham testified that the documentation for prescribing Dilaudid was within the standard of care. (Tr. at 1110) However, Dr. Cunningham noted that the patient's allergies to ibuprofen, aspirin, and codeine, which the patient had noted on his new patient forms, were not included in the progress notes. Dr. Cunningham opined that, when a patient is being seen primarily for pain management, it is important to note the pain medications to which the patient is allergic. (Tr. at 1111)

Dr. Lundeen's Written Defense

669. With regard to Patient 26, Dr. Lundeen stated in his written position:

> Patient 26 [patient identifying information omitted] has neck, shoulder and biceps injuries that occurred at work. Dr. Lundeen's took Patient 26 off of Oxycontin and put him on Percocet instead. Patient 26 is Temporary Total Disability for psych conditions in his claim.

> Overall, treatment has failed to resolve his psych conditions and his physical conditions might improve with surgery, but his psych conditions are a barrier.
>
> Medications allowed by BWC: Dilaudid 4mg hs; Soma 2x (self-pay); Valium 10 mg hs; Percocet 10 mg 8x.
>
> * * *
>
> Dr. Lundeen's care of Patient 26 has been authorized by the Bureau of Worker's Compensation for each service, diagnosis, medication, and prescriptions provided, *except for the Soma.* Dr. Lundeen's work has been subject to prospective, concurrent and retrospective peer review by case managers, nursing managers, and physician and medical directors, including the medical policy review committees at the Bureau of Workers Compensation. At all times Dr. Lundeen's care to Patient 26 was within or above the minimum standard of care; and, Dr. Lundeen's use of controlled substances for the management of chronic intractable pain were within the guidelines of the State Medical Board of Ohio, it's statutes and administrative rules.

(Resp. Ex. Z)

Evidence Regarding the Number of Patients Seen Per Day

670. During his interview with Board investigators, Dr. Lundeen described the number of patients he sees per day in the Portsmouth office.

> Q. Okay. How many patients do you see, on average, here a day?
>
> A. I am here once every other week on a Wednesday for 11 hours.
>
> * * *
>
> Q. Well, just how many people do you -- come through your door a day?
>
> A. Down here? About 90 people in 11 hours, and we might end up doing 20 or 30 reports.
>
> Q. What's the most you ever had in a visit down here?
>
> A. I wouldn't know. I mean, if I put in 13 hours, you could do the multiples or something.

(St. Ex. 34A at 12-14)

671. With regard to Dr. Lundeen's appointment schedules, Dr. Cunningham testified that he was given "quite a few of them" to review and picked out five dates. Dr. Cunningham opined that Dr. Lundeen could not conduct "sufficient physical examinations" in the times periods shown on the appointment schedules. (Tr. at 1129-1133, 1175-1177; St. Ex. 30 at 3-4)

672. However, Dr. Cunningham acknowledged that physicians do not always see patients at the times shown on the schedule and that "patients back up." Therefore, he stated that the listing of patients on an appointment schedule allows only an approximation or estimate of the amount of time that a patient was actually seen. In addition, Dr. Cunningham further testified that, when a physician works alone, without an assistant, the pace of seeing patients is much slower. (Tr. at 1131, 1178-1186)

673. Dr. Cunningham agreed that, regardless of whether a patient's visit takes three minutes or three hours, the central question is whether the care was within the standard of care, not how much time the visit lasted. (Tr. at 1183-1184)

Interview of Dr. Lundeen by Board Investigators in March 2011

Testimony of Board Investigator

674. Curtis Fortner testified that he is employed by the Board as an Enforcement Investigator. He stated that he was present at Dr. Lundeen's office in Portsmouth, Ohio, when the office was being searched in March 2011 pursuant to a search warrant. Mr. Fortner stated that he and his supervisor, Randy Beck, conducted an interview of Dr. Lundeen while the office was being searched. (Tr. at 918-921)

675. Mr. Fortner testified that a recording was made of the interview. However, he noted that there was a problem with the recorder that caused the first 35 to 45 seconds of the conversation to be unrecorded. Mr. Fortner testified that, during those seconds, the two investigators introduced themselves and explained why they were present at Dr. Lundeen's office. Mr. Fortner testified that there was no other conversation that was unrecorded. (Tr. at 921-922, 958)

676. In addition, Mr. Fortner described the circumstances of the interview. For example, he stated that he did not hear anyone tell Dr. Lundeen that he was under arrest or that he was not free to leave. Conversely, Dr. Lundeen was not expressly advised that he could leave if he wanted to. Mr. Fortner stated that the room where they were talking was not locked and the door was open. Mr. Fortner further stated that the tape recorder was in plain view on the table where they were talking with Dr. Lundeen. (Tr. at 922-957)

Dr. Lundeen's Statements During the Interview

677. During the interview with the Board's investigators in March 2011, Dr. Lundeen's statements included the following:

> INVESTIGATOR B: How often do you come down?
>
> LUNDEEN: Every other week.

INVESTIGATOR A: Every other week. How many office practices do you have, sir?

LUNDEEN: I have one operation, but I have 12 locations that I go to. * * *

INVESTIGATOR A: Okay. So you've got the one main office location then some little subbranches out?

LUNDEEN: This was the busiest. This is gone now. This has just destroyed me.

INVESTIGATOR A: How many do you have overall, locations that you go to?

LUNDEEN: Twelve.

* * *

INVESTIGATOR B: So you think you're going to close this office?

LUNDEEN: Well, you just destroyed my reputation down here; whether it was you or somebody else, I don't know.

INVESTIGATOR A: How long have you been currently practicing here?

LUNDEEN: Ten years.

INVESTIGATOR A: Ten years here?

LUNDEEN: Yeah. All the other doctors have come and gone because they haven't done it right. They're the oxy docs and all that crap. I don't do that. We're real strict. We get rid of people. I don't have any problems whatsoever. We maintain good records. We just -- We just do everything -- tightest -- I run the tightest ship we know how to run. Very proud of it.

INVESTIGATOR A: How many days a week are you here?

LUNDEEN: I'm every other -- here every other week on Wednesday now. I got up at 3:30 this morning, **drove 178 miles. Start at 8:00 o'clock, I work until patients are seen. Then I drive back or I might drive to a motel or something.**

INVESTIGATOR A: Okay. What's your normal hours of operation here, then?

LUNDEEN: **About 11 hours.**

INVESTIGATOR A: So from 8:00 till --

LUNDEEN: 8:00 to 7:00, generally.

INVESTIGATOR A: Generally. Okay. And * * * are you the only -- the office staff here? I mean, do you have security or anything here in the office with you?

LUNDEEN: I have well-behaved patients because I can't get anybody who's not.

INVESTIGATOR A: Okay. So you're -- you're just by yourself, then, when you

see the patients?

LUNDEEN: Yeah.

INVESTIGATOR B: Okay.

LUNDEEN: Yeah. And we're not doing pelvics here. No.

So we had a physician assistant that was approved by the State Medical Board. She didn't work out. She had problems, so we let her go.

INVESTIGATOR A: Okay. Is there -- any other staff that works for you here in this office, then?

LUNDEEN: Not regularly, no.

* * *

LUNDEEN: Well, I don't have a corporation. I'm a sole proprietor. * * *

INVESTIGATOR A: Okay. So how many employees do you have overall, then?

LUNDEEN: I don't have any employees for my medical practice as -- as a sole proprietor, but I hire my company, Lundeen Medical Support Group, who is the equivalent of about seven or eight full-time equivalents, to keep up with all the -- all the paperwork that's involved. Workers' Comp's very busy.

INVESTIGATOR A: I can understand that. * * * So you've got seven or eight people that work at another –

LUNDEEN: Not at one location.

INVESTIGATOR A: Okay.

LUNDEEN: No. They -- scattered over several locations. And we use the Internet voice-over-IP protocol so we can have a virtual phone system that anybody can pick up a call and the —

INVESTIGATOR A: Okay. Yeah.

LUNDEEN: No, we're -- we're out there. We're different than the rest. This is probably part of the -- all of this is, like, guy's an oddball.

INVESTIGATOR A: What -- What is your spec- -- your medical specialty?

LUNDEEN: Best described, probably, as "occ" med, industrial med, office orthopedics, office neurology, general practice.

I'm one of the most astute diagnosticians that I've ever met. Don't need too many of those expensive tests to know which disk is bad. I can do it by talking to you about your gallbladder symptoms, about erectile dysfunction, about which muscle groups are cramped, and watch you walk and whether or not

you walk on your heels and toes, and things like that.

I have patents pending -- in fact, I just got a patent approved for treating pain by controlling barometric pressure in a room or a vehicle. I had two calls pending, but they took my phone, from two fund managers that each have up to a hundred-million dollars to put into this patent development. So that -- all that may get screwed up.

I mean, I have been working real hard to try to figure out non-pill answers to pain. And here I have the first patent for controlling pain. No one else has it. The barometer's down, it's a gray sky; the barometer's up, blue sky. Blue skies, people that are pressure sensitive feel better. This is to make them feel better in their own home environs or in a vehicle.

* * *

LUNDEEN: It'll -- It'll create millions of jobs. * * *

* * *

I have run a practice for 25 years, and I've been a good people person for 25 years.

INVESTIGATOR A: Okay. What -- Are you board certified in any specific –

LUNDEEN: No.

INVESTIGATOR A: -- area?

LUNDEEN: Just -- Just as an independent medical examiner, which I know you guys think is bogus, but, you know, it -- it's what you need to do an IME exam, so...

* * *

INVESTIGATOR A: What's your typical office visit like?

* * *

LUNDEEN: * * * I have a copy of my previous typed notes * * * from the computer. And then up in the corner it has today's date and the -- it would be this office. And then I circle that that, it's being used at that location on that date; that they didn't, like, reschedule and show up at another office * * * somewhere else.

Then I'll go -- and then it lists my -- their information and their diagnosis codes. And then the subjective portion's got a nice paragraph. And I -- I circle the five or ten parameters that I need to double-check on.

(Unintelligible) you guys want pain scales zero to ten, so we ask that of everybody -- * * * and so I'll circle it. If I circle it, don't put another number by it, it means it stayed the same. If I circle it and draw a line over here, put another number in, then my staff will make an -- a similar note when -- * * * I fax this to them or drop it off, or sometimes I have to do it myself.

We'll pull up the templates that created the previous note and start plugging in these parameters that are the same or different -- * * * and then save that.

INVESTIGATOR A: So you've got a -- a template on a computer?

LUNDEEN: Oh, many templates. * * * Oh, yeah. And I do the same thing for my independent medical exams. I have 5-or 600 templates for different body parts.

* * *

INVESTIGATOR A: Okay. So you just have to go in and add what changed, then, or is it already pre- -- how do you –

LUNDEEN: No. The template has a backslash for each parameter. * * *

So you have to fill in.

INVESTIGATOR A: Okay.

LUNDEEN: Yeah. No, it's not -- it's not a copy thing, but it's -- it's looking at something similar that's been marked up.

INVESTIGATOR A: Yeah. Okay.

LUNDEEN: And then if I put down on here, well, you're going to have to add this other template, here are the parameters for it, then they might have to pull that one in, too.

INVESTIGATOR A: Okay.

LUNDEEN: So it's -- it makes it easier to read than my scribbles or other -- other people's scribbles.

* * *

INVESTIGATOR A: **So do you do physical exams here in this office?**

LUNDEEN: **I observe the patient, yeah.**

INVESTIGATOR A: Okay.

LUNDEEN: **I do chair examinations. I do ambulation examinations. I don't take people's clothes off because there isn't an orthopedic thing that you need to – to see unless you have a burn or a cut. That's something we don't do, open wound management, here.**

INVESTIGATOR A: Okay.

LUNDEEN: I don't want any -- I don't -- we don't need **staph – staph aureus problems**[134] by having open wound management. * * * We don't try to take work

[134] The court reporter who transcribed the audio recording (following the start of the hearing) concluded that Dr. Lundeen was not saying "staff" but "staph." The context supports that interpretation. Both parties received a copy of the transcript mid-hearing, and neither requested that the Hearing Examiner declare an errata in this line of the transcript.

away from urgent cares or people who want that sort of stuff. **I want the chronic care, the ones that are on permanent total. Their doctor's retired. "Can you see me and get my – my – my meds." "Can you say 'hi' to me?" "Will you shake my hand?" That's the type of patient I like.**[135]

INVESTIGATOR A: Okay. I mean, do you -- do you do -- do you take vitals and stuff –

LUNDEEN: No.

INVESTIGATOR A: -- when patients come in?

LUNDEEN: Because Work- -- Well, I'm talking about Workers' Comp. Worker's Comp, no. But if they come in and they're ashen gray or they're graying or they're wheezing, call 911 or tell them, "Let's get your doc on the -- your -- your internal medicine doc on the phone, get you over there for an EKG.

INVESTIGATOR A: Okay.

LUNDEEN: Okay. **Because Workers' Comp, that's been our main focus, basically. And in that, you're allowed to document things that are part of their allowed conditions. If you document extraneous things, they don't pay you. (Unintelligible) blood pressure, then they won't pay for the back exam. Yeah. So we're not monitoring something we're not paid for. We'd have a liability to deal with.**

INVESTIGATOR A: Okay.

LUNDEEN: So I -- I -- I never hold out that on a Workers' Comp exam we're doing that.

INVESTIGATOR A: Okay.

LUNDEEN: If we -- If we have an internal medicine patient, which we don't have too many of -- and they're being -- for blood pressure, then that would be something appropriate to check, sure.

INVESTIGATOR A: Okay. Do you keep the equipment here to do that –

LUNDEEN: Sometimes.

INVESTIGATOR A: -- blood pressure –

LUNDEEN: Sometimes I carry a cuff.

INVESTIGATOR A: Okay.

LUNDEEN: **You can also tell by palpation. I was taught in medical school**

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[135] While Dr. Lundeen was making these statements, the investigator said "okay" and "right" several times, and those interjections have been omitted here. (St. Ex. 34A at 16-18)

at Cook County where they didn't have any equipment, basically, back in 1979, how you can tell if somebody has high – hypertension that is significant –* * * by feeling the – the pulse.

INVESTIGATOR A: Okay. On average, about how long does it take an office -- an office visit patient to come in?

LUNDEEN: Well, we try to have a mixture of people who are not prescription -- * * * so that there aren't concerns about how many people we see in a time period. * * * And this morning when all this started, I was an hour-and-a-half behind. So they don't -- it's not in and out here.

INVESTIGATOR A: Right.

LUNDEEN: No. It's just that I have a day here. * * * And a lot of people find me kind of easy to get along with; look at the way I dress. So they like to come out -- come down here and talk with their friends that they worked at the factory with or something. So the place gets packed. * * * You know, it looks bad. It looks like a fucking eyesore. So I took a (unintelligible) be on good behavior, don't do anything wrong, don't loiter, litter in the hallway, don't cause any trouble, and I gave you the appointment, please come at that time. So this place might have 30 or 40 people in it when there should be six or seven ahead. * * * It just -- * * * It seems to be, you know, the place to go.

INVESTIGATOR A: Yeah. So, I mean -- so, I mean, for -- and I know there's no such thing as a typical, average patient. I understand that. * * * But about how much time does it take with each patient, ballpark? If you had to -- If you had to put a number to it.

LUNDEEN: If you had to -- if -- **if I would see 90 occurrences in 11 hours, just divide – just do the math. And then if a third of those are** reports, then that gives that many more minutes to other people. Because when I do an independent medical exam --* * * after you've done 120,000 of them and you're good at math and you can see angles and I'm good at shooting pool, okay, an IME exam is about two minutes, so gives them more average time to people with prescriptions -- * * * where -- where people are more concerned if you're billing a level 3 or level 4 or level 5.

* * *

INVESTIGATOR A: * * * Do you take new patients now?

LUNDEEN: We prescreen them. * * * We aren't encouraging them, per se.

INVESTIGATOR A: Okay.

LUNDEEN: Yeah, we have an open-door policy that we'll consider somebody, but they have to fill out a pack[et], they've got to send it in, we've got to look it over. If there's anything about their behavior and other notes; look at the way I dress take them.

INVESTIGATOR A: Okay.

LUNDEEN: As far as insisting on having a new MRI, that's a very expensive test. I mean, because I'm very astute at diagnosing -- for instance, I'll just give you an example. If somebody has an isolated L4-5 disk protrusion or herniation, they can't do this. It's not possible.

INVESTIGATOR A: Okay.

LUNDEEN: Because mechanically, their back has an inter- -- intersegmental instability at a critical point.

INVESTIGATOR A: Okay.

LUNDEEN: They also can't do this for any period of time. [demonstrating] And they certainly can't do this for any period of time. [demonstrating][136]

INVESTIGATOR A: Okay.

LUNDEEN: That's an L4-5. And that's kind of typical in the type of people I see any of the 4-5, or 5-1, or both.

INVESTIGATOR A: Okay.

LUNDEEN: If they get a 3-4, they get testicular pain or -- or labial pain.

INVESTIGATOR A: Okay.

LUNDEEN: If they have a 5-1, they have diarrhea and irritable bowel, it's diarrhea predominant. If it's 5-1, they get a cramp in the -- in here, charley horses, (unintelligible) treat with muscle relaxers. If they have a 4-5, their charley horses hit up here. If they have a 4-5, they notice the heel spur that everybody's born with, everybody's got one, but only certain people go to the podiatrist for; they're all referred pain from L4-5.

INVESTIGATOR A: Okay.

LUNDEEN: So I can diagnose without running MRIs and EMGs and running up the bills for Comp all the time.

INVESTIGATOR A: Okay.

LUNDEEN: Okay. **I'm real astute at diagnosing things.**

INVESTIGATOR A: Okay.

LUNDEEN: I can give you a similar rundown for something in an arm or a neck or something. **I know anatomy extremely well. I know * * * function and physiology very well**. I enjoy what I do because I -- **I can spot things**. Somebody comes in, "I went to the podiatrist and he took out my heel spur." "Oh. Can you do this?"

[136] These parenthetical descriptions of the audio were added by the Hearing Examiner.

"No." Their knee's down here.

"Stand up," I put my thumb over L4-5, they [groan].[137]

I said, "How many times have you crapped yourself because you couldn't get to the bathroom on time?"

"How did you know?"

"Because you get spontaneous defecation with L4-5."

INVESTIGATOR A: * * * Obviously, you do BWC here, but do you take other insurances here or --

* * *

* * * It's tough to get paid. But my money I get from my reports. And my retirement, if there is one, comes from my patents.

INVESTIGATOR A: Okay.

LUNDEEN: Okay. I'm not in this business to have a pill mill. I don't have that many patients at any one location and I don't have that many overall. Overall, I have about 580 to 620 established comp patients.

INVESTIGATOR A: Okay.

LUNDEEN: Okay. We bought 150 to 160, maybe 180 others. Of those, I'd say half of those are probably Medicare, and I hope to -- we start getting paid on them.

UNIDENTIFIED SPEAKER: Okay. Do you have any cash patients here?

LUNDEEN: We have about 10 percent cash patients in the practice because people have sat on Comp or they have Molina or Amerigroup or some of the -- of the ones that don't want to hire any more doctors. * * * So they were offered that. But we had discouraged typically throughout the 25-year history of this practice of having cash pay patients because the chances that you're going to have aberrant behavior with them is very high, even if you prescreen, even if they're referred by a stable patient who had a longtime -- that the chances of having trouble there with cash pay or Medicaid is very high relative to any other payer group. Medicare, we don't have that trouble. * * * But the people on welfare and the people that are cash pay, no matter how careful we are, we get a trojan horse we gotta kick out, and we kick them right out. There's no chances; they are out. They have a drug contract. We draw all this stuff up. There's no -- no tolerance - -- zero tolerance.

* * *

LUNDEEN: * * * So there's nothing I'm embarrassed about here. There's

[137] The parenthetical descriptions of the audio recording were added by the Hearing Examiner.

nothing I'm worried you're going to find. But the fact that down here is so contentious to be a comp doctor or to be a doctor who is willing to write appropriate medications for appropriate things * * * that this happening today will destroy this practice.

INVESTIGATOR A: * * * What do you charge for your cash office visits?

* * *

LUNDEEN: Roughly 90 bucks. * * * That's for an established patient. And the initial one's a hundred-and-a-half. I mean, if you go to certain people around town here, it's two-and-a-quarter cash per month, cash, every month, and she sells the pills to them and they're OxyContins. Yeah. There's -- you know, I'm not an oxy doctor. When OxyContin came out 12 years ago, I prescribed it for about five years until it became an issue, then I tapered it off and we went -- decided that wasn't something I need in my practice. There's Opana, there's -- there's all sorts of other products that work just fine.

Why do something to sucker people in and build up a pill mill and just to make money? Because if you're an oxy doc, you'll have people flying in from all over the world for you, okay?

INVESTIGATOR A: Okay.

LUNDEEN: It's -- that's not what -- That's not why I'm in this. I'm in this for patient care, and I'm also in this because I'm an engineer, chemist, I'm a physician, I'm an inventor, mechanically inclined. Love God, love my country, try to do a good job.

Have a neat patent pending that might stabilize our economy that if all of a sudden they're -- people are getting home remodelings throughout the country to put in these little pressure areas. * * *

Really proud of my work. Honestly. Very proud of my work.

INVESTIGATOR A: Good. Are the majority of your patients from Ohio, then, or do you have any across the state, or how's –

LUNDEEN: Well, we discourage [sic; the context suggests that Dr. Lundeen meant "encourage"] anybody from out of state, but let -- let me tell you where the exceptions come in. If -- If somebody has moved to Florida and they come back twice a year, and they're on medications that are appropriate for refills or maybe they'll get one month's worth of a Schedule II but then they're going to get the rest of their Schedule III, they can fill Walmart * * * down in Orlando or something, and the little old lady is retired, I don't have a problem. * * * Okay. **If they live across the river, I consider them local.** I don't look at the river as a dividing line.

INVESTIGATOR A: Right.

LUNDEEN: **There's one patient who drives from the other southern side of**

the state of Kentucky, but he's a retired engineer, he's about 75 years old, clean cut, nice guy. Not a problem.

By and large, no, they're not out of state. Are there exceptions? Maybe one percent of the practice, eight, ten, twelve people, sure, you know. If somebody goes out of state because they've got work for several months and they get medicine that they can refill at Walmart, if they come back too soon and they can't transfer it back, they don't get a replacement.

INVESTIGATOR A: Okay.

LUNDEEN: And they're warned of that ahead of time and they always come back too soon and they always want it and the answer is no. * * * Nothing else to fill in with.

INVESTIGATOR A: Okay. What sort of treatments do you do for pain management?

LUNDEEN: I -- Depending on what their need is. If they need a surgeon, I try to find one of the ones I -- that I would find one of the best. * * * But if they have a preference, I'm not going to down somebody, but -- * * * I might not give them a real enthusiastic –

INVESTIGATOR A: Do you do, like, trigger point injections or something like that or...

LUNDEEN: I don't want to have my insurance bill higher, and there are lots of people who love to make money on injections. * * * So we'll do a C-9 through Workers' Comp, get them approved, let them go over there and do it. * * * I -- I try to be a good neighbor to all practitioners, to the therapists, massotherapists, surgeons, anesthesiology. Try be to be a -- just a good neighbor, but not saying I want all that * * *.

INVESTIGATOR A: Right. Okay.

* * *

LUNDEEN: -- (unintelligible). Yeah. This is mischaracterized if it's looked at as a pill mill. I mean, this is real high-level triage of people for appropriate things. We try to keep the cost to Workers' Comp down. **We try not to attract anybody in here unsavory. If we get one, we get rid of them. I'm real proud of our operation and I'm -- I'm careful** we -- careful how we do things -- * * * and how consistent we are about them.

* * *

INVESTIGATOR A: * * * What percentage of -- of all your patients that you have are getting a controlled substance prescription?

LUNDEEN: If -- These people come to me when their primary care physician doesn't want to do * * * something, but I try not to take too many of those. * * * **So**

it's mainly comp patients who are chronic care because they've got a bad back, knee, shoulder, something of that sort. So they're going to need a controlled prescription each time they come in. And that's the nature of their visit. It's the reason for their visit. I mean, it is perfectly good rationale. * * * You're chronic care. Most of them are permanent total.

INVESTIGATOR A: So do all of your chronic care patients have -- get a controlled substance?

LUNDEEN: I mean, **most of them are – that's the nature of the people over – over time that we've gotten that have had the surgeries or couldn't have the surgery because of their heart or whatever. Yeah. They – They need their Vicodin, or their Percocet, or their morphine tablet, or something**, and -- and maybe something for rest (unintelligible).

INVESTIGATOR A: So it's not a hundred percent of your patients getting controlled substances?

LUNDEEN: **I can't say it's a hundred percent. It's a high percentage**. * * * I mean, it's kind of been the focus but there was a time when I had other doctors working for me in the early '90s, I mean, collectively, we had thousands of patients. I didn't like it. And they didn't want to get rid of any of them. Oh, they wanted the money. So I got rid of those doctors, I -- I got rid of those patients. I trimmed it down, I kept it small, kept it manageable, kept it clean.

And in the last couple of weeks, we had to get rid of eight patients. Patients get desperate because they have to pay a rent payment or car payment. And we get a phone call, they're done. No chances. No pill counts. Done. Out. And it's in their contract.

INVESTIGATOR A: Okay. Do you dispense any medication here?

LUNDEEN: No.

INVESTIGATOR A: Okay.

LUNDEEN: No. Because people break in for it. People point guns about it. You have to keep it double locked. If it's the DEA, you have to keep records of it. So we've never done it * * *. In downtown Cleveland, when [a pharmacist] convinced us that we could have it in our office and give them a prescription.

And I went to the * * * State Pharmacy Board and turned him in, and they did an investigation and brought down a bunch of other doctors on -- on my tip-off. This is why I find all this ironic.

INVESTIGATOR A: Okay. What steps do you take in the practice to combat drug-seeking behavior?

LUNDEEN: Well, we don't take walk-ins.

INVESTIGATOR A: Okay.

LUNDEEN: We try not to take anybody from out of state unless it's -- it's proximate out of state, like here. * * * Or in Toledo, it would be just across the line * * * into Michigan or something like that. So we -- we try not to -- It's not urgent care, don't take walk-ins. One lady was with -- with her mother here today and her -- her mother had been an established patient who hadn't been seen since last December because Molina won't give me a contract because they're just maxed out on doctors.

She said, "Could I have my prescriptions today?" I said, "Sure, I would be happy to do that for you. No charge." I said, "You're still having the same problems?" "Yes, I am." So I saw her today, gave her her scripts.

Can't bill anybody for it. But that -- that's not really a walk-in. It's a * * * established person that we couldn't treat because we weren't getting paid and we were owed a thousand dollars on her and never going to see it, but she -- she's in our system. So there's an occasional -- it's not really a walk-in. But, no, we don't take walk-ins.

INVESTIGATOR A: Okay.

LUNDEEN: We discourage cash paying. I always encourage people to write a check whenever possible. * * * We do get cash, but I encourage people to write checks.

INVESTIGATOR A: Okay.

LUNDEEN: Whether or not they pay in cash, there's some indication somewhere in our system that it was a cash visit and they showed up; therefore, they paid.

INVESTIGATOR A: Okay. Do you do any of the (unintelligible), you know, random pill counts, drug testing?

LUNDEEN: The -- I'm not a pharmacist. I wouldn't know a Percocet from a Vicodin, so I don't do pill counts. And the reason is people can borrow some from their friends and fill up their bottle and come in. I wouldn't -- they -- I wouldn't know one from another.

INVESTIGATOR A: Okay.

LUNDEEN: Okay. And I also don't want to be accused of tampering with it.

INVESTIGATOR A: Okay.

LUNDEEN: Okay. But for the -- the drug screens, we'd asked Workers' Comp on the C-9s for permission and were denied most of the time.

INVESTIGATOR A: Okay.

LUNDEEN: We did a whole bunch of them up at the Plymouth office when we opened that office a year or so ago for all payer types, and Ameritox didn't get paid very well and they're kind of pissy about it, and -- but we still -- we'll send people

out from time to time with stuff. But, generally, before you get to that point * * * you've got a tip-off call. We have an honor system with our patients.

INVESTIGATOR A: Okay.

LUNDEEN: If you -- If you know of something that I need to know about, I find out you knew and didn't -- you're out. So it's, they drop the dime on each other all the time. * * * The problem is if there's a domestic quarrel, they'll -- they'll lie about each other.

INVESTIGATOR A: Yeah.

LUNDEEN: And they're -- they're both out. But we'd rather err on the side of kicking them out than * * * keeping them. So we're -- we're real strict about that if they have any unusual behavior like calling early, or my dog ate it, or it went down the toilet, or it went in the sink. It's like, your drug contract said don't even ask. You're fired. You're done.

INVESTIGATOR A: Okay.

LUNDEEN: I'm not in it for the money. We run it strict.

* * *

INVESTIGATOR A: What labs do you use for lab (unintelligible).

LUNDEEN: Ameritox. * * * I suppose there may have been some others from time to time like -- you know, like a local thing. But if -- if we're trying to do it to -- to discern if somebody acted up, no, we just get rid of them. So it would have been -- there would have been numerous instances where we would have run it [a lab test] if we wanted to keep them for the money * * * but we don't.

INVESTIGATOR A: Okay. So do you do all your patients, or just when they're -- * * * suspect?

LUNDEEN: We -- We put in our templates that they're going to have random drug tests approximately twice a year.

INVESTIGATOR A: Okay.

LUNDEEN: But, generally, by the time we're -- think this guy needs a drug test, we get rid of them. * * * So we do drug tests, but we do more pruning than we do drug tests.

I -- I think that's more final because they don't come back. They don't get another chance.

INVESTIGATOR A: So you -- you do have patients on a drug contract or pain contract?

LUNDEEN: Oh, yeah.

INVESTIGATOR A: And any violations of that –

LUNDEEN: Any.

INVESTIGATOR A: Okay.

LUNDEEN: No chances. * * * Zero.

INVESTIGATOR A: Okay. Any -- Any new patients that -- that you have coming in, do you do any urine screens for that -- during that prescreening process, or how do you –

LUNDEEN: The prescreening process here? We get their -- We try to get their records. * * * We have them fill out all sorts of forms to us. If there's anything we don't like, we just don't need to see the person.

INVESTIGATOR A: Okay.

LUNDEEN: But if it looks like something that's pretty reasonable, we get them on board. Then we want to use the OARRS thing. We've been using OARRS. We overutilized it and they shut us off. Overutilization. We're not allowed to use it to prescreen patient applicants. You have to have them as a patient before you're allowed to use it. Did you realize that? They shut us down for -- for using it as a screening tool for new applicants of patients to the practice.

* * *

We got a new * * * password; I need to get re-logged back in. But we were -- what we were doing, we were checking all of our patients pretty frequently. * * *

If they went to dentist and had, you know, four Percocets because they had a tooth pulled, that was one thing. They're going to another doctor, got 120 of something * * * they're done. I don't even need an explanation. They're done.

INVESTIGATOR A: Okay.

LUNDEEN: We were looking at people that were prospective patients, they had multiple pharmacies, multiple doctors, no. They had took Suboxone, no. Methadone, yes, because it's cheap and it's effective for pain control and Medicaid -- it keeps Medicaid's cost down. I don't look at that as an indicator of heroin use like I do Suboxone.

INVESTIGATOR A: Right.

LUNDEEN: So a Suboxone patient, no.

INVESTIGATOR A: Okay. Do you ever presign a prescription blank to keep -- like sign a pack of them the day as you're going to (unintelligible)?

LUNDEEN: I don't have a prescription blank. We print them fresh * * * off the laser printer. If I have to preprint the days for the next day because there isn't a printer working at that location, they're not signed.

INVESTIGATOR A: Okay. But you can give me -- They're not signed, but you can print them off, that way you can take it because there's no printer in shop A or something that --

LUNDEEN: Yeah. * * * And I'll sign them if the patient shows up, if I'm going to hand them to him directly. You can't send in a proxy to pick up scripts. * * * Tell them, "Sorry, can't do that. * * * Got to see the bod."

INVESTIGATOR A: Have you ever prescribed anybody that you knew had a drug-related criminal conviction?

LUNDEEN: No.* * * No. I've kicked out a lot of people when I found that out. Dr. [name omitted] had a lot of them that -- that he knew of that he had wrote in the chart he scolded them, he scolded them and he scolded them. Well, the State Medical Board took him out of business.

* * *

LUNDEEN: And they [the patients] have to sign in, so if I'm audited, you'll find the signature. Hope to God they do it because I don't look till after the day's gone if I have enough signatures to match up. * * * But, generally, they're pretty good about it. * * * I don't call them like cattle call, come in, you know, you push this one out of the way, you can get in and be seen.

* * *

LUNDEEN: And even though they're scheduled at a certain time doesn't mean they're going to get in then. * * * We tend -- tend to run an hour-and-a-half behind. * * * And that's not because I started an hour-and-a-half late. It's because everybody wants an 8:00 o'clock appointment.

INVESTIGATOR A: Right.

LUNDEEN: So I -- We pack them in. We pack them in, pack them in, and they get seen as they get seen.

INVESTIGATOR A: Okay.

LUNDEEN: And all this happened [the arrival of investigators] at the hump of everybody coming in for the morning when we were an hour-and-a-half behind. * * * It looked terrible. But we have plenty of seating. It's a nice, clean environment. We try to do a good job. They all insist on being morning patients so they try to be.

INVESTIGATOR B: How many seats do you have here?

LUNDEEN: (Unintelligible) that will hold a couple. That's for fat people. We have some that, you know -- Unfortunately, you get some that you don't want to give any pills to at all, but they got pain and they got a bad back or a rotten knee. If you're 600 pounds, you might have a bad knee. I suppose you probably see 25 people.

INVESTIGATOR A: Okay. Okay. So we -- when you see the patient, where do you see them at from here? (Unintelligible)?

LUNDEEN: **They come in the office and sit in the chair and I watch how they ambulate.**

INVESTIGATOR A: Okay.

LUNDEEN: And I have them tiptoe around in there, have them bend. If I need to, for some of them, I have -- clear off the exam table and have them sit up there. But there's hardly a need, the things I can't do standing, ambulatory, or sitting. It's the type of their injuries.

INVESTIGATOR A: Okay.

LUNDEEN: This isn't a ped's practice. This -- I mean, this -- this isn't a general practice.

INVESTIGATOR A: Uh-huh.

LUNDEEN: Very specialized. Very tailored to orthopedic/neurology problems. And all the depression and anxiety, erectile dysfunction, bowel dysfunction, all the other things that go along with it.

* * *

INVESTIGATOR B: Okay. Why didn't you accept or -- or bill Medicaid instead of making the patients pay cash?

LUNDEEN: You would have to give me a specific instance because I would rather bill Medicaid for them.

INVESTIGATOR B: Okay.

LUNDEEN: Yeah. No. No, that -- it's -- it's not one of those -- we're -- we're -- we're trying to accommodate these people with -- with whatever they have.

INVESTIGATOR B: Uh-huh.

LUNDEEN: But if -- There was a time when it was we didn't take any Medicaid or Medicare private insurance, just a bunch of hassle, and now I'm starting to remember what all the hassle was about. * * *

* * *

* * * [W]e -- we gave away tremendous amounts of free service.

* * *

INVESTIGATOR B: (Unintelligible) so are all your charts electronic?

LUNDEEN: Mostly.

INVESTIGATOR B: Mostly.

LUNDEEN: I mean, there's -- we have are 2 million sheets of paper in the practice, and everybody's got a folder somewhere and some stuff like work in progress that may have (unintelligible) the fax and (unintelligible) do this and it will go in the to-be-filed thing and -- but we try to be.

* * *

INVESTIGATOR B: So when you do your charting, you said you have your day -- I think you called them day sheets?

LUNDEEN: My day sheet of who should come in, in what order.

INVESTIGATOR B: Okay.

LUNDEEN: And I have some little bits -- bits of information about the person on there. And then I have -- If they -- they're an established patient, then I have a semblance of their previous note – with today's date and office location up here that I have to confirm or change if they don't come in, but they come in tomorrow in Springfield or sometime. And then -- So I have those sheets. And -- But if they're brand new, I don't have a sheet like that. So I have to make other handwritten notes, or type in the note myself, or dictate it, or * * * whatever I would do. So noting is done 99 percent contemporaneously on these templates * * * or by typing it in. Very little loose ends other than that, but (unintelligible) loose ends are loose ends. But the vast majority, 99 percent of the stuff is done as we go along.[138]

INVESTIGATOR B: Okay. So, I mean, you have a sheet with John Doe's patient information since he's been an established patient * * * and you make notes on that sheet for that day's office visit, you know, what -- if any changes or any –

LUNDEEN: Yeah. All -- if -- If the straight-leg raising on the left was 30 degrees last time and it's 15 degrees today, I'll circle the "30," put "15" next to it.

INVESTIGATOR B: Okay.

LUNDEEN: If it's still 30, I'll circle the "30," and I don't write a number next to it. My staff knows how to build the -- the new note.

INVESTIGATOR B: Okay. And then you -- how do you get those sheets to your staff? Do you drop them off or –

LUNDEEN: Drop them off, fax, do whatever I have to do to get them to them. * * * Sometimes I have to enter them myself.

INVESTIGATOR B: Okay. * * * So, I mean, if you get a new patient, you don't have that sheet so you just -- do you have a form you document it on?

LUNDEEN: Well, we have a -- We have some sort of a manila envelope with

[138] The investigator said "okay" several times during this explanation by Dr. Lundeen, and the Hearing Examiner removed them from this quotation.

their outside records ** all the papers they've filled out.

UNIDENTIFIED SPEAKER: Okay. So you make some kind of documentation and then take that in to the (unintelligible).

LUNDEEN: And then if I have a printer there so I can print prescriptions, I could do it that day.* * * If I don't, then I write down what I'm going to prescribe and what quantities and frequencies, and refills, if any. And double-check their mailing address.

Then I would go back in the office, another office, and do that, send it to them in an envelope so they could then take those to the -- to the drugstore. * * *

INVESTIGATOR A: Okay.

INVESTIGATOR B: So you don't bring any paper charts or any charts here with you?

LUNDEEN: I brought one today because there was somebody that was new to be seen here today.

* * *

INVESTIGATOR B: So how would you -- If you had a new patient, how would you get them to sign a pain contract?

LUNDEEN: They sign it in advance.

INVESTIGATOR B: Okay.

LUNDEEN: Yeah. I have (unintelligible) I have that. I had a -- I had a book in there today but, I mean, I have whatever is in this packet. There's the approval to be seen by Workers' Comp. * * * There's a printout of some demographics on them. Printout from the attorney. Some of these Workers' Comps are attorney based.

He's a wannabe. He's a referral from [name omitted]. * * * Guy's rationale was the last doctor wasn't doing enough for him. Doesn't tell me anything, but it raises my antenna a notch.

And then there are the forms with information and numbers and * * * more information. * * * Here's a pain contract. We've got a photo ID of them (unintelligible). So we really try to document the hell out of anybody that wants to come in, get * * * old records, have them fill out lots of things.

INVESTIGATOR A: There was something here, (unintelligible) on this last form here, "I understand that if I do not comply with this agreement, I will -- I may be terminated as a patient from the Lundeen Physical Medical without 30 days notice."

LUNDEEN: Right. Because, normally, the Board requires 30 days written notice

to somebody. We're telling them you got your 30 days notice, it's today, your next appointment is not for a month. If you ever screw up, you're out. You've -- Here, you've got your 30-day notice."

INVESTIGATOR A: So you don't actually -- you don't actually do an actual notice when they're -- when they're terminated?

LUNDEEN: Oh, sometimes we do. Sometimes we even -- depending on the reason. And it may be * * * that maybe we had to try real hard to get them into a surgeon, finally got them an appointment, they no-showed the surgeon.

INVESTIGATOR A: Okay.

LUNDEEN: Well, we'll terminate them for -- for not maintaining a treatment regimen, but we might let them have another set of scripts during that 30 days.

INVESTIGATOR A: Okay.

LUNDEEN: Okay. Try to be real reasonable about this, but not soft.

INVESTIGATOR A: Uh-huh. Okay.

LUNDEEN: Appropriate for the situation. * * * We do send out others. We send out termination letters.

INVESTIGATOR A: Okay.

LUNDEEN: But they're told in -- up front, if you violate these, consider you -- that you had 30-day notice whether or not you -- because most of these people say they don't get it. And we're not going to send it certified because they're not going to accept the envelope. We know that game, you know.

I don't know what the requirement is to prove service that you got the 30-day notice to the patient. We call them. We document it in the computer they were called. You're terminated. Under many circumstances, we allow them medicines for 30 days.

INVESTIGATOR A: Okay.

LUNDEEN: But not if it's under -- doing something where they're selling their drugs. We're not going to do that because, obviously, they didn't need them, right? Or as -- not as much as they needed the money from them.

INVESTIGATOR B: What do you normally prescribe to your patients?

* * *

LUNDEEN: I mean, there's -- I mean -- throughout all of my patients they may be treated for anxiety, depression, erectile dysfunction, gallbladder disorders, spasms, sleep disorders, pain, seizures, okay, it's not -- this is -- isn't just a pain clinic here.

* * *

INVESTIGATOR B: So I'm talking about a Schedule II, III or IV narcotic. What do you normally prescribe.

LUNDEEN: All right. Darvocets were wonderful until they were found to be a dangerous drug after 60 years so they could make room for new drugs. That was a nice one.

* * *

LUNDEEN: Darvocet and wygesic are gone. Their -- FDA won't allow them. Those are gone. Which is really sad because the next step up from -- That was a Class IV. The next step up is Class III, which is the hydrocodones. And they make you alert. Well, Darvocets neither made you tired nor alert, but . . .

It was for LOLs, little old ladies, who needed some help, or people who are a little bit older, needed just a modest -- a modest pain medication. That's not an option now. And the Ultram makes a lot of them sick. So * * * we haven't found a good substitute for Darvocet. So I've had to bump them up from Class IV to Class III to the 5 milligram Norco.

Most people with enough chronic pain, with enough surgeries, have to be on generic Percocet. And it's usually a 10 milligram, it's usually three or four times a day. I try not to be too narrow in my prescribing habits. I try to tailor to the person to what has worked before in reasonable doses for the right diagnosis, symptoms, to consideration of cost for people paying the bills.

That's very important because I don't want to be a thorn in anybody's butt. There's some real expensive things I could try to prior auth. We try to avoid prior auths to all providers. * * * Okay. I have drug reps begging me to prior auth their products. No. There are other alternatives. * * *

So I can write a report on the computer and it shows me that about -- of my 7- 800 patients that we have, typically half of them are seen once a month. The typical reason for that is it's Class II [the drug the patient is receiving]. * * *

* * *

It's -- it's a monthly visit. And I don't do 30-day intervals because we have seven-day weeks, four weeks is a month. It's not because I'm trying to get a -- squeeze in the 13th visit in the year. It's to offer it in 30-day intervals on appointments. I mean, it's just logistically too difficult.

So about half the patients are -- are monthly because they're on a Schedule II.

* * *

LUNDEEN: I do clinical research. I do computerization. I am such an outlier, I must look like a pterodactyl flying around where the rest are robins. Who the hell is this guy?

INVESTIGATOR B: Okay. * * *

> LUNDEEN: All right. I -- I mean, I'm happy to answer anything that you want. I'm proud of my work, I'm proud of my staff, and I'm proud of everything in our operation. And I apologize to whoever I need to apologize for seeming so absurd. This certainly wouldn't have happened unless I looked like an absurdity.
>
> * * *
>
> LUNDEEN: * * * I'm proud of my work. I do a good job. I do a good legal job.

(St. Ex. 34A, emphasis added)

Dr. Cunningham's Testimony Regarding Dr. Lundeen's Interview Statements

678. Dr. Cunningham testified that it was not a violation of the standard of care to have a medical practice with 12 different locations. Further, it was not a violation of the standard of care for Dr. Lundeen to state that he was very strict in maintaining his practice. Dr. Cunningham opined that Dr. Lundeen's statement of running the "tightest ship" and being proud of his practice was a legitimate goal and statement, but that "as far as his medications are concerned, his records don't reflect that." (Tr. at 1215-1216)

679. Dr. Cunningham testified that he was not rendering an opinion on the following matters but simply describing what Dr. Lundeen had said:

- that Dr. Lundeen said that would see 90 patients, by himself, working from 8 a.m. to 7 p.m. without staff;
- that Dr. Lundeen said that he had a staff of seven or eight people in locations around the state who perform administrative services;
- that Dr. Lundeen said that about 10% of Dr. Lundeen's patients pay in cash; and
- that Dr. Lundeen described his practice as "occ med, industrial med," as well as "office orthopedics" and "office neurology." (Tr. at 1217-1219, 1246-1247)

680. Dr. Cunningham also testified with respect to his written report that Dr. Lundeen had made "medically provocative statements" about his physical examinations. Dr. Cunningham explained that he was referring to statements made by Dr. Lundeen that he could take a blood pressure by feeling the pulse and could evaluate a bad intervertebral disc by how a person walks and on the basis of a stated history. Dr. Cunningham testified that such statements are a violation of the standard of care if Dr. Lundeen believes them to be true and is "diagnosing and treating people on that basis, yes." (Tr. at 1219-1225)[139]

681. Dr. Cunningham also testified in regard to the process for getting approval from the BWC for diagnostic tests and whether it is time-consuming or difficult to obtain such approval.

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[139] The Hearing Examiner notes that Dr. Lundeen's statements, in and of themselves, do not constitute a violation of the standard of care. The State's burden of proof under R.C. 4731.22(B) requires the State to prove an actual occurrence of substandard care for an actual patient, that is, proof of actual care that did not comply with, or departed from, the minimal standard of care.

He agreed that it could take much longer than 21 days and that he had seen instances of appeals taking more than a year. He agreed that this is especially applicable in older claims when BWC claimants have been found to be permanently and totally disabled. (Tr. at 1226-1228)

682. Dr. Cunningham also commented on Dr. Lundeen's statement that he does not document "extraneous things," that is, medical issues unrelated to the BWC claim allowances. Dr. Cunningham testified that the lack of documentation of "extraneous things" is a violation of the standard of care if Dr. Lundeen is treating those things and not documenting it. (Tr. at 1244-1246)

683. In addition, Dr. Cunningham was asked about Dr. Lundeen's statement that he has "zero tolerance" for individuals who violate his pain contracts. Dr. Cunningham testified that it would be a good thing, "if he were doing it." Dr. Cunningham acknowledged, however, that he does not have information regarding the number of patients that Dr. Lundeen has discharged from his practice in the last year. (Tr. at 1248)

684. Dr. Cunningham stated that he did not render an opinion on, accepting patients from out of state. Further, he does not have a concern with Dr. Lundeen's choosing to treat "chronic patients." (Tr. at 1249-1250)

685. In addition, Dr. Cunningham testified as follows with regard to a statement by Dr. Lundeen regarding his taking of the blood pressure of patients whose BWC claims are allowed for a back condition:

> Q. Another statement of Dr. Lundeen in the audio that you listened to said something to the effect of, talking about, what Workers' Comp would pay for, saying they don't pay for a blood pressure, they don't pay for a back exam, so we're not monitoring something that we're not paid for.
>
> If Dr. Lundeen is treating a patient for hypertension, would he be required monitor the blood pressure, even if BWC or whatever the – is not paying for it?
>
> A. Doesn't matter who's paying for or not paying for blood pressure management, I think it would be below the standard not to take a blood pressure with each visit.
>
> Q. And he also -- Dr. Lundeen also made a statement in that interview that you can tell by palpation, by feeling the pulse, if someone has hypertension that is significant. Would you agree with that statement?
>
> A. I would say in the vast majority of cases, no. I would think that if you had very severe hypertension, you might be able to say, well, this person's blood pressure is up because the pulse is really, really strong. But other than that, I would say that's not a -- I don't think that's a valid statement.

Q. And if it were -- you said if it were very, very high, you could possibly feel it by palpation. Could a person have hypertension that is -- that needs to be treated that would be lower than the point where you would likely be able to feel it by palpation?

* * *

A. The answer is yes.

(Tr. at 1126-1127)

686. In addition, Dr. Cunningham was asked about Dr. Lundeen's statements that he was an astute diagnostician and that he could tell whether a disc was bad by asking patients about their bowel and bladder system, erectile dysfunction, which muscle groups cramped, and watching them walk, and seeing whether they could walk in their heels and toes. Dr. Cunningham testified that he did not agree that a physician "can tell what disc is bad by asking those questions." (Tr. at 1123-1124) As to what the standard of care requires, Dr. Cunningham testified:

Q. And is it a violation of the standard of care to make that determination based on interviews with the patients, as opposed to diagnostic testing?

A. If you're going to treat people for a specific spinal diagnosis, a history is important, physical examination is important, but diagnostic testing is most important.

Q. And is it the standard of care to get – to obtain those diagnostic tests when making that type of diagnosis?

A. If you were to treat someone for a diagnosed, quote-unquote, structural abnormality of the spine, you can't do that on the basis of history and physical examination alone, in my opinion.

Q. When Dr. Lundeen made a reference to the – a disk being bad, are there multiple conditions that can relate to a disk?

A. Yes, many things can happen to the disk.

Q. Could you name some examples?

A. One, degeneration; one, rupture, herniated disk; you can have an infection of the disk; you can have a tumor, malignancies of the -- involving the spine or the disk. You can have a fracture in your -- you know, the interspace of the disk, within the interspace. You can have instability of the spine – * * * You can have a fracture which injures the – injures the intervertebral space in the disk. You can have instability of the spine, which can injure the disk. And then with newer imaging studies, we now know the disk can just be torn without being ruptured.

Q. And would a physician be able to determine which of those many problems a person–even if they could determine the location of where the problem was, could they determine which of these problems was an issue by reviewing the things that Dr. Lundeen indicated in the statement that I summarized for you?

A. Not in my opinion.

Q. And would it be a violation of the standard of care to do that?

A. Yes, in my opinion.

(Tr. at 1124-1126)

Conditions in Dr. Lundeen's Plymouth Office As Shown on Video-Recording

Testimony of the Videographer

687. Jeffrey Adams, a BWC employee, testified that he had participated in the investigation of Dr. Lundeen's office at 26 Sandusky Street in Plymouth, Ohio, in March 2011. He stated that he was part of a team executing a search warrant. Mr. Adams explained that his role was to take photos, make a sketch of the general layout, and make a video-recording of the premises before and after the search [hereinafter the "video"]. He was not looking for any particular items but was simply making a recording. (Tr. at 631-634, 656-660, 669-670, 690-698)

688. Mr. Adams stated that the primary purpose of creating the video-recording was to show that the investigators did not "go in and trash the place." He explained that he takes an "entry video" before the team goes in, to show the condition before the search, and he takes an "exit video" to show the condition after the search. (Tr. at 648-649, 670)

689. Mr. Adams explained the sequence of events: first, officers of the State Highway Patrol entered Dr. Lundeen's office with the search warrant and cleared the premises, requiring anyone present to leave; next, Mr. Adams and an evidence technician entered the premises, labeled all the rooms, and recorded the entry video; and then the investigators entered to commence the search. (Tr. at 657-662, 698-701, 719-720, 766)

690. Mr. Adams stated that the investigative team had thought that there was a woman in the building due to a car in the lot behind the building, but it turned out that no one was inside, and the Highway Patrol had to break in the door. He testified that he had no knowledge as to whether the areas actually searched had constituted two addresses on Sandusky Street, and that he had simply assumed that the areas searched were part of 26 Sandusky Street. (Tr. at 698-699, 707, 712-713, 730-735)

691. Mr. Adams testified that State's Exhibit 36 consists of several drawings he had made to show the general layout of the rooms that are shown in the video. He sketched the layout by hand at

the site and later used computer software to make final drawings. However, Mr. Adams made clear that the different rooms and floors shown in his drawings are not drawn to scale, and the areas were not measured, but that his drawings merely show the general relationship and location of the rooms and floors. Some furniture is shown in his drawings but not all. Mr. Adams noted that the different drawings are individually on different scales from each other, so that the same item shown on one page will be a very different size on the next page. Further, Mr. Adams noted that he labeled each space on the drawings by letter, and also placed an alphabetic sign on the wall of each room videotaped, so that a viewer of the video can see the sign "A" in a room shown on the video and then refer to the area labeled "A" on the drawings. In addition, the identification of the rooms by letter allows the persons packing the seized evidence to note the location from which the items were taken. (Tr. at 632-649, 723-730, 736, 738)

692. Mr. Adams also provided a written key or table of contents to the video, which states the room letter that is shown on each of the numbered files on the disk's numerical list of files. (Tr. at 686, St. Ex. 33A)

693. Among other things, Mr. Adams testified that there was a separate unit on the second floor. In order to access that separate unit, which is shown on page 4 of his drawings, he had to exit the rear door of the office, and then walk outdoors to an external stairway that led to a locked door of separate unit on the second floor. It was not possible to enter the separate, second-floor unit from the medical office, although there were stairs in the first-floor office that led up to a residential area on the second floor. Similarly, it was necessary to leave the office, to exit the building, to enter the basement area. (Tr. at 638-639, 643-647, 705)

694. Mr. Adams explained why there are so many separate "files" on the video disk. He explained that his digital-recording equipment makes a new "file" every time he stops shooting. Formerly, when using videotape, the tape would provide one continuous visual presentation, but the digital format breaks the recording into many files. He explained that he stopped shooting every time he finished a room. (Tr. at 662-663)

695. Mr. Adams further explained that there were problems with darkness when he recorded the exit video, in that there was no electricity in certain areas on the second floor, and there was a back bedroom with the window-blinds nailed to the windowsill and no lighting fixtures, so that lighting had to be provided by the local fire department.[140] (Tr. at 663-665, 671-673, 639-640, 742)

696. Mr. Adams also testified that

- some of the areas that he video-recorded appeared to be storage areas, and that these storages areas consisted of Rooms N, O, P, Q, R, S and T, which were the rooms without electricity (Tr. at 739-741);

[140] Dr. Lundeen's business stationery in 2010 and 2011 lists his Plymouth office as being located at 26 Sandusky Street, First Floor, Plymouth, OH 44865. See, e.g., (St. Ex. 10 at 4, St. Ex. 11 at 1)

- Rooms U and V appeared to be used only for the furnace and further storage (Tr. at 741);
- the loose wires, missing drywall, open ceiling areas, and missing ceiling lights were observed on the second floor in the "attic" area, which was the area without electricity (Tr. at 749);
- there was only one mattress on the premises, and it was on the second floor of the building, in the back bedroom, which was Room M (Tr. at 749-750);
- in his drawings, he labeled Rooms C and L as bathrooms because there was a sink and a commode in each of them, and he acknowledged that he had not checked to see whether the sink and commode were in working order (Tr. at 751-752);
- in his drawings, he labeled Room A as a "waiting room," and labeled Room F, a room with wall charts and an exam table, as "Lundeen office," based on his assumptions regarding the rooms' uses (Tr. at 676-741; St. Ex. 36 at 2);
- he did not personally see any "medical equipment" being removed from the premises (Tr. at 682);
- when making the videos, he did not open drawers, cupboards or closets, and that the videos do not show the contents of drawers, cupboards, or closets (Tr. at 721-722);
- the floors were hardwood floors, uncarpeted, except for the basement, which had a concrete floor (Tr. at 750-751);
- after making the entry video and drawing his sketch, he had assisted in searching some of the rooms and was therefore familiar with the process for labeling the contents of the boxes of seized items and for creating the inventory logs (Tr. at 743-748); and
- the two videos were not recorded in the same order—the same sequence of rooms and stairs—because the lighting problem had to be resolved and there were workers still busy in Room D after other areas had been vacated. (Tr. at 677).

Dr. Cunningham's Testimony Regarding the DVD and Standards for Medical Offices

697. Dr. Cunningham testified that he had viewed the DVD of Dr. Lundeen's medical office.[141] He stated that what he recalled was that there were boxes, mostly cardboard boxes, that were stacked on top of each other. (Tr. at 1114, 1165-1166)

698. However, Dr. Cunningham acknowledged that he was not told that the DVD shows more than Dr. Lundeen's "medical office" at the search location. He was not informed that the DVD also shows storage rooms and a personal residence. He testified that he was told only that the video showed Dr. Lundeen's "Plymouth office." Dr. Cunningham agreed that, if the video shows "areas not included in his [Dr. Lundeen's] medical office," it could affect

[141] Dr. Cunningham also submitted a written commentary on the DVD, dated May 2, 2011, in which he stated that the office environment at the Plymouth, Ohio facility constitutes multiple departure from, or failures to confirm to, the minimal standards of care. (St. Ex. 30 at 4; Tr. at 1204-1213)

his opinion of the conditions in the office. Dr. Cunningham testified that he was not familiar with "the medical records storage rooms" that were shown on the DVD. He agreed that a physician who had been in practice a long time will have lot of old records to store, and that it would not be unusual for Dr. Lundeen to have storage rooms containing old documents. He further agreed that patients are not allowed in medical-records storage areas under HIPAA standards, and that only the physician and staff are allowed to enter areas where medical records are stored. (Tr. at 1188-1193)

699. Dr. Cunningham testified that it would be a violation of the standard of care for Dr. Lundeen, with his type of practice, to maintain medical offices where he sees patients without a scale to measure weight and height. He also testified that, if a physician is going to treat people with high blood pressure and cardiovascular disease, then he needs to have a blood pressure cuff. He noted that Dr. Lundeen had treated patients for high blood pressure and other cardiac conditions. (Tr. at 1118-1121)

700. In addition, Dr. Cunningham testified that he had listened to Dr. Lundeen's recorded interview in which Dr. Lundeen had stated that he "sometimes" had a blood-pressure cuff with him. Dr. Cunningham testified that, if the physician "is going to see someone with high blood pressure and treat them for hypertension," a blood-pressure measurement is needed at each visit, and, even if the physician "doesn't know whether or not he's going to see a hypertensive on that particular day, "he going to have to have the * * * blood-pressure cuff with him every day." (Tr. at 1112)

701. On cross-examination, Dr. Cunningham agreed that patients' blood pressures were included in some of Dr. Lundeen's progress notes, so that Dr. Lundeen probably had a blood pressure cuff. He further agreed that a blood pressure cuff could have been in Dr. Lundeen's pocket, briefcase, cupboard, drawer or closet, and not visible on the DVD. (Tr. at 1209)

702. In addition, with regard to other equipment for a medical office, Dr. Cunningham testified: "I don't think you can practice primary care without an examining table." With respect to whether it is necessary to have paper to cover the table, Dr. Cunningham stated that it was necessary to meet the requirements for cleanliness, and that one way of doing that is to use fresh paper to cover the table for every patient. He stated that the standard is that the physician should have a "clean and sanitary" office because "you're asking people to disrobe and get on various pieces of equipment and so forth." He further testified: "I don't know how you can practice primary care without – without doing that [asking patients to disrobe] at least on occasion. (Tr. at 1118-1119)

703. Dr. Cunningham testified further about the standard for examination tables:

> Q. If they -- If a patient has clothes on, doesn't disrobe, and sits on the examination table, could that still be unsanitary?

A. I'll give you an example. If I am seeing a person with a hand and wrist injury, I will not ask them to take their clothes off, but I will ask them to sit on the examining table because it's very difficult to examine people when they're sitting in a chair.

But I'll just answer the question. In most cases, I won't even -- Can you ask your question again? I don't want to -- I don't want to mislead anybody. I'm sorry.

* * * (Question read back as requested.)

THE WITNESS: I guess it's possible.

Q. So is it your opinion -- is -- Does the standard of care require the exam table to have paper on it for the person practicing in – in occupational health/primary care?

A. I don't know about the paper being on it, but it needs to be sanitary; it needs to be cleaned.

(Tr. at 1120-1121)

704. On cross-examination, Dr. Cunningham agreed that, if "a patient comes in fully clothed and sits down on a chair, it is just about as much risk of sanitation risk as sitting on a table." He further agreed that physicians do not have to cover the chair in which a patient has sat, every time a patient leaves. (Tr. at 1208-1209)

705. With regard to his opinion regarding tools for conducting physical examinations that "should be available to a physician to appropriately practice occupational medicine," Dr. Cunningham testified:

> I think an ophthalmoscope, an otoscope; look in the eyes and ears, nose and throat. Probably need a flashlight, stethoscope, blood pressure cuff. A thing called a goniometer, there's several sizes, for measuring ranges of motion. Tape measure, reflex hammer, tuning fork.

(Tr. at 1136) He explained that a tuning fork allows a quick test to assess the cause of a hearing loss (bone conduction versus air conduction) and to do a neurologic test for vibration. (Tr. at 1136-1137)

706. Dr. Cunningham also testified that "you need to have some method to test sensation." He explained that it is no longer acceptable to stick pins into people to test sensation, due to pathogen standards, and he uses a paperclip or plastic toothpick. He opined that an instrument to measure grip strength, while often used, is not required. However, at least one goniometer to measure range of motion is required for practicing occupational medicine. (Tr. at 1138-1139)

707. With regard to what is shown on the DVD, Dr. Cunningham testified that he did not see in Dr. Lundeen's office an otoscope, ophthalmoscope, or tuning fork. (Tr. at 1140)

708. However, in describing the things shown on the DVD, Dr. Cunningham acknowledged that the contents of every cabinet and drawer are not shown, although there were some partially open drawers and "a couple of closets" shown. He saw one examining table. The DVD shows a "medical office desk and chairs," a waiting room, a file room, and there was a bathroom or bathrooms with a sink that could be used for washing hands. Dr. Cunningham agreed that otoscopes, ophthalmoscopes, penlight flashlights, sensory-testing tools, and measuring tapes can be quite small, small enough to fit into a drawer, pocket, briefcase, or box. The same is true of tuning forks, which are small. He agreed that it would *not* be a violation of the standard of care to keep such tools in a drawer, pocket, or briefcase. In addition, a goniometer could fit into a drawer. Further, Dr. Cunningham agreed that it was okay to keep tongue blades in an opaque container and that Dr. Lundeen might have kept his tongue blades in an opaque jar. Accordingly, Dr. Cunningham agreed that all these items could have been present in Dr. Lundeen's Plymouth office even if they are not readily visible on the DVD. (Tr. at 1194-1205, 1207, 1358)

709. Dr. Cunningham did not recall whether there was a scale shown in the DVD of Dr. Lundeen's office. (Tr. at 1358)

710. With regard to the hygiene requirements for clean hands, Dr. Cunningham testified that the medical standard of care requires the physician to have hand sanitizer or a sink to wash his or her hands. With respect to gloves, Dr. Cunningham testified that the "bloodborne pathogen standard" requires the use of gloves. Dr. Cunningham acknowledged that, if it is correct that Dr. Lundeen does not have people take their clothes off and does not do "open wound management," then that excuses him from using gloves, but it would not excuse him from using hand sanitizer or washing his hands between patients. (Tr. at 1122-1123)

711. Dr. Cunningham agreed on cross-examination that gloves are not usually necessary, routinely, "for doing seated exams." Further, he agreed that a box of gloves could be half the size of a small shoebox and could fit into a drawer, cupboard, or shoebox, and Dr. Lundeen could have had some gloves in his pocket. (Tr. at 1210-1211)

712. With regard to a strength meter, Dr. Cunningham testified that it fits into a case that is about as big as a 2.5 inch notebook, and would fit into a drawer or cupboard. It is used occasionally and need not be sitting out on the counter at all times, and having one is not required to meet the standard of care. (Tr. at 1212-1213)

713. In addition, Dr. Cunningham testified that he had not rendered an opinion regarding the following matters relating to Dr. Lundeen's office conditions as shown on the DVD: mattresses without sheets; open ceiling in areas or missing ceiling tiles; exposed walls, drywall, exposed insulation, or missing drywall; exposed wiring hanging loose from the

ceiling; ashtrays with cigarette butts, dirt, trash, or accumulated trash bags; unfinished floors in some areas; or peeling paint. (Tr. at 1204-1206)

Additional Testimony by Dr. Cunningham on Cross-Examination and Redirect Examination

714. Dr. Cunningham expressed criticism of sending out pain contracts in advance of the first visit, with the new-patient questionnaires. He testified that an "ideal" pain contract "is a face-to-face thing." However, he testified that it is *not* a violation of the standard of care to send the pain contract to the patient beforehand for signing and for the contract to be signed before the patient's first visit. Further, Dr. Cunningham acknowledged that he did not know whether Dr. Lundeen had talked with his patients about their pain contracts; however, Dr. Cunningham noted that Dr. Lundeen did not document such discussions in the patient-visit notes. (Tr. at 1169-1170)

715. Dr. Cunningham agreed that, although Dr. Lundeen did not identify the patients' then-current medications in the progress notes for the patient's initial visit, or discuss allergies in his progress notes for initial visits, it is true that such information was present in new-patient materials on file in his office, along with other information such as prior treatment. Dr. Cunningham agreed that, in some cases, the letters written by Dr. Lundeen to attorneys and other persons included an extensive review of prior treatment, surgeries, current conditions, and so forth, which demonstrated knowledge of prior care. However, Dr. Cunningham insisted that the omission of drug allergies and then-current medications from the electronic medical records for the initial visit constituted a violation of the standard of care. (Tr. at 1170-1174)

716. With regard to electronic medical records, Dr. Cunningham acknowledged that, to some extent, there's always going to be some amount of repetition and use of standard, "boilerplate" language. He testified that a physician's use of the same phrases over and over is not a violation of the standard of care and is appropriate. He also testified that using a template or a checklist format is not a violation of the standard of care. However, Dr. Cunningham objected to "a lot of the repetitive statements [that] weren't borne out by the remaining—remaining portion of the record." (Tr. at 1140-1141, 1204-1205, 1246)

717. Dr. Cunningham agreed that, when he listened to Dr. Lundeen's interview, his understanding was that all the patients had a chart somewhere in the practice other than the electronic medical records. He acknowledged that he had felt, upon reviewing Dr. Lundeen's EMRs in the spring of 2011, that there were additional medical records that he did not have. For example, Dr. Lundeen would refer to documents he had reviewed, and they were not in the records that Dr. Cunningham had received. When Dr. Lundeen received the additional records at the end of July 2011, there were in fact medical records he had not seen yet for Patient 1 through 26, such as pain contracts, which took care of one of his concerns about Dr. Lundeen's care. Dr. Cunningham acknowledged that he had not gone back and revised his original reports but had written an addendum report addressing the additional documents he had been given. (Tr. at 1347-1349)

718. With regard to his determination of the standard of care, Dr. Cunningham stated that he used several sources:

- The ACOEM guidelines. Dr. Cunningham testified that these are the only peer-reviewed practice guidelines for occupational medicine.
- Several other guidelines about treating and prescribing, including the Official Disability Guide that covers all practice areas. In his written reports on Patients 1 through 26, Dr. Cunningham had stated that Dr. Lundeen violated the ACOEM Guidelines and the Official Disability Guide.
- The practice of occupational medicine for more than 30 years, with many years reviewing peer-reviewed guidelines on a daily basis.
- The knowledge and experience gained from reviewing thousands of patient files for the BWC.
- The Medical Board's rules for intractable pain. A copy of these were provided to Dr. Cunningham in connection with the request to review Dr. Lundeen's materials for the Board. However, Dr. Cunningham declined to testify about what these rules require, stating that he did not have an independent recollection of what the rules require and that he was not familiar enough with them to talk about them, at a level of expertise, without having them in front of him.
- A brochure published by the Ohio Pain Initiative, which provided information regarding analgesic medications. However, Dr. Cunningham testified that he did not agree with all the statements and recommendations in the brochure.

(E.g., St. Ex. 30; Tr. at 1296, 1339-1343, 1393-1401, 1404, 1478-1479, 1517, 1528-1530, 1574-1578, 1592, 1597-1600)

719. Dr. Cunningham explained that a physician's increasing the dosage of narcotics is not, in and of itself, a violation of the standard of care. Increases of narcotics constitute a violation when there is no documented objective medical reason for the increase. He stated that there must be a documented change in medical status to justify the increase in narcotics. In addition, Dr. Cunningham testified that the occurrence of tolerance of medication does not, in and of itself, show a violation of the standard of care; the question is how the physician identifies the tolerance and addresses it. If the physician properly documents a need for more pain medication, then there is no violation of the standard of care. However, treatment of pain with controlled substances must be based on verifiable evidence. An "inappropriate" amount of narcotic is prescribed when there is no documented change in medical status to support the increasing level of narcotic medication. (Tr. at 1278-1282, 1312)

720. Dr. Cunningham illustrated: "If a person sprained their ankle 30 years ago, and their ankle hasn't changed, they don't have any arthritis, they don't have any swelling, they don't have any

limp, they don't have any problem with their ankle, but they are getting pain medicine for it, and their pain medicine levels are going up, and it's all attributed to the ankle, that's not medically supported, sir." He stated that if the patient asserts that the remote ankle sprain is so painful that narcotics are needed, then the physician must look for an explanation other than the remote ankle sprain. There may be a new medical condition in the area, or the person may need to be referred to an addictionologist. (Tr. at 1283, 1381)

721. Dr. Cunningham summarized that, when there is drug-seeking behavior or evidence of tolerance or addiction in a patient, the standard of care requires the physician to take the following steps, and he opined that Dr. Lundeen had not met the standard of care:

> A. I think the standard requires, first of all, discussing the situation with the patient. If there's drug-seeking behavior, confront a patient. They should be notified in writing, in my opinion, that they have been put on notice that they were in violation of the pain contract.
>
> The pain contract should be renewed if the physician wishes to continue caring for the patient. Many physicians will just discontinue caring for the patient at that point. And put them on random drug screening.
>
> Q. And would the standard of care require the physician to document that he had these discussions with the patient?
>
> A. Yes, in my opinion.
>
> Q. Did you see anything in the record to indicate that Dr. Lundeen addressed issues of possible addiction or drug-seeking in the records?
>
> A. No, he did not.

(Tr. at 1594-1595)

722. Dr. Cunningham generally agreed with the principle of titration of pain medication. (Tr. at 1417) However, in his experience, he has found that, after a few visits, the dose of pain medication remains "pretty stable over time." He testified that the medication "might change a little bit once in a while, but not on a monthly basis or even on a two- to three-month basis. It should be a rare event." When asked whether conditions of the back, knee and shoulder will deteriorate over time, Dr. Cunningham responded: "They can. They don't have to." He nonetheless opined that continued upward adjustments of pain medication for such conditions would be rare, and requires documentation to support it. (Tr. at 1418-1419)

723. Dr. Cunningham testified that, when he reviews BWC files, he does not "often" see increasing dosages of narcotics for well-established patients on permanent total disability [PTD], but he sees it "on occasion." He could not say whether it is common, but he agreed, "You do see it." Depending on the circumstances, it can be a violation of the standard of care. Dr. Cunningham testified that, when he has seen increasing doses of narcotics, he has sometimes recommended

to the BWC that the patient be referred to an addictionologist. He makes this recommendation about 3 to 5 times per year. (Tr. at 1375, 1381)

724. In addition, Dr. Cunningham discussed prescribing for "breakthrough" pain at greater length. He reiterated that none of Dr. Lundeen's prescriptions were for breakthrough pain, that is, to be taken "as needed" or "p.r.n." Dr. Lundeen's prescriptions instructed patients take the drug a specific number of times per day, such as once a day, four times a day, and so forth. Dr. Lundeen did not prescribe medications to be taken "p.r.n.," which means that he "did not prescribe any breakthrough pain doses," according to Dr. Cunningham. (Tr. at 1405-1406)

725. Dr. Cunningham testified that if the "rescue" doses for breakthrough pain are used more than 60 times per month, then the physician should consider whether the regular "round-the-clock" dosing is adequate and whether to increase the regular dosing and reduce the breakthrough dose. (Tr. at 1405-1406)

726. In addition, Dr. Cunningham's testimony on cross-examination and redirect examination included the following:

- He received additional documents at the end of July, and there was additional information for some patients, including the patient's height, weight, blood pressure, and drug allergies. (Tr. at 1270-1274)

- He did not see records establishing that any of Dr. Lundeen's patients have been arrested for drug diversion. He initially stated that he had not seen any "direct evidence" of diversion by Patients 1 through 26, but then he discussed the suicide-treatment records indicating that the patient had taken Patient 15's medications, which was "strong evidence" of diversion. (Tr. at 1274, 1607, 1612, 1616)

- He did not see documentary evidence of early refills for Dr. Lundeen's patients except for one that was understandable. (Tr. at 1275-1277)

- He acknowledged that patients had been told they would not get early refills or additional prescriptions; however, he insisted that Dr. Lundeen should have confronted the patient in each and every one of these incidents. (Tr. at 1298)

- He relied on Dr. Lundeen's own records in his Drug Utilization Report with regard to the medications that Dr. Lundeen prescribed, and with regard to doses and so forth of Dr. Lundeen's prescriptions; he did not review all the actual scripts from the pharmacies, although he did look at them. (Tr. at 1406-1408, 1607-1608)

- Dr. Cunningham has not conducted research on receptor binding, and is not familiar with Dr. Lundeen's research on receptor binding. (Tr. at 1415)

- Dr. Cunningham is not familiar with recent, peer-reviewed literature regarding the usefulness of pain contracts in identifying aberrant drug-related behaviors. He testified that pain contracts are not "required." (Tr. at 1314-1315, 1609)

- Dr. Cunningham is not familiar with literature regarding the use of Lidoderm for chronic-pain patients. (Tr. at 1372-1373)

- Prescribing Soma for more than three or four weeks after an injury or surgery is not a violation of the standard of care, and he agreed that he has seen where many physicians have prescribed Soma "for longer than two or three weeks." (Tr. at 1436, 1438)

- Dr. Cunningham does not have any peer-reviewed literature that shows patients who take Soma for "more than three or four weeks after an injury or surgery" are placed at "great risk" by that use of Soma.[142] (Tr. at 1439)

- He stated that "the use of muscle relaxants for the management of chronic musculoskeletal pain is not supported." He agreed that, when there are complaints of spasms "within a few weeks or * * * a few months, after an injury or surgery," a prescription for Soma would be appropriate if the practitioner performed an examination of the person's body and found spasms to be present, as opposed to relying on a patient's report of spasms. (Tr. at 1436-1438)

- Dr. Cunningham has seen instances where a physician had prescribed Soma or another muscle relaxant for more than three or four months. He nonetheless maintains that prescribing muscle relaxants such as Soma for more than three to four months is not supported, and prescribing Soma for a period of years is a violation of the standard of care. (Tr. at 1604, 1610)

- The maximum recommended daily dose of acetaminophen is a recommendation, and there is no recommended daily maximum for narcotics such as morphine and hydromorphone. (Tr. at 1312-1313, 1401, 1403)

- There is not a clinical test to measure the presence of pain or the absence of pain. (St. Ex. 1423)

- It is possible that a patient could have a needle EMG that does not show significant damage and the patient would still experience pain. (Tr. at 1425-1426)

- It is possible, when a patient reports that his/her narcotics were stolen and asks for more drugs, that the narcotics were actually stolen; however, the patient's report is still a "red flag" that the physician must consider and act upon. (Tr. at 1426, 1482)

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[142]This cross-examination did not address Dr. Cunningham's testimony on direct examination, which was that prescribing Soma for a period in excess of three *months*, or four months at the outside, was not appropriate. (E.g., (Tr. at 1592-1594)

- When a "red flag" is raised that suggests drug-seeking behavior, the standard of care requires the physician to evaluate the patient and determine whether a referral to an addictionologist is necessary; however, a referral to an addictionologist is not required for every patient, depending on the circumstances and the evaluation that the physician conducts. If a physician recognizes a problem regarding a patient's dependency, addiction, and tolerance, and documents it, Dr. Cunningham would not find a violation of the standard of care. (St. Ex. 1426-1429, 1462, 1484)

- When a pharmacist informs a physician that the physician's prescriptions "may exceed" the recommended daily dosage of acetaminophen, a physician is not required to change his or her prescribing. (Tr. at 1605-1606)

- It is possible that a physician will need to prescribe additional anti-anxiety medication over time to maintain a constant level of control. (Tr. at 1441)

- If a physician has thousands of patient files, and if only the files that show Valium-prescribing are selected, it could appear that the physician prescribes Valium to all of his patients. (Tr. at 1372)

- It is conceivable that a patient could experiencing atrophy in both lower limbs, such as where there are two separate processes going on; in that event, a comparison of the two limbs could be irrelevant. (Tr. at 1364-1366)

- The voluntary straight-leg-raising as performed by patients during Dr. Lundeen's visits is really subjective in nature, not objective. (Tr. at 1470)

- Dr. Cunningham acknowledged that the SLR test, when done with the physician moving the leg rather than the patient voluntarily raising the leg, can cause pain to the patient. In addition, the test could cause injury, but that would be rare. Also, like any other test, the SLR test has validity issues. (Tr. at 1363-1364)

- With regard to the standard of care for measuring blood pressure and height/weight, Dr. Lundeen testified that this information should be recorded during the initial visit and any time treatment is going to be changed. (Tr. at 1317-1318) However, Dr. Cunningham then agreed that, if Dr. Lundeen was not treating blood-pressure problems, a blood-pressure was not necessary every time the medication is changed. (Tr. at 1317-19)

727. In addition, Dr. Cunningham testified that each of the following things, in and of itself, would *not* constitute a violation of the standard of care:

- if Dr. Lundeen preprinted the prescriptions for the patients he was going to see, and then handed the prescription to the patient during the office visit (Tr. at 1355);

- if Dr. Lundeen's patients "sat in chairs" (Tr. at 1355);
- if Dr. Lundeen practiced medicine in Portsmouth for ten years (Tr. at 1355);
- if Dr. Lundeen had 12 offices, with Portsmouth being the busiest one (Tr. at 1355-1356)
- if Dr. Lundeen saw 90 patients in a day (Tr. at 1356); or
- if Dr. Lundeen accepted cash for his services (Tr. at 1247)

728. Dr. Cunningham agreed that, in his own medical practice, he focuses primarily on short-term care following an injury, with the goal being to get the person back to work. He does not have patients on PTD although he may have done so at one time. He agreed that he has been treating a "very different population" from the population that Dr. Lundeen treats. Dr. Cunningham stated that he is not a "pain management" specialist. However, he stated that he sees "patients with chronic pain every day almost" and has performed thousands of file reviews for the BWC, doing several hundred per year. He testified that, in his work, he sees the practice of pain specialists and what they do. (Tr. at 1350-1376, 1415-1432)

729. Dr. Cunningham testified that he himself does not ask patients to use pain scales to rate their pain from 1 to 10, although he knows that many practitioners use them. Instead, he asks the patient on the follow-up visit whether the pain medication provided adequate relief, and he will adjust the medication if needed. However, he stated that many of his patients do not want pain pills, and that he maintains his patients on Schedule III medications such as tramadol (Ultram) or Vicodin, and that he prescribes Schedule II narcotics only once or twice per year. He stated that most of his patients go back to work and that Schedule II medications would be inappropriate in the workplace, and his treatment usually lasts for only three to six weeks. (Tr. at 1349-1351, 1410-1413, 1418-1421)

730. Dr. Cunningham testified that he has not signed up to use the Ohio Automatic Rx Reporting System (OARRS) and has never used it. (Tr. at 1334) He further testified that he had not applied to be a "pain clinic" pursuant to the Board's rules under House Bill 93 nor applied with the Pharmacy Board to be a terminal distributor of dangerous drugs. Dr. Cunningham stated that he usually treats patients during the acute phase, while they are recovering from an injury and getting back to work, and that his patients typically receive pain medications for about three to six weeks after an injury or surgery. There are a few that are longer, but not for "months and years." When his patients go back to work, he releases them from his care and recommends that they return to their primary-care physician. Dr. Cunningham testified that he sometimes does continue to provide pain management for post-operative periods of recovery and therapy, which can last six months. Dr. Cunningham testified that he prescribes Schedule II drugs only once or twice per year, and that many of his patients do not want pain pills at all. He stated that the vast majority of his patients, more than half, receive only Tramadol or Vicodin. (Tr. at 1334-1336, 1349-1350, 1413-1418)

731. Dr. Cunningham stated that most of the PTD patients that he has examined for the BWC were people applying for PTD benefits, although he has sometimes examined people who are already on PTD, but it is a very low percentage. In addition, Dr. Cunningham performs file reviews for people who are on PTD. He stated that most of the patients have been "pretty stable as far as their medication is concerned." (Tr. at 1377-81, 1416)

732. Dr. Cunningham observed that many of the people who are applying for PTD, whose cases he has seen, are "chronic Schedule II users." (Tr. at 1414)

733. Dr. Cunningham testified that, when a patient (of the 26 patients identified in the Notice) was a BWC claimant, the diagnoses that Dr. Lundeen listed as his diagnoses were identical to the conditions allowed in the BWC claim. (Tr. at 1231)

734. Dr. Cunningham agreed that, once the BWC has approved a diagnosis, that diagnosis stays with the claimant for the entire length of the claim and the rest of their disability. He stated that some of the conditions are "self limiting" and had long ago resolved, even though the diagnosis is still listed in the claim. An example of this would be a diagnosis of "contusion" following an industrial injury. (Tr. at 1228-1234)

735. Dr. Cunningham agreed that, when he provides billing to the BWC, he provides a copy of his notes for each visit, which means that the BWC is aware of the care he provides. Further, he acknowledged that the BWC tries to scrutinize the care that is provided to injured workers, and that the BWC has peer-review committee that look at the care that is provided and determines whether it is appropriate for the allowed conditions, and that decide whether or not the BWC is going to pay for the treatment. Dr. Lundeen further acknowledged that these review committees often deny care because they believe it is inappropriate. Dr. Cunningham agreed that information about prescriptions is provided to the BWC and that prescriptions are reviewed in the peer-review system. However, he stated that denials are less frequent in medication issues, in that treatments are denied more frequently than medications. Twenty-three of the patients named in the Notice were BWC patients, and Dr. Cunningham stated that he "assumes" that, within the BWC, the treatment information for those 23 patients of Dr. Lundeen "would have been reviewed." (Tr. at 1234-1244)

736. At several points in his testimony, Dr. Cunningham indicated that billing the BWC for care that was not reasonably related to an allowed condition constituted or was part of a violation of the standard of *care*. Dr. Cunningham also indicated that increasing the pain medication was a reimbursement issue. (E.g., 1299, 1303-1304, 1309-1310, 1374, 1474, 1479-1480)

737. However, Dr. Cunningham later clarified that guidelines on reimbursement were not relevant. He stated that providing treatment for a non-allowed condition is appropriate as long as the care is not *stated* to be for an allowed condition. If the patient presents with the symptoms, then the patient should be treated. He agreed that the analysis of whether a procedure is within the medical standard of care is different from the analysis of whether a procedure is for an allowed

condition. Dr. Cunningham emphasized that, with the BWC patients, Dr. Lundeen said he was treating them only "for the allowed conditions, every time." He explained that he meant that prescribing is a violation if there is no explanation as to why that drug is being used for the stated condition. When Dr. Cunningham opined that the medication prescribed by Dr. Lundeen was not appropriate for an allowed condition, he intended to indicate that Dr. Lundeen did not establish that the medical was appropriate for the condition that Dr. Lundeen said he was treating with that medication. If Dr. Lundeen stated a diagnosis that was appropriate for the medication, then Dr. Lundeen was practicing within the standard of care. Conversely, when Dr. Lundeen prescribed a medication for bladder dysfunction without explaining why the bladder dysfunction was causally related to the diagnosed condition, or when Dr. Lundeen stated that the drug was to treat a condition that does not cause bladder dysfunction, then Dr. Lundeen was not practicing within the standard of care. As long as the stated diagnosis supports the prescription medication, Dr. Cunningham has no problem with the prescribing. (Tr. at 1298-1309)

738. In addition, Dr. Cunningham testified:

Q. * * * If Dr. Lundeen is not charged with inappropriate billing for these services, then your criticism of the physical examination no longer exists; is that correct? Because the only criticism you have is that it's not under the BWC claim allowances.

A. The criticism -- according to his records, those are the diagnoses he was treating this person for.

Q. Under BWC claim allowances; isn't that correct?

A. That's what he was determined to be treating this person for according to his record.

Q. So if he was treating them for the same diagnosis after the claim, it was okay, correct? * * * Your issue has been so far that it is a billing issue where we talk about BWC claim allowances.

A. Physical examination still is inappropriate for someone with low-back pain and lower -- and the diagnosis for which he was treating this individual, regardless of whether it was a BWC claim or not.

Q. But you didn't say it here [in your written report]. You said that the opinion you rendered for the Medical Board for us to review is related solely to whether or not these difficulties are under the Ohio BWC claim allowances; isn't that correct, sir? "Yes" or "no"?

A. That's what he says he's treating this person for, yes.

Q. And that's your opinion, that if it's a BWC claim, then it's a problem for you; isn't that correct?

A. Yes.

* * *

Once again, the fourth line down [in your written report], "Because they are not related in any way to the BWC claim allowances for which this individual was provided with various medications." Isn't that correct?

A. That's what it says.

Q. So that that's a billing issue about Ohio BWC claim allowances; isn't it correct?

A. In part. He also does not have any other diagnoses in his record to justify those medications.

* * *

Q. [You stated in your report:] "There are multiple discussions early in the file of urinary bladder difficulties which are not related to BWC claim allowances." Isn't it true that your discussion of whether or not it should be within a BWC claim allowance is solely related to billing?

A. He doesn't have any other diagnosis in his record, because he says he's treating this person for -- including a urinary bladder problem.

Q. Clearly he says he's treating a urinary bladder infection, isn't it?

A. For what? For what diagnosis?

Q. For a urinary bladder incontinence.

A. There's no urinary diagnosis in his record.

Q. Is it true, sir, that the records do show this patient has subjective complaints of urinary bladder difficulties?

A. Again, there is no diagnosis in the record regarding urinary –

* * *

Q. Does the record reflect urinary bladder difficulties for this patient?'

A. Yes.

Q. Does it matter whether the urinary bladder infection or difficulties are related to a BWC claim?

A. Yes, if he is treating this individual exclusively for that claim.

Q. So if he is treating her for the * * * urinary bladder difficulties, and it's not part of a BWC claim, you don't have a concern about his care; is that correct?

A. That's correct.

* * *

Q. You talk on Page 19, "The individual was placed on Lyrica for the treatment of her frequent falls. * * * The psychotropic drugs this individual provided were not supported as being related to these BWC claim allowances." If Dr. Lundeen

is appropriately using psychotropic drugs for this individual for their subjective and objective findings, does it matter that they are related or unrelated to BWC claim allowances?

A. It matters if he's exclusively treating this individual for their BWC claim.

Q. If he's treating them for psychotropic injuries or conditions, does it matter if they are related to BWC claim allowances, "yes" or "no"?

A. Yes, it does matter. If he's treating her for the BWC claim allowance, then it's not supported by the diagnoses in the file.

Q. But it isn't against the standard of care for him to treat this individual with psychotropic drugs, is it, "yes" or "no"?

A. Absent the BWC issue? No. No, it is not below the standard of care.

* * *

Q. [You stated in your report,] "Treatment appropriate to the clinical situation?" "No, for multiple reasons, as discussed above, emphasis on the strength of the lower extremity, but he knew from the first day the EMG and nerve conduction study of the low back showed both extremities were normal, and the 2002 low back MRI showed no neurological compromise."

How does that deal with his appropriate treatment of her bladder problems?

A. Well, if you have a bladder problem related to the spine, you would have an abnormal EMG and/or an abnormal MRI.

Q. But if you have an abnormal bladder problem, isn't it appropriate to deal with the abnormal bladder problem regardless of the MRI or the EMG and nerve conduction study?

A. Same answer, sir. There's no diagnosis regarding the bladder. The only diagnosis for which he is treating this individual are Ohio BWC claim allowances.

Q. Sir, isn't it appropriate that, in fact, there may be more diagnosis than what the Bureau has accepted as their allowed diagnoses in the care of a patient?

A. Then why aren't those additional diagnoses in Dr. Lundeen's notes?

(Tr. at 1453-1458, 1467-1468; see, also, Tr. at 1598-1603)[143]

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[143] In a similar exchange, Dr. Cunningham was asked whether, assuming there were no BWC issues, it makes "any difference as a violation of the standard of care that Dr. Lundeen was using Lidoderm patches." Dr. Cunningham answered, "No." (Tr. at 1460; see, also, Tr. at 1608) However, he also reiterated that Lidoderm is a local anesthetic used to anesthetize the skin, and that, if the pain generators are not in the skin, then a Lidoderm patch is not appropriate. He then reaffirmed his opinion that a Lidoderm patch is not appropriately used for musculoskeletal problems, based on the pharmacology of Lidocaine, which is the

739. Dr. Cunningham subsequently testified:

> Q. * * * Of what relevance to your determination of whether or not Dr. Lundeen is within the standard of care is based upon whether or not the medications are within the BWC treatment guidelines?
>
> A. If he's treating the patient for only BWC diagnoses, and billing BWC for those diagnoses, and that treatment, as his exclusive diagnosis and his exclusive treatment and his exclusive billing, then it's outside the standard of care, because many of the things Dr. Lundeen treated had nothing to do with his -- with the Ohio BWC claim allowances, including in this patient.

(Tr. at 1474-1475)

740. Dr. Cunningham was asked whether his "determination that Dr. Lundeen was outside the standard of care on billing issues" was "a significant portion," and Dr. Cunningham answered: "I think it's a significant portion. It's not the only issues that I found, but it's a significant issue in my opinion, yes."[144] (Tr. at 1475-1476) However, when asked whether it was "relevant in this hearing as to how Dr. Lundeen billed," Dr. Cunningham answered: "That is up to the [hearing examiner] sitting right up there, and the Board."

741. On redirect examination, Dr. Cunningham testified:

> Q. In your testimony for several of the patients, you said there was not a basis to prescribe certain narcotic medications, based in part on the length of time that had passed since the injury. Do you recall that?
>
> A. Yes.
>
> Q. And in Dr. Lundeen's records, he often has a diagnosis that is -- also happens to be the allowed claim under BWC. Would you agree with that?
>
> A. Yes.
>
> Q. And then Mr. Graff asked you questions about billing, and questions of that nature. Do you recall that?

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substance in the dermal patches. However, he stated that the Lidocaine does not do any harm to the patient, and, so, based on the lack of harm, he was not sure whether the Lidoderm patches constituted practice below the standard of care. (Tr. at 1592-1593)

[144] The Hearing Examiner did not give probative value or effect to Dr. Cunningham's testimony regarding billing issues, with respect to whether Dr. Lundeen violated any portion of R.C. 4731.22, because billing issues were not raised in the Notice. However, the Hearing Examiner did consider this evidence with respect to the issue of whether Dr. Cunningham was a credible, persuasive witness in general.

A. Yes.

Q. If a patient -- Regardless of the billing, when a physician prescribes medications, does the standard of care require the physician to have a diagnosis to justify those medications?

A. In my opinion, yes.

Q. And does the record -- Does that diagnosis need to be reflected in the records?

A. Yes.

Q. * * * If there is a new condition or a new injury that a physician is prescribing medication for, that is not what has been documented before, would the new condition or injury be required to be documented in the medical records?

A. Yes.

Q. And is that regardless of who it's being billed to?

A. Yes.

Q. In your review of these records, did you find that Dr. Lundeen had prescribed medications without documenting a diagnosis relating to those diagnoses?

A. Yes.

Q. And did you find that he prescribed medications without doing an appropriate physical exam to justify the prescription of those medications?

A. Yes.

Q. Did you find that he increased the narcotic dosages without sufficient examination or objective evidence?

A. Sufficient evidence or --

Q. Or objective evidence of a changing condition.

A. Yes.

Q. Did you find that he prescribed psychiatric medications without doing a mental status exam, or an appropriate psychiatric exam?

A. Yes.

Q. And did he continue to prescribe psychiatric medications without documenting any examination of the patient's psychiatric symptoms?

A. Yes.

Q. In your opinion, that violates the standard of care?

A. Yes.

Q. Do you find that he prescribed dosages of medication that were excessive based on the patient's condition documented in the records?

A. Yes.

* * *

Q. * * * What did you find with respect to Dr. Lundeen's prescription of the levels of Acetaminophen for several patients?

A. He exceeded the recommended maximum dosage on at least two occasions that I can remember. And when you exceed the maximum dosage of 4 grams, or 4,000 milligrams, of Acetaminophen, you're supposed to monitor those people for their liver function or kidney function tests, with liver and kidney function tests, which was not the case. Also, on one occasion he was actually informed that he was exceeding the dose, and --but he never changed it.

Q. In your opinion, does that violate the standard of care?

A. On the basis of his documentation, yes.

(Tr. at 1579-1583)

742. Dr. Cunningham further testified that, when a physician chooses to prescribed in excess of the recommended dose, the physician must document the reasons for that choice. And if the drug prescribed above the recommended dosage is acetaminophen, the physician should obtain periodic tests of liver and kidney functions. Dr. Lundeen did not do that, and it violated the standard of care. (Tr. at 1610-1611)

Testimony of Board Enforcement Staff

743. A Board Enforcement Attorney, Marcie Pastrick, testified, among other things, regarding the summary-suspension proceedings, the obtaining of Dr. Lundeen's medical records from Dr. Lundeen and from the BWC, and the copying of those records. Fonda Brooks, who testified that she works as a Secretary in the Enforcement Department of the Board, testified regarding her participation in receiving the medical records, scanning them, and assisting in the maintaining of those records for the Board. (Tr. at vols. 2, 6.)

Testimony of BWC Employee

744. Jeanette McCorkle stated that she is employed by the BWC as a Fraud Analyst. She testified regarding the BWC's production of documents to the Board, explaining the process by which documents that had been seized from Dr. Lundeen and were in the BWC's custody had been selected, copied, and provided to the Board in response to the Board's investigatory subpoena. Ms. McCorkle also testified that she was familiar with the search and seizure activities that were conducted at several of Dr. Lundeen's locations, which she described. (Tr. at 770-832. 1826-1879)

Awards and Praise Given to Dr. Lundeen

745. Dr. Lundeen submitted letters, awards, reports, and personal testimonials praising his excellent qualities as a person and as a physician. (Resp. Exs. C, K, N, U)

Articles Submitted by Dr. Lundeen

746. Dr. Lundeen submitted a magazine article regarding the treatment of chronic pain. Among other things, the author highlights the distress of those who suffer from chronic pain. In addition, Dr. Lundeen submitted press releases and news reports regarding the searches and seizures conducted of his offices in March 2011, the government's concerns regarding "pill mills" in Ohio, the Board's summary suspension of his Ohio medical license, and reactions to the summary suspension. (Resp. Exs. G, U)[145]

CREDIBILITY AND WEIGHT OF EVIDENCE

1. Dr. Lundeen did not appear to testify at the hearing under oath and, therefore, was not subject to cross-examination or subject to observation of his demeanor and tone. The Hearing Examiner evaluated his credibility based on all the evidence, including whether Dr. Lundeen's written statements—in his written defense as well as his statements in patient charts, letters and so forth—were internally consistent and whether his statements were consistent with other evidence in the hearing record. The Hearing Examiner notes that Dr. Lundeen, in his written defense, set forth information regarding his patients that was absent from his medical records.

With respect to the recorded interview with Board investigators, the Hearing Examiner found that Dr. Lundeen appeared to be cooperative, forthcoming, and candid. He appeared to believe in what he was saying. Although the Hearing Examiner does not agree with many of Dr. Lundeen's characterizations of his medical practice as expressed in the interview, Dr. Lundeen nonetheless appeared to be open and sincere with regard to the majority of what he said, including his pride in his medical practice. For example, he appeared to believe that he was actually being vigilant about narcotics issues. Further, the Hearing Examiner accepts Dr. Lundeen's statements that he did in fact terminate some patients who had violated his rules for patient conduct.

With respect to the testimony from a patient witness that Dr. Lundeen had explicitly called himself a legal drug dealer, the Hearing Examiner believes that Dr. Lundeen was joking. He was not making an admission of wrongful conduct.

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[145] Although the Hearing Examiner carefully maintained a lack of contact with, and a lack of awareness of, information about Dr. Lundeen that was not presented in the hearing room or in formal filings, Dr. Lundeen offered into evidence news articles and press releases regarding accusations that had been made against him. This evidence is not relevant to whether Dr. Lundeen is subject to discipline under R.C. 4731.22, that is, whether he violated the minimal standard of care or committed prescribing violations. Dr. Lundeen indicated that he had presented this evidence for the purpose of showing that the administrative action against him was politically motivated and that he is a victim of unfair treatment. (E.g., Tr. at 1672, 1675)

2. On the whole, the Hearing Examiner found Dr. Cunningham to be a knowledgeable and credible witness. Nevertheless, there were some problems with parts of his written reports and testimony. For example, he made some mistakes with regard to facts, such as what was in certain patients' medical records. In addition, his discussions of the minimal standards of care were not always clear: he talked about what a physician "should" do, what he personally does, and what the "standard of care" is rather than what the "minimal standard of care" is. He also made statements about BWC requirements that, at times, were muddled with regard to the standard he applied in rendering his opinion. The Hearing Examiner therefore disregarded portions of his testimony. However, even with disregarding portions of Dr. Cunningham's testimony, the Hearing Examiner still found that there was substantial evidence that was probative and reliable to support the findings of fact set forth below.

Overall, the Hearing Examiner found that the flaws in Dr. Cunningham's reports and testimony reduced the probative value of his testimony overall, but did not eliminate it. The Hearing Examiner disregarded and discounted some of his statements, but relied on his testimony in part. However, because the Respondent's expert witness did not attend the hearing and was not duly offered and qualified as an expert witness, and because there were some flaws in the presentation by the State's expert witness, it is especially important for the Board to exercise its collective medical expertise in making the final determination with regard to the findings and conclusions in this matter.

3. With regard to the testimony of Patients 15 and 22, the Hearing Examiner acknowledges that there were some discrepancies in their testimony, as set forth above. For example, it is likely that, where the blood pressure was specifically recorded in the chart, the blood pressure was probably taken on that date. Also, both of these witnesses, in the Hearing Examiner's view, seemed to place full and complete responsibility on Dr. Lundeen for their situations and did not seem to understand fully that they had also played a large part. However, overall, the Hearing Examiner found them to be believable witnesses. Their testimony came across as heartfelt and genuine. Further, it was consistent with other evidence in the hearing record.

4. As noted above, Dr. Ross did not testify at the hearing under oath, and, indeed, he was not formally offered and qualified as an expert witness during the hearing. Nonetheless, there was one portion of his written report that was instructive and rang true: his comments on electronic medical records. He stated that systems of electronic medical records, by their very nature, "tend to use templated, stereotypic inputs and printouts." The Hearing Examiner accepts that EMRs have a great deal of repetitive, standardized language and that this causes some loss of the personal, individual feel that is often present in non-electronic records. Dr. Cunningham's testimony was consistent on this subject, and the Hearing Examiner was cognizant that EMRs can appear unduly repetitive and not sufficiently individualized. Nonetheless, the problem with Dr. Lundeen's progress notes was the lack of meaningful information in many of them and the absence of important considerations, as well as information in the progress notes that conflicted with the patient's medication chart and/or other information in the patient's file.

5. Dr. Lundeen argued that there were additional paper records that the BWC had not provided to him from the group of documents seized from his offices in March 2011. However, in making findings of fact, the Hearing Examiner relied on papers that were present in the hearing record rather than papers that might be viewed as absent. For example, the absence of a pain contract in some patients' files was not a factor in the Hearing Examiner's findings. Similarly, the Hearing Examiner accepted Dr. Lundeen's representation that he had discharged patients from his practice, even though documentation was not provided.

THE BOARD'S RULES ON THE TREATMENT OF INTRACTABLE PAIN

Chapter 4731-21 of the Ohio Administrative Code, titled "Drug Treatment of Intractable Pain," provides as follows:

4731-21-01 Definitions.

As used in Chapter 4731-21 of the Administrative Code:

(A) "Addiction" means a compulsive disorder in which an individual becomes preoccupied with obtaining and using a substance, despite adverse social, psychological and/or physical consequences, the continued use of which results in a decreased quality of life. Physical dependence alone is not evidence of addiction.

(B) "Believes" or "has reason to believe" does not require absolute certainty or complete unquestioning acceptance; but only an opinion based on reasonable information that a patient is suffering from addiction or drug abuse or engaging in diversion of drugs.

(C) "Board" means the state medical board of Ohio.

(D) "Diversion" means the conveyance of a prescription drug to a person other than the person for whom the drug was prescribed or dispensed by a practitioner.

(E) "Drug abuse" means a maladaptive or inappropriate use or overuse of a medication.

(F) "Emergency" means an unforeseen combination of circumstances or the resulting state that calls for immediate action.

(G) "Intractable pain" means a state of pain that is determined, after reasonable medical efforts have been made to relieve the pain or cure its cause, to have a cause for which no treatment or cure is possible or for which none has been found. "Intractable pain" does not include pain experienced by a patient with a terminal condition. "Intractable pain" does not include the treatment of pain associated with a

progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition.

(H) "Pain" means an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

(I) "Physical dependence" means a physiologic state of adaptation to a specific drug or medication characterized by the development of a withdrawal syndrome following abrupt cessation of a drug or on administration of an antagonist.

(J) "Practitioner" means any of the following:

(1) An individual holding a certificate to practice medicine and surgery or osteopathic medicine and surgery under Chapter 4731. of the Revised Code;

(2) An individual holding a certificate to practice podiatric medicine and surgery under Chapter 4731. of the Revised Code and practicing within his or her scope of practice as defined in section 4731.51 of the Revised Code; or

(3) An individual holding both of the following:

(a) A certificate to practice as a physician assistant under Chapter 4730. of the Revised Code and practicing within his or her scope of practice in compliance with that chapter; and
(b) A certificate to prescribe under Chapter 4730. of the Revised Code and exercising physician delegated prescriptive authority in compliance with that chapter.

(K) "Prescription drug" means a drug which under state or federal law may be administered or dispensed only by or upon the order of a practitioner and includes the term "dangerous drug" as defined by section 4729.02 of the Revised Code.

(L) "Protracted basis" means for a period in excess of twelve continuous weeks.

(M) "Terminal condition" means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury, which will likely result in death. A terminal condition is one in which there can be no recovery, although there may be periods of remission.

A terminal condition shall be determined to a reasonable degree of medical certainty in accordance with reasonable medical standards by a patient's attending medical doctor or doctor of osteopathic medicine and one other individual holding a certificate under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery who has examined the patient.

(N) "Tolerance" means decreasing response to the same dosage of a prescription drug over time as a result of physiologic adaptation to that drug.

(O) "Utilizing prescription drugs" means prescribing, administering, dispensing, supplying, selling or giving a prescription drug.

Effective: 11/30/2008
Prior Effective Dates: 11/11/98

4731-21-02 Utilizing prescription drugs for the treatment of intractable pain.

(A) When utilizing any prescription drug for the treatment of intractable pain on a protracted basis or when managing intractable pain with prescription drugs in amounts or combinations that may not be appropriate when treating other medical conditions, a practitioner shall comply with accepted and prevailing standards of care which shall include, but not be limited to, the following:

(1) An initial evaluation of the patient shall be conducted and documented in the patient's record that includes a relevant history, including complete medical, pain, alcohol and substance abuse histories; an assessment of the impact of pain on the patient's physical and psychological functions; a review of previous diagnostic studies and previously utilized therapies; an assessment of coexisting illnesses, diseases or conditions; and an appropriate physical examination;

(2) A medical diagnosis shall be established and documented in the patient's medical record that indicates not only the presence of intractable pain but also the signs, symptoms, and causes and, if determinable, the nature of the underlying disease and pain mechanism;

(3) An individualized treatment plan shall be formulated and documented in the patient's medical record. The treatment plan shall specify the medical justification of the treatment of intractable pain by utilizing prescription drugs on a protracted basis or in amounts or combinations that may not be appropriate when treating other medical conditions, the intended role of prescription drug therapy within the overall plan, and, when applicable, documentation that other medically reasonable treatments for relief of the patient's intractable pain have been offered or attempted without adequate or reasonable success. The prescription drug therapy shall be tailored to the individual medical needs of each patient. The practitioner shall document the patient's response to treatment and, as necessary, modify the treatment plan;

(4) (a) The practitioner's diagnosis of intractable pain shall be made after having the patient evaluated by one or more other practitioners who specialize in the treatment of the anatomic area, system, or organ of the body perceived as the

source of the pain. For purposes of this rule, a practitioner "specializes" if the practitioner limits the whole or part of his or her practice, and is qualified by advanced training or experience to so limit his or her practice, to the particular anatomic area, system, or organ of the body perceived as the source of the pain. The evaluation shall include review of all available medical records of prior treatment of the intractable pain or the condition underlying the intractable pain; a thorough history and physical examination; and testing as required by accepted and prevailing standards of care. The practitioner shall maintain a copy of any report made by any practitioner to whom referral for evaluation was made under this paragraph. A practitioner shall not provide an evaluation under this paragraph if that practitioner would be prohibited by sections 4731.65 to 4731.69 of the Revised Code or any other rule adopted by the board from providing a designated health service upon referral by the treating practitioner; and

(b) The practitioner shall not be required to obtain such an evaluation, if the practitioner obtains a copy of medical records or a detailed written summary thereof showing that the patient has been evaluated and treated within a reasonable period of time by one or more other practitioners who specialize in the treatment of the anatomic area, system, or organ of the body perceived as the source of the pain and the treating practitioner is satisfied that he or she can rely on that evaluation for purposes of meeting the further requirements of this chapter of the Administrative Code. The practitioner shall obtain and review all available medical records or detailed written summaries thereof of prior treatment of the intractable pain or the condition underlying the intractable pain. The practitioner shall maintain a copy of any record or report of any practitioner on which the practitioner relied for purposes of meeting the requirements under this paragraph; and

(5) The practitioner shall ensure and document in the patient's record that the patient or other individual who has the authority to provide consent to treatment on behalf of that patient gives consent to treatment after being informed of the benefits and risks of receiving prescription drug therapy on a protracted basis or in amounts or combinations that may not be appropriate when treating other medical conditions, and after being informed of available treatment alternatives.

(B) Upon completion and satisfaction of the conditions prescribed in paragraph (A) of this rule, and upon a practitioner's judgment that the continued utilization of prescription drugs is medically warranted for the treatment of intractable pain, a practitioner may utilize prescription drugs on a protracted basis or in amounts or combinations that may not be appropriate when treating other medical conditions, provided that the practitioner continues to adhere to accepted and prevailing standards of care which shall include, but not be limited to, the following:

(1) Patients shall be seen by the practitioner at appropriate periodic intervals to assess the efficacy of treatment, assure that prescription drug therapy remains indicated, evaluate the patient's progress toward treatment objectives and note any adverse drug effects. During each visit, attention shall be given to changes in the patient's ability to function or to the patient's quality of life as a result of prescription drug usage, as well as indications of possible addiction, drug abuse or diversion. Compliance with this paragraph of the rule shall be documented in the patient's medical record;

(2) Some patients with intractable pain may be at risk of developing increasing prescription drug consumption without improvement in functional status. Subjective reports by the patient should be supported by objective data. Objective measures in the patient's condition are determined by an ongoing assessment of the patient's functional status, including the ability to engage in work or other gainful activities, the pain intensity and its interference with activities of daily living, quality of family life and social activities, and physical activity of the patient. Compliance with this paragraph of the rule shall be documented in the patient's medical record;

(3) Based on evidence or behavioral indications of addiction or drug abuse, the practitioner may obtain a drug screen on the patient. It is within the practitioner's discretion to decide the nature of the screen and which type of drug(s) to be screened. If the practitioner obtains a drug screen for the reasons described in this paragraph, the practitioner shall document the results of the drug screen in the patient's medical record. If the patient refuses to consent to a drug screen ordered by the practitioner, the practitioner shall make a referral as provided in paragraph (C) of this rule;

(4) The practitioner shall document in the patient's medical record the medical necessity for utilizing more than one controlled substance in the management of a patient's intractable pain; and

(5) The practitioner shall document in the patient's medical record the name and address of the patient to or for whom the prescription drugs were prescribed, dispensed, or administered, the dates on which prescription drugs were prescribed, dispensed, or administered, and the amounts and dosage forms of the prescription drugs prescribed, dispensed, or administered, including refills.

(C) If the practitioner believes or has reason to believe that the patient is suffering from addiction or drug abuse, the practitioner shall immediately consult with an addiction medicine specialist or other substance abuse professional to obtain formal assessment of addiction or drug abuse.

(1) For purposes of this rule:

(a) Addiction medicine specialist means a physician who is qualified by advanced formal training in addiction medicine or other substance abuse specialty, and includes a medical doctor or doctor of osteopathic medicine who is certified by a specialty examining board to so limit the whole or part of his or her practice.

(b) Substance abuse professional includes a psychologist licensed pursuant to Chapter 4732. of the Revised Code and certified as a clinical health psychologist, an independent chemical dependency counselor, or a chemical dependency counselor III.

(2) The practitioner shall do all of the following:

(a) Document the recommendations of the consultation in the patient's record;
(b) Continue to actively monitor the patient for signs and symptoms of addiction, drug abuse or diversion; and
(c) Maintain a copy of any written report made by the addiction medicine specialist or substance abuse professional to whom referral for evaluation was made under this paragraph.

(3) Prescription drug therapy may be continued consistent with the recommendations of the consultation. If the consulting addiction medicine specialist or other substance abuse professional believes the patient to be suffering from addiction or drug abuse, prompt referral shall be made to one of the following:

(a) An addiction medicine specialist or substance abuse professional; or
(b) An addiction medicine or substance abuse treatment facility.

Effective: 11/30/2008 (Emphasis added)

Prior Effective Dates: 11/11/98

4731-21-03 Continuing Medical Education.

The board encourages those practitioners who encounter patients with intractable pain in the usual course of their practices to complete continuing medical education related to the treatment of intractable pain, including coursework related to pharmacology, alternative methods of pain management and treatment, and addiction medicine.

Prior Effective Dates: 11/11/03

4731-21-04 Tolerance, Physical Dependence and Addiction.

(A) Physical dependence and tolerance by themselves do not indicate addiction.
(B) Physical dependence and tolerance are normal physiological consequences of extended opioid therapy, and do not, in the absence of other indicators of drug abuse or addiction, require reduction or cessation of opioid therapy.

Prior Effective Dates: 11/11/98

4731-21-05 Violations.

A violation of any provision of any rule in this chapter of the Administrative Code, as determined by the board, shall constitute "failure to use reasonable care discrimination in the administration of drugs," as that clause is used in division (B)(2) of section 4731.22 of the Revised Code; "selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes," as that clause is used in division (B)(3) of section 4731.22 of the Revised Code, if done knowingly or recklessly, as those words are defined in section 2901.22 of the Revised Code; and "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

Prior Effective Dates: 11/11/98

4731-21-06 Exceptions.

(A) A practitioner who treats pain by utilizing prescription drugs is not subject to disciplinary action pursuant to this chapter of the Administrative Code under the following circumstances:
(1) The treatment of pain for a patient with a terminal condition:

(2) The treatment of pain associated with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition;

(3) Treatment utilizing only drugs that do not exert their effects at the central nervous system level; and

(4) Treatment utilizing only drugs that are not controlled substances and are classified as antidepressants.

(B) A practitioner who treats intractable pain by utilizing prescription drugs is not subject to disciplinary action by the board under section 4731.22 of the Revised Code solely because the practitioner treated the intractable pain with prescription drugs.

The practitioner is subject to disciplinary action only if the prescription drugs are not utilized in accordance with section 4731.052 of the Revised Code and the rules adopted under this chapter of the Administrative Code.

(C) A Medical doctor or doctor of osteopathic medicine who provides comfort care as described in division (E)(1) of section 2133.12 of the Revised Code to a patient with a terminal condition is not subject to disciplinary action by the board under section 4731.22 of the Revised Code if the treatment of pain for a patient with a terminal condition is provided pursuant to the requirements of section 2133.11 of the Revised Code.

RESPONDENT'S MOTION TO DISMISS

During the hearing, the Respondent moved to dismiss this administrative action. The Hearing Examiner, not having the authority to rule on a motion to dismiss, allowed the parties to present oral argument on the motion. Neither party filed a brief on the issue. The Hearing Examiner ***recommends that the Board DENY*** the Respondent's motion to dismiss, for the reasons set forth in the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. James E. Lundeen, Sr., M.D., provided care and treatment to Patients 1 through 26, as identified in a confidential patient key. Dr. Lundeen prescribed controlled substances and/or drugs of abuse to these patients in the course of his medical practice. Some of the patients commenced treatment in the mid-1990s, but others did not commence treatment until much later. For example, there were patients who started treatment with Dr. Lundeen in 2009.

2. Dr. Lundeen inappropriately treated, and/or failed to appropriately treat, and/or failed to appropriately document his treatment of, these patients. Examples of such conduct include the following:

   (a) Dr. Lundeen failed to conduct appropriate physical examinations.

   (b) Dr. Lundeen excessively and inappropriately prescribed narcotic analgesics and other drugs of abuse despite indications of possible addiction, drug abuse, or diversion in some patients. In some instances, he failed to appropriately refer the patient to an addictionologist.

   (c) Dr. Lundeen prescribed increasing dosages of narcotics that were not supported by any objective change in the medical status of the patients, and/or he failed to document that there was any objective change in the clinical status, essentially documenting a subjective opinion that more analgesic medication was required.

(d) Dr. Lundeen's medical management and/or treatment was not appropriate to patients' diagnoses and/or their clinical situation. For example, he prescribed medications that were not appropriate for the diagnosis that he stated was being treated with the medication.

3. During an interview on or about March 16, 2011, Dr. Lundeen made the following statements to Board Investigators:

- "I'm one of the most astute diagnosticians that I've ever met. Don't need too many of those expensive tests to know which disk is bad. I can do it by talking to you about your gallbladder symptoms, about erectile dysfunction, about which muscle groups are cramped, and watch you walk and whether or not you walk on your heels and toes, and things like that."

- "I observe the patient, yeah. * * * I do chair examinations. I do ambulation examinations. I don't take people's clothes off because there isn't an orthopedic thing that you need to -- to see unless you have a burn or a cut. That's something we don't do, open wound management, here. * * * I don't want any -- I don't -- we don't need staph -- staph aureus problems by having open wound management. * * * We don't try to take work away from urgent cares or people who want that sort of stuff. I want the chronic care, the ones that are on permanent total. Their doctor's retired. 'Can you see me and get my -- my -- my meds.'"

- Because Workers' Comp, that's been our main focus, basically. And in that, you're allowed to document things that are part of their allowed conditions. If you document extraneous things, they don't pay you. (Unintelligible) blood pressure, then they won't pay for the back exam. Yeah. So we're not monitoring something we're not paid for. We'd have a liability to deal with." * * * So I -- I -- I never hold out that on a Workers' Comp exam we're doing that. * * * If we -- If we have an internal medicine patient, which we don't have too many of -- and they're being -- for blood pressure, then that would be something appropriate to check, sure. * * * [Question: Do you keep the equipment here to do that –] Sometimes I carry a cuff. * * * You can also tell by palpation. I was taught in medical school at Cook County where they didn't have any equipment, basically, back in 1979, how you can tell if somebody has high -- hypertension that is significant --* * * by feeling the -- the pulse.[146]

4. Patients 15 and 22 testified during the hearing. Their prehearing interview was not offered into evidence. Patient 15 and 22 reported:

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[146] Although the Hearing Examiner did not conclude that these statements set forth in Finding of Fact 3 constitute a violation of R.C. 4731.22 or a Board rule, the statements were useful in understanding some of Dr. Lundeen's medical records, in considering the credibility of the two patient witnesses, and in considering the appropriate discipline.

(a) Dr. Lundeen did not perform physical examinations during the appointments after the initial visit.

(b) During the appointment, they sat in chairs and Dr. Lundeen sat at a computer.

(c) Dr. Lundeen saw both patients together at the same time for approximately eight minutes total or less. The patients agreed to be seen together at the same time.

(d) Dr. Lundeen typically asked Patient 22 what his pain level was and to turn his head/neck a certain way. Dr. Lundeen then printed prescriptions, handed the prescriptions to them, and they were out the door.

5. The following facts were established by the evidence:

(a) Dr. Lundeen operated approximately twelve different office locations across the state of Ohio, including his main office.

(b) For the last ten years, Dr. Lundeen worked in Portsmouth, Ohio, which is in Scioto County, Ohio. The Portsmouth office was his busiest office.

(c) Dr. Lundeen visited the Portsmouth office one day every two weeks, and during that day treated approximately 90 patients.

(d) Dr. Lundeen stated that he worked at the Portsmouth office approximately 11 hours, from 8:00 a.m. to 7:00 p.m.

(e) Dr. Lundeen stated that "a high percentage" of his patients received controlled substances.

(f) Dr. Lundeen reported that it was not unusual to have 30 to 40 people waiting at one time, because people liked to socialize and it seemed to be the place to go.

(g) Dr. Lundeen would drive 178 miles from his residence to the Portsmouth office, see patients, and then return home or stay at a hotel.

(h) At the Portsmouth office, Dr. Lundeen did not have employees or staff.

(i) Dr. Lundeen stated that he did not have clinical privileges at any hospitals in Scioto County.

(j) However, there is insufficient evidence in the hearing record to establish that these facts about Dr. Lundeen "practice situation" were "atypical from standard medical practice."

6. On March 16, 2011, State Medical Board investigators participated with other agencies in raids on Dr. Lundeen's offices in Plymouth and Portsmouth, Ohio. A video-recording of his office in Plymouth was made at the time of the raid.

   (a) The video-recording does not establish by a preponderance of the evidence that Dr. Lundeen failed to maintain his medical office in a clean, sanitary and/or safe condition. A number of the rooms shown on the video are not part of the medical office, and it is these rooms that are in disrepair, contain a mattress as described in the Notice, and contain trash.

   (b) The video-recording does not establish by a preponderance of the evidence that Dr. Lundeen failed to adequately or appropriately equip and/or supply his medical office in Plymouth, Ohio, with sufficient and/or appropriate equipment and supplies and/or in a readily available location to appropriately practice medicine and surgery. This finding is based on the video-recording itself and the testimony of Dr. Cunningham.

   The Hearing Examiner notes that, in the Notice, the Board did not allege that Dr. Lundeen's statements during his interview established a failure to equip and/or supply his medical office in Plymouth adequately and/or appropriately.

CONCLUSIONS OF LAW

1. The acts, conduct, and/or omissions of James E. Lundeen, Sr., M.D., on or after March 9, 1999, as set forth above in Findings of Fact 1, 2 and 4, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as that language is used in Ohio Revised Code Section [R.C.] 4731.22(B)(2) as currently in effect.

2. Dr. Lundeen's acts, conduct, and/or omissions occurring between 1996 and March 8, 1999, inclusive, as set forth above in Findings of Fact 1 and 2, individually and/or collectively, constitute "[f]ailure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as that language is used in R.C. 4731.22(B)(2) as in effect prior to March 9, 1999.

3. Dr. Lundeen's acts, conduct, and/or omissions occurring between 1996 and March 2011, inclusive, as set forth above in Findings of Fact 1, 2 and 4, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that language is used in R.C. 4731.22(B)(6).

4. Dr. Lundeen's acts, conduct, and/or omissions occurring on or after November 30, 2008, as set forth in Findings of Fact 1, 2 and 4 above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that language is used in R.C. 4731.22(B)(20) with respect to: Ohio Admin. Code Section [Rule] 4731-21-02 as currently in effect.[147]

   Pursuant to Rule 4731-21-05, as currently in effect, a violation of Rule 4731-21-02 also constitutes violations of R.C. 4731.22(B)(2) and 4731.22(B)(6).

5. Further, Dr. Lundeen's acts, conduct, and/or omissions occurring between November 11, 1998, through November 29, 2008, as set forth in Findings of Fact 1 and 2 above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that language is used in R.C. 4731.22(B)(20), as in effect at that time, with respect to: Rule 4731-21-02 as in effect at that time.

   Pursuant to Rule 4731-21-05 as in effect at that time, a violation of Rule 4731-21-02 also constitutes violations of R.C. 4731.22(B)(2), and 4731.22(B)(6).

Discussion of Proposed Order

Dr. Lundeen's departures from the minimal standards of care were numerous. Even if the State had presented evidence regarding only half of the patients identified in the Notice, the evidence would still be substantial enough to support the conclusion that the Board must impose discipline in this matter. The question is what discipline should be imposed.

The Hearing Examiner considered factors including the following:

- Dr. Lundeen has not acknowledged that his prescribing practices were flawed. If he had recognized the need to make substantial changes in his practices, there would be an argument for remediation.

- There were multiple violations. The pattern of violations continued for many years and affected numerous patients. This administrative action does not involve an isolated incident.

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[147] In the Notice, the Board distinguished between Dr. Lundeen's conduct that occurred before "November 30, 2009," and conduct that occurred on or after that date.

However, the Hearing Examiner was unable to find any amendment of Rule 4731-21-02 that became effective on November 30, 2009. In contrast, there was an amendment of Rule 4731-21-02 that took effect on November 30, 2008. Therefore, the Hearing Examiner believes that the Notice contains a typographical error and that the rule at issue was in fact amended in November 2008, not 2009.

- Mitigating factors include that Dr. Lundeen appears to have believed that he was providing adequate care and running a "tight ship."

- Although his prescriptions were challenged in some BWC proceedings, Dr. Lundeen apparently practiced in the same or similar way for years, during which his practice and services received some amount of review and approval by the BWC. Nonetheless, it is clear that reviews, payments, and/or actions by third-party payors do not limit or control the Board's evaluation of a physician's practice of medicine.

Overall, the Hearing Examiner does not believe that Dr. Lundeen is amenable to improvement through education, monitoring, or other similar tools that the Board can use to protect the public. He has demonstrated enormous carelessness and arrogance that are central to the repeated violations demonstrated in the hearing record.

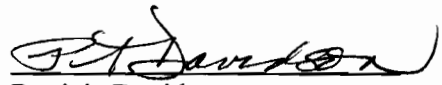
In sum, the Hearing Examiner finds that violations by Dr. Lundeen are so pervasive and serious that the public in Ohio cannot be adequately protected by anything less than a permanent revocation of Dr. Lundeen's medical license.

PROPOSED ORDER

It is hereby ORDERED that:

> The certificate of James E. Lundeen, Sr., M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.



Patricia Davidson
Hearing Examiner

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

EXCERPT FROM THE DRAFT MINUTES OF DECEMBER 14, 2011

REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDERS

Dr. Suppan announced that the Board would now consider the Reports and Recommendations, and the Proposed Findings and Proposed Order appearing on its agenda.

Dr. Suppan asked whether each member of the Board had received, read and considered the hearing records; the Findings of Fact, Conclusions of Law, Proposed Orders, and any objections filed in the matters of: James E. Lundeen, Sr., M.D.; Myron Lyle Shank, M.D.; Oscar Augustine Linares, M.D.; Karin Petra Simon-Demel, M.D.; and Rajiv Yakhmi, M.D. A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Madia	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Suppan	- aye
	Dr. Amato	- aye
	Dr. Talmage	- aye
	Dr. Ramprasad	- aye

Dr. Suppan asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Madia	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Suppan	- aye
	Dr. Amato	- aye
	Dr. Talmage	- aye
	Dr. Ramprasad	- aye

Dr. Suppan noted that, in accordance with the provision in section 4731.22(F)(2), Ohio Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters. In the matters before the Board today, Dr. Talmage served as Secretary and Dr. Amato served as Supervising Member.

Dr. Suppan reminded all parties that no oral motions may be made during these proceedings.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

.....

JAMES E. LUNDEEN, SR., M.D., Case No. 11-CRF-055

.....

Dr. Mahajan exited the meeting prior to this discussion.

.....

Dr. Steinbergh moved to approve and confirm Ms. Davidson's Findings of Fact, Conclusions of Law, and Proposed Order in the matter of James E. Lundeen, Sr., M.D. Mr. Hairston seconded the motion.

.....

A vote was taken on Dr. Steinbergh's motion to approve:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Madia	- aye
	Dr. Steinbergh	- aye
	Dr. Suppan	- aye
	Dr. Amato	- abstain
	Dr. Talmage	- abstain
	Dr. Ramprasad	- aye

The motion to approve carried.

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

May 11, 2011

Case number: 11-CRF- 055

James E. Lundeen, Sr., M.D.
26 Sandusky Street
Plymouth, Ohio 44865

Dear Doctor Lundeen:

Enclosed please find certified copies of the Entry of Order, the Notice of Summary Suspension and Opportunity for Hearing, and an excerpt of the Minutes of the State Medical Board, meeting in regular session on May 11, 2011, including a Motion adopting the Order of Summary Suspension and issuing the Notice of Summary Suspension and Opportunity for Hearing.

You are advised that continued practice after receipt of this Order shall be considered practicing without a certificate, in violation of Section 4731.41, Ohio Revised Code.

Pursuant to Chapter 119, Ohio Revised Code, you are hereby advised that you are entitled to a hearing on the matters set forth in the Notice of Summary Suspension and Opportunity for Hearing. If you wish to request such hearing, that request must be made in writing and be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice. Further information concerning such hearing is contained within the Notice of Summary Suspension and Opportunity for Hearing.

THE STATE MEDICAL BOARD OF OHIO

Lance A. Talmage, M.D., Secretary

LAT/MAP/flb

Enclosures

Mailed 5-12-11

CERTIFICATION

I hereby certify that the attached copies of the Entry of Order of the State Medical Board of Ohio and the Motion by the State Medical Board, meeting in regular session on May 11, 2011, to Adopt the Order of Summary Suspension and to Issue the Notice of Summary Suspension and Opportunity for Hearing, constitute true and complete copies of the Motion and Order in the Matter of James E. Lundeen, Sr., M.D., Case number: 11-CRF-055 as they appear in the Journal of the State Medical Board of Ohio.

This certification is made under the authority of the State Medical Board of Ohio and in its behalf.

Lance A. Talmage, M.D., Secretary

May 11, 2011
Date

(SEAL)

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	:
	:
JAMES E. LUNDEEN, SR., M.D.	:
	:
CASE NUMBER: 11-CRF-055	:

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio the 11th day of May 2011.

Pursuant to Section 4731.22(G), Ohio Revised Code, and upon recommendation of Lance A. Talmage, M.D., Secretary, and Raymond J. Albert, Supervising Member; and

Pursuant to their determination, based upon their review of the information supporting the allegations as set forth in the Notice of Summary Suspension and Opportunity for Hearing, that there is clear and convincing evidence that James E. Lundeen, Sr., M.D., has violated Sections 4731.22(B)(2), (B)(6) and (B)(20), Ohio Revised Code, as alleged in the Notice of Summary Suspension and Opportunity for Hearing that is enclosed herewith and fully incorporated herein; and,

Pursuant to their further determination, based upon their review of the information supporting the allegations as set forth in the Notice of Summary Suspension and Opportunity for Hearing, that Dr. Lundeen's continued practice presents a danger of immediate and serious harm to the public;

The following Order is hereby entered on the Journal of the State Medical Board of Ohio for the 11th day of May, 2011:

It is hereby ORDERED that the certificate of James E. Lundeen, Sr., M.D., to practice medicine and surgery in the State of Ohio be summarily suspended.

It is hereby ORDERED that James E. Lundeen, Sr., M.D., shall immediately cease the practice of medicine and surgery in Ohio and immediately refer all active patients to other appropriate physicians.

This Order shall become effective immediately.

Lance A. Talmage, M.D., Secretary

(SEAL)

May 11, 2011

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

EXCEPRT FROM THE DRAFT MINUTES OF MAY 11, 2011

CITATIONS, PROPOSED DENIALS, ORDERS OF SUMMARY SUSPENSION & NOTICES OF IMMEDIATE SUSPENSION

JAMES E. LUNDEEN, SR., M.D. – ORDER OF SUMMARY SUSPENSION AND NOTICE OF OPPORTUNITY FOR HEARING

At this time the Board read and considered the proposed Order of Summary Suspension and Notice of Opportunity for Hearing in the above matter, a copy of which shall be maintained in the exhibits section of this Journal.

Dr. Steinbergh moved to enter an Order of Summary Suspension in the matter of James E. Lundeen, Sr., M.D., in accordance with Section 4731.22(G), Ohio Revised Code, and to issue the Notice of Summary Suspension and Opportunity for Hearing. Mr. Hairston seconded the motion. A vote was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- abstain
	Dr. Steinbergh	- aye
	Dr. Suppan	- aye
	Mr. Albert	- abstain
	Dr. Madia	- aye
	Dr. Talmage	- abstain
	Dr. Amato	- aye
	Ms. Elsass	- aye
	Dr. Ramprasad	- aye

The motion carried.

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

NOTICE OF SUMMARY SUSPENSION
AND
OPPORTUNITY FOR HEARING

May 11, 2011

Case number: 11-CRF-055

James E. Lundeen, Sr., M.D.
26 Sandusky Street
Plymouth, Ohio 44865

Dear Doctor Lundeen:

The Secretary and the Supervising Member of the State Medical Board of Ohio [Board] have determined that there is clear and convincing evidence that you have violated Sections 4731.22(B)(2), Ohio Revised Code; 4731.22(B)(6), Ohio Revised Code; and 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-21-02, Ohio Administrative Code; and have further determined that your continued practice presents a danger of immediate and serious harm to the public, as set forth in paragraphs (1) through (4), below.

Therefore, pursuant to Section 4731.22(G), Ohio Revised Code, and upon recommendation of Lance A. Talmage, M.D., Secretary, and Raymond J. Albert, Supervising Member, you are hereby notified that, as set forth in the attached Entry of Order, your certificate to practice medicine and surgery in the State of Ohio is summarily suspended. Accordingly, at this time, you are no longer authorized to practice medicine and surgery in Ohio.

Furthermore, in accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the Board intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) During the time period in or about October 1977 through in or about March 2011, you provided care and treatment to Patients 1 through 26, identified on the attached Patient Key, to whom you prescribed controlled substances and/or drugs of abuse, in the course of your medical practice. The Patient Key is confidential and to be withheld from public disclosure. You inappropriately treated, and/or failed to appropriately treat, and/or failed to appropriately document your treatment of these patients. Examples of such conduct include, but are not limited to, the following:

(a) You failed to conduct appropriate physical examinations, and your patient records reflect the absence of objective physical examination findings such as height and weight, blood pressure, a list of medication allergies, reflexes present or absent, sensation, ability to stand and sit, or sit and lie, and/or walk on toes or heels.

(b) You excessively and inappropriately prescribed narcotic analgesics and other drugs of abuse despite indications of possible addiction, drug abuse, or diversion in some patients, and failed to appropriately refer such patients to an addictionologist.

(c) You often prescribed increasing dosages of narcotics which were not supported by any objective change in the medical status of your patients, and/or you failed to document that there was any objective change in the clinical status other than the fact that he/she required more analgesic medication.

(d) Your medical management and/or treatment was not appropriate to the patients' diagnoses and/or their clinical situation.

(2) During an interview on or about March 16, 2011, you made the following statements to Board Investigators:

- I'm one of the most astute diagnosticians that I've ever met. Don't need too many of those expensive tests to know which disc is bad. I can do it by talking to you about your bowel and bladder system, about erectile dysfunction, about which muscle groups are cramped and watch you walk, and whether or not you walk on your heels and toes.

- I observe the patient, yeah. I do chair examinations. I do ambulation examinations. I don't take people's clothes off, because there isn't an orthopedic thing you need to see unless they have a burn or a cut, we don't do open wound management here, [because] I don't want any, I don't need staff.

- I want the chronic care, the ones that are on permanent total, their doctor's retired, can you see me and get my meds.

- Worker's Comp, that's been our main focus, basically, and in that you are allowed to document things that are part of their allowed conditions. If you document extraneous things, they don't pay you. [Do] a blood pressure, then they don't pay for a back exam. So we're not monitoring something we're not paid for. We would have a liability to deal with.

- If we have an internal medicine patient, which we don't have too many of, and they're being [monitored] for blood pressure, then that would be something appropriate to check . . . Sometimes I carry a cuff. You can also tell by palpation . . . How you can tell if somebody has hypertension that is significant is by feeling the pulse.

(3) On or about April 8, 2011, a Board Investigator interviewed Patient 15 and her significant other, Patient 22. They reported that you did not perform physical examinations during appointments despite treating Patient 15 for conditions including COPD and hypertension; that you saw both patients together at the same time for approximately a total combined time of eight to ten minutes; that you asked each of them the same questions, such as what was their pain level and to turn their neck a certain way; and that during the appointment, they sat in chairs and you sat at a computer. They reported that you then printed prescriptions, handed the prescriptions to them, and then they were out the door.

(4) Additional facts about your practice situation are atypical from standard medical practice. You maintain one main office and operated approximately twelve different offices across the state of Ohio. For the last ten years, you worked in Portsmouth, Scioto County, Ohio, your busiest office, one day every two weeks, treating approximately 90 patients per day. By your own statement, "a high percentage" of your patients received controlled substances. You reported that you worked at the Portsmouth office approximately 11 hours, from 8:00 a.m. to 7:00 p.m. You reported that your office often had 30-40 people waiting at one time, because people liked to socialize and it seemed to be the place to go. You would drive 178 miles from your residence, see patients, and return home or stay at a hotel. At the Portsmouth office, you had no employees or staff. You have no clinical privileges at any hospitals in Scioto County.

On March 16, 2011, State Medical Board investigators participated with other agencies in raids on your offices in Plymouth and Portsmouth, Ohio. A video of your office in Plymouth was recorded at the time of the raid. The video shows that

you failed to maintain your office in a clean, sanitary and/or safe condition. Examples of such failure include, but are not limited to, the following:

- dozens of boxes of paper stacked several high throughout the office;
- a mattress with no sheets;
- the ceiling open in places, missing ceiling tiles;
- exposed walls, no drywall or missing drywall;
- exposed insulation in the walls;
- exposed wires hanging loose from the ceiling;
- ashtrays with cigarette butts;
- dirt, trash, and trash bags accumulated on the floor;
- floor unfinished in some areas; and
- peeling paint.

The video also shows that you failed to adequately or appropriately equip and/or supply your medical office in Plymouth, Ohio, with sufficient and/or appropriate equipment and supplies and/or in a readily available location to appropriately practice medicine and surgery. Examples of such failures include, but are not limited to, the following:

- a scale to measure height and weight;
- tools used for physical examinations;
- tools used for sanitation, hand sanitizer and/or a sink for hand washing;
- an examination table with paper;
- a blood pressure cuff; and
- latex or other appropriate gloves.

Your acts, conduct, and/or omissions on or after March 9, 1999, as alleged in paragraphs (1) through (4) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code, as currently in effect.

Further, your acts, conduct, and/or omissions occurring between October 1977 through March 8, 1999, as alleged in paragraphs (1) through (4) above, individually and/or collectively, constitute "[f]ailure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code, as in effect prior to March 9, 1999.

Further, your acts, conduct, and/or omissions occurring between October 1977 through March 2011, as alleged in paragraphs (1) through (4) above, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions occurring on or after November 30, 2009, as alleged in paragraphs (1) through (4) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-21-02, Ohio Administrative Code, as currently in effect. Additionally, pursuant to Rule 4731-21-05, Ohio Administrative Code, as currently in effect, a violation of Rule 4731-21-02, Ohio Administrative Code, also constitutes violations of Sections 4731.22(B)(2), and 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions occurring between November 11, 1998, through November 29, 2009, as alleged in paragraphs (1) through (4) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, as in effect at that time, to wit: Rule 4731-21-02, Ohio Administrative Code, as in effect at that time. Additionally, pursuant to Rule 4731-21-05, Ohio Administrative Code, as in effect at that time, a violation of Rule 4731-21-02, Ohio Administrative Code, also constitutes violations of Sections 4731.22(B)(2), and 4731.22(B)(6), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, and Chapter 4731., Ohio Revised Code, you are hereby advised that you are entitled to a hearing concerning these matters. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke,

suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Lance A. Talmage, M.D.
Secretary

LAT/MAP/flb
Enclosures

CERTIFIED MAIL #91 7108 2133 3938 3087 9933
RETURN RECEIPT REQUESTED

cc: HAND DELIVERY