IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Franklin Donald Demint, D.O.,	:	
Appellant-Appellant,	:	No. 15AP-456 (C.P.C. No. 14CV-12547)
v.	:	(REGULAR CALENDAR)
State Medical Board of Ohio,	:	
Appellee-Appellee.	:	

JUDGMENT ENTRY

For the reasons stated in the decision of this court rendered herein on June 21, 2016, appellant's twelve 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 are assessed against appellant.

BROWN, J., DORRIAN, P.J., & SADLER, J.

/s/ Judge
Judge Susan Brown

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Tenth District Court of Appeals

Date: 06-21-2016

Case Title: FRANKLIN DONAL DEMINT DO -VS- OHIO STATE MEDICAL BOARD

Case Number: 15AP000456

Type: JEJ - JUDGMENT ENTRY

So Ordered

/s/ Judge Susan Brown, P.J.

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State Medical Board of Ohio,	:	
Appellee-Appellee.	:	

D E C I S I O N

Rendered on June 21, 2016

On brief: *James R. Kingsley*, for appellant. **Argued:** *James R. Kingsley*.

On brief: *Michael DeWine*, Attorney General, *Kyle C. Wilcox*, and *Melinda Snyder*, for appellee. **Argued:** *Henry G. Appel*.

APPEAL from the Franklin County Court of Common Pleas

BROWN, J.

{¶ 1} Franklin Donald Demint, D.O., appellant, appeals the judgment of the Franklin County Court of Common Pleas affirming an order of appellee, State Medical Board of Ohio ("board"), imposing certain limitations on appellant's certificate to practice medicine and permanently revoking his ability to prescribe narcotic analgesic drugs.

{¶ 2} The following factual background draws from the trial court's decision as well as from the summary of evidence set forth in the report and recommendation issued by a board hearing examiner. Appellant obtained his osteopathic medical degree in 1990. He was certified by the American Osteopathic Board of Family Physicians and by the

American Osteopathic Board of Neuromusculoskeletal Medicine and a diplomate of the American Academy of Pain Management.

{¶ 3} Appellant currently practices as a solo practitioner in Kingston, Ohio. His practice includes family medicine and addiction medicine, including Suboxone therapy. Appellant testified that between 80 to 90 percent of his current patients are Suboxone patients. He testified he formerly specialized in pain management, but discontinued that specialty when House Bill. No. 93 took effect in 2011.

{¶ 4} Pursuant to a Step I Agreement, in 2009, appellant's certificate was suspended for at least 180 days based on violations of R.C. 4731.22(B)(5), (10), (20), and (26). The actions constituting the basis for the Step I Agreement were appellant's dependence on marijuana, and his admission of dispensing generic Tylenol 3 tablets to a family member under circumstances that did not constitute an emergency situation while not performing and documenting an examination and without maintaining patient records. Appellant was required to complete 28 days of inpatient treatment, to maintain sobriety, and submit to interim monitoring requirements. Pursuant to a March 2010 Step II Consent Agreement, appellant's certificate was reinstated subject to probationary requirements, including practice monitoring.

{¶ 5} On March 14, 2012, the board issued a Notice of Opportunity to appellant informing him that the board intended to take disciplinary action against his certificate to practice osteopathic medicine and surgery. The disciplinary action was the result of appellant's treatment of Patients 1-14[1] from March 2010 through April 2011, which the board alleged was below the minimum standard of care and violated the board's rules for utilizing prescription drugs for the treatment of intractable pain. The board alleged that appellant's care of these 14 patients constituted a violation of R.C. 4731.22. Appellant's treatment of these 14 patients fell below the minimal standard of care as follows:

> (a) In regards to Patient 1, you inappropriately prescribed narcotics for treatment of diagnosed fibromyalgia;
>
> (b) In regards to Patients 3-5, 7-8, 11, and 13, you failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records;

[1] To protect patient confidentiality, the patients and their records are referred to by an assigned number.

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> (c) In regards to Patients 1-5, and 7-14, the amount and/or type of narcotics prescribed was not supported by history, physical exam and/or test findings;
>
> (d) In regards to Patients 9, and 12, you inappropriately prescribed high doses of narcotics despite diagnoses of underlying Chronic Obstructive Pulmonary Disease.
>
> (e) In regards to Patients 1, 2, 4, 6-10, and 12-14, you failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, selective serotonin reuptake inhibitors [SSRI] and/or physical therapy;
>
> (f) In regards to Patients 1, 2, 5, 9, and 11-14, you failed to obtain toxicology screens prior to prescribing narcotics;
>
> (g) In regards to Patients 3, 6, 8, 9, 11, 12, and 13, you failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports;
>
> (h) In regards to Patients 2-6, 9, and 13, you failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment; and
>
> (i) In regards to Patients 1-3, 6, 8, and 12, your medical charting was incomplete, often illegible and/or disorganized.

(State's Ex. 20A at 2-3.)

{¶ 6} On August 3, 2012, appellant's counsel filed a notice of withdrawal. Appellant's new counsel appeared as counsel of record and requested a continuance on August 16, 2012. Appellant's counsel requested the continuance to identify and prepare an expert witness, which former counsel failed to do. The hearing officer denied the request.

{¶ 7} The hearing officer conducted a three-day hearing and issued a report and recommendation. The board convened and issued an order on April 18, 2013, finding

appellant inappropriately prescribed controlled medications, failed to maintain minimal standards of care, and failed to employ acceptable scientific methods in the selection of drugs. The order included a six-month to indefinite license suspension and monitoring conditions.

{¶ 8} Appellant appealed and the Franklin County Court of Common Pleas reversed the order of the board and remanded the matter for a new hearing, finding that the hearing officer's denial of the continuance was arbitrary, unreasonable, and contrary to law.

{¶ 9} On remand, appellant submitted the previously proffered testimony of his prior monitoring physician, Dr. Phillip Prior, the affidavit of his current monitoring physician, Dr. Ellis Frazier, Exhibits M-Z, which are summaries of his care of these patients in question, and additional records. The hearing officer issued a report and recommendation on February 13, 2013, recommending the board find appellant violated the standards of practice and violated board rules regarding the prescribing of controlled substances. The board agreed and suspended appellant from the practice of medicine for a minimum of 90 days and permanently revoked his ability to prescribe narcotic analgesic drugs, except buprenorphine-containing products or any other products that are approved to treat drug addiction. At that time of the order, there were four new board members from the time of the first consideration.

{¶ 10} Appellant again appealed to the Franklin County Court of Common Pleas, which affirmed the order of the board. Appellant filed a timely notice of appeal and raised the following assignments of error for our review:

> [1.] WAS IT PREJUDICIAL ERROR TO ALLOW THE TESTIMONY OF DR. CICEK?
>
> [2.] WAS IT PREJUDICIAL ERROR TO FIND THAT DR. DEMINT'S HANDWRITING WAS A BASIS FOR DISCIPLINE?
>
> [3.] WAS THE FINDING OF IMPROPER CHARTING REVERSIBLE ERROR?
>
> [4.] WAS IT PREJUDICIAL ERROR TO FIND THAT DR. DEMINT IMPROPERLY PRESCRIBED NARCOTICS?

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> [5.] WAS IT PREJUDICIAL ERROR TO FIND THAT DR. DEMINT PRESCRIBED BEFORE RECEIVING INFORMATION WAS RECEIVED OR FAILED TO ACT UPON INCONSISTENT TEST RESULTS?
>
> [6.] WAS IT PREJUDICIAL ERROR TO FIND THAT DR. DEMINT FAILED TO NOTE IN THE FILE THAT HE READ THE FILE EACH TIME HE SAW A PATIENT?
>
> [7.] WAS IT PREJUDICIAL ERROR TO FIND THAT DR. DEMINT TREATED OR FAILED TO DISCHARGE A PATIENT WHO ADMITTED TO ABUSING ILLEGAL DRUGS?
>
> [8.] WAS IT PREJUDICIAL ERROR TO FIND THAT DR. DEMINT IMPROPERLY TREATED FIBROMYALGIA?
>
> [9.] WAS IT PREJUDICIAL ERROR TO FIND THAT DR. DEMINT FAILED TO PROPERLY WARN A COPD PATIENT?
>
> [10.] WAS IT PREJUDICIAL ERROR TO APPLY POST CLAIM STATUTORY CHANGES AND NEWLY ANNOUNCED STANDARDS OF CARE?
>
> [11.] WAS THE BOARD'S DECISION BASED UPON A NEW BOARD MEMBERS' MATERIALLY MISCHARACTERIZED AND INFLAMMATORY EVIDENCE NOT IN THE RECORD?
>
> [12.] DID THE BOARD IMPOSE VINDICTIVE PUNISHMENT?

{¶ 11} The Ohio Revised Code "vests the Board with broad authority to regulate the medical profession in this state, and to discipline any physician whose care constitutes '[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.' " *Griffin v. State Med. Bd.*, 10th Dist. No. 09AP-276, 2009-Ohio-4849, ¶ 3, quoting R.C. 4731.22(B)(6). In an appeal from an order of the board, "a reviewing trial court is bound to uphold the order if it is supported by reliable, probative, and substantial evidence, and is in accordance with law." *Pons v. State Med. Bd.*, 66 Ohio St.3d 619, 621 (1993), citing R.C. 119.12. " '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." *Our Place, Inc. v. Ohio Liquor Control Comm.*, 63 Ohio St.3d 570, 571 (1992). " 'Probative' evidence is evidence that tends to prove the issue in question; it must be relevant in determining the issue." *Id.* " 'Substantial' evidence is evidence with some weight; it must have importance and value." *Id.*

{¶ 12} The common pleas court's " ' "review of the administrative record is neither a trial *de novo* nor an appeal on questions of law only, but a hybrid review in which the court 'must appraise all [the] evidence as to the credibility of the witnesses, the probative character of the evidence, and the weight [thereof].' " ' " *Temponeras v. Ohio State Med. Bd.*, 10th Dist. No. 14AP-970, 2015-Ohio-3043, ¶ 8, quoting *Akron v. Ohio Dept. of Ins.*, 10th Dist. No. 13AP-473, 2014-Ohio-96, ¶ 19, quoting *Lies v. Ohio Veterinary Med. Bd.*, 2 Ohio App.3d 204, 207 (1st Dist.1981), quoting *Andrews v. Bd. of Liquor Control*, 164 Ohio St. 275, 280 (1955). When there is conflicting testimony, the court must give due deference to the administrative determination of conflicting testimony, including resolution of credibility conflicts. *Temponeras* at ¶ 8, citing *Crumpler v. State Bd. of Edn.*, 71 Ohio App.3d 526, 528 (10th Dist.1991). Unless the findings of fact are " ' "internally inconsistent, impeached by evidence of a prior inconsistent statement, rest upon improper inferences, or are otherwise unsupportable," ' " the court must defer to such findings by the agency. *Id.* at ¶ 8, quoting *Kimbro v. Ohio Dept. of Adm. Servs.*, 10th Dist. No. 12AP-1053, 2013-Ohio-2519, ¶ 7, quoting *Ohio Historical Soc. v. State Emp. Relations Bd.*, 66 Ohio St.3d 466, 471 (1993). The common pleas court reviews legal questions de novo. *Id.*

{¶ 13} An appellate court's review "is even more limited than that of the trial court." *Pons* at 621. Specifically, "[w]hile it is incumbent on the trial court to examine the evidence, this is not a function of the appellate court. The appellate court is to determine only if the trial court has abused its discretion, *i.e.*, being not merely an error of judgment, but perversity of will, passion, prejudice, partiality, or moral delinquency." *Id.* Thus, "[a]bsent an abuse of discretion on the part of the trial court, a court of appeals may not substitute its judgment for those of the medical board or a trial court." *Id.* An appellate court's review is plenary when it is determining whether the board's order was in accordance with law. *Temponeras* at ¶ 9, citing *Weiss v. State Med. Bd. of Ohio*, 10th

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Dist. No. 13AP-281, 2013-Ohio-4215, ¶ 15, citing *Univ. Hosp., Univ. of Cincinnati College of Medicine v. State Emp. Relations Bd.*, 63 Ohio St.3d 339, 343 (1992).

{¶ 14} In his first assignment of error, appellant contends that it was prejudicial error to allow the testimony of the state's expert witness, Dr. Wendy Cicek. The trial court found the record contained ample evidence establishing Dr. Cicek's expertise in treating patients with chronic pain.

{¶ 15} Dr. Cicek is an assistant professor and former clinical instructor at Case Medical School. She is board certified by the American Board of Family Medicine. Until a few weeks prior to the hearing, she was employed at MetroHealth Medical Center ("MetroHealth") where she was practicing when she reviewed the records for this case. However, just weeks before the hearing, she started working at Kaiser Permanente. At MetroHealth, she worked as a family physician with five other providers, providing primary care to patients. She averaged approximately 25 patients per day and utilized controlled prescription narcotics in her practice. Approximately 30 to 40 percent of her patients included ones with chronic pain, many of them utilizing opioid medications. Ninety percent of her practice prior to her recent job change was clinical work and currently 100 percent is clinical work. She received CME training in pain management. When she worked at MetroHealth, she had a DEA certification to prescribe Suboxone. Dr. Cicek reviewed the 14 patient records and prepared a report regarding her findings.

{¶ 16} Although the board is not required to present expert testimony to support the charges against a physician, reliable, probative, and substantial evidence must support the charges. *Griffin* at ¶ 13. This court has set forth that an expert may testify in a medical board proceeding if the expert's experience and practice is similar to the physician facing discipline. *Leak v. State Med. Bd.*, 10th Dist. No. 09AP-1215, 2011-Ohio-2483, ¶ 12. "[T]he 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." *Id.*, citing *Lawrence v. State Med. Bd. of Ohio*, 10th Dist. No. 92AP-1018 (Mar. 11, 1993).

{¶ 17} Appellant is board certified in family medicine and, similar to Dr. Cicek, he received his training in pain management through CME. His practice includes family medicine and addiction medicine, including Suboxone therapy. Dr. Cicek's training,

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clinical practice, and experience is similar to appellant's practice and the record supports that she has expertise in treating patients with chronic pain.

{¶ 18} Moreover, given that the board is comprised of individuals who are trained medical professionals, the board may rely on its own expertise to determine whether a physician failed to conform to minimum standards of care. *Arlen v. Ohio State Med. Bd.*, 61 Ohio St.2d 168, 172 (1980). The *Arlen* court further explained, at 174, as follows:

> The requirement for expert testimony in the record of a license revocation proceeding usurps the power of the State Medical Board's broad measure of discretion. The very purpose for having such a specialized technical board would be negated by mandating that expert testimony be presented. Expert opinion testimony can be presented in a medical board proceeding, but the board is not required to reach the same conclusion as the expert witness. The weight to be given to such expert opinion testimony depends upon the board's estimate as to the propriety and reasonableness, but such testimony is not binding upon such an experienced and professional board.

{¶ 19} Further, appellant argues that Dr. Cicek was not credible. As stated, the common pleas court in its review must give due deference to the administrative resolution of evidentiary conflicts. *Univ. of Cincinnati v. Conrad*, 63 Ohio St.2d 108, 111 (1980). We cannot find fault with the trial court for refusing to substitute its judgment for the board's judgment. Appellant's first assignment of error is overruled.

{¶ 20} Many of appellant's other assignments of error contest whether the board properly concluded that he failed to meet the standard of care in various ways. A review of Dr. Cicek's report, as the state's expert, is appropriate to determine whether the trial court abused its discretion in finding there was reliable, probative, and substantial evidence in the record and that the decision was in accordance with law.

{¶ 21} Dr. Cicek's report reviewed each of the 14 patient's records and concluded, as follows:

> [Patient 1:]
>
> Although the notes were VERY difficult to read due to illegible handwriting, there did not appear to be a notation of where the patient was receiving treatment during her absence from Dr. DeMint's practice.

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> * * *
>
> [T]he initial exam was essentially normal and there was no reference to prior therapies attempted or to tests on file. An [Ohio Automated Rx Reporting System] report was completed when he assumed care however no urine toxicology was done.
>
> At the initial visit, narcotic medication was prescribed, along with cyclobenzaprine and ibuprofen. The physical exam and test findings did not support the level of pain described or the medications used. There were no goals of therapy or plan for trying different medications (ie appropriate medication for Fibromyalgia). There were no referrals for Physical Therapy or other non-medication therapies. Narcotics are specifically NOT recommended for fibromyalgia. All of the above deviate from the standard of care.
>
> In my opinion, the care instituted did depart from the minimal standard of care that would be provided by similar practitioners and a failure to employ acceptable scientific methods in drug selection occurred. No obvious patient harm occurred. The patient notes were often illegible, which is also not acceptable patient care, specifically in the setting of pain management.
>
> [Patient 2]
>
> Her initial visit with Dr. DeMint was 8/20/10 at which time there is no note of a narcotic contract, no toxicology screen, and no written review of previous tests. In notes, he states she is returning from a different provider due to dissatisfaction with the previous provider's care. At her initial visit, the patient was prescribed oxycodone and Oxycontin (patient stated that Oxycontin had worked for her in the past). There were multiple mentions of anxiety and depression and significant life/home stressors and Dr. DeMint appropriately referred her to a psychiatrist in October 2010 after trying a few different antidepressants. The patient never followed through with this referral due to "problems with insurance."
>
> The documentation for this patient was often difficult to read and information was scant. Physical exams were not consistent with the subjective level of disability. The patient's severe anxiety and depression did not appear to have been

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well treated, as there were constant complaints of this through the record. Treating her anxiety and depression appropriately and utilizing the expertise of a psychiatrist would likely have aided in her pain management. The medication used to manage her chronic anxiety was not ideal. The amount of narcotic the patient received was not supported by her clinical findings (exam and tests). This demonstrates a departure from minimal standards of care that would be employed by similar practitioners.

[Patient 3]

There is no note of review of previous records/radiology received from the ED, nor is there any note regarding the urine toxicology results. It remains unclear where the patient obtained Valium.

There are several concerns in the care of this patient. Sloppy records, including lack of co-signatures on narcotic contracts, incorrect dates on forms and urine tests that do not correlate with the patient's prescriptions. The patient received a large number of oxycodone at his initial visit prior to any record review. He was not brought back for one month. When the patient had buprenorphine in his urine and lacked oxycodone and did not appear to be in opiate withdrawal, he was given his normal prescriptions.

This care does not meet minimal standards of care for similar practitioners and the medication doses and amounts are not supported by radiologic findings. (the CT of the lumbar spine in 9/10 is essentially normal). The documentation is insufficient to support the medication choices and red flags are not addressed, showing failure to employ scientific methods in drug selection/treatment.

[Patient 4]

Concerns regarding this patient include the incomplete past medical history (hepatitis B), personal and family drug history and high dose narcotics with minimal findings on lumbar spine MRI and lumbar spine exam. The patient did have some findings on thoracic spine MRI but physical exam findings were essentially normal with the exception of decreased shoulder abduction. The patient was referred to physical therapy at the last note in April 2011 and this is the first time previous PT was noted.

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> The minimal standards of care were not met in regards to documentation of need for high dose narcotics; other standard therapies for pain and anxiety were not documented and the choice of medication was excessive considering the radiologic findings. The patient has Hepatitis B which raises the question of previous IV drug use and a chaotic home environment was mentioned which is a less than ideal situation for using large amounts of and high dose narcotics.
>
> [Patient 5]
>
> The initial visit documentation is vague, mentioning an ankle surgery and "knee fracture" but no dates, details or previous therapies are addressed in this note. There is no active problem list in the chart and the initial history and physical form in the chart (2004) is incomplete.
>
> * * *
>
> The patient had been on high dose narcotics prior to Dr. DeMint's assumption of his care. A more thorough review of his previous history may have supported the high dose narcotics, however, the amount of medication appears to be excessive for what is documented in the chart (by subjective findings, physical exam and previous tests). Lack of an OARRS search and urine toxicology at the time Dr. DeMint assumed the patient's care is also not consistent with standard practice.
>
> Deviations from the minimal standard of care include insufficient chart notes to support chosen medications, large amounts of Valium in a person working as a carpenter and who drinks and insufficient physical findings to support the amount of medication prescribed.
>
> [Patient 6]
>
> The initial exam is essentially a "fill in the blank" form and mentions decreased lumbar spine ROM and decreased sensation on right but unable to read what area of the body due to illegible handwriting.
>
> * * *
>
> Pain medication for this patient is not inappropriate but there are concerns. His urine toxicology was inappropriately

negative for oxycodone, he had consistently high levels of pain but mentions fishing and camping as activities, and he is receiving no mental health care with the exception of daily benzodiazepines. It is not clear how the inappropriate toxicology tests were addressed. It was also not clear the patient was progressing toward any goals.

This patient's care deviated from minimal standards as evidenced by the lack of follow through on inappropriate toxicology screens and continued prescriptions for narcotics. The choice of medication for the patient's anxiety also deviates from standards of care reflected by the dose and amount prescribed as well as duration of use. The medical record is illegible in places and very difficult to read which is inappropriate for a patient receiving this type of treatment (covering providers need to be able to read the chart).

[Patient 7]

Issues of concern regarding this patient's care include his receipt of a month supply of Xanax and Percocet 10/325 with a minimal physical exam and undocumented history. A more prudent approach would have been to give the patient a 1-2 week supply of medication and require him to return with documentation of prior care and prior therapy, including specialist consult reports and PT reports. The documented physical exam did not support this amount of medication. There was no note of the patient receiving any other therapy for his anxiety, ie counseling or SSRI medication. (old records indicate patient was hospitalized in July 2010 for suicidal ideation)

The patient was promptly and appropriately discharged when it was found that he was receiving prescriptions from other providers, however, this patient's initial treatment deviated from minimal standards of care as evidenced by a physical exam that does not support the amount of medication he was given and lack of records/information to support such a large amount of medication.

[Patient 8]

She had a brief history including prior medications but no note of previous non-medicine therapies. * * * The physical exam was brief and the only noted abnormality was decreased range of motion in the lumbosacral spine "in all planes".

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Approximately 40 to 50% of the notes are illegible and it is unclear from the chart if the patient was seen in this clinic previously. (It appears she was treated for a Worker's Comp claim in 2008/9.) The chart was somewhat disorganized as well with no legible reference to the prior Worker's Comp care.

* * *

There are several concerns regarding this patient's care. She is given a substantially larger dose of narcotic at her first visit than she had been receiving from her previous provider. Her documented physical exam does not support the amount of narcotic prescribed. There is mention of patient having a problem with the previous provider which is not investigated prior to her one month prescription. No urine toxicology is sent at her first visit. When the patient complains of feeling stressed, she is given #90 Xanax and not referred for any behavioral therapy. The more logical approach would be to provide a small number of benzodiazepines while the SSRI is taking effect. There was no history documented regarding prior evaluation or treatment for anxiety or depression. I was unable to locate any notes from Dr. DeMint regarding documentation supporting her prior back surgeries or radiology tests.

This departed from minimal standards in several areas noted above. The selection of medications/amount of medication was not appropriate. Appropriate non-medication therapies were not explored for the patient's skeletal pain and anxiety. The physical exam did not support the level of the patient's pain or amount of medication prescribed. The notes were often difficult to read/interpret.

[Patient 9]

Concerns regarding this patient's care include his receiving a month of medicine despite the note he was discharged from another provider, no urine drug screen at initial visit and 3 more urine drug screens which had at least one inconsistent value. This patient also appeared to have fairly severe COPD (noted to be on oxygen) and was taking very large doses of drugs that depress the respiratory center in the brain. There was no family history documented re: drugs/etoh and later in the chart it is noted that the patient had 3 relatives staying with him who were on Suboxone.

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> The medication selection and treatment deviated from minimal standards for similar providers as evidenced by high doses of narcotics with minimal objective findings (exam and radiology) and continued prescriptions with inconsistent toxicology screens. The medications used to treat this patient's anxiety (Alprazolem) is not the appropriate first line of therapy.
>
> [Patient 10]
>
> The patient was on high doses of narcotics for his MRI finding (both oxycodone and tramadol). His physical exam was normal at all visits, including reflexes and lower extremity strength. There was no note of a positive straight leg raise test.
>
> This patient's care deviated from minimal standards in regards to the amount of narcotic medication he was prescribed (high doses and large amounts) considering an essentially normal physical exam. The care also deviated from what is considered typical care, a regular non-steroidal anti-inflammatory with either gabapentin or Lyrica and a small amount of narcotic pain medication for exacerbations.
>
> [Patient 11]
>
> This patient was being treated for chronic low back pain, DDD and depression. His MRI findings were not consistent with his pain complaint. A urine toxicology sent 9/9/10 was positive for THC, hydrocodone (which the patient stated he was allergic to) and benzodiazepine. These were all inconsistent with his prescribed medication.
>
> It would not be in the best interest of a patient to provide a one month prescription of narcotic when there is a question of previous drug abuse. The patient's history of an inconsistent urine toxicology is not noted in the chart at this initial visit although it appears that they were available. A more thorough evaluation of this patient's history should have been completed and at the very least, he should only have been given one week of medicine pending review of old records. Physical exam notes are difficult to read and minimal at most visits, with the exception of right SI joint pain. This patient's care does not meet the minimal standards of care expected in regards to the choice and amount of medication prescribed related to the patient's

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radiologic findings and physical exam. There is also a departure from the minimal standard of care as compared to the care of similar practitioners as evidenced by the initial prescription in light of a clear history of illicit drug use.

[Patient 12]

On the patient's initial visit with Dr. Demint, there is no note of a chart review, there is a brief past medical history, past surgical history and social history where it is noted "no drugs". * * * There is no indication of previous treatment (ie counseling, non-controlled drugs) for this patient's anxiety, nor is any indication of review of prior therapies for pain or prior imaging. Several of the notes are illegible.

* * *

There is also no indication that this patient has had any appropriate counseling, non-narcotic drug trial or other therapy for his anxiety and there is no discussion of the effect of marijuana on his anxiety and other medications. This patient is noted to have COPD which is called moderate to severe on chest x-ray and is on high doses of medications which are known to depress the respiratory drive.

This patient's care departs from minimal standards in several ways, including prescribing narcotics and anxiolytics to a known illicit drug user and prescribing high doses of narcotics to someone with underlying COPD. The office notes are poorly organized and it is difficult to determine the extent of the patient's physical findings without going through extensive old records. This is another example of deviation from minimal standards of care. The medications used also do not meet minimal standards as suggested by using benzodiazepines for anxiety in an illicit drug user and not trying non-controlled options or psychotherapy first.

[Patient 13]

There was no active problem list in the chart, no initial history and physical and basically little to no past med history. Dr. Demint's initial note in March 2010 is brief, does not address previous care, tests or treatment.

* * *

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The physical exams did not support the patient's pain level. Previous radiology included MRIs of the lumbar spine and ankle, both with some abnormalities, however they do not support the high dose of narcotic the patient was receiving (30 mg oxycodone #120/mo). The patient's depression did not appear to be adequately treated and it was unclear if she was receiving counseling. Her undertreated depression likely increased her pain perception.

In general, the documentation for this patient did not support the amount of medication she was receiving and despite requiring an early refill in 4/10, urine toxicology screens were not done until October 2010. OARRS reports and ancillary therapies were not documented in her notes. The absence of these measures deviates from the minimal standard of care. The large amounts of high doses of narcotic do not meet minimal standards for appropriate medication choice in this patient at high risk for narcotic addiction/abuse.

[Patient 14]

At the time of transfer of care, there was no urine toxicology screen, no OARRS report and very brief HPI and physical exam. The chart has a large amount of old records, including information regarding discharge from a previous pain clinic for a failed urine toxicology and an evaluation by an independent examiner expressing concern regarding this patient's high dosage of controlled medications in the situation of an essentially normal physical exam.

Throughout his course of care, the patient seemed to need continually higher doses of narcotic medication and did not tolerate for various reasons, non-controlled drugs which are indicated for neuropathic pain.

* * *

Office notes are difficult to read due to illegible handwriting, however, improvements in function are not noted and physical exams, which are brief, are normal.

This patient's care did not meet the minimal care standards. Deviations of standard of care include continually escalating doses of narcotic medication when they do not seem to be improving pain or function as well as not sending a urine toxicology at the time of assuming the patient's care. (he was

> discharged from a previous physician for a failed toxicology screen). There was no summary of the plan to date when Dr. Demint assumed care and no measure of improvement in function. Also, of concern, is the patient's inability to tolerate gabapentin or Lyrica, both indicated for neuropathic pain. The patient is only able to tolerate Soma which is metabolized to a barbiturate. This was never addressed with the patient or mentioned in the assessment and plan. The patient does not receive any psychological referral or counseling which is clearly indicated. The doses and amounts of medication the patient received are excessive compared to the physical exam and radiology findings. Lastly, consulting physicians comment on the high doses of narcotics and near normal physical exam, this is not addressed by Dr. Demint.

(Emphasis sic.; State's Ex. 16.)

{¶ 22} By his second, third, and sixth assignments of error, appellant argues that the board improperly disciplined him for poor handwriting, inadequate charting of the treatment of his patients, and failure to document in the file that he reviewed the file each time he did so. The board found that appellant's medical charting for Patients 3, 6, 8, and 12 was incomplete, often illegible and/or disorganized.

{¶ 23} In addition to her written report, Dr. Cicek testified at the hearing regarding her concerns with the care given to each of these patients. As to Patient 3, she stated she had "a lot of trouble reading the notes [due to the handwriting]." (Tr. Vol. II at 363.) Dr. Cicek found that there was no documented reason for increasing the patient's narcotics and appellant did not document that he had reviewed the previous records. Dr. Cicek testified regarding Patient 6 that appellant did not document the goals or expectations for the patient's treatment and that violates the board's rules because a practitioner must develop an individualized treatment plan. The records do not indicate the reason for the prescriptions. The record does not properly reflect how appellant addressed the inconsistency of the toxicology screens with the patient and the follow-up with the patient. Dr. Cicek stated Patient 6's record fell below the standard of care because there was no documentation as to the follow through on the toxicology screens, the lack of individualized treatment plans, and the legibility.

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{¶ 24} Dr. Cicek testified that Patient 8 received a higher dose of narcotics at the initial visit with appellant, but no documentation as to the rationale. The assessment or plan does not address the increase in medication. Appellant did not document that he reviewed the prior records. There is no individualized treatment plan. Dr. Cicek stated the overall charting fell below the standard of care.

{¶ 25} Regarding Patient 12, Dr. Cicek testified that appellant failed to record in the record any review of attempted modalities of pain management, any review of the patient's current level of function or functional goals, and any individualized treatment plan. Appellant's notes were "poorly organized and it was difficult to determine the extent of the patient's physical findings without going through extensive old records." (Tr. Vol. II at 449.) Parts of the record were illegible.

{¶ 26} Appellant argues that Dr. Ellis Frazier found his records were substantially legible. Dr. Frazier also stated that a physician is not required to note in the patient file at each consultation that the physician reviewed the file. Further, Dr. Frazier stated that a physician is not required to state what each prescribed drug is intended to treat as long as the entire record shows a specific diagnosis and that the prescribed drug is a known treatment for the diagnosis. Dr. Frazier believed appellant appropriately documented evaluations, diagnoses, and treatment plans.

{¶ 27} Board member Dr. Steinbergh found that appellant's "medical records lacked a great deal of information." (Board's Ex. D at 5.) Dr. Steinbergh stated that "one of the reasons medical records are kept is so that any practitioner can follow the physician's thought process and treatment plan." (Board's Ex. D at 5.) At that board meeting, Dr. Steinbergh noted that Dr. Prior testified at the hearing that, in his opinion, appellant's records demonstrated minimal standards.

{¶ 28} Moreover, appellant focused his arguments on specifics, such as his argument that handwriting cannot be the basis of discipline. However, the board found more here than illegible handwriting. The board found both his medical documentation and charting were incomplete and not thorough, disorganized, illegible, and lacking necessary medical information. Despite appellant's evidence supporting his position, the record is replete with evidence supporting the board's determinations. The trial court determined that it could not substitute its opinion as to proper and adequate charting for

the opinion of the experts that serve on the board. The record contains evidence constituting substantial, reliable, and probative evidence. We cannot find that the trial court abused its discretion in so finding. Appellant's second, third, and sixth assignments of error are overruled.

{¶ 29} In his fourth assignment of error, appellant contends the board erred in finding that he improperly prescribed narcotics. Appellant argues that the board improperly found that he prescribed large doses of opioids because the doses he prescribed were "in the box." Since appellant prescribed a dose below the 180 milligram per day morphine equivalent, he contends that he did not prescribe a dose that was too high.

{¶ 30} Appellant testified that "in the box" refers to practices that are commonly accepted and "out of the box" refers to uncommon practices, pursuant to an article from medscape.org. (Tr. Vol. III at 671.) The article references opiate doses in the moderate range of 180 milligrams morphine equivalent per day. Thus, appellant argues that he prescribed doses that were "within the box" and, thus, the board cannot discipline him on that basis.

{¶ 31} However, Dr. Cicek focused on more than the amount of drugs prescribed. Her testimony focused on the fact that the type and amount of narcotics was inappropriate given the patient's history, assessment, and the medical judgment employed based on the presentation of these patients. For example, regarding Patient 1, Dr. Cicek testified that 30 milligrams of hydrocodone per day that appellant prescribed at the patient's first visit was excessive. The physical examination documented by appellant did not support that medication dosage. Dr. Cicek testified that Norco 10/325 is stronger than Vicodin and the record was not clear for what diagnoses appellant prescribed the Norco. Dr. Cicek testified that appellant inappropriately prescribed narcotics for Patient 1's fibromyalgia.

{¶ 32} Regarding Patients 1 through 5, and 7 through 14, Dr. Cicek testified that appellant failed to document a physical examination. Dr. Cicek testified there was a lack of physical examination findings documented to support the level of narcotics prescribed. She noted that the examinations were incomplete, minimal, or not documented at all. Dr. Cicek testified that a family physician's chart should include the following:

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> [A]n initial visit with a primary care provider, a family physician, typically reviews the patient's past medical history, past surgical history, family history, and social history. If they are coming in for a specific problem, the previous treatment of that problem and how the problem responded to that treatment. The current medications the patient's taking, their current allergies, and what their current complaints are.
>
> And, again, if we're talking about a situation where they're complaining of chronic pain, how that pain's limiting their function, their ability to proceed or, you know, live a productive life.
>
> And then a thorough physical exam. Often a review of systems if something's not addressed in what we call the HPI, the history of the present illness. A review of systems, a physical exam, and then an assessment and plan. And your assessment isn't simply a diagnosis; it's your thought process behind what leads you to that particular diagnosis.

(Tr. Vol. II at 354-55.)

{¶ 33} Dr. Cicek testified that regarding Patient 1, she found the dose of hydrocodone per day that appellant prescribed at the first visit was excessive and the physical examination documented at that first visit does not support that dose of medication.

{¶ 34} Moreover, regarding Patient 2, Dr. Cicek testified that the physical findings appellant documented did not support the amount of controlled substance medication he prescribed. Dr. Cicek testified that the documentation of the physical examination was only "MS full ROM LS spine" and that documentation was lacking because a "musculoskeletal exam encompasses more than range of motion of the lumbosacral spine. It encompasses reflex testing, strength, sensation, range of motion, muscle asymmetry or atrophy." (Tr. Vol. II at 357-58.)

{¶ 35} Dr. Cicek testified similarly for Patients 3 through 5 and 7 through 14, that the history and physical examination findings documented did not support the amount of narcotics prescribed. She consistently found that appellant should have determined whether the patients were proper candidates for narcotics or should have been treated with other non-narcotic methods.

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{¶ 36} Appellant argues that the board and the trial court failed to distinguish *In re Williams*, 60 Ohio St.3d 85 (1991). Appellant contends that *Williams* holds that with the facts of this case, the board could not rely on its own expertise. However, the facts of this case are distinguishable from the facts in *Williams*. In *Williams*, the Supreme Court of Ohio found that the board has "broad discretion to resolve evidentiary conflicts * * * and determine the weight to be given expert testimony." *Id.* at 87. In that case, the doctor dispensed controlled substances in a legally permitted manner but in a manner disfavored by the medical community. The only evidence in the record was the expert testimony that the practice of Dr. Williams did not fall below the acceptable standard of medical practice. The board then disagreed with the expert. The Supreme Court determined that the board cannot convert its disagreement with an expert's opinion into affirmative evidence of the opposite position where the issue is one on which medical experts are divided and there is no statute or rule governing the issue. This case differs from the one in *Williams*, however, because here there was expert opinion evidence submitted on both sides of the issue. The board did not simply choose the opposite position of appellant, but, rather, the board chose an expert opinion other than appellant's expert's opinion. The record contains evidence supporting the board's position.

{¶ 37} Given this evidence in Dr. Cicek's report and testimony, the trial court did not abuse its discretion in finding that the record contains evidence constituting substantial, reliable, and probative evidence. Appellant's fourth assignment of error is overruled.

{¶ 38} In his fifth assignment of error, appellant contends the board erred in finding that he prescribed narcotics before receiving information and failed to act on inconsistent test results.

{¶ 39} The hearing officer found the evidence was insufficient to support a finding that appellant practiced below the minimal standard of care by failing to obtain toxicology screens prior to prescribing narcotics to Patients 2, 5, 9, and 11 through 14. The evidence establishes that appellant did obtain an in-house urine screen on Patient 1 at her initial visit. The hearing officer found that appellant's assertion that the standard of care does not require a physician to obtain an initial drug screen prior to prescribing narcotics was persuasive and found the evidence insufficient to support a finding that appellant

practiced below the minimal standard of care. The board did not amend this finding. Thus, the first contention in appellant's fifth assignment of error is overruled.

{¶ 40} Appellant also contends the board erred in finding that he failed to act on inconsistent test results. Appellant contends that he did act on inconsistent test results. However, he continued to prescribe a one-month supply of narcotics for months before he acted on the inconsistent test results. Dr. Cicek testified that although urine screens should be verified because of the possibility of false positives, a cautious approach to further treatment is necessary after an inconsistent result. She testified that a one to two-week supply of narcotics should be prescribed rather than an entire month. The medication should be changed in amount or number of pills prescribed. The patient should be more closely monitored. Given this evidence, appellant's fifth assignment of error is overruled.

{¶ 41} In his seventh assignment of error, appellant contends the trial court erred in finding there was substantial, reliable, and probative evidence that appellant treated or failed to discharge a patient who admitted to abusing illegal drugs. Patient 12 admitted using marijuana after a urine screen tested positive. Appellant discussed that marijuana was illegal in Ohio with the patient, but appellant admitted he continued to prescribe controlled substances to the patient for months.

{¶ 42} Appellant further contends in his argument section in this assignment of error that he disagrees with Dr. Cicek's opinion that when a patient admits to drinking six beers in a weekend, that the patient must be counseled not to mix alcohol and narcotics. Appellant claims he can rely on the warning from the pharmacist.

{¶ 43} Dr. Cicek testified under circumstances that indicate drug abuse, especially illegal drugs, that the provider should discharge the patient. When a urine sample indicates the patient is using drugs that were not prescribed or not using drugs that were prescribed, at a minimum, the provider must limit prescribing to ten days to two weeks worth of medication and then re-evaluate the patient after confirmation of the laboratory results. Appellant continued prescribing a one-month supply. Given this evidence in Dr. Cicek's report and testimony, the trial court did not abuse its discretion in finding that the record contains evidence constituting substantial, reliable, and probative evidence. Appellant's seventh assignment of error is overruled.

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{¶ 44} In his eighth assignment of error, appellant contends that it was prejudicial error to find that he improperly treated fibromyalgia. Appellant diagnosed Patient 1 with a degenerative disk disease of the lumbar spine, fibromyalgia, tendonitis, bunion, and skin lesion. Appellant testified he prescribed Norco, not just for the patient's fibromyalgia, but also as treatment for her overall pain.

{¶ 45} Dr. Cicek's report specified that prescribing narcotics for fibromyalgia deviated from the standard of care. Dr. Cicek also testified:

> Fibromyalgia is a constellation of symptoms that is -- has no appreciable objective test besides pressure points to make the diagnosis. Often it's a diagnosis of exclusion when people have a pain syndrome often complicated by a mood disorder, fatigue.

(Tr. Vol. II at 344.)

{¶ 46} Dr. Cicek continued and stated that narcotics are not appropriate for fibromyalgia "because there are classes of drugs that are appropriate and have been proven to actually improve function in fibromyalgia," including Lyrica and Cymbalta. (Tr. Vol. II at 345.) Dr. Cicek testified that the physical examination documented by appellant did not support the level of medication he prescribed.

{¶ 47} Moreover, appellant submitted evidence on remand that supported the finding that it is not appropriate to treat fibromyalgia with an opioid. The formerly proffered testimony of Dr. Prior provided that it was not appropriate to do so. Appellant also submitted an article published in the September 2013 issue of The Journal of the American Osteopathic Association, *Fibromyalgia: A Clinical Update*, in which the author writes that opioids have not been demonstrated as effective in the management of fibromyalgia and should be avoided.

{¶ 48} Appellant further argues that the hearing officer found appellant improperly prescribed narcotics for the treatment of fibromyalgia and this finding must be reversed due to a fatal variance. Appellant contends that the charge was inappropriately prescribing narcotics for fibromyalgia but the finding was an improper diagnosis for fibromyalgia. A fatal variance occurs where the allegations and the evidence do not correspond. *James Reynolds & Co. v. Morris*, 7 Ohio St. 310 (1857). While appellant is correct that the board discussed the methodology of his diagnosing Patient 1's

fibromyalgia, the finding was not that he had misdiagnosed the patient, but, rather, he prescribed narcotics for a condition that narcotics were inappropriate to treat. Thus, given this evidence, the trial court did not abuse its discretion in finding that the record contains evidence constituting substantial, reliable, and probative evidence. Appellant's eighth assignment of error is overruled.

{¶ 49} In his ninth assignment of error, appellant contends that it was prejudicial error for the board to find that he failed to warn a Chronic Obstructive Pulmonary Disease ("COPD") patient properly of the dangers of narcotics and oxygen. Appellant again argues that a fatal variance exists because the board focuses on prescribing these medications and not the documentation of the discussion of the risks with the patient.

{¶ 50} However, the finding by the board was that appellant fell below the standard of care by prescribing high doses of narcotics to Patients 9 and 12, both of whom had COPD, without properly documenting the proper patient consultation. In her report, Dr. Cicek stated, "[Patient 9] also appeared to have fairly severe COPD (noted to be on oxygen) and was taking very large doses of drugs that depress the respiratory center in the brain." (State's Ex. 16 at 9.) Regarding Patient 12, Dr. Cicek noted, "This patient is noted to have COPD which is called moderate to severe on chest x-ray and is on high doses of medications which are known to depress the respiratory drive. This patient's care departs from minimal standards in several ways, including prescribing narcotics and anxiolytics to a known illicit drug user and prescribing high doses of narcotics to someone with underlying COPD." (State's Ex. 16 at 11.)

{¶ 51} Further, in her testimony, Dr. Cicek testified that it was below the standard of care to prescribe such a high dose of narcotics on the first visit. "And the last time the patient had received a long-acting opioid was * * * four months prior to the visit where he's given OxyContin 60 and 120 high-dose Percocets. So to go from nothing to that in a patient with COPD severe enough to require oxygen is very concerning" and below the standard of care. (Tr. Vol. II at 424-25.) She expressed the same concern regarding high-dose narcotics in a patient with an underlying lung dysfunction for Patient 12.

{¶ 52} The minutes of the November 5, 2014 meeting indicate that when discussing Patient 9, who had been prescribed OxyContin and oxycodone by appellant, Dr. Ramprasad commented that "while [it] was not a fatal mistake, physicians must be

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very careful when prescribing these medications because of possible respiratory depression." (Nov. 5, 2014 Minutes at 3.) The board is the one to resolve any evidentiary conflicts regarding medical issues and is in the best position to do so. The trial court found the evidence meets the requisite legal standard and we cannot find that the trial court abused its discretion in so finding. Appellant's ninth assignment of error is overruled.

{¶ 53} By his tenth assignment of error, appellant contends that it was prejudicial error for the board to apply post-claim statutory changes and newly announced standards of care. Appellant's argument under this assignment of error is that "[a]ny standard of care espoused by Dr. Cicek is not practiced by any other doctor. If her standard of care is accepted, then Dr. Demint was unaware of it and due process is violated when a rule is created after the fact and applied to him." (Appellant's Brief at 48.)

{¶ 54} The board has promulgated rules for treating intractable pain with narcotics. *See* Ohio Adm.Code 4731-21-02. Dr. Cicek repeatedly testified regarding the standard of care. "[C]ourts must afford due deference to the board's interpretation of the technical and ethical requirements of its profession." *Pons* at 621. The reasoning behind this standard is that " ' "[T]he 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 [people] equipped with the necessary knowledge and experience pertaining to a particular field." ' " *Id.* at 621-22, quoting *Arlen* at 173, quoting *Farrand v. State Med. Bd.*, 151 Ohio St. 222, 224 (1949). Thus, the board is comprised of experts in the field of medicine and, therefore, the board is in the best position to determine whether a physician met the standard of care in the field of medicine. We cannot say the trial court abused its discretion in finding that the record contains evidence constituting substantial, reliable, and probative evidence. Appellant's tenth assignment of error is overruled.

{¶ 55} In his eleventh and twelfth assignments of error, appellant contends the basis of the board's decision was a new board member's comments that were inflammatory and mischaracterizations of the evidence and the board imposed vindictive punishment. Appellant argues that board members made improper comments not based on the evidence and then penalized him. In essence, appellant contends that "[t]he Board

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silently found and punished a 'pill mill' specifically found not to exist." (Appellant's Brief at 52.)

{¶ 56} Appellant complains that Dr. Soin's comments were inflammatory. The November 5, 2014 board minutes contain statements attributed to Dr. Soin noting:

> [I]rregularities with Dr. Demint's practice, most notably that it was a cash-pay practice, visits cost $200.00, and patients had a 99% chance of being prescribed controlled substances. Dr. Soin stated that, according to a Medicare profile of physicians, 74% of pain management physicians wrote at least one prescription for a scheduled substance that year. Dr. Soin therefore found it very concerning that Dr. Demint, who was not a pain management physician, prescribed scheduled substances for 99% of his patients.

(Nov. 5, 2014 Minutes at 4.)

{¶ 57} Dr. Soin's remarks were a restatement of the evidence. Appellant testified that his practice only accepted cash and 99 percent of his patients received controlled substances. When a board member restates appellant's own testimony, those comments cannot be construed as "highly prejudicial." Dr. Soin also proposed the amendment to the hearing examiner's proposed order and commented that appellant "did not 'get it' when it comes to pain medications." (Nov. 5, 2014 Minutes at 4.) Dr. Soin believed appellant had the ability to offer good service to patients, but not in the field of pain management. Dr. Soin utilized his own expertise to interpret the evidence and conclude that appellant should not be prescribing narcotics to patients.

{¶ 58} Mr. Giacalone agreed with Dr. Soin. Mr. Giacalone commented that appellant was not operating a "pill mill" because "a typical 'pill mill' pattern would be to prescribe the same regiment for every patient, whereas Dr. Demint's prescriptions varied between patients." (Nov. 5, 2014 Minutes at 15-16.) Mr. Giacalone believed it was clear that appellant "overprescribed" and his "prescription habits do not necessarily fit within proper parameters." (Nov. 5 2014 Minutes at 16.) Mr. Giacalone expressed concern that given the "arrogance" of appellant's testimony and the "forthrightness of his convictions" appellant will return to his previous prescribing habits. (Nov. 5, 2014 Minutes at 16.) Mr. Giacalone supported Dr. Soin's amendment because it permanently prohibits appellant from prescribing narcotic analgesics.

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{¶ 59} Here, the board members' expertise and the evidence formed the basis of their comments. All the board members had the benefit of the hearing examiner's report and, therefore, mitigated the danger of any one board member's comments unduly influencing the other board members. The board minutes set forth in some detail the factors and evidence in the record that the board considered exacerbating, leading to the modification of the order and penalty. Despite the fact that appellant does not agree with the result, the comments do not constitute reversible error.

{¶ 60} Appellant further argues that, upon remand, the board imposed an increased penalty and he has demonstrated actual vindictiveness on the board's part in penalizing him for exercising his right to an appeal, thereby denying him due process.

{¶ 61} On remand, the trial court tasked the board with considering the matter again. A trial court may remand for further proceedings, which means "that the case is returned to the administrative agency so that it may take further action in accordance with applicable law. Such a remand does not dismiss or terminate the administrative proceeding but, rather, means that the agency may take a fresh look at the matter." *Chapman v. Ohio State Dental Bd.*, 33 Ohio App.3d 324, 328 (9th Dist.1986), citing *Tucson v. Mills*, 114 Ariz. 107 (App.1976). The composition of the board had changed between the meetings. The board was not required to impose the same sanction.

{¶ 62} Furthermore, another aspect of the hearing may have influenced the board to impose a heavier penalty after remand. It is apparent from the minutes of the meeting that the board members found appellant arrogant during his testimony and appellant exhibited a disregard for the standards of care. Under the board's disciplinary guidelines, aggravating circumstances can include dishonest or selfish motive, a pattern of misconduct, multiple violations, refusal to acknowledge wrongful nature of conduct, and adverse impact and misconduct on others. The board minutes set forth the factors and evidence from the record that the board considered to be exacerbating, which led to the modification of the penalty.

{¶ 63} The board has the authority to impose a wide range of sanctions, pursuant to R.C. 4731.22, ranging from reprimand to revocation. The board has the authority to restrict a physician's license permanently. *Clark v. State Med. Bd. of Ohio*, 10th Dist. No. 14AP-212, 2015-Ohio-251. The court of common pleas, in concluding that the board's

order was supported by reliable, probative, and substantial evidence was precluded from modifying the penalty imposed if the penalty was authorized by law. *Henry's Cafe, Inc. v. Bd. of Liquor Control*, 170 Ohio St. 233 (1959), paragraphs two and three of the syllabus. The discretion granted to the board in imposing a wide range of potential sanctions reflects the deference due to the board's expertise in carrying out its statutorily granted authority over the medical profession.

{¶ 64} Moreover, there is no evidence that the board changed appellant's sanction for "vindictive" purposes. In *North Carolina v. Pearce*, 395 U.S. 711 (1969), the United States Supreme Court set aside the sentence of a prisoner who had successfully appealed his conviction but, on remand, a harsher sentence was imposed. The United States Supreme Court found that the prisoner's due process rights were violated when the harsher sentence was imposed after the successful appeal because of vindictiveness. The United States Supreme Court held that if a harsher sentence is imposed following appeal, the reasons for the harsher sentence must appear in the record and must be "based upon objective information concerning identifiable conduct on the part of the defendant occurring after the time of the original sentencing proceeding." *Id.* at 726. The United States Supreme Court clarified its holding in *Pearce* in *Wasman v. United States*, 468 U.S. 559 (1984). In *Wasman*, the United States Supreme Court held that harsher sentences on remand were not prohibited unless the enhancement was motivated by actual vindictiveness against the defendant as punishment for having exercised his rights. *Id.* at 568. In *Alabama v. Smith*, 490 U.S. 794 (1989), the United States Supreme Court further clarified *Pearce*, by holding that unless there was a "reasonable likelihood" that the increased sentence was the result of actual vindictiveness, the burden was on the defendant to show actual vindictiveness. *Id.* at 799.

{¶ 65} In this case, the board explained its reasoning for its actions and the reasons were based on the evidence. There is no evidence that the board was acting vindictively. The board acted within its authority when it issued the order. Based on this court's review of the administrative record, the trial court did not err in finding there was reliable, probative, and substantial evidence supporting the limitations and restrictions imposed by the board. Appellant's eleventh and twelfth assignments of error are overruled.

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

Judgment affirmed.

DORRIAN, P.J., and SADLER, J., concur.

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Franklin County Ohio Court of Appeals Clerk of Courts- 2015 Jun 03 12:36 PM-15AP000456

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Franklin Donal Demint D.O.,	:	
Appellant-Appellant,	:	
v.	:	No. 15AP-456
Ohio State Medical Board,	:	(REGULAR CALENDAR)
Appellee-Appellee.	:	

JOURNAL ENTRY

Appellant having not demonstrated that he has moved the trial court for a stay as required by App.R. 7(A), appellant's May 18, 2015 motion for a stay of the trial court's judgment pending appeal to this court is denied.

Judge G. Gary Tyack

Judge Julia L. Dorrian

Judge Jennifer Brunner

cc: Clerk, Court of Appeals

Court Disposition

Case Number: 15AP000456

Case Style: FRANKLIN DONAL DEMINT DO -VS- OHIO STATE MEDICAL BOARD

Motion Tie Off Information:

1. Motion CMS Document Id: 15AP0004562015-05-1899980000

   Document Title: 05-18-2015-MOTION TO STAY

   Disposition: 3200

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IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

CIVIL DIVISION
DIVISION FROM WHICH YOU ARE APPEALING

Franklin Donald Demint, D.O.
535 Jadwin Road
Kingston, Ohio 45644

PLAINTIFF'S NAME AND ADDRESS

Vs.

CASE NUMBER 14CV-12-12547

Ohio State Medical Board
30 East Broad Street
Columbus, Ohio 43215-6127

DEFENDANT'S NAME AND ADDRESS

Notice is hereby given that Franklin Donald Demint, D.O. (PARTY NAME) hereby appeals to the Court of Appeals, Tenth Appellate District of Franklin County, Ohio, from the final judgment entry of the Common Pleas, Civil Division (NAME OF TRIAL COURT) entered on 04/09/2015 (DATE).

James R. Kingsley (0010720)
Attorney for Appellant
157 West Main Street
Circleville, Ohio 43113
NAME AND ADDRESS

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COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO
CIVIL DIVISION

Franklin Donal Demint D.O.,	:	
Appellant,	:	CASE NO. 14CV-12-12547
-vs-	:	**JUDGE SERROTT**
Ohio State Medical Board	:	
Appellee.	:	

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

Rendered this 9th day of April, 2015.

SERROTT, J.

This appeal is before the Court a second time after the Court previously remanded the case for a new hearing. The Court reversed the Board's prior decision because the Board refused to grant appellant a continuance to secure an expert witness regarding the standard of care. However, on remand, Appellant proffered testimony and offered expert testimony by Affidavit. Dr. Cicek, the Board's expert opined Appellant's care of fourteen (14) patients fell below the standard of care and violated standards for prescribing drugs to patients. Dr. Cicek offered specific testimony as to each Patient regarding the Standard of Care. The hearing officer issued a report recommending that the Board find that Appellant was in violation of the standards of practice and violated Board rules regarding the prescribing of controlled substances. The Board agreed and suspended Appellant from practice of Medicine for a minimum of ninety (90) days and permanently revoked his ability to prescribe narcotic analgesic drugs. Appellant timely filed this appeal.

Appellant generally argues that he is the "victim" of the alleged "witch-hunt" of the government to discipline doctors who prescribe narcotics and to shut down alleged "pill mills." (Appellant's Brief pp 2-3). Appellant further complains that the treatment of chronic pain patients is difficult and complicated because of controversy surrounding the modalities of treatment best suited to treat chronic pain. While this Court may agree with some of Appellant's commentary, this Court is in no position to "second guess" the experts and the eight (8) physicians who sit on the Medical Board who have the medical expertise regarding the treatment of chronic pain with narcotics.

The reality of this case is that Appellant prescribed large quantities of narcotics to numerous (at least 14) patients without adequate charting and in violation of the Board's rules. Appellant, and every physician with any common sense, should know and have known that the use of narcotics for such patients was going to be carefully scrutinized. Lay persons, let alone physicians who specialize in chronic pain care, are aware of the abuse of narcotics by patients with addictions.

While the Court is sympathetic to the Appellant's claim that he merely attempted to treat patients with real and chronic pain, common sense dictated that Appellant prescribe in a manner to ensure the medical conditions warranted narcotic medications and that he treat the patients in a manner to avoid abuse of these powerful narcotics. Instead, the record clearly shows Appellant worked at a facility that charged $200.00 cash to patients who almost all received powerful narcotics upon their initial visit. The Court has carefully reviewed the record and the applicable law.

In reviewing this appeal, the Court must determine whether the order of the Board is supported by reliable, probative, and substantial evidence and is in accordance with law. This Court cannot substitute its judgment for the Board's where there is some evidence supporting the

order. University of Cincinnati v. Conrad (1980), 63 Ohio St. 2d 108. The rationale for the above is simple. The Board is comprised of experts in the field of medicine and therefore, the Board is in the best position to determine whether stands of care in the field of medicine are met. This Court has no such expertise. The Court may engage in a limited weighing of the evidence, but must give "due deference" to the Board's interpretation of the technical and ethical requirements of the medical profession. Pons v. Ohio State Medical Board (1993), 66 Ohio St. 3d 619. This Court takes its role seriously and when convinced an agency's order is not supported by the evidence or is contrary to law, this Court has not hesitated to reverse the order of the agency. This Court has in fact reversed the orders of this very Board on a number of occasions. However, this is not such a case. The Board's order is supported by substantial, reliable, and probative evidence and is not contrary to law.

This Court will now address each assignment of error.

ASSIGNMENT OF ERROR NUMBER 1:

The Board did not err in admitting the testimony of its expert, Dr. Cicek. Appellant's objections as to Dr. Cicek's opinions go to the weight of her testimony not its admissibility. The record is replete with evidence establishing Dr. Cicek's expertise in treating patients with chronic pain. (TR. 321-330) Three Fourths (3/4) of Dr. Cicek's time was spent on clinically treating patients. Moreover, Dr. Cicek had teaching experience and specialized training in prescribing suboxone for opioid dependency patients. (TR. 329-330). An expert is permitted to testify in a medical board proceeding if the expert's experience and practice is similar to the physician being disciplined. Leak v. Medical Board 2011-Ohio-243 ¶12. In the case at bar, Dr. Cicek's training, clinical practice, and experience was very similar to Appellant's practice. Thus, Dr. Cicek was

well qualified to give opinions in this case. Dr. Cicek gave detailed testimony as to Appellant's deficiencies in treating each and every patient. (See State's Exhibit 17 and TR.)

In contradistinction, the Appellant's proffered testimony did not relate to the standard of care of each patient but instead were generalized opinions. The Board and the hearing officer thus discounted the proffered testimony and Dr. Frazier's affidavit because it failed to address specific allegations as to each patient. (Report pp. 8-9) This Court cannot re-weigh the testimony and substitute its opinion for that of the hearing officer and the Physicians on the Board who have the expertise with regard to charting and treatment of opioid dependent or chronic pain patients.

Finally, Appellee is correct in pointing out the Board itself is comprised of medical experts who can determine for themselves whether a physician's conduct falls below a reasonable standard of care. Arlen v. Ohio State Medical Board (1980), 61 Ohio St. 2d 168. In the Arlen case, the Ohio Supreme Court ruled that "expert testimony is not mandatory in a license revocation hearing" because of the Board's own expertise. Id. at 172. Dr. Cicek's testimony constitutes "some" evidence supporting the Board's decision and the Board and hearing officer were in the best position to determine the credibility of the witnesses. Therefore, the first Assignment of Error is OVERRULED.

ASSIGNMENTS OF ERROR NUMBERS TWO, THREE AND SIX:

The Appellant in the above claimed errors argues that he was improperly disciplined for his "poor handwriting" and poor or inadequate charting of his treatment of patients. He argues Dr. Frazier found his charting in proper form. However, Dr. Cicek and the Physician Board members found that the charting was inadequate because the medical rationale for medication, either new or higher doses, was not recorded. Again, this Court cannot substitute its opinion for

what is proper and adequate charting for the opinion of the experts (physicians) that serve on the Board. The record does contain some competent testimony that meets the standard of substantial, reliable, and probative evidence. (TR. 363-366 and State's Exhibits 6, 8, 10 and 12) See the Conrad case cited, supra, wherein the Supreme Court held that a Common Pleas Court must give deference to the administrative resolution of evidentiary conflicts. Thus, the fact that this Court may have reached a difference conclusion than that of the Board is irrelevant. Therefore, the three interrelated assignments of Error Nos. 2, 3, and 6 are OVERRULED.

ASSIGNMENT OF ERROR NUMBER FOUR:

Appellant next argues his prescription of opioids was proper and met the standard of care and the Board failed to consider O.A.C. §4731-21-04 which allows contained opioid therapy in spite of addiction. However, this Court is bound by the legal standard of review of administrative appeals. Appellant's arguments again go to the weight of the credibility of the witnesses. The Board did present some substantial, reliable and probative testimony that Appellant improperly prescribed large doses of opioids without considering a multi-modal approach. (TR. 340) Furthermore, O.A.C. §4731-21-02 does set forth explicit rules for treating intractable pain. This Court cannot "second guess" the Medical Board and its expertise in the area of prescribing narcotics even if this Court may have reached a different resolution of the issue. See Conrad, case Id. The record contains the requisite evidence supporting the Board's conclusion that he improperly prescribed opioids and violated the standard of care for the patients in question. (TR. 340,535-537 and State's Exhibit 16) Assignment of Error number 4 is OVERRULED.

ASSIGNMENT OF ERROR NUMBER 5:

This Assignment of Error is encompassed within Assignment of Error number 4 but, the Court will point out that the record contains the requisite evidence of Appellant's failure to closely monitor patients with inconsistent urine tests regarding illicit drug usage. (TR. 535-537.) This Assignment of Error is also OVERRULED.

ASSIGNMENTS OF ERROR NUMBERS 7, 8 AND 9:

Appellant next argues that he was disciplined for "failing to discharge patients" who tested positive for illegal drugs. The requisite standard of care requires that a patient be evaluated for addiction and referred to an addiction pain specialist O.A.C. §4731-21-02. Appellant did not meet these standards of care for patients testing positive for illicit drugs. (TR.266, 535-537) Assignment of Error number 7 is OVERRULED.

ASSIGNMENT OF ERROR NUMBER 8:

Appellant complains that the Board's finding with regard to Patient 1 was improper. Appellant treated Patient 1 diagnosed with fibromyalgia with narcotics. Patient 1 was treated with narcotics upon the actual initial visit with Appellant. The Board's expert found this method of initial treatment improper and that it fell below the standard of care. (TR.336-337.) The Board members themselves opined during the review of Appellant's case that narcotics should not be the initial form of treatment. (Board minutes April 2013 p. 21276) This Court cannot substitute its opinion for that of the expertise of the Board. (See Pons v. Ohio State Medical Board (1995), 66 Ohio St 3d 619 at 621-622 requiring this Court to defer to the Board's expertise in medical treatment protocol. This Assignment of Error is OVERRULED.

ASSIGNMENT OF ERROR NUMBER 9:

Appellant claims he was improperly disciplined for treating patients with COPD with opiates. The record again is replete with evidence regarding the alleged inappropriate dosages

and modalities of treatment for these patients. (See Dr. Cicek's testimony, TR. 424-25, 448-449 and State's Exhibit 16.) This Court cannot substitute its opinion for that of the Board's. The evidence on these issues meets the requisite legal standard. This Court cannot resolve evidentiary conflicts on technical points of medicine. The Board is in the best position to do so. This Assignment of Error is OVERRULED.

ASSIGNMENT OF ERROR NUMBER 10:

The Board's decision was not the result of "inflammatory evidence" not in the record. The Board, as did the hearing officer, chose to believe Dr. Cicek's expert opinions. The Board was entitled to consider her evidence, the conflicting evidence and weigh the evidence. The Board chose to believe Dr. Cicek. Her testimony, if believed, was sufficient to sustain all the allegations and findings the Board made against the Appellant. Therefore, this Assignment of Error is OVERRULED.

ASSIGNMENT OF NUMBER 11:

Finally, Appellant claims the Board, on remand, improperly added the sanction of permanently revoking his ability to prescribe opiates. On remand, Appellant was afforded complete due process. He sought reversal of the first order and this Court reversed the initial order. On remand, the Board was to consider this matter anew. The Board make-up had changed by the time it reconsidered Appellant's case. The Board was entirely justified in imposing a new sanction. On remand, the Board was deciding the matter anew and it could impose any new penalty that was in accordance with law. Chapman v. Ohio State Dental Board (1986), 33 Ohio App. 3d 324, 328. No evidence exists in the record to prove Appellant's allegation that the penalty was increased because Appellant exercised his rights in the first appeal. In fact, the Board reduced his actual suspension. The Board has the authority under law to restrict a

physician's license. Clark v. Medical Board, 10th Dist. No. 14AP-212, 2015-Ohio-251 ¶¶15-20. This Court is not permitted to change an agency's punishment or sanction if the sanction is in accordance with law. Henry's Café Inc. v. Bd of Liquor Control (1959), 170 Ohio St. 233. Thus, even if this Court would not have imposed the limitation (which it would not have) or imposed other lesser sanctions it has no authority to substitute its opinion of the sanction for that of the Board. Therefore, this Assignment of Error is OVERRULED.

CONCLUSION:

For all these reasons set forth herein, this Court OVERRULES ALL Assignments of Error in their entirety. The Board's findings, order, and sanctions imposed were all supported by substantial, reliable and probative evidence, and in accordance with law.

The previous Stay of the Board's order is hereby REVOKED AND DISSOLVED. Costs to Appellant. The order of the Board is AFFIRMED and shall take effect upon the filing and electronic service of this Decision and Entry. Pursuant to Civ. R. 58, the Clerk of Courts shall provide all parties notice of and the date of this judgment.

IT IS SO ORDERED.

Franklin County Court of Common Pleas

Date: 04-09-2015

Case Title: FRANKLIN DONAL DEMINT DO -VS- OHIO STATE MEDICAL BOARD

Case Number: 14CV012547

Type: DECISION/ENTRY

It Is So Ordered.

/s/ Judge Mark Serrott

Court Disposition

Case Number: 14CV012547

Case Style: FRANKLIN DONAL DEMINT DO -VS- OHIO STATE MEDICAL BOARD

Case Terminated: 18 - Other Terminations

Final Appealable Order: Yes

0C324 - Y47 Franklin County Ohio Clerk of Courts of the Common Pleas- 2015 Feb 17 11:46 AM-14CV012547

IN THE COURT OF COMMON PLEAS OF FRANKLIN COUNTY, OHIO
CIVIL DIVISION

Franklin D. DeMint., D.O.,	:	
Appellant,	:	**Case No. 14CV-12547**
-v-	:	**JUDGE SERROTT**
State Medical Board of Ohio,	:	
Appellee.	:	

ORDER

This matter is before the Court upon the request of Appellee for the Court to review and clarify terms of the "Agreed Upon Stay Order." The Court enters the following Order: The stay is only as to his suboxone practice of medicine, and the Appellant is permitted to only practice medicine as it relates to suboxone practice.

IT IS SO ORDERED.

Franklin County Court of Common Pleas

Date: 02-17-2015

Case Title: FRANKLIN DONAL DEMINT DO -VS- OHIO STATE MEDICAL BOARD

Case Number: 14CV012547

Type: ORDER

It Is So Ordered.

/s/ Judge Mark Serrott

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

FRANKLIN D. DEMINT, D.O.,	:	
Appellant,	:	Case No. 14-CV-012547
vs.	:	Judge Serrott
STATE MEDICAL BOARD OF OHIO,	:	
Appellee.	:	

JOURNAL ENTRY
CONDITIONALLY STAYING THE NOVEMBER 5, 2014 ORDER
OF THE STATE MEDICAL BOARD

This case is before the Court upon the appeal, pursuant to R.C. 119.12, of the Entry of Order of the State Medical Board of Ohio issued November 5, 2014 (mailed November 11, 2014). The order indefinitely suspended Dr. Smith's certificate to practice medicine and surgery in Ohio for a minimum of 90 days, with interim monitoring and conditions for reinstatement imposed. Appellant has petitioned this Court for a limited stay that will require him to comply with all terms in the November 5, 2014 order of the Medical Board, EXCEPT that he may continue in the practice of medicine pending the duration of the appeal to this Court. The State does not oppose this motion.

For good cause shown,

The November 5, 2014, order of the Appellee, State Medical Board of Ohio, be, and hereby is, STAYED AS TO THE SUSPENSION OF SUBOXONE PRACTICE OF MEDICINE ONLY. All other terms and conditions of the order shall remain in full force and effect.

This conditional stay shall expire at the time this Court issues a final Judgment entry in the above captioned matter.

IT IS SO ORDERED.

Date

JUDGE SERROTT

APPROVED BY:

/s/ James R. Kingsley
JAMES R. KINGSLEY (0010720)
Kingsley Law Office
157 West Main Street
Circleville, Ohio 43113
740-477-2546
740-477-2976 Facsimile

Counsel for Franklin D. Demint, D.O.

/s/ Kyle C. Wilcox
KYLE C. WILCOX (0063219)
Assistant Attorney General
Health & Human Services Section
30 East Broad Street, 26th Floor
Columbus, Ohio 43215-3400
614 466-8600
614-466-6090 Facsimile

Counsel for the State Medical Board

Franklin County Court of Common Pleas

Date: 12-24-2014

Case Title: FRANKLIN DONAL DEMINT DO -VS- OHIO STATE MEDICAL BOARD

Case Number: 14CV012547

Type: AGREED ORDER

It Is So Ordered.

/s/ Judge Mark Serrott

Court Disposition

Case Number: 14CV012547

Case Style: FRANKLIN DONAL DEMINT DO -VS- OHIO STATE MEDICAL BOARD

Motion Tie Off Information:

1. Motion CMS Document Id: 14CV0125472014-12-0399930000

   Document Title: 12-03-2014-MOTION

   Disposition: MOTION GRANTED

Franklin County Ohio Clerk of Courts of the Common Pleas- 2014 Dec 03 9:06 AM-14CV012547

IN THE COURT OF COMMON PLEAS FOR FRANKLIN COUNTY, OHIO

BEFORE THE STATE MEDICAL BOARD OF OHIO
ATTN: Case Control Officer

In the matter of:	:	Common Pleas No. _____
Franklin Donald Demint, D.O.	:	Medical Board No. 12-CRF-018

NOTICE OF APPEAL

Pursuant to RC §119.12, Franklin D. Demint hereby appeals the decision of the Medical Board mailed on 11/19/14.

NOTE: This case was previously appealed, docketed as Case No. 13-CV-004850 and assigned to Judge Serrott who reversed and remanded it.

/s/ James R. Kingsley
James R. Kingsley (0010720)
Attorney for Franklin D. Demint
157 West Main Street
Circleville, Ohio 43113
Telephone: 740-477-2546
FAX: 740-477-2976
email: kingsleyjrlaw@yahoo.com

MEMORANDUM IN SUPPORT

The agency's order is not supported by reliable, probative and substantial evidence and is not in accordance with law.

Appellant's grounds for appeal include:

1. It was error to allow/consider the testimony of Dr. Cicek because:

   A. RC §2743.43 barred her testimony.

B. She lacked foundational qualifications

C. She was impeached to the extent that her testimony was incredible.

2. The violations are contrary to law, are not supported by the evidence and are too vague to be enforceable; there was no prior rule or case creating a standard to discipline; Appellant's actions were in accordance with the medical standards of the community, and no other standard was introduced, for:

A. Illegible handwriting.

B. Charting.

C. Acting without receiving/before a patient's prior records are received.

D. Not reducing the amount of medication to a patient until receipt of prior records and/or test results.

E. Not acting until a confirmation test is received.

F. Not suspending treatment for an inconsistent test result that is explained.

G. Not written, not done is not a medical standard.

H. A doctor need not discharge a patient who admits to abusing illegal drugs.

I. A doctor may treat a patient for fibromyalgia and/or COPD in accordance with medical literature.

3. The Board improperly considered evidence not in the record.

4. The decision of the Board was improperly influenced by misstatements and inflammatory comments of a member.

5. The Board improperly increased the sanction after remand with no new evidence.

6. The findings were not supported by facts or law.

7. The sanctions were not supported by the facts and were contrary to law.

Respectfully submitted

/s/ James R. Kingsley
James R. Kingsley (0010720)
Attorney for Franklin D. Demint

CERTIFICATE OF SERVICE

The undersigned does hereby certify that he personally delivered to the State Medical Board a second original of the above Notice of Appeal on the 3rd day of December, 2014 and by mailing a copy to Kyle C. Wilcox, Assistant Attorney General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215-3400 and by email to kyle.wilcox@ohioattorneygeneral.gov on this 3rd day of December, 2014.

/s/ James R. Kingsley
James R. Kingsley (0010720)
Attorney for Franklin D. Demint

State Medical Board of Ohio

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

(614) 466-3934 med.ohio.gov

November 5, 2014

Franklin Donald Demint, D.O.
535 Jadwin Road
Kingston, OH 45644

RE: Case No. 12-CRF-018

Dear Doctor Demint:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation on Remand of R. Gregory Porter, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on November 5, 2014, including motions approving and confirming the Report and Recommendation on Remand as the Findings and Order of the State Medical Board of Ohio, and adopting an Amended Order.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Any such appeal much be filed in accordance with all requirements specified in Section 119.12, Ohio Revised Code, and must be filed with the State Medical Board of Ohio and the Franklin County Court of Common Pleas within (15) days after the date of mailing of this notice.

THE STATE MEDICAL BOARD OF OHIO

Mark A. Bechtel

Mark A. Bechtel, M.D.
Secretary

MAB:jam
Enclosures

CERTIFIED MAIL NO. 91 7199 9991 7033 2014 9588
RETURN RECEIPT REQUESTED

Cc: James R. Kingsley, Esq.
CERTIFIED MAIL NO. 91 7199 9991 7033 2014 9595
RETURN RECEIPT REQUESTED

Mailed 11-19-14

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation on Remand of R. Gregory Porter, State Medical Board Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on November 5, 2014, 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, and adopting an amended Order; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Franklin Donald Demint, D.O., Case No. 12-CRF-018, 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.

Mark A. Bechtel

Mark A. Bechtel, M.D.
Secretary

(SEAL)

November 5, 2014
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*	
	*	CASE NO. 12-CRF-018
FRANKLIN DONALD DEMINT, D.O.	*	

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on November 5, 2014

Upon the Report and Recommendation on Remand of R. Gregory Porter, State Medical Board Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation on Remand is attached hereto and incorporated herein, and upon the modification, 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:

A. **SUSPENSION OF CERTIFICATE**: Commencing on the thirty-first day following the date on which this Order becomes effective, the certificate of Franklin Donald Demint, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than 90 days. During the thirty-day interim, Dr. Demint shall not undertake the care of any patient not already under his care.

B. **PERMANENT LIMITATION/RESTRICTION**: Upon reinstatement or restoration of Dr. Demint's certificate to practice osteopathic medicine and surgery in the State of Ohio, said certificate shall be permanently LIMITED and RESTRICTED as follows:

1. Dr. Demint shall not prescribe, administer, dispense or otherwise provide any narcotic analgesics including but not limited to single entity or combination products containing oxycodone, hydrocodone, hydromorphone, oxymorphone or codeine.

2. This limitation shall not apply to buprenorphine-containing products or any other products that are approved to treat drug addiction, provided that

they are prescribed, administered, dispensed or otherwise provided in accordance with FDA-approved labeling and other federal and state requirements.

C. **INTERIM MONITORING**: During the period that Dr. Demint's certificate to practice osteopathic medicine and surgery in Ohio is suspended, Dr. Demint shall comply with the following terms, conditions, and limitations:

1. **Obey the Law**: Dr. Demint shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

2. **Declarations of Compliance**: Dr. Demint shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the date his quarterly declaration would have been due pursuant to his March 2010 Step II Consent Agreement. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Demint shall appear in person for interviews before the Board or its designated representative. The first such appearance shall take place on or before the date his appearance would have been scheduled pursuant to his March 2010 Step II Consent Agreement. Subsequent personal appearances shall occur every three months thereafter, and/or as otherwise directed by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

4. **Absences from Ohio:** Dr. Demint shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have the discretion to grant a waiver of part or all of the probationary terms set forth in this Order for occasional periods of absence of fourteen days or less.

   In the event that Dr. Demint resides and/or is employed at a location that is within fifty miles of the geographic border of Ohio and any of its contiguous states, Dr. Demint may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or

Supervising Member provided that Dr. Demint is able to otherwise maintain full compliance with all other terms, conditions and limitations set forth in this Order.

5. **Ban on Administering, Furnishing, or Possessing Controlled Substance; Log**: Dr. Demint shall not, without prior Board approval, administer, personally furnish, or possess (except as allowed under Paragraph C.6.a) any controlled substances as defined by state or federal law.

   In the event that the Board agrees at a future date to modify this Order to allow Dr. Demint to administer or personally furnish controlled substances, Dr. Demint shall keep a log of all controlled substances prescribed, administered or personally furnished. Such log shall be submitted in the format approved by the Board and shall be submitted to the Board no later than the date upon which Dr. Demint's declarations of compliance quarterly declaration is due, or as otherwise directed by the Board. Further, Dr. Demint shall make his patient records with regard to such prescribing, administering, or personally furnishing available for review by an agent of the Board immediately upon request.

6. **Sobriety**

   a. **Abstention from Drugs**: Dr. Demint shall abstain completely from the personal use or personal possession of drugs, except those prescribed, dispensed or administered to him by another so authorized by law who has full knowledge of Dr. Demint's history of chemical dependency. Further, in the event that Dr. Demint is so prescribed, dispensed or administered any controlled substance, carisoprodol, or tramadol, Dr. Demint shall notify the Board in writing within seven days, providing the Board with the identity of the prescriber; the name of the drug Dr. Demint received; the medical purpose for which he received said drug; the date such drug was initially received; and the dosage, amount, number of refills, and directions for use. Further, within thirty days of the date said drug is so prescribed, dispensed, or administered to him, Dr. Demint shall provide the Board with either a copy of the written prescription or other written verification from the prescriber, including the dosage, amount, number of refills, and directions for use.

   b. **Abstention from Alcohol**: Dr. Demint shall abstain completely from the use of alcohol.

7. **Drug and Alcohol Screens/Drug Testing Facility and Collection Site**: Dr. Demint shall submit to random urine screenings for drugs and alcohol at least two times per month, or as otherwise directed by the Board. Dr. Demint shall ensure that all screening reports are forwarded directly to the Board on a quarterly basis. The drug testing panel utilized must be acceptable to the Secretary of the Board, and shall include Dr. Demint's drug(s) of choice.

   Dr. Demint shall abstain from the use of any substance and the consumption of poppy seeds or any other food or liquid that may produce a low level positive result in a toxicology screen. Dr. Demint shall be held to an understanding and knowledge that the consumption or use of such substances, including but not limited to substances such as mouthwash or hand cleaning gel, may cause a positive drug screen that may not be able to be differentiated from intentional ingestion, and therefore such consumption or use is prohibited under this Order.

   All such urine screenings for drugs and alcohol shall be conducted through a Board-approved drug testing facility and collection site pursuant to the global contract between said facility and the Board, that provides for the Board to maintain ultimate control over the urine screening process and to preserve the confidentiality of all positive screening results in accordance with Section 4731.22(F)(5), Ohio Revised Code, and the screening process shall require a daily call-in procedure. Further, in the event that the Board exercises its discretion, as provided in Paragraph C.8 below, to approve urine screenings to be conducted at an alternative drug testing facility and/or collection site or a supervising physician, such approval shall be expressly contingent upon the Board retaining ultimate control over the urine screening process in a manner that preserves the aforementioned confidentiality of all positive screening results.

   Dr. Demint shall submit, at his expense and on the day selected, urine specimens for drug and/or alcohol analysis. All specimens submitted by Dr. Demint shall be negative, except for those substances prescribed, administered, or dispensed to him in conformance with the terms, conditions and limitations set forth in this Order. Refusal to submit such specimen, or failure to submit such specimen on the day he is selected or in such manner as the Board may request, shall constitute a violation of this Order.

   Further, within thirty days of the effective date of this Order, Dr. Demint shall enter into the necessary financial and/or contractual arrangements with the Board-approved drug testing facility and/or collection site in order to facilitate the urine screening process in the manner required by this Order. Further, Dr. Demint shall promptly provide to the Board

written documentation of completion of such arrangements, including a copy of any contract entered into between Dr. Demint and the Board-approved drug testing facility and/or collection site. Dr. Demint's failure to timely complete such arrangements, or failure to timely provide written documentation to the Board of completion of such arrangements, shall constitute a violation of this Order.

Dr. Demint shall ensure that the urine screening process performed through the Board-approved drug testing facility and/or collection site requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Demint and the Board-approved drug testing facility and collection site shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

Dr. Demint shall ensure that the Board-approved drug testing facility and/or collection site provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Order, and whether all urine screens have been negative.

In the event that the Board-approved drug testing facility and/or collection site becomes unable or unwilling to serve as required by this Order, Dr. Demint must immediately notify the Board in writing, and make arrangements acceptable to the Board pursuant to Paragraph C.8 below, as soon as practicable. Dr. Demint shall further ensure that the Board-approved drug testing facility and/or collection site also notifies the Board directly of its inability to continue to serve and the reasons therefore.

The Board expressly reserves the right to withdraw its approval of any drug testing facility and/or collection site in the event that the Secretary and Supervising Member of the Board determine that the drug testing facility and/or collection site has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

8. **Alternative Drug-testing Facility and/or Collection Site**: It is the intent of this Order that Dr. Demint shall submit his urine specimens to the Board-approved drug testing facility and collection site chosen by the Board. However, in the event that utilizing said Board-approved drug testing facility and/or collection site creates an extraordinary hardship upon Dr. Demint, as determined in the sole discretion of the Board, then subject to the following requirements, the Board may approve an alternate

drug testing facility and/or collection site, or a supervising physician, to facilitate the urine screening process for Dr. Demint:

a. Within thirty days of the date upon which Dr. Demint is notified of the Board's determination that utilizing the Board-approved drug testing facility and/or collection site constitutes an extraordinary hardship upon Dr. Demint, he shall submit to the Board in writing for its prior approval the identity of either an alternate drug testing facility and collection site, or the name of a proposed supervising physician, to whom Dr. Demint shall submit the required urine specimens. In approving a facility, entity, or an individual to serve in this capacity, the Board will give preference to a facility located near Dr. Demint's residence or employment location, or to a physician who practices in the same locale as Dr. Demint. Dr. Demint shall ensure that the urine screening process performed through the alternate drug testing facility and/or collection site, or through the supervising physician, requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Demint acknowledges that the alternate drug testing facility and collection site, or the supervising physician, shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

b. Dr. Demint shall ensure that the alternate drug testing facility and/or collection site, or the supervising physician, provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Order, and whether all urine screens have been negative.

c. In the event that the designated alternate drug testing facility and/or collection site, or the supervising physician, becomes unable or unwilling to so serve, Dr. Demint must immediately notify the Board in writing. Dr. Demint shall further ensure that the previously designated alternate drug testing facility and collection site, or the supervising physician, also notifies the Board directly of the inability to continue to serve and the reasons therefore. Further, in order to ensure that there will be no interruption in his urine screening process, upon the previously approved alternate drug testing facility, collection site, or supervising physician becoming unable to serve, Dr. Demint shall immediately commence urine screening at the Board-approved drug testing facility and collection site chosen by the Board, until

such time, if any, that the Board approves a subsequent alternate drug testing facility, collection site, or supervising physician, if requested by Dr. Demint.

d. The Board expressly reserves the right to disapprove any entity facility proposed to serve as Dr. Demint's designated alternate drug testing facility and/or collection site, or any person proposed to serve as his supervising physician, or to withdraw approval of any entity, facility or person previously approved to so serve in the event that the Secretary and Supervising Member of the Board determine that any such entity, facility or person has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

e. In the event that the Board approved an alternate drug testing facility and/or collection site, or a supervising physician, pursuant to the March 2010 Step II Consent Agreement between Dr. Demint and the Board, the entity, facility or person previously approved by the Board to so serve pursuant to the March 2010 Step II Consent Agreement may, in the sole discretion of the Board, be approved to continue as Dr. Demint's designated alternate drug testing facility and collection site or as his supervising physician under this Order.

9. **Reports Regarding Drug and Alcohol Screens**: All screening reports required under this Order from the Board-approved drug testing facility and/or collection site, or from the alternate drug testing facility and/or collection site or supervising physician, must be received in the Board's offices no later than the due date for Dr. Demint's quarterly declaration. It is Dr. Demint's responsibility to ensure that reports are timely submitted.

10. **Additional Screening Without Prior Notice**: Upon the Board's request and without prior notice, Dr. Demint shall provide a specimen of his blood, breath, saliva, urine, and/or hair for screening for drugs and alcohol, for analysis of therapeutic levels of medications that may be prescribed for Dr. Demint, or for any other purpose, at Dr. Demint's expense. Dr. Demint's refusal to submit a specimen upon the request of the Board shall result in a minimum of one year of actual license suspension. Further, the collection of such specimens shall be witnessed by a representative of the Board, or another person acceptable to the Secretary and Supervising Member of the Board.

11. **Rehabilitation Program**: Dr. Demint shall maintain participation in an alcohol and drug rehabilitation program, such as A.A., N.A., C.A., or Caduceus, no less than twice per week with a minimum of ten per month. At least one of the abovementioned meetings shall be a Caduceus meeting.

Substitution of any other specific program must receive prior Board approval.

Dr. Demint shall submit acceptable documentary evidence of continuing compliance with this program, including submission to the Board of meeting attendance logs, which must be received in the Board's offices no later than the due date for Dr. Demint's quarterly declarations.

12. **Comply with the Terms of Aftercare Contract**: Dr. Demint shall maintain continued compliance with the terms of the aftercare contract entered into with a Board-approved treatment provider, provided that, where terms of the aftercare contract conflict with terms of this Order, the terms of this Order shall control.

13. **Releases**: Dr. Demint shall provide authorization, through appropriate written consent forms, for disclosure of evaluative reports, summaries, and records, of whatever nature, by any and all parties that provide treatment or evaluation for Dr. Demint's chemical dependency or related conditions, or for purposes of complying with this Order, whether such treatment or evaluation occurred before or after the effective date of this Order. To the extent permitted by law, the above-mentioned evaluative reports, summaries, and records are considered medical records for purposes of Section 149.43 of the Ohio Revised Code and are confidential pursuant to statute. Dr. Demint shall also provide the Board written consent permitting any treatment provider from whom he obtains treatment to notify the Board in the event he fails to agree to or comply with any treatment contract or aftercare contract. Failure to provide such consent, or revocation of such consent, shall constitute a violation of this Order.

14. **Required Reporting of Change of Address**: Dr. Demint shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

D. **CONDITIONS FOR REINSTATEMENT OR RESTORATION**: The Board shall not consider reinstatement or restoration of Dr. Demint's certificate to practice medicine and surgery until all of the following conditions have been met:

1. **Application for Reinstatement or Restoration**: Dr. Demint shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.

2. **Compliance with Interim Conditions**: Dr. Demint shall have maintained compliance with all the terms and conditions set forth in Paragraph C of this Order.

3. **Controlled Substances Prescribing Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide acceptable documentation of successful completion of a course or courses dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

   In addition, at the time Dr. Demint submits the documentation of successful completion of the course(s) dealing with the prescribing of controlled substances, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

4. **Medical Records Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

   In addition, at the time Dr. Demint submits the documentation of successful completion of the course(s) on maintaining adequate and appropriate medical records, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

5. **ACOFP Course**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide acceptable documentation of successful completion of the Annual ACOFP Intensive Update and Board Review in Osteopathic Medicine. This course shall be taken in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) during which it is completed.

In addition, at the time Dr. Demint submits the documentation of successful completion of the ACOFP course, he shall also submit to the Board a written report describing the course, setting forth what he learned from the course, and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

6. **Additional Evidence of Fitness To Resume Practice**: In the event that Dr. Demint has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

E. **PROBATION**: Upon reinstatement or restoration, Dr. Demint's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:

1. **Terms, Conditions, and Limitations Continued from Suspension Period**: Dr. Demint shall be subject to the terms, conditions, and limitations specified in Paragraphs B and C of this Order.

2. **Practice Plan and Monitoring Physician**: Within 30 days of the effective date of Dr. Demint's reinstatement or restoration, or as otherwise determined by the Board, Dr. Demint shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan will be directly supervised and overseen by a monitoring physician approved by the Board. Dr. Demint shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

   At the time Dr. Demint submits his practice plan, he shall also submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Demint and who is engaged in the same or similar practice specialty.

   The monitoring physician shall monitor Dr. Demint and his medical practice, and shall review Dr. Demint's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

   Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Demint and his medical practice, and on the review of Dr. Demint's patient charts. Dr. Demint shall ensure that the reports are

forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Demint's declarations of compliance.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Demint shall immediately so notify the Board in writing. In addition, Dr. Demint shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Demint shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Demint's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Demint's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

F. **TERMINATION OF PROBATION; PERMANENT LIMITATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Demint's certificate will be restored, but shall thereafter be permanently LIMITED and RESTRICTED as specified in Paragraph B, above.

G. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training, and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Demint shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments.

   In the event that Dr. Demint provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30

days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.

These requirements shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Administration, through which he currently holds any professional license or certificate. Also, Dr. Demint shall provide a copy of this Order at the time of application to the proper licensing authority of any state or jurisdiction in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

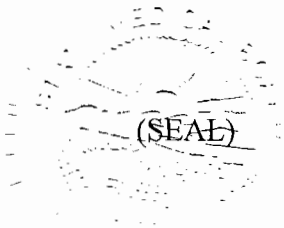
3. **Required Reporting to Treatment Providers/Monitors**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to all persons and entities that provide chemical dependency/abuse treatment to or monitoring of Dr. Demint. This requirement shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

4. **Required Documentation of the Reporting Required by Paragraph G**: Dr. Demint shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (a) the return receipt of certified mail within 30 days of receiving that return receipt, (b) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (c) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (d) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

H. **VIOLATION OF THE TERMS OF THIS ORDER**: If Dr. Demint violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

I. **SUPERSEDE PREVIOUS CONSENT AGREEMENT**: Upon becoming effective, this Order shall supersede the terms and conditions set forth in the March 2010 Step II Consent Agreement between Dr. Demint and the Board.

EFFECTIVE DATE OF ORDER: This Order shall become effective immediately upon the mailing of the notification of approval by the Board.



Mark A. Bechtel, M.D.
Secretary

November 5, 2014
Date

OCT - 6 2014
STATE MEDICAL BOARD
OF OHIO

BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of	*	
		Case No. 12-CRF-018
Franklin Donald Demint, D.O.,	*	
		Hearing Examiner Porter
Respondent.	*	

REPORT AND RECOMMENDATION ON REMAND

Basis for September 2012 Hearing

By notice of opportunity for hearing dated March 14, 2012 ("Notice"), the State Medical Board of Ohio ("Board") notified Franklin Donald Demint, D.O., that it had proposed to take disciplinary action against his certificate to practice osteopathic medicine and surgery in Ohio. The Board based its proposed action on allegations concerning Dr. Demint's care and treatment of 14 patients.[1] The Board further alleged that Dr. Demint's conduct in treating those patients constituted the following:

- "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," as those clauses are used in Ohio Revised Code Section ("R.C.") 4731.22(B)(2);

- "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 R.C. 4731.22(B)(6);

- "Violation of the conditions of limitation placed by the board upon a certificate to practice," as that clause is used in R.C. 4731.22(B)(15); and/or

- "[V]iolating 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 R.C. 4731.22(B)(20), to wit: Ohio Administrative Code Rule ("Rule") 4731-21-02, Utilizing Prescription Drugs for the Treatment of Intractable Pain. Furthermore, pursuant to Rule 4731-21-05, a violation of Rule 4731-21-02 also constitutes violation of R.C. 4731.22(B)(2) and 4731.22(B)(6).

Accordingly, the Board advised Dr. Demint of his right to request a hearing, and received his written hearing request on April 9, 2012. (State's Exhibits ("St. Exs.") 20A, 20B; Board Exhibit ("Bd. Ex.") I)

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[1] All patients referenced herein were identified on a Confidential Patient Key. (State's Exhibit 15)

A hearing was held on September 4 through 6, 2012. The Hearing Examiner filed his Report and Recommendation on February 13, 2013, and the matter was considered by the Board at its meeting on April 10, 2013. On April 18, 2013, the Board issued its Entry of Order that suspended Dr. Demint's certificate for at least 180 days, set forth interim monitoring conditions and requirements for reinstatement, followed by probationary terms and conditions for at least three years. (Bd. Ex. E)

Remand for New Hearing

Following the issuance of the Board's Order, Dr. Demint filed a timely appeal with the Franklin County Common Pleas Court. On or around August 8, 2013, the court issued an Opinion and Final Judgment Entry that reversed the Board's April 2013 Order and remanded the case to the Board for a new hearing. The basis for the court's decision was that Dr. Demint should have been afforded additional time to obtain an expert witness prior to the hearing. (Bd. Ex. F)

By entry dated November 1, 2013, the new hearing was scheduled to proceed on February 25 through 27, 2014. Later, by entry dated January 28, 2014, the hearing was continued to June 2 and 3, 2014. Subsequently, as set forth in an entry dated May 29, 2014, the parties elected to preserve the original hearing record and supplement that record on remand. Dr. Demint presented additional exhibits on his behalf on June 2, 2014, and both parties submitted written closing arguments. (Bd. Exs. G, H, J)

Appearances

Mike DeWine, Attorney General, and Kyle C. Wilcox and Melinda R. Snyder, Assistant Attorneys General, for the State of Ohio. James R. Kingsley, Esq., on behalf of Dr. Demint.

Original Hearing Dates: September 4 through 6, 2012

Informal Presentation of Exhibits on Remand: June 2, 2014

PROCEDURAL MATTERS

1. Following an informal presentation of exhibits on remand by Dr. Demint on June 2, 2014, the following exhibits were admitted to the record:

    - Board Exhibit A, which consists of the formerly proffered testimony of Dr. Phillip Prior from the original hearing. On remand, Board Exhibit A was admitted to the record and may be reviewed and considered.

    - Respondent's Exhibits M through CC, Respondent's Substitute Exhibit DD, and Respondent's Exhibits EE through HH. Respondent's Exhibits M through Z are sealed to protect patient confidentiality.

- Respondent's Exhibit II, which consists of Dr. Demint's written closing argument; and State's Exhibit 22, which consists of the State's written closing argument.

2. Following the informal presentation of exhibits, the hearing record was held open to give the State time to consider and possibly object to the new documents presented by Dr. Demint, and to give the parties an opportunity to prepare written closing arguments. The hearing record on remand finally closed on August 26, 2013. (Bd. Exs. H, J)

3. The hearing record on this matter includes all transcripts of testimony and exhibits admitted at the original hearing, as well as the additional exhibits and written closing arguments admitted on remand. Accordingly, the Summary of Evidence on Remand includes the Summary of Evidence from the original Report and Recommendation with only minor changes. Additional information derived from the evidence presented on remand appears in **bold**.

SUMMARY OF THE EVIDENCE ON REMAND

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 Information

1. Franklin Donald Demint, D.O., obtained his osteopathic medical degree in 1990 from the Ohio University College of Osteopathic Medicine[2] in Athens, Ohio. From 1990 through 1991 he completed an internship at Metropolitan General Hospital in Pinellas Park, Florida, and from 1991 through 1992 he completed eight months of family practice residency at that same institution. Dr. Demint was certified by the American Osteopathic Board of Family Physicians and by the American Osteopathic Board of Neuromusculoskeletal Medicine. He is also a diplomate of the American Academy of Pain Management ("AAPM"). (Hearing Transcript ("Tr.") at 16-17, 55; Respondent's Exhibit "(Resp. Ex.") C)

2. Dr. Demint testified that he obtained certification from the American Board of Osteopathic Family Physicians because he was allowed to "grandfather" in. Dr. Demint testified that, in order to obtain board certification, he had had to practice for five years, complete a certain number of hours of continuing medical education ("CME"), then sit for an examination. Dr. Demint obtained his board certification around 1997, and the option to grandfather in ended shortly after that. (Tr. at 18-19)

3. Dr. Demint testified that he does not currently hold admitting privileges at any hospitals. Dr. Demint further testified that he last held privileges at Doctor's Hospital of Nelsonville in Nelsonville, Ohio, in 1997. Dr. Demint indicated that he does only outpatient practice and prefers to leave inpatient practice to hospitalists. (Tr. at 19-20)

[2] Dr. Demint testified that this school is now known as the Heritage College of Osteopathic Medicine. (Tr. at 19)

Dr. Demint's Pain Management Practice

4. Dr. Demint testified that he currently practices as a solo practitioner in Kingston, Ohio, and that his practice is called Kingston Family Medicine, LLC, which he had begun in 1998 or 1999. Dr. Demint further testified that his practice includes family medicine but that he also does a substantial amount of addiction medicine, including Suboxone therapy. Dr. Demint testified that between 80 to 90 percent of his current patients are Suboxone patients. Dr. Demint indicated that he had formerly specialized in pain management, but discontinued when House Bill 93 took effect in mid-2011. Dr. Demint testified that he currently has only ten pain patients out of a total population of about 200 patients. (Tr. at 14-16, 32-34, 284-286, 300-301, 619-620)

5. Dr. Demint testified that he had taken several hundred hours of CME in pain medicine, and had taken and passed a credentialing examination to become a diplomate of the AAPM. Dr. Demint further testified that he has taken pain management CMEs since 1992, but did not begin concentrating his practice in that area until 2002. (Tr. at 17, 21)

6. Pursuant to an August 2009 Step I Consent Agreement, Dr. Demint's certificate was suspended for at least 180 days based upon violations of R.C. 4731.22(B)(5), (10), (20), and (26). The Step I Consent Agreement was based upon Dr. Demint's dependence on and excessive and habitual use of marijuana, and his admission of having possessed and dispensed generic Tylenol #3 tablets to a family member under circumstances not constituting an emergency, without performing and documenting an examination and without maintaining patient records. Among other things, Dr. Demint was required to complete 28 days of inpatient treatment at a Board-approved treatment facility for his abuse of and/or dependency upon marijuana, his drug of choice, and to maintain sobriety and submit to interim monitoring requirements. Pursuant to a March 2010 Step II Consent Agreement, Dr. Demint's certificate was reinstated subject to various probationary requirements, including practice monitoring. Dr. Demint remains subject to the requirements of his Step II Consent Agreement. (St. Ex. 18; Tr. at 46-50)

7. Dr. Demint testified that, shortly before his license was suspended, he had entered into a contract with Adena Health Systems in Chillicothe, Ohio, to work in their pain management practice. Dr. Demint testified that he had sent letters to his patients informing them that he was leaving his practice and going to work for Adena. However, prior to starting his position at Adena, his license was suspended and his position with Adena fell through. (Tr. at 33-34)

8. Dr. Demint testified that, following the reinstatement of his certificate, and during the time period relevant to this hearing, which is from March 2010 through about April 2011, he had worked at three locations, two of which are relevant to this matter. One location was Lance Family Medicine ("Lance") in Jackson, Ohio. Dr. Demint testified that he had been the only physician at that location. Dr. Demint started working there in March 2010 and continued until June 2011. (Tr. at 21-23; St. Ex. 19 at 7)

   Dr. Demint further testified that, when his license was reinstated in March 2010, he did not want to reopen his practice because he had grown tired of the business side of medicine.

Dr. Demint testified that he had planned on finding full-time employment as a physician, which he had thought he had found at Lance. However, Dr. Demint testified that he had only been needed about two days per week. When it became obvious to Dr. Demint that practicing at Lance would not provide him sufficient income, he reopened his practice. Dr. Demint testified that his practice reopened in the same location as before; however, his old patients did not return and the practice grew very slowly. Dr. Demint testified that "a lot of pain patients * * * came in when [he] first opened up[,]" but that by 2011 his patient load had grown to only about 200 patients. (Tr. at 35-37)

Dr. Demint testified that he had worked Mondays and Fridays at Lance, and worked Tuesday, Wednesday, and Thursday, plus a half day on Saturday, at his Kingston practice. (Tr. at 24-27, 32-34)

9. Dr. Demint testified that he had seen approximately 20 to 30 patients per day at Lance. (Tr. at 25)

10. Dr. Demint testified that approximately 95 percent of the patients at Lance had been treated with controlled substances. Dr. Demint further testified that approximately 99 percent of his patients at his own practice had been treated with controlled substances. (Tr. at 25-28, 38-39)

11. Dr. Demint testified that Lance took insurance, and most of the patients he saw there had some form of insurance. (Tr. at 297)

12. Dr. Demint testified that his practice in Kingston was cash-only during the time period relevant to this hearing. Dr. Demint testified that he had tried accepting insurance from about 2003 to about 2007, but that the reimbursements he received from private insurance were at or below Medicare levels. Dr. Demint testified that that had been insufficient, so he returned to accepting cash only. (Tr. at 38-40)

13. Dr. Demint testified that he had charged his pain management patients $200 for an initial visit and $120 for follow-up visits. Dr. Demint testified that he gave all of his patients receipts with billing codes so that they could send them to their insurance companies for reimbursement. Dr. Demint further testified that his policy was for the patients to pay in advance of service: "[I]t got to the point where I took the cash first because, if you didn't do what they wanted [you] to [such as give them the medications they wanted], they wouldn't pay you on the way out, you know. So if I got the cash first, I knew I would be paid for my visit." (Tr. at 41-42)

14. Dr. Demint testified that he drew his patients primarily from the area around Kingston up to about a 50- or 60-mile radius. He testified that Kingston is located between Chillicothe and Circleville, Ohio, and he drew most of his patients from those communities. (Tr. at 44)

<u>The State's Expert Witness – Wendy Cicek, M.D.</u>

15. Wendy Cicek, M.D., obtained her medical degree in 1998 from the Case Western Reserve University School of Medicine ("CWRU") in Cleveland, Ohio. From 1998 through 1999, she completed her first year of family practice residency at the University of Wisconsin in

Madison, Wisconsin. From 1999 through 2001, she returned to Cleveland and completed a family practice residency at MetroHealth Medical Center, where she was Chief Resident during her final year. Dr. Cicek was licensed to practice medicine and surgery in Ohio in 2001. She also holds an inactive license in Wisconsin. She was certified by the American Board of Family Practice in 2001 and her certification remains current. (St. Ex. 17; Tr. at 317-319)

16. Dr. Cicek testified that she is not board-certified in pain management. (Tr. at 466)

17. Prior to embarking on a career as a physician, Dr. Cicek had been a registered nurse. Dr. Cicek had obtained her nursing degree in 1987 from the Huron Road Hospital School of Nursing in Cleveland. (St. Ex. 17)

18. Dr. Cicek recently changed employment in August 2012 and currently practices in the Clinical Decision Unit at Kaiser Permanente where she "assesses patients to determine if they need to be admitted to the hospital or they can be discharged after being sent over to the emergency room." Prior to that, from 2006 through July 2012, Dr. Cicek practiced family medicine at MetroHealth Medical Center-McCafferty Clinic ("McCafferty Clinic") in Cleveland. She also serves on a part-time basis as a Clinical Instructor in the Department of Family Medicine at CWRU. In addition, she has an academic appointment through 2014 as a Clinical Assistant Professor of Family Medicine at the Ohio University College of Osteopathic Medicine. She also assists third-year medical students rotating through family medicine clerkships. (St. Ex. 17; Tr. at 320-322)

19. Dr. Cicek is a member of several professional associations. Among these, she has been a member of the American Society of Addiction Medicine since 2008. (St. Ex. 17)

20. Dr. Cicek described her family practice experience with the McCafferty Clinic:

> I was a * * * family physician working with five other providers, physicians, and a nurse practitioner, providing primary care to adults, children, pregnant patients, in a mostly inner-city population, small amount of ring suburb patients, large uninsured population and Medicaid population.
>
> * * *
>
> * * * Averaged about 25 patients a day. * * * We were the safety net hospital in the area, the county hospital, so we saw anybody who came in.
>
> My patient population spanned from birth to my oldest patient[s] [were] in their 90s. The majority of my patients, I would say, were between the ages of 21 and 50, 55, with a wide range of medical problems.
>
> * * *
>
> We had patients with—a lot of patients with chronic back pain; patients with back injuries, herniated disks; we had a large amount of patients with fibromyalgia; patients with acute injuries where we used narcotics acutely.

* * *

> We did have a handful of patients also with malignant situations that were, you know, being managed a little differently in terms of their pain management.

(Tr. at 322-324) Dr. Cicek added that about 30 to 40 percent of the patient population was treated for chronic pain, and many of them received opioids. (Tr. at 324)

21. Dr. Cicek testified that her training in the field of pain management consists of CME conferences and online training. Dr. Cicek also testified that she had utilized Suboxone while practicing at the McCafferty Clinic and had done some additional training in pain management for that. (Tr. at 329-330)

22. Dr. Cicek testified that, in connection with her review in this matter, the Board had provided her with copies of patient records along with the Board's intractable pain rules. (Tr. at 331) She further testified that she had referenced other materials as well:

> I referred to my facility's guidelines on prescribing narcotics for chronic pain. I referred to some guidelines that were available through the Federation of State Medical Boards. I referred to a couple of textbooks that I have at home. And then some of the different CME items I have received from—from the American Board of Family Physicians and information and written documents I have from my Suboxone training.

(Tr. at 332)

<u>Dr. Demint's Expert Witness from the Original Hearing – Phillip Prior, M.D.</u>

23. Phillip Prior, M.D., testified that he is an addictionologist and that he practices at the Veterans Administration hospital in Chillicothe. Dr. Prior testified that he is board-certified in family medicine and in addiction medicine. Dr. Prior further testified that he has been an addictionologist for about ten years. (Tr. at 588, 595)

24. At the time of the original hearing on this matter, Dr. Prior was Dr. Demint's monitoring physician for purposes of Dr. Demint's consent agreement with the Board. (Tr. at 588-589)

25. **During the original hearing on this matter, a portion of Dr. Prior's testimony was not admitted to the hearing record. That portion of testimony was marked for identification purposes as Board Exhibit A and held as proffered material for Dr. Demint. As proffered material, it was not reviewed or considered by either the Hearing Examiner or the Board during the original action. Since the original hearing on this matter, Dr. Prior has passed away. (See Tr. at 597-600; Bd. Ex. A at 601; Ohio eLicense Center website, *https://license.ohio.gov/Lookup/*, Search Terms "Prior, Phillip," accessed September 22, 2014)**

On remand, at Dr. Demint's request and with no objection from the State, Board Exhibit A was admitted to the hearing record. It may now be reviewed and considered by the Hearing Examiner and the Board. (Bd. Ex. A)

26. For the most part, Dr. Prior did not address Dr. Demint's individual patients in his testimony. Accordingly, the bulk of his opinions are addressed later in this report following the review of the individual patients. (Bd. Ex. A)

<u>Dr. Demint's Expert Witness on Remand – Ellis Frazier, M.D.</u>

27. On remand, Dr. Demint presented the expert opinion of Ellis Frazier, M.D., via a May 20, 2014 Affidavit. According to Dr. Frazier's curriculum vitae, he obtained his medical degree from the University of Kentucky College of Medicine in 1984. He then completed a residency in family medicine at Grant Medical Center in Columbus, Ohio, in 1987. Dr. Frazier has been licensed to practice medicine in Ohio since August 1985.[3] Dr. Frazier is certified by the American Board of Family Medicine. (Resp. Ex. AA; Ohio eLicense Center, *https://license.ohio.gov/Lookup/*, Search Terms "Frazier" and "Ellis," accessed August 25, 2014)

Dr. Frazier currently practices at Adena Family Practice in Piketon, Ohio. In addition, he is a member of the Ohio AIDS Drug Assistance Advisory Board, is a Volunteer Faculty member of the Ohio State University College of Medicine, and is active in the Association of Clinicians for the Underserved, for which he also serves as the Treasurer. Moreover, Dr. Frazier serves as the Medical Director of the Portsmouth City Health Department Primary Care Clinic/Ryan White Care Clinic. (Resp. Ex. AA)

28. Dr. Frazier indicated in his Affidavit that he had reviewed the medical records for Patients 1 through 14, as well as the February 13, 2013 Report and Recommendation and the final decision of the Board. For the most part, Dr. Frazier did not provide patient-specific opinions in his affidavit, and the bulk of his opinions are addressed later in this report following the review of the individual patients. (Resp. Ex. AA)

<u>Dr. Demint's Pain Management Practice</u>

"The Four A's"

29. During his testimony concerning individual patients, Dr. Demint made reference to a concept he referred to as the "four A's":

> The four A's is one of the ways you—you, you know, evaluate patients in pain and how well they're responding to treatment and stuff.

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[3] Dr. Frazier's affidavit states that he has been licensed to practice medicine in Ohio since November 2013. That date is clearly an error. The Ohio eLicense Center website indicates that he has been licensed in Ohio for nearly 30 years. (Resp. Ex. AA; Ohio eLicense Center, *https://license.ohio.gov/Lookup/*, Search Terms "Frazier" and "Ellis," accessed August 25, 2014)

> The first A is analgesia. You know, you can ask anybody, "How's your pain doing?", versus using a numerical scale. I—I often use what we call a multidimensional scale where I don't just ask what's your pain at now, but I ask you, you know, what's the best it's been in—since I've last seen you, what's the worst it's been, or the average.
>
> The second A is activities. I ask about, you know, what—what can you do, what can't you do, things like that.
>
> Let's see. Analgesia, activities. Adverse effects. You know, are you having problems with the medication? Is it causing you constipation, sedation, any other problems?
>
> And then the—the last A is aberrant behavior. And that's the—you know, that's just looking at, you know, are they calling in for pill counts a lot? Or, you know, do they have—the drug screens.

(Tr. at 621-622; See, also, Tr. at 53, 57-59)

Dr. Demint also testified that he used a "brief pain inventory," which is a questionnaire that asks the patient to assign a numerical value of zero through ten to elements such as the severity of pain at its worst, at its least, and on average, and its effect on the patient's general activity, mood, walking ability, work, interpersonal relationships, sleep, and enjoyment of life. It also asks the patient to note on a diagram where the patient's pain is located. (Tr. at 623-624)

Dr. Demint testified that he believes that the SOAP notes,[4] four A's, and the brief pain inventory together provide him sufficient information to diagnose and treat his patients. (Tr. at 624-625)

30. In support of his use of the four A's, Dr. Demint presented a medscape.org CME article dated March 15, 2012, that he had completed entitled *Treatment Initiation*. This article discusses the "four A's" of pain management. (Tr. at 670-674; Resp. Ex. G)

31. Dr. Cicek testified that "[t]he four A's are not a universally accepted assessment of pain." Dr. Cicek further testified that an assessment based on the four A's does not meet the minimal standard of care "as outlined by the State of Ohio in their document."[5] (Tr. at 511-512)

32. On remand, Dr. Demint provided the following statement in rebuttal to Dr. Cicek's criticism of the 4 As:

> **As far as the 4 A's, Dr. Cicek testified that "[t]he 4 A's are not a universal[ly] accepted assessment of pain." She further testified that an**

[4] SOAP is a mnemonic for Subjective, Objective, Assessment, and Plan.
[5] The Hearing Examiner presumed that Dr. Cicek was referring to the Board's intractable pain rules.

> **assessment based on the 4 A's does not meet the minimal standard of care "as outlined by the State of Ohio in their document.["] (Tr. at 511-512) Since that time the State of Ohio Medical Board (May 9, 2013) has come up with some new PM guidelines which heavily endorse the 4 A's as the way to document. This is another example of Dr. Cicek['s] ignorance when it comes to chronic pain management. * * ***

(Resp. Ex. M)

Prescribing In or Out of "The Box"

33. Another medscape.org CME article that Dr. Demint submitted is dated June 2008 and entitled *The Changing Paradigm of Pain Policy: Effects on Clinical Care,* authored by Kenneth L. Kirsh, Ph.D., and Steven D. Passik, Ph.D. This article describes the concept of prescribing "in and out of the box." Dr. Demint testified that "in the box" refers to practices that are commonly accepted and "out of the box" refers to practices that may be uncommon. The article also makes reference to opiate doses "in the moderate range (up to 180 mg morphine equivalent per day)" and indicates that "[d]aily doses above [that amount] involving patients with chronic noncancer pain have not been validated in clinical trials of significant size. National prescribing data suggest that 80% of patients are taking less than this dose in any case." Moreover, it states that individual patients frequently need higher doses and that such prescribing is legitimate; however, "it is important for a clinician to recognize that a "high dose" (as defined by being in the upper 20% of doses nationally) might require better and more detailed documentation to protect the patient and the prescriber in such cases." It further indicates that prescribing in the upper 20% nationally would be "out of the box." (Tr. at 671-672; Resp. Ex. B)

34. Dr. Cicek testified that Medscape is an authoritative source that she uses in conjunction with other sources; however, she testified that she is unfamiliar with the Kirsch and Passik article and the concept of prescribing in or out of the "box." Dr. Cicek indicated that that terminology is not used in the facilities where she has worked. (Tr. at 515; Resp. Ex. B)

    In addition, Dr. Cicek disagreed that that a daily dose of morphine equivalent dose of 180 milligrams per day is a moderate dose. She further testified that "[t]here's actually data showing that above 150 milligrams of morphine equivalent a day, there's increased risk of death." Dr. Cicek further testified that patients who receive more than that dose should consult a specialist. (Tr. at 519-521)

35. On remand, Dr. Demint submitted the *Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain,* published online by The Journal of Pain, *http://www.jpain.org/article/S1526-5900(08)00831-6/fulltext,* printed on May 4, 2014. (Resp. Ex. BB) Although the Hearing Examiner was unable to find use of the phrase "in the box" in those guidelines, the guidelines do state:

> **Theoretically, opioids have no maximum or ceiling dose, but there is little evidence to guide safe and effective prescribing at higher doses and there is no standardized definition for what constitutes a "high" dose. By panel**

> **consensus, a reasonable definition for high dose opioid therapy is >200 mg daily of oral morphine (or equivalent), based on maximum opioid doses studied in randomized trials, and average opioid doses observed in observational studies.**

(Resp. Ex. BB at 7)

The guidelines further characterize daily doses of 60 to 80 mg of morphine or morphine equivalent as "relatively low daily doses." (Resp. Ex. BB at 8)

Dr. Cicek's Definition of "Minimal Standard of Care"

36. Dr. Cicek defined the concept of "minimal standard of care" as follows:

> [The minimal standard of care for a family physician] is being able to care for a patient with the minimal—the minimal amount of knowledge, expertise, and treatment that would differentiate one—one person as a family physician from someone without that particular knowledge. So someone who has the training and experience to provide a basic level of care to a patient.

(Tr. at 333-334)

The Board's March 14, 2012 Notice of Opportunity for Hearing

37. On March 14, 2012, the Board issued a notice of opportunity for hearing to Dr. Demint alleging that he had practiced below the minimal standard of care in his treatment of 14 identified patients in a manner including, but not limited to, specific alleged conduct. (St. Ex. 20A) In the next section of the report, each patient and the allegations relevant to each patient will be described individually.

Patient 1

38. Patient 1, a female born in 1961, first saw Dr. Demint on June 7, 2010, at Lance. Previously, she had been an established patient at that practice, and she had last visited Lance in March 2008. The medical record indicates that, on March 27, 2008, a former physician at the practice had referred Patient 1 to an addictionologist to "[e]valuate if pt is appropriate for pain mgt" due to her "misuse of pain meds."[6] According to a progress note dated March 28, 2008, and an undated note on the same page, Patient 1 was unable to see the addictionologist at that time because of her current job assignment. The undated note also states, "Will wait till current job is done (construction work)." The medical records do not reflect any more visits until she saw Dr. Demint in June 2010. (St. Ex. 1 at 26, 32, 34, 52)

[6] A January 2008 urine drug screen report indicates inconsistent positive results for alcohol and propoxyphene. (St. Ex. 1 at 11)

Dr. Demint's initial visit note is reproduced below:

DIAGNOSIS
Rx
DRUG ALLERGIES
DATE / VITAL SIGNS | SUBJECTIVE | OBJECTIVE | ASSESSMENT | PLANS

6-7-10
BP 110/70
H T W T B M I
P 72 T

States she suffers from low and mid back pain. Feels as though she may have pinched nerve in (R) shoulder — depending on what work activities she does she has throbbing and tingling in (R) shoulder and (R) arm — works as union carpenter. Wears heavy harness (DIC) and tool belt.
States been taking ALT 7 qs Tylenol + Ibuprofen + [illegible] relief. Pt states was in MVA in 2007. c/o pain in (R) shoulder + (R) upper arm. States she can't sleep on her (R) side.
PX she c/o pain = lower back + Mid thoracic spine
Pain also c/o numbness in (R) foot.
Never got addictionologist consult done - states just quit cold.
PMH - Pain issue PSH - 2-C-section. Meds - Tylenol + Ibuprofen.
ALL - NKDA FH - Heart dz, Lung Cancer, Alzheimers
SH - (+) Smoke - 1 ppd + ETOH - 2 beers / 3 days - 4 days sick
Drugs - Ø
BP
H T W T B M I
P T
O. HEENT - TMs clear + good COR. Nasal + oral mucosa moist + pink
(R) foot - (+) edema 1st MP CV - RRR ≠ Ø by Bruit LS - full ROM LS Spine - (+) tender on L/S
Tr ō ROM tech. (+) tender over L/S paraspinal muscles +
(+) round multiple A 1) DDD LS spine 2) Fibromyalgia 3) Tendinitis 4) Burn
(R) shoulder + Burn in sign
5) Shoulder
P. 1) Norco 10/325 + q6 12 ct 90 & RF
2) Ibuprofen 800 mg + q8 ct 90 & RF
3) Zanaflex q + q6 8 ct 90 & 2 RF
4) Refer to Nutritionist
5) Refer to Neurologist
6) RTC ~ 3 m

(St. Ex. 1 at 32) (Image cropped to remove patient-identifying information and save space, and edited to remove Dr. Demint's signature.)

39. Dr. Demint indicated in his initial visit note that Patient 1 "[n]ever got addictionologist consult done – [illegible] just quit [illegible]." He further documented that Patient 1 consumes two beers three to four days per week. (St. Ex. 1 at 32)

40. An in-house urine drug screen taken at Patient 1's initial visit indicates negative results for all substances tested. An OARRS report obtained that day indicates that she had last received a prescription for tramadol, a controlled substance, in July 2009. (St. Ex. 1 at 8, 18)

41. Dr. Demint diagnosed Patient 1 as suffering from (1) degenerative disk disease of the lumbar spine, (2) fibromyalgia,[7] (3) tendonitis, (4) bunion, and (5) skin lesion. (St. Ex. 1 at 32)

42. At Patient 1's initial visit on June 7, 2010, Dr. Demint prescribed Norco 10/325 #90 with 2 refills, with instructions to take one tablet every six to twelve hours; ibuprofen 800 mg #90 with 2 refills, with instructions to take one tablet every eight hours; and Zanaflex 4 mg #90 with 2 refills, with instructions to take one tablet every 6 to 8 hours. In addition, Dr. Demint referred Patient 1 to a dermatologist concerning her skin lesion to rule out melanoma, and to a podiatrist concerning a bunion on her right foot. (St. Ex. 1 at 2, 32, 48, 50)

43. Following her initial visit, Patient 1 continued to see Dr. Demint on a regular basis through March 14, 2011, the last visit documented in State's Exhibit 1. During this time Dr. Demint maintained Patient 1 on the same dose of Norco. (St. Ex. 1 at 2, 28-33)

44. Patient 1 submitted to and passed a pill count of Norco on March 30, 2011. (St. Ex. 1 at 11)

45. Dr. Demint documented no additional urine drug screens from Patient 1 other than the in-house screen performed at Patient 1's initial visit. (St. Ex. 1)

Allegation 2(a): Dr. Demint inappropriately prescribed narcotics to Patient 1 for treatment of diagnosed fibromyalgia

Testimony of Dr. Cicek

46. Dr. Cicek testified: "Fibromyalgia is a constellation of symptoms that is—has no appreciable objective test besides pressure points to make the diagnosis. Often it's a diagnosis of exclusion when people have a pain syndrome often complicated by a mood disorder, fatigue." Dr. Cicek further testified that narcotics are not appropriate for fibromyalgia "because there are classes of drugs that are appropriate and have been proven to actually improve function in fibromyalgia," including Lyrica, Cymbalta, and amitriptyline. (Tr. at 344-345)

Dr. Demint's Evidence and Testimony from the Original Hearing

47. Dr. Demint acknowledged that Patient 1 had had fibromyalgia, but that she had also suffered from other conditions as well. He further testified that he had prescribed Norco not just for her fibromyalgia, but as treatment for her pain overall. (Tr. at 697-698)

[7] Dr. Demint described fibromyalgia as a neurological disease where the patient experiences widespread pain. (Tr. at 73-74)

48. The medical records indicate that Dr. Demint actually treated Patient 1 for several diagnoses, including degenerative disk disease of the lumbar spine, tendonitis, and fibromyalgia. (St. Ex. 1 at 32)

49. Dr. Demint testified that it may be appropriate to use an opioid to treat fibromyalgia and presented a collection of literature in support of his position. The first item is an excerpt from the *Handbook of Pain Management: A Clinical Companion to Wall and Melzack's Textbook of Pain,* published in 2003. Dr. Demint referenced a statement in that book that "Opioids are effective in most acute and chronic pain states. Although opioids are fairly commonly used in the treatment of fibromyalgia * * * there have been no controlled clinical trials." (Tr. at 654-655, 680-682; Resp. Ex. I at 102)

    The next document is a medscape.com article dated February 6, 2012, entitled *Pain Negatively Affects Cognition in Fibromyalgia*. Dr. Demint described the article:

    > [T]he gist of this article is that—that people with fibromyalgia, when given opioids, have improved cognition, which was even opposite of what they thought they were going to find. Because they figured you're on an opiate, it, you know, clouds your mind. That's not what they found.
    >
    > And, again, this makes sense in pain management in that, if they are truly just treating the pain, it won't affect. It just—you know, your pain is controlled, you're not high, you're not whatever. And if your pain is controlled, then you can think better because, I don't know about you, but when my back's hurting me, I don't think as well as I do when it's not, or any other pain.

    (Tr. at Tr. at 683)

    The last document is a medscape.com abstract from a 2011 article published in the American Journal of Health-System Pharmacy entitled *Pharmacotherapy of Fibromyalgia*. Dr. Demint testified that the article discusses the various medications that are prescribed for fibromyalgia, which includes opioids. (Tr. at 683-684; Resp. Ex. J)

<u>Original Finding of Fact 3 and Entry of Order Amending Finding of Fact 3</u>

50. In the original Report and Recommendation, the Hearing Examiner found that the allegation set forth in paragraph 2(a) of the Notice had not been proven, as stated in Finding of Fact 3:

> **The evidence is insufficient to support a finding that Dr. Demint practiced below the minimal standard of care by inappropriately prescribing narcotics to Patient 1 for treatment of diagnosed fibromyalgia. First, Dr. Demint had also diagnosed Patient 1 as suffering from degenerative disk disease of the lumbar spine, and there is no evidence that narcotics would be inappropriate to treat that condition.**

> **Second, Dr. Demint presented medical literature in support of his position that narcotics are not per se inappropriate to treat fibromyalgia.**

(Bd. Ex. B at 79; Bd. Ex. E at 94)

However, at its April 10, 2013 meeting, the Board found that this allegation was proven and amended Finding of Fact 3 accordingly. (Bd. Ex. D; Bd. Ex. E at 3, 109) Specifically, in its April 10, 2013 Entry of Order, the Board amended Finding of Fact 3 to state: "The evidence is sufficient to support a finding that Dr. Demint practiced below the minimal standard of care by inappropriately prescribing narcotics to Patient 1 for treatment of diagnosed fibromyalgia." (Bd. Ex. E at 3) Further, the Board stated, with reference to the amended finding: "Finding of Fact 3 is amended to reflect the Board's determination that there was not adequate documentation for the diagnosis of fibromyalgia for Patient 1." (Bd. Ex. E at 3)

Additional Evidence on Remand

51. In his affidavit, Dr. Frazier opined, "In regard to diagnosing fibromyalgia, the presence or absence of tender points are common but not required. That disease may be treated with narcotics." (Resp. Ex. AA)

52. In the formerly proffered testimony of Dr. Prior, Dr. Prior testified as follows:

> **Q. [By Mr. Kingsley] Is it appropriate to treat fibromyalgia with an opioid?**
>
> **A. [By Dr. Prior] No.**
>
> **Q. Ever?**
>
> **A. Not to my knowledge.**
>
> **Q. All right.**
>
> **A. There may be some controversy in the literature regarding that, but from an addictionologist's standpoint, no.**

(Bd. Ex. A at 7)

53. In his written testimony on remand, Dr. Demint stated:

> **The hearing officer found for Dr. Demint. The Board found against him. The Board stated no reason. The Hearing Officer's Decision is in**

> **accordance with the new JAOA article.[8] This patient was [diagnosed] with Fibromyalgia back in 2003 by her previous physician. It was a tertiary diagnosis. As the hearing officer correctly decided I was treating other ailments besides the fibromyalgia. The trigger points aren't required for diagnosis (recent JAOA article) and in a patient that is as physically active as this one is her fibromyalgia would be well controlled and may no longer exhibit trigger points. This should have been a non-issue as it was a well-controlled tertiary diagnosis.**

(Resp. Ex. M; See, also, Resp. Ex. CC at 681)

54. The JAOA article states at page 681 and 683-684 that tender points are not required in order to diagnose fibromyalgia. However, the article also includes the following statement in its discussion of the pharmacological management of that condition: "Opioids have not been shown to be effective in the management of fibromyalgia and should be avoided if possible. Opioid-induced hyperalgesia and long-term adverse effects limit the usefulness of this drug class." (Resp. Ex. CC at 688)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

55. Dr. Cicek testified that Dr. Demint diagnosed Patient 1 with: 1) low back pain, 2) tendonitis, and 3) fibromyalgia. Dr. Cicek further testified that neither tendonitis nor fibromyalgia are diagnoses that are treated with narcotics. (Tr. at 337)

    Moreover, Dr. Cicek testified that she found that 30 milligrams of hydrocodone per day that Dr. Demint prescribed to Patient 1 at her first visit had been excessive. Dr. Cicek further testified that the physical examination documented by Dr. Demint at Patient 1's first visit does not support that dose of medication. (Tr. at 347-348)

    Dr. Cicek testified that Norco 10/325 is stronger than traditional Vicodin, which has 5 mg of hydrocodone rather than the 10 mg of Norco. Dr. Cicek further testified that it is not clear from Dr. Demint's notes what diagnoses the Norco was intended to treat. (Tr. at 343-344)

56. Dr. Demint testified that his prescribing *was* supported by Patient 1's test findings. Dr. Demint referred to Patient 1's December 2006 MRI report indicating, among other things, that at L1-L2 "[t]here is mild wedging of the super endplate of L1 with a prominent Schmorl's node at this level. The study shows no evidence of prominent disc bulging, herniation, or canal stenosis." The report also referenced "mild disc bulging without focal herniation or canal stenosis" at L4-L5. Dr. Demint further referenced a September 22, 2010, MRI of Patient 1's humerus showing a "mildly displaced fracture of the proximal left humerus. There is some callus formation. Hence, findings may relate to a subacute fracture. Close clinical correlation

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[8] **The article Dr. Demint referred to is *Fibromyalgia: A Clinical Update,* published in the September 2013 issue of The Journal of the American Osteopathic Association. A copy of that article is included in the hearing record. (Resp. Ex. CC)**

and appropriate followup is suggested." That report also stated, "Oval abnormal osseous area along the posterior aspect of the humeral head/neck region. This may represent a fracture fragment versus osteophyte. Further evaluation with x-ray or CT scan of the left shoulder may be considered." Dr. Demint testified that those reports confirm the patient's report of pain in those areas. (Tr. at 690-691; St. Ex. 1 at 45, 55)

57. Dr. Demint testified that he had prescribed Norco to Patient 1 because she had taken it before and it provided relief, and she had already been taking over-the-counter NSAIDs and analgesics without sufficient relief. He further testified that she was a working carpenter and was physically active, and she needed stronger pain relief to keep her working. (Tr. at 76, 692)

    Dr. Demint testified that Norco is a combination of hydrocodone and acetaminophen. Dr. Demint testified that the morphine equivalent dose of her prescription was 30 mg per day if she took three tablets per day. The prescription allowed for a range of two per day to four per day, but 90 tablets were prescribed per month which was sufficient for three tablets per day over the course of 30 days. (Tr. at 75-76)

58. In his written rebuttal testimony, Dr. Demint stated:

> **A low dose of Norco is 60-80mg. A high dose is over 200mg. See Journal of Family Medicine, February 2009.[9] The new trigger point is 80mg.**
>
> **This patient was experiencing significant pain with work, as a union carpenter, which was not being relieved with used [sic] of NSAIDs. Since 16,500 patients a year die from the GI adverse events it was prudent to add a low dose opioid to give some additional pain relief. She has a long history of Chronic pain going back [to] at least 2003. Has an MRI which confirms diagnosis of Disc bulging at L4-5 and compression fracture L1. Has an MRI which confirmed fracture of proximal left humerus. On PE she had tenderness in both the shoulder region and low back with decreased Range of Motion. She reported pain of 8 and 9/10 without opioid medication which decreased to 3/10 with opioid medication.**

(Resp. Ex. M)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy

59. Dr. Cicek testified that the Board's intractable pain rules require physicians to develop individualized treatment plans for their intractable pain patients. Dr. Cicek further testified

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[9] The Hearing Examiner could not find a February 2009 article from the Journal of Family Medicine anywhere in the record. Dr. Demint probably misspoke and was referring to a February 2009 online article from the Journal of Pain, which is included in the record as Respondent's Exhibit BB.

that she did not see such an individualized plan in Dr. Demint's medical record for Patient 1. (Tr. at 349-350)

60. Dr. Cicek testified concerning individualized treatment plans:

> [A]n individualized treatment plan for a patient is assessing what their current level of function is, where their lack of ability to do what they need to do or want to do lies. Not just what their level or number of pain is, but how that's actually functioning their every—or, affecting their everyday life. What are they able to do? What are they not able to do that they need to do or want to do? And what are going to be the goals of pain treatment? The goals are never to make someone pain free. The goals are to make somebody functional.
>
> * * *
>
> And there needs to be some type of objective measure of that function. For example, the patient's not able to vacuum the house, or the patient's not able to take care of their own activities of daily living like showering, bathing. The goals of this patient's treatment are to maintain that middle level where they're able to provide their self-care, clean up around the house, back the car out of the driveway, et cetera. Some type of measurable goal.

(Tr. at 348-349)

The physician should then document whether the patient is meeting or not meeting the goals established. (Tr. at 350)

61. In his written rebuttal testimony, Dr. Demint stated:

> **In this case as in all chronic pain the goal is increased/stabilized function and tolerable level of pain. She was self-medicating with NSAIDs with less than ideal pain control and was likely to over use and experience the adverse effects of NSAIDs; i.e. GI bleeds, Kidney Failure, Liver Damage and Heart damage. She could not do PT due to her transit occupation. In addition her occupation as a Union carpenter is very physically demanding. She did not exhibit any psychological signs or symptoms to warrant treatment or referral. SSRIs do not help with pain. Another example of Dr. Cicek[']s] lack of basic pain medicine knowledge. This was documented by my SOAP notes under P for plan and use of the 4 A's.**

(Resp. Ex. M)

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics

62. Dr. Cicek noted that Dr. Demint obtained an in-office urine screen at Patient 1's first visit in June 2010 that yielded negative results for all substances tested. Dr. Cicek testified that

the physician "can be somewhat comfortable with the fact that the—the tests are negative." However, Dr. Cicek further testified that if chronic narcotics are being prescribed by a family practitioner for non-cancer pain at a first visit, the standard of care is to send an in-house urine toxicology screen to a laboratory for confirmation:

> [F]amily physicians can have expertise in areas of things like pain management; however, we're not formally trained like a pain specialist would be. Therefore, we need to talk all appropriate precautions, making sure we're prescribing correct medications in a safe situation.

(Tr. at 341)

Finally, Dr. Cicek testified that "[t]here was no formal opioid risk tool or assessment of the patient's risk for prescribing opiates." (Tr. at 337)

Allegation 2(i): Medical charting was incomplete, often illegible and/or disorganized

63. Dr. Cicek testified that she used to engage in chart review at her previous position with the McCafferty Clinic. When asked what she looks for in a family physician's chart, Dr. Cicek replied:

> [A]n initial visit with a primary care provider, a family physician, typically reviews the patient's past medical history, past surgical history, family history, and social history. If they are coming in for a specific problem, the previous treatment of that problem and how the problem responded to that treatment. The current medications the patient's taking, their current allergies, and what their current complaints are.
>
> And, again, if we're talking about a situation where they're complaining of chronic pain, how that pain's limiting their function, their ability to proceed or, you know, live a productive life.
>
> And then a thorough physical exam. Often a review of systems if something's not addressed in what we call the HPI, the history of the present illness. A review of systems, a physical exam, and then an assessment and plan. And your assessment isn't simply a diagnosis; it's your thought process behind what leads you to that particular diagnosis.

(Tr. at 353-355)

Dr. Cicek testified that the same is true if the patient had previously been treated by a physician in the same practice: "If the patient is seeing me as a first visit for anything—diabetes, hypertension, pain management—my responsibility as the new provider is to review the things I just mentioned." (Tr. at 355) Dr. Cicek further testified regarding the standard of care:

A. [by Dr. Cicek] You can't provide care to someone if you don't know what care has been provided or what their comorbidities are. That's just dangerous.

Q. [by Mr. Wilcox] Okay. And it's not necessarily that you may not know, but you have to document that you know?

A. Correct. Correct.

Q. Otherwise, it wasn't done, correct?

A. And it can be as simple as the statement, "Past medical history was reviewed and updated. Past surgical history was reviewed and updated." But then that has—that assumes that it's actually documented somewhere in the chart that's easy to find; on a problem list or on an initial paper that lists the patient's past history.

(Tr. at 355-356)

64. Dr. Cicek testified that she is familiar with the adage, "If it wasn't documented it wasn't done." Dr. Cicek further testified:

> As early as nursing school I learned that, if you don't write down what you're doing, what your assessment was, what you examined, or what you discussed, that it essentially wasn't done. The importance of documentation was—was essentially drilled into me as a nursing student, a medical student, and then as a physician.
>
> Because not only are we legally bound by that, but if someone else is providing care for that patient, it's very difficult if the information isn't written down to know either what was done, or what was evaluated, or what the person was thinking when they were putting together the plan of care.

(Tr. at 352-353)

65. Dr. Cicek testified that she had trouble reading some of Dr. Demint's notes. Dr. Cicek further testified that a physician's notes have to be readable to other physicians: "The charts need to be legible because, in the event the provider who's writing the notes is removed from care for whatever reason—injury, illness—the person covering needs to be able to read the notes and know what the treatment plan is." (Tr. at 342-343)

66. Dr. Cicek testified that she was unable "to decipher from his note where she was receiving treatment" prior to her first return visit with Dr. Demint in June 2010. (Tr. at 336-337)

67. Dr. Cicek further testified that Dr. Demint's documentation in Patient 1's chart fell below the minimal standard of care. (Tr. at 352)

68. In his affidavit, Dr. Frazier opined, "I do not believe that there is a standard of care known as 'not written, not done.'" (Resp. Ex. AA)

69. In his written rebuttal testimony, Dr. Demint stated:

> **I do not know how to address this any further. Several individuals have testified they can read my records. I have had three monitoring Physicians and all stated my records are legible and in accordance to standards. Even the Board Members said I was legible.**
>
> **No where has anyone stated any specific short comings on the organization of my charts. There [were] sections for notes, old records, tests results, OARRS reports and etc. So, I do not know what to address.**
>
> **As far as the 4 A's, Dr. Cicek testified that "[t]he 4 A's are not a universal[ly] accepted assessment of pain." She further testified that an assessment based on the 4 A's does not meet the minimal standard of care "as outlined by the State of Ohio in their document.["] (Tr. at 511-512) Since that time the State of Ohio Medical Board (May 9, 2013) has come up with some new PM guidelines which heavily endorse the 4 A's as the way to document. This is another example of Dr. Cicek['s] ignorance when it comes to chronic pain management. * * ***
>
> **In the end the charges are based on faulty assumptions made by the hearing officer based on false testimony by Dr. Cicek. If Dr. Cicek could not read my notes and did not have basic understanding of chronic pain management she should have not done the review and report.**

(Resp. Ex. M)

Additional Information Concerning Patient 1

70. Dr. Cicek testified that Patient 1's drinking habits are concerning because she had previously identified as testing positive for alcohol on a drug screen, plus the fact that the in-office screen she submitted to during her June 2010 visit did not test for alcohol. (Tr. at 345-346)

71. Dr. Cicek testified that she found it to be concerning that Dr. Demint's only statement concerning Patient 1's previous referral to an addictionologist was the fact that it did not get done. She testified that there was no explanation of where the patient had been treated in the interim or what had happened. (Tr. at 346)

72. Dr. Cicek testified:

> The departure from the standard of care in this particular case was not further addressing the reason she was initially discharged from the practice, or at least providing some type of risk tool for providing narcotics to a patient who was

> previously discharged, nor sending a urine toxicology at the initial visit for a patient who had been previously discharged.

(Tr. at 337)

73. Dr. Demint acknowledged that Patient 1 had had an inconsistent urine screen prior to coming to him. However, Dr. Demint testified that he chose to see her as a patient because she had made a good-faith effort to see an addictionologist to whom her prior physician had referred her, her OARRS was consistent, and he believed that, if he monitored her properly, it would be okay. Dr. Demint noted that he had had no problems with Patient 1 during the time he treated her. (Tr. at 691-692, 696)

74. Dr. Demint acknowledged that he had not referred Patient 1 to a specialist, but indicated that she had seen an orthopedic specialist on her own between her first and second visits. (Tr. at 693)

75. Dr. Demint testified that he had placed Patient 1 on a medication regimen that she had previously taken with good results. Dr. Demint further testified that his prescribing had been well within "the box," and that she had received a morphine equivalent dose of 30 milligrams. (Tr. at 694-695)

76. Dr. Demint opined that his medical documentation concerning Patient 1 had been sufficient. (Tr. at 698)

77. Dr. Demint testified that he stopped seeing Patient 1 in June 2011 as a result of the change in the pain management rules. (Tr. at 696)

<u>Patient 2</u>

78. Patient 2, a female born in 1965, first saw Dr. Demint on March 25, 2010. By that time she had been an established patient at Lance. The medical assistant documented Patient 2's complaints on March 25, 2010, as follows: "[Recheck.] States her back and thoracic area of back achy and painful. Having muscle spasms in back and legs. [Left] knee giving her a lot of pain. Oxycontin helping more c̄ pain than opana."[10] Dr. Demint documented:

> [Complained of left] knee swelling & achy all the time. States had synvisc injection help for a little while & then pain returned. Dr. Petty now gone from

[10] The symbol c̄ is a standard medical abbreviation for "with." Other common medical abbreviations used in this note are: PMH (past (or patient) medical history), HTN (hypertension), PSH (past (or patient) surgical history), CTS (carpal tunnel syndrome), Bx (biopsy), SH (social history), ETOH (alcohol), FH (family history), CAD (coronary artery disease), DM (diabetes mellitus), HEENT (head, eyes, ears, nose, throat), WNL (within normal limits), CV (cardiovascular), RRR (regular rate and rhythm), s̄ (without), MS (musculoskeletal), ROM (range of motion), LS (lumbosacral), CLBP (chronic low back pain), DDD (degenerative disc disease), and DJD (degenerative joint disease).

area. Never saw Dr. Freeman.[11] Neurontin → upset stomach. Lyrica → caused her to swell. Insurance wouldn't pay for Voltaren. PMH – HTN, Anxiety attacks, Depression, Allergy [continued on a different page]

PSH – CTS release, Partial hysterectomy, ovarian cyst removal. 2 Bx Breast.
SH – (+) Smoker 1 ppd X 30 yrs.
ETOH – seldom
Drugs – [none]
FH - CAD, Cancer – Ovarian, Skin melanoma, Prostate
DM

(St. Ex. 2 at 48, 50)

In the Objective portion of his progress note, Dr. Demint documented: "HEENT – WNL CV – RRR s̄ [illegible] [lungs] – BCTA MS – Full ROM LS spine –" (St. Ex. 2 at 48)

In his Assessment, Dr. Demint documented:

1) CLBP
2) DDD lumbar spine
3) DJD knee

(St. Ex. 2 at 48)

Finally, Dr. Demint noted in his Plan:

1) [Illegible – Explain?] need to be on long acting opioid eventually
2 short acting agents.
2) Morphine Sulfate ER 30 mg [one tablet twice per day] #60 [no] refill
3) Oxycodone IR 5 mg [one tablet every 4 to 6 hours as needed for breakthrough pain
#90 [no] refill
4) Naproxen 500 mg [one tablet twice per day] #60
5) [Return to clinic] 1m

(St. Ex. 2 at 48)

79. Patient 2's next visit with Dr. Demint occurred about five months later on August 20, 2010. The progress note indicates that Patient 2 was returning to Lance after having been seen by another physician, with whom Patient 2 stated she was dissatisfied. Dr. Demint's assistant noted that Patient 2 was suffering from lumbar and thoracic pain, "[a]lso c̄ knee, arm and elbow pain." Dr. Demint documented: "Pt [complained of] pain [with or in] back, knee & arm. States [illegible] [illegible – got?] pain in low back & radiates [left] leg to foot." On physical

[11] According to a note dated October 28, 2009, an appointment had been scheduled for Patient 2 to see Dr. Petty for an orthopedic consult on November 10, 2009. Also, an appointment had been scheduled for Patient 2 to see Dr. Freeman for a pain management consult on November 24, 2009. (St. Ex. 2 at 54)

examination, Dr. Demint made the following musculoskeletal findings: "↓ ROM [illegible – ll (left (or lower) leg)?] [illegible – plus?] LS spine." (St. Ex. 2 at 47)

In addition, Dr. Demint documented her current medications as: Opana 30 mg, one tablet twice per day; oxycodone 15 mg, one tablet four times per day; alprazolam 1 mg, one tablet three times per day; tizanidine 4 mg,[12] one tablet three times per day; along with verapamil, spironolactone, and Celexa. Dr. Demint documented that Patient 2 had advised that "Opana does nothing" and that Celexa was not helping with her depression. She further stated that her pain was better controlled with OxyContin 10 mg.

Dr. Demint listed the same diagnoses previously identified in the March 2010 progress note. (St. Ex. 2 at 47)

Dr. Demint testified that his plan was for Patient 2 "was the medication" and for Patient 2 to return in one month. However, the progress note does not specify which medications were utilized: the medications that Dr. Demint previously prescribed or the medications that Patient 2 claimed to have been taking at that time. (St. Ex. 2 at 47; Tr. at 96) Fortunately, Dr. Demint kept a medication log elsewhere in the chart that indicates he prescribed the following medications: Oxycodone IR 5 mg #120, one tablet every 4 to 6 hours as needed for breakthrough pain; OxyContin 20 mg # 60, one tablet twice per day; tizanidine 4 mg #90, one tablet three times per day; plus fluoxetine, furosemide, and verapamil. (St. Ex. 2 at 3)

80. The following table identifies the medications and dosages prescribed by Dr. Demint to Patient 2:

Date of Script	Medication(s) Prescribed by Dr. Demint
3/25/10	morphine sulfate ER 30 mg #60 twice per day oxycodone IR 5 mg #90 three times per day Naprosyn 500 mg #60 twice per day [note Patient 2 still had refills for Xanax 1 mg #60, among other non-controlled meds]
8/20/10	OxyContin 20 mg #60 twice per day oxycodone IR 15 mg #120 every 4-6 hrs prn Xanax 1 mg #90 every 8-12 hours Verelan 120 mg[13] #30 x 2 refills twice per day verapamil 120 mg #30 x 2 refills[14] twice per day tizanidine 4 mg #90 x 2 refills three times per day fluoxetine 2 mg[15] #30 once per day furosemide 20 mg[16] #30 x 2 refills once per day

[12] Tizanidine is the generic name for Zanaflex. (Tr. at 91)
[13] Verelan is a brand name of verapamil, which is used to treat high blood pressure and control angina. (MedLine Plus, *Verapamil*, http://www.nlm.nih.gov/medlineplus/druginfo/ meds/a684030.html, accessed November 28, 2012)
[14] Note that verapamil and Verelan are the same medication. The medication log indicates that Patient 2 was instructed to take one tablet of Verelan in the morning and one at night. With respect to verapamil, the medication log first indicates QID (four times per day) which is scratched out, then QD (one per day) which is also scratched out, then BID (twice per day). However, Dr. Demint only prescribed 30 tablets of each medication, which is a sufficient quantity for Patient 2 to have taken one of each per day, totaling 240 mg of the medication per day.

Date of Script	Medication(s) Prescribed by Dr. Demint
9/13/10	OxyContin 20 mg #60 twice per day oxycodone IR 15 mg #120 every 4-6 hrs prn Xanax 1 mg #90 every 8-12 hours gabapentin 300 mg[17] #72 three times per day Effexor 25 mg[18] #72 three times per day
10/11/10	OxyContin 20 mg #60 twice per day oxycodone IR 15 mg #120 every 4-6 hrs prn Xanax 1 mg #90 every 8-12 hours verapamil 120 mg #60 x 2 refills twice per day gabapentin 300 mg #90 three times per day
11/15/10	OxyContin 20 mg #60 twice per day oxycodone IR 15 mg #120 every 4-6 hrs prn Xanax 1 mg #90 every 8-12 hours Claritin 10 mg #30 x 2 refills once per day tizanidine 4 mg #90 x 2 refills three times per day furosemide 20 mg #30 x 2 refills once per day gabapentin 300 mg #90 x 2 refills three times per day
12/10/10	OxyContin 20 mg #60 twice per day oxycodone IR 15 mg #120 every 4-6 hrs prn Xanax 1 mg #90 every 8-12 hours Z-Pak[19] as directed
1/10/11	oxycodone 30 mg #112[20] every 6 hrs prn Xanax 1 mg #84 every 8-12 hours verapamil 120 mg #60 x 2 refills
2/4/11	oxycodone 30 mg #112 every 6 hrs prn Xanax 1 mg #84 x 2 refills every 8-12 hours tizanidine 4 mg #90 x 2 refills three times per day gabapentin 300 mg #90 x 2 refills three times per day
2/28/11	oxycodone 30 mg #112 every 6 hrs prn furosemide 300 mg #30 x 2 refills three times per day
4/1/11	The progress note references the medication log, but there is no medication log for this date. A new medication log lists medications but no date and identifies no prescriptions issued. (St. Ex. 2 at2)

Dr. Demint's progress note for the August 20, 2010, visit does not explain why the medication was prescribed this way. Later, in October and November 2010, Dr. Demint discontinued the brand name prescription and prescribed only verapamil 120 mg #60, with instructions to take one tablet twice per day. (St. Ex. 2 at 3, 47)

[15] Fluoxetine is the generic name for Prozac, an antidepressant. (MedLine Plus, *Fluoxetine*, http://www.nlm.nih.gov/ medlineplus/druginfo/meds/a689006.html, accessed November 28, 2012)

[16] Furosemide is the generic name for Lasix, a diuretic used to treat water retention and high blood pressure. (MedLine Plus, *Furosemide*, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682858.html, accessed November 28, 2012)

[17] Gabapentin is the generic name for Neurontin, an anticonvulsant that is also used to treat radicular pain. (Tr. at 427; MedLine Plus, *Gabapentin*, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a694007.html, accessed November 28, 2012)

[18] Effexor is a brand name for venlafaxine, an antidepressant. (MedLine Plus, *Venlafaxine*, http://www.nlm.nih.gov/ medlineplus/druginfo/meds/a694020.html, accessed November 28, 2012)

[19] Z-Pak was documented in the progress note only. (St. Ex. 2 at 41)

[20] Dr. Demint discontinued prescribing OxyContin. The progress note indicates that Patient 2 had complained about the cost of OxyContin versus oxycodone IR. (St. Ex. 2 at 3, 38)

(St. Ex. 2 at 3)

81. The chart indicates that Patient 2 submitted to and passed a pill count on October 11, 2010. (St. Ex. 2 at 13)

82. No urine toxicology screens are documented during the time period that Dr. Demint treated Patient 2. (St. Ex. 2)

83. On May 3, 2010, Dr. Demint obtained an OARRS report on Patient 2. Subsequently, in March 2011, Dr. Demint obtained reports concerning Patient 2 from OARRS, KASPER, and the West Virginia Board of Pharmacy. (St. Ex. 2 at 15-20)

84. On June 28 and August 20, 2010, Patient 2 signed medical records releases directed to her former treatment provider. (St. Ex. 2 at 64, 139)

85. On October 11, 2010, Dr. Demint referred Patient 2 for a psychiatric consult based upon a diagnosis of depression. However, a Post-it note on the referral form says, "patient no longer has insurance or her job. Wants to wait on psychiatrist." (St. Ex. 2 at 61)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

86. Dr. Cicek stated that the amount of controlled substance medication prescribed to Patient 2 by Dr. Demint was not supported by the physical findings he documented in the chart. (Tr. at 360-362)

    Dr. Cicek testified that, at Patient 2's first visit with Dr. Demint, Dr. Demint addressed the patient's surgical, medical, social, and family history. However, she testified that documentation of the physical examination was simply that Patient 2 had full range of motion in her lumbosacral spine. Dr. Cicek further testified: "A musculoskeletal exam encompasses more than range of motion of the lumbosacral spine. It encompasses reflex testing, strength, sensation, range of motion, muscle asymmetry or atrophy" as well as the "patient's ability to walk, sit, stand." Dr. Cicek further testified that observing the patient's ability to get on and off the examination table can often be useful. (Tr. at 357-358)

87. Dr. Demint testified that MRIs from June and October 2009 confirm Patient 2's subjective complaints:

    - A June 16, 2009, report of a lumbar spine MRI stated the following impression: "Degenerative changes are seen in the facet joints." (St. Ex. 2 at 88)

    - An October 8, 2009, report of an MRI of Patient 2's left knee stated the following impressions: (1) Moderate Baker's cyst; (2) Mild osteoarthritis at the patellofemoral and medial compartments of the knee joint with associated chondromalacia as described elsewhere in the report, which references Grade II and Grade I

> chondromalacia; and (3) Mucoid degeneration at the posterior horn of the medial meniscus without evidence of discrete meniscal tear. (St. Ex. 2 at 91-92)

(Tr. at 699-701)

88. Dr. Demint testified that his prescribing to Patient 2 had been within "the box," and that he had started her on a morphine equivalent dose of between 45 to 55 milligrams. However, assuming that the "morphine equivalent dose" concept applies to a *daily* dose, Dr. Demint's testimony does not agree with the medical records. For example, on March 25, 2010, Dr. Demint prescribed, among other things: morphine sulfate 30 mg to be taken twice per day, and oxycodone 15 mg with a supply sufficient to take three per day over the course of 30 days. That is 60 milligrams of morphine per day plus 45 milligrams of oxycodone per day. Assuming a one-to-one ratio between oxycodone and morphine, that is 105 milligrams morphine equivalent dose ("MED") per day at the first visit. (Tr. at 702-703; St. Ex. 2 at 3, 48, 50)

89. Dr. Demint testified that he had not tried Patient 2 on any non-medication therapies because she had already been taking OxyContin 10 mg and oxycodone 15 mg. However, Dr. Demint testified that he had discussed with Patient 2 going to physical therapy, and that he had documented that discussion in his April 1, 2011, progress note. (Tr. at 701-702; St. Ex. 2 at 33)

90. In his written rebuttal statement, Dr. Demint stated:

> **[Patient 2] had MRI's and X-rays documenting her disease states. She has seen Orthopedics prior to my treatment of this patient. She also was treated by numerous physicians at Lance Family medicine which also documents her conditions. My exams over the [course] of her [care] covered ROM, Strength, SLR, Atrophy, Sensations, Reflexes and etc. Her dose was elevated from a lower dose to a dose which gave her tolerable pain relief.**

(Resp. Ex. N)

91. In addition, Dr. Demint responded to Dr. Cicek's criticism that he had documented only range of motion and strength for his physical examination. He stated:

> **Dr. Cicek ignores the fact that a complete physical exam was done on a prior or subsequent occasion. A complete physical examination does not have to be done all in one visit or on each visit. [Her] requirement is excessive and not appropriate and is contradicted by Dr. Gronbach in the CME attended by Dr. Demint.[21]**

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[21] Dr. Demint appears to be referring to the CME materials for Chronic Pain: A Regional Collaboration Symposium, offered by Adena Health System on December 14, 2013. (Resp. Ex. GG) Kort Gronbach, M.D., was listed as the event leader and was one of the speakers. However, the Hearing Examiner was unable to

(Resp. Ex. N)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy

92. Dr. Cicek testified that she could not find any documentation of an individualized treatment plan for Patient 2 in her medical record, and that that is a violation of the Board's intractable pain rules. (Tr. at 360-362)

93. Dr. Demint disagreed with Dr. Cicek's opinion that he had failed to develop an individualized treatment plan for Patient 2. (Tr. at 714)

94. Dr. Demint stated:

> **This patient went through multiple drug changes due to her inability to tolerate or afford many of the drugs. This is individualism. She did go to PT in 5/12 and she was on two different SSRIs and an SNRI. She could not afford mental health counseling though I suggested it several times.**

(Resp. Ex. N)

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics

95. Dr. Cicek testified that Dr. Demint failed to obtain a toxicology screen during the time he treated Patient 2. (Tr. at 360-362)

96. Dr. Demint acknowledged that he did not order a urine drug screen for Patient 2, but testified:

> I saw no reason to. Again, the—at that time, the law said "may" when you suspect aberrant behavior. This patient had no aberrant behavior. This patient had been consistent. Her pill counts was consistent. Her drug screens [from other physicians] were consistent. Her OARRS were consistent. Her [KASPER] and West Virginia was consistent.

(Tr. at 102)

97. Dr. Demint testified that he had obtained an OARRS report on Patient 2, as well as KASPER and West Virginia Board of Pharmacy reports. He also testified that he had performed a pill count, which was consistent. In addition, Dr. Demint testified that he had

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find a reference supporting Dr. Demint's statement that a complete physical examination does not have to be performed at a patient's initial visit as long as one was performed "on a prior or subsequent occasion." (Resp. Exs. N, GG)

obtained a urine drug screen on April 21, 2010; however, that screen had been ordered by another physician at Chillicothe Acute Care Clinic, not Dr. Demint. (Tr. at 703-704; St. Ex. 2 at 10)

98. Dr. Demint stated:

> **In all my training in PM [pain management] and all the courses I took I never heard the requirement of initial drug tests. Neither the old guidelines nor the new guidelines require a drug tests before starting opioid therapy. Per [Ohio Administrative Code Chapter] 4731-21, "Based on evidence or behavioral indications of addiction or drug abuse, the practitioner *may* obtain a drug screen on a patient." This was the guideline at the time of these visits. The new guidelines state that after treating for longer than 3 months with opioids, "*Consider* a patient pain treatment agreement that *may* include: * * * drug screens * * *." So, even the Board's guidelines don't require an initial drug test before starting opioid therapy. Two articles [were] presented that stated that initial drug tests [are] not necessary and [do] not predict compliance outcome. The article ["]Identification and Management of Pain Medications Abuse and Misuse: Current State and Future Direction["] * * * stated, "There is, however, long standing evidence that *random* may result in better outcomes. Again, this is a fabrication of PM ignorant Dr. Cicek.**

(Resp. Ex. N) (Italics substituted for original bold emphasis)

Allegation 2(h): Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment

99. Dr. Cicek stated: "There were multiple mentions of anxiety and depression and significant life/home stressors and Dr. Demint appropriately referred [Patient 2] to a psychiatrist in October 2010 after trying a few different antidepressants. The patient never followed through with this referral due to 'problems with insurance.'" (St. Ex. 16 at 2)

Allegation 2(i): Medical charting was incomplete, often illegible and/or disorganized

100. In her report, Dr. Cicek stated, in part:

> The documentation for [Patient 2] was often difficult to read and information is scant. Physical exams were not consistent with the subjective level of disability. The patient's severe anxiety and depression did not appear to have been well treated, as there were constant complaints of this through the record. Treating her anxiety and depression appropriately and utilizing the expertise of a psychiatrist would likely have aided in her pain management. The medication used to manage her chronic anxiety was not ideal. The amount of

> narcotic the patient received was not supported by her clinical findings (exam and tests). **This demonstrates a departure from the minimal standards of care that would be employed by similar practitioners.**

(St. Ex. 16 at 2) (Emphasis in original)

101. In his written rebuttal testimony, Dr. Demint repeated the same statement made with respect to this allegation as applied to Patient 1, with the following addition: "Another Error by Dr. Cicek was missing the first visit I had with this patient. Just how [thoroughly] did Dr. Cicek review these records? Doesn't appear to be very [thorough]. (Resp. Ex. N)

Additional Information

102. Dr. Demint noted that Dr. Cicek had stated in her report that his first visit with Patient 2 had taken place in August 2010 when, in fact, he first started treating Patient 2 on March 25, 2010. (Tr. at 704; St. Ex. 16 at 2)

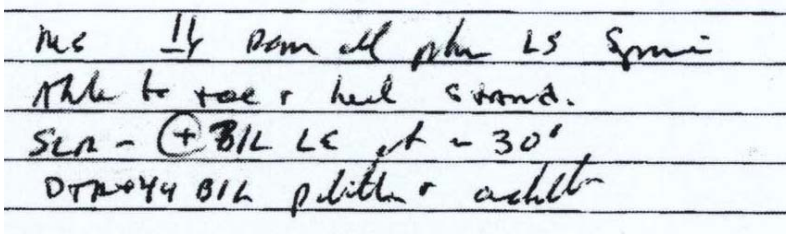
<u>Patient 3</u>

103. Patient 3, a male born in 1963, had previously been a patient of Dr. Demint's at his office in Kingston, Ohio, in the early 2000s. On December 29, 2010, Patient 3 returned to Dr. Demint at his re-opened Kingston practice and complained of constant pain in his lower back. Dr. Demint documented:

> States at night pain goes [left] gluteal/hip area. Pain level [illegible] 9/10. Use cane for stability. [Symptoms] "years" at least 7 yrs. Saw Southern Ohio Pain for years. Has been going to ER & taking lots of Tylenol & Ibuprofen. States went to ER at least 1/month. States x-rays were done in ER. States ER said his stomach was torn up from the otc meds he was taking.

(St. Ex. 3 at 19, 51) Dr. Demint further noted that Patient 3's urine drug screen had been positive for oxycodone and benzodiazepines.[22] Dr. Demint also documented that Patient 3 "denies arrest or legal problems [illegible] drugs or ETOH." (St. Ex. 3 at 51-52)

Dr. Demint documented the following physical examination findings:



[22] No prescription for a benzodiazepine was identified on the December 29, 2010 OARRS report or in the ER records for Patient 3's visits on December 19, 21, and 25, 2010. (St. Ex. 3 at 56-61)

(St. Ex. 3 at 51)

Dr. Demint diagnosed chronic lower back pain, and degenerative disc disease and spondylosis in the lumbosacral spine. (St. Ex. 3 at 51; Tr. at 107)

Dr. Demint prescribed oxycodone 15 mg #120, one tablet four times per day, gabapentin 300 mg #72, gradually increased to one table three times per day, and told Patient 3 to return in one month. (St. Ex. 2 at 15, 51)

104. An OARRS report obtained by Dr. Demint on December 29, 2010, indicates that Patient 3 had obtained tramadol, hydrocodone/APAP, and oxycodone/APAP[23] from several different practitioners since September 2010, the last prescription having been tramadol issued on December 21, 2010. (St. Ex. 3 at 53)

In addition, the chart contains records of ER visits including a visit on December 18, 2010, for dental pain, when she received Vicodin and Pen Vee K. Two days later, on December 21, 2010, Patient 2 visited the ER for a complaint of dental pain and again received Vicodin and Pen Vee K. A few days later, on December 25, 2010, Patient 2 was seen at the ER for complaints of dental pain and diagnoses of dental abscess and odontalgia.[24]

105. At Patient 3's February 26, 2011, visit, Dr. Demint added a diagnosis of radicular symptoms. At that visit, he referred Patient 3 to physical therapy. (St. Ex. 3 at 47, 49)

106. The following table identifies the controlled substance medications prescribed by Dr. Demint to Patient 2, and the results of his urine drug-screens:

Date of Script	**Controlled Substance Medication(s) Prescribed by Dr. Demint**	**Date of Urine Sample**	**Positive Results for Urine Sample**	**Negative Results For Prescribed Medication(s)**
12/29/10	oxycodone 15 mg #120	12/29/10[25]	temazepam oxazepam hydromorphone[26] oxycodone oxymorphone[27]	hydrocodone

[23] APAP is acetaminophen, the active ingredient in over-the-counter Tylenol. Hydrocodone/APAP is a generic equivalent of brand-name medications such as Vicodin and Norco; oxycodone/APAP is a generic equivalent of brand-name medications such as Percocet and Endocet. (MedLine Plus, *Acetaminophen*, http://www.nlm.nih.gov/medlineplus/druginfo/meds/ a681004.html, accessed November 30, 2012)
[24] Odontalgia means toothache. (MedLine Plus Medical Dictionary, http://www.merriam-webster.com/medlineplus/odontalgia, accessed February 1, 2013)
[25] This tested for substances in Patient 3's urine *before* receiving any prescription from Dr. Demint. As previously noted, Patient 3 had received prescriptions for tramadol, hydrocodone/APAP, and oxycodone/APAP
[26] Hydromorphone is the generic name for Dilaudid. Hydromorphone is also detectable in urine as a metabolite of hydrocodone. (St. Ex. 3 at 13; MedLine Plus, *Hydromorphone Oral and Rectal*, http://www.nlm.nih.gov/medlineplus/druginfo/ meds/a682013.html, accessed November 30, 2012; National Center for Biotechnology Information/Mayo Clinic/Smith, H.S., *Opioid Metabolism*, July 2009, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2704133/, accessed November 30, 2012)

Date of Script	Controlled Substance Medication(s) Prescribed by Dr. Demint	Date of Urine Sample	Positive Results for Urine Sample	Negative Results For Prescribed Medication(s)
1/26/11	oxycodone 15 mg #120	n/a		
2/26/11	oxycodone 15 mg #150	n/a		
3/26/11	oxycodone 15 mg #150	3/26/11	buprenorphine[28]	oxycodone

(St. Ex. 3 at 15, 46-52)

107. Patient 3's March 26, 2011, visit was his last visit with Dr. Demint. Following that, the chart includes a note dated March 30, 2010, that states: "Set pt. appt for April 6th @10:10 a.m. w/ Dr. Evans." (St. Ex. 3 at 46)

Allegation 2(b): Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records

108. Dr. Cicek testified that Dr. Demint made no notation on the initial visit form that he had reviewed Patient 3's prior medical records: "[T]ypically, when you receive old records on a patient, either a notation is made on the chart that the records have been received and reviewed, or a notation is made on the actual records * * * that they're received and reviewed. Because, again, if it's not written down, it's not done." Dr. Cicek testified that it is important that a physician review the prior records "[t]o know what their previous treatment had been and if there were any heightened concerns about opioid prescribing for a patient." (Tr. at 365-366)

109. Dr. Demint testified that he routinely goes through the prior treatment records of patients he sees for the first time. He further testified that he routinely reviews a patient's chart every time he looks at it. However, Dr. Demint testified that he does not always document his review. (Tr. at 99-101)

110. Dr. Demint testified that he diagnosed chronic low back pain, degenerative disk disease, spondylosis, and "lumbosacral spine," which is why he is sure that he had had Patient 3's prior medical records. Dr. Demint further testified that he had seen Patient 3 previously, in 2003, and identified an earlier progress note from May 10, 2003. (Tr. at 107; St. Ex. 3 at 115)

111. In his written rebuttal testimony, Dr. Demint stated: "I had previously seen this patient and was already aware of his history and had previous X-ray results which revealed his DDD/Spondylosis of LS spine from my own notes. I received after his

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[27] Oxymorphone is the generic name for Opana. Oxymorphone is also detectable in urine as a metabolite of oxycodone. (St. Ex. 3 at 13; MedLine Plus, *Oxymorphone*, http://www.nlm.nih.gov/medlineplus/druginfo/ meds/a610022.html, accessed November 30, 2012; National Center for Biotechnology Information/Mayo Clinic/Smith, H.S., *Opioid Metabolism*, July 2009, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2704133/, accessed November 30, 2012)

[28] Buprenorphine is the generic name for Suboxone, a medication used to treat opioid dependence. (MedLine Plus, *Buprenorphine Sublingual*, http://www.nlm.nih.gov/medlineplus/druginfo/ meds/a610022.html, accessed November 30, 2012)

first visit the results from the ER as noted on the fax cover sheet dated 12/30/10." (Resp. Ex. O)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

112. Noting that Dr. Demint prescribed oxycodone 15 mg #120 at Patient 1's December 2010 visit, Dr. Cicek found that the amount of narcotics he prescribed was not supported by the history and physical examination findings. She noted that Patient 3 had normal reflexes and normal strength in his lower extremities, although his straight-leg raise was positive, which can be indicative of radicular pain. Dr. Cicek further testified that the patient had been receiving just regular-strength Vicodin and tramadol for his pain, and then Dr. Demint placed him "on high-dose oxycodone. So it was a drastic jump from what he had been receiving, according to his OARRS report." Moreover, Dr. Cicek testified that no reason was documented for the increase in medication from what Patient 3 had been receiving: "The assessment is only a statement of the diagnoses. There is not an assessment of his previous pain control in the assessment or, again, what his goals or objectives for the treatment were." (Tr. at 363-364)

113. When asked what nonnarcotic alternatives he had considered prior to prescribing oxycodone, Dr. Demint noted that his plan included (along with oxycodone) obtaining EMG and nerve conduction studies, and that he increased Patient 3's gabapentin and added a medication called Savella, "an SNRI antidepressant" used to treat neuropathic pain. When asked again if he had considered nonnarcotic alternatives *prior* to initiating oxycodone, Dr. Demint did not answer directly, responding that the patient needed pain medication while Dr. Demint was working up the cause of his pain. (Tr. at 115-116)

114. Dr. Demint stated:

> **This patient had abnormal x-ray and CT scan and abnormal Physical exam findings, decrease range of motion and bilateral positive straight leg test. Patient had been taking the non-narcotic alternative before coming to me in the form of NSAIDS and APAP to such an extent that an ER doctor told him "it was eating up his stomach." Since 16,500 patients die a year in the US from the GI side effects of NSAIDS alone. This was one of the reasons for the push to use more opioids in the late 1990's and early [2000]'s.**

(Resp. Ex. O)

Allegation 2(g): Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports; <u>and</u>

Allegation 2(h): Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any

illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment.

115. With respect to Patient 3's December 29, 2010, urine drug screen, Dr. Cicek testified that Patient 3 tested positive for benzodiazepines and oxycodone but not hydrocodone, even though hydrocodone had been prescribed to him recently. She further noted that, according to an OARRS report, Patient 3 had not filled a prescription for oxycodone since September 2010, three months earlier. Moreover, she noted that Patient 3 had not been prescribed any benzodiazepines. Therefore, Dr. Cicek testified that, even though the positive benzodiazepine results were marked "Consistent" on a confirmation report, the results were actually inconsistent because there is no record of Patient 3 having received a prescription for a benzodiazepine. (Tr. at 366-368)

    Additionally, with respect to a urine sample submitted by Patient 3 at his last visit on March 26, 2011, Dr. Cicek noted that the in-house test was positive for buprenorphine, which Dr. Demint did not prescribe, and negative for oxycodone, which Dr. Demint *did* prescribe. Dr. Demint documented in his progress note for that visit that Patient 3 denied using buprenorphine, and told Dr. Demint that he thought he had the flu and had been unable to keep anything down for two days. (Tr. at 368-370; St. Ex. 3 at 8, 46)

    Dr. Cicek testified that, under those circumstances, the standard of care would have required that Dr. Demint limit his prescribing to ten days' worth of medication and then bring Patient 3 back following laboratory confirmation of the in-house results. However, Dr. Cicek testified that the prescriptions Dr. Demint provided authorized the usual one-month supply of medication. (Tr. at 370-371)

116. Dr. Demint testified that he obtained OARRS, KASPER, and West Virginia Board of Pharmacy reports on Patient 3. Dr. Demint further testified that he obtained a second OARRS report in March 2011 that led to Patient 3's discharge from his practice. (Tr. at 709-710)

    Dr. Demint further testified that he performed a urine drug screen on Patient 3 that he had believed at the time to be consistent. Dr. Demint testified that, even though Patient 3 had tested positive for hydrocodone, and Dr. Demint had prescribed only oxycodone, he had reasoned that Patient 3 had been receiving medication from ERs and he may have had some hydrocodone left in his system. Dr. Demint further testified that a positive test with a reasonable explanation is not a red flag. However, Dr. Demint testified that he later discharged Patient 3 for a second failed drug test. (Tr. at 710-711; St. Ex. 3 at 11)

117. On March 26, 2011, Dr. Demint obtained an in-house urine drug screen on Patient 3 that tested positive for buprenorphine. When asked why he had continued to prescribe oxycodone despite the positive test, Dr. Demint replied that he would not discontinue the patient's medication because it could have been a false positive. He further testified that he would first have to obtain laboratory confirmation of the positive result. (Tr. at 110-112)

Dr. Demint acknowledged that there is no lab confirmation in State's Exhibit 3 for the March 26, 2011, urine drug screen but testified that the Board had subpoenaed the medical records shortly after Patient 3's March 26, 2011 appointment. He testified that he probably received the confirmation after the Board had subpoenaed Patient 3's record. (Tr. at 110-111)

118. Dr. Demint stated, "His first drug test was interpreted as consistent as explained above. As soon as I got confirmation of an inconsistent on his second drug test I ordered a pill count which this patient failed to respond and was discharged." (Resp. Ex. O)

119. By letter dated April 7, 2011, Dr. Demint dismissed Patient 3 from his practice due to a failed drug test and Patient 3's failure to respond or appear for a pill count. Dr. Demint stated that he had screened Patient 3 on March 26, 2011, and the results showed possible buprenorphine use. Following laboratory confirmation he called Patient 3 into the office for a pill count. Patient 3 did not appear and was dismissed. (Resp. Ex. O)

Allegation 2(i): Medical charting was incomplete, often illegible and/or disorganized

120. At hearing, Dr. Cicek noted that the initial visit note for Patient 3 was more thorough than for the previous two patients. Nevertheless, Dr. Cicek testified that she found overall that Dr. Demint's chart for Patient 3 was below the minimal standard of care because of the illegibility of Dr. Demint's handwriting; she "had a lot of trouble reading the notes." (Tr. at 362-363)

121. Dr. Demint responded in the same way as he did for Patient 1. (Resp. Exs. M, O)

Additional Information

122. Dr. Demint criticized Dr. Cicek for stating that he did not order physical therapy when, in fact, he did. Dr. Demint further disagreed with Dr. Cicek's opinions that he failed to appropriately document the patient's history, that his prescribing was not supported by the findings, and that he failed to properly document the actions taken in response to signs of patient drug abuse. Regarding the last point, Dr. Demint testified that he "discharged the patient after he failed a drug test and failed to respond to a pill count." (Tr. at 713-716)

123. In his written rebuttal testimony, Dr. Demint indicated that he had referred Patient 3 to physical therapy on February 26, 2011, and that the patient started physical therapy on April 6, 2011. (Resp. Ex. O)

124. Dr. Demint further testified at the original hearing and in his written statement on remand that he referred Patient 3 to "Dr. Karen Evans and PMR specialist" for EMG studies. (Tr. at 710; St. Ex. 3 at 46; Resp. Ex. O)

Patient 4

125. Patient 4, a male born in 1960, first saw Dr. Demint on March 25, 2010, at Lance. At that time he was an established patient at that practice and had last been seen (by another physician) on February 19, 2010. (St. Ex. 4 at 31, 59-60)

Dr. Demint's initial visit note states that Patient 4 had complained of "a lot of pain" in his back, right knee, and right shoulder, and that he had been out of medication. Dr. Demint documented that Patient 4 had advised that Percocet and oxycodone IR were not helping with his pain. Dr. Demint noted that Patient 4 has a history of Hepatitis B, hiatal hernia, and anxiety: "states grandchild died in his arms in 2008, has been upset since." Dr. Demint documented a physical examination finding that Patient 4 had decreased range of motion in all planes of the lumbosacral and thoracic spine. Dr. Demint diagnosed chronic back pain, degenerative disc disease in the thoracic and lumbosacral spine, anxiety, and hiatal hernia. (St. Ex. 4 at 59)

Dr. Demint documented as his plan to explain to Patient 4 the need to switch to an extended release opioid rather than take two short-acting opioids. Dr. Demint discontinued Percocet and prescribed morphine sulfate ER 30 mg #60 with instructions to take one tablet twice per day, continued oxycodone IR 30 mg #120 with instructions to take one tablet every six hours, continued Xanax 2 mg #75 with instructions to take one-half to one pill every eight hours as needed. Further, although not mentioned on the progress note, the medication log indicates that Dr. Demint also continued Patient 4's prescriptions for Zantac and Nexium and discontinued Veramyst Spray and Androgel. (St. Ex. 4 at 2, 59)

126. Medical records obtained from another practice, Chillicothe Acute Care Clinic, indicate that Patient 4 had been seen at that practice beginning in April 2010 by the same physician who had previously treated him at Lance. On April 21, 2010, Patient 4 received prescriptions including MS Contin, oxycodone IR, and alprazolam. In May and June 2010 he received prescriptions for OxyContin, oxycodone IR, and alprazolam, among other, non-controlled medications. As of June 2010, Patient 4 was receiving 200 milligrams of oxycodone per day: OxyContin 40 mg twice per day and oxycodone IR 30 mg every six hours, in addition to six milligrams of alprazolam per day. On July 21, 2010, Nucynta 100 mg #120, one tablet four times per day, was substituted for oxycodone IR. Patient 4 continued to receive OxyContin and alprazolam. (St. Ex. 4 at 91-106)

Subsequently, a note dated July 26, 2010, written by staff at Chillicothe Acute Care indicates that Patient 4 had been repeatedly calling the clinic complaining that "he wants his Percocets back" and that his disability coverage would not pay for them. The note further states that Patient 4 "proceeded to get rude and obnoxious" with the staff member. The note includes a description of an ensuing argument between the staff member and Patient 4:

> I told him, he still has not produced the records from Social Security where he told us he had been disabled some twenty years ago. We have records from 2006 and 2008, new MRI's etc., which show nothing. He stated he had a back injury; muscles were ripped from his spine. I told him, all of his tests we have [show]

> nothing, but a tear in his shoulder, that he never did anything about. He stated he did see a doctor in Portsmouth who wouldn't do the surgery, but was unable to produce the records. He said he did not want to contact SS, as they will get "nosey" and start snooping around. He came to this appointment and still did not have any records.

(St. Ex. 4 at 90) The note goes on to state that the treating physician decided that Patient 4 should be discharged "[d]ue to his misconduct and disagreeing with" the physician with respect to his care. (St. Ex. 4 at 90)

127. About one week later, on August 2, 2010, Patient 4 returned to Lance and saw Dr. Demint. Dr. Demint documented among other things that the patient advised that the other doctor had given him Nucynta breakthrough pain medication that he cannot obtain approval or preauthorization for. Dr. Demint prescribed oxycodone IR 15 mg #70 with instructions to take one tablet every six to eight hours as needed. (St. Ex. 4 at 2, 58)

128. Patient 4 next saw Dr. Demint on August 20, 2010. Dr. Demint prescribed essentially the same regimen that Patient 4 had received at the other practice in June: OxyContin 40 mg twice per day and oxycodone IR 30 mg every six hours, totaling 200 milligrams of oxycodone per day, plus Xanax 2 mg every eight hours, totaling six milligrams of alprazolam per day, in addition to other, non-controlled medications such as Nexium, Claritin, Advair, and Ventolin. (St. Ex. 4 at 2, 58)

129. Patient 4 continued to see Dr. Demint on a regular, monthly basis through April 2011, the last visit documented in State's Exhibit 4. Patient 4 received prescriptions for the same quantities of oxycodone and alprazolam each month. (St. Ex. 4 at 2, 40-58)

130. Dr. Demint obtained a urine sample for toxicology screening from Patient 4 in February 2011 that yielded results that were consistent with Dr. Demint's prescribing. (St. Ex. 4 at 9-11)

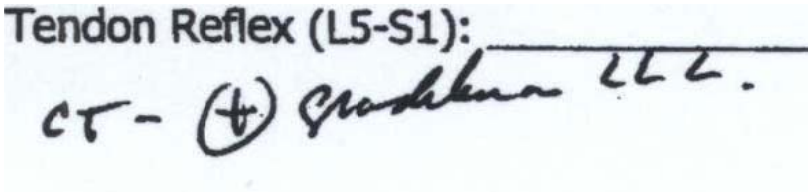
131. During the time that Dr. Demint treated Patient 4, Dr. Demint referred him to, or obtained for him various other medical or medically-related services including a urological consult in April 2010, a chest x-ray to rule out lung cancer and blood tests in August 2010, an MRI of the left shoulder in early September 2010, an MRI of the thoracic spine in late September 2010, a colonoscopy and a CT lung scan in October 2010, renewal of a five-year vehicle disability placard in January 2011, and physical therapy in April . (St. Ex. 4 at 111-117, 137, 139, 145-147, 161; St. Ex. 16 at 5)

132. The September 2010 MRI of the thoracic spine revealed, among other things, "[s]cattered disc herniations throughout the thoracic spine as detailed" in the report, as well as a nodule in the patient's left lung. (St. Ex. 4 at 112)

133. The October 2010 CT lung scan was ordered in response to the radiologist's recommendation following the September 2010 thoracic spine MRI: "Indeterminate 3 mm T2 hyperintense nodular focus in the posterior left lung. Pulmonary nodule versus artifact. This is nonspecific for post inflammatory neoplastic etiology. Further evaluation with

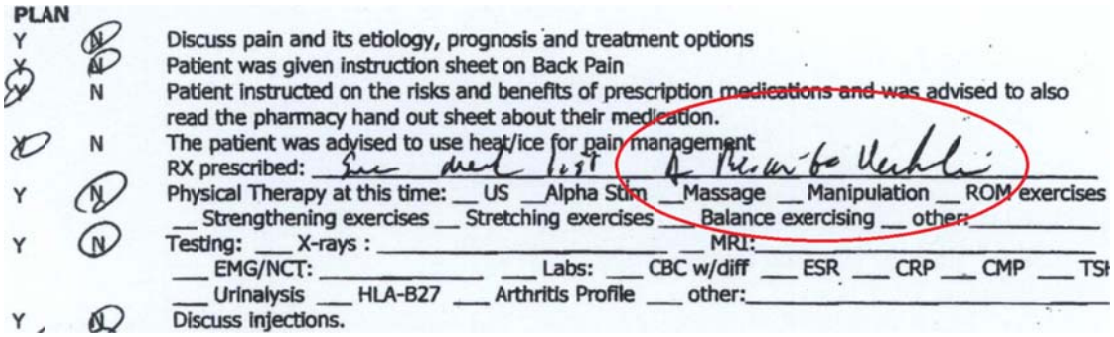
contrast enhanced CT of the chest is advised as a precautionary measure." (St. Ex. 4 at 53, 112, 161)

Dr. Demint documented the results of the CT lung scan in his November 15, 2010 progress note which appear to be positive for something; however, the Hearing Examiner is unable to read Dr. Demint's handwriting. (St. Ex. 4 at 51) Dr. Demint's note is reproduced below, enlarged from the original exhibit:



(St. Ex. 4 at 51)

Dr. Demint's plan might include a referral for something; however, again, the Hearing Examiner cannot read Dr. Demint's handwriting. It might also concern Dr. Demint's discontinuation of Patient 4's Proventil inhaler (see State's Exhibit 4 at 2). The possible referral is circled below:



(St. Ex. 4 at 51)

Allegation 2(b): Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records

134. Dr. Cicek testified that if a new patient comes to a physician who has Hepatitis B or C, the physician needs to find out how the patient acquired that disease, whether the patient had a blood transfusion, obtained tattoos someplace other than a tattoo shop, or has a history of intravenous ("IV") drug use. Dr. Cicek noted that Dr. Demint obtained a liver function test in August 2010; however, she testified that Hepatitis B could not be ruled out based upon the results of that test. Dr. Cicek further testified that there is a specific test for hepatitis B and C. Moreover, if a patient informs a physician that he or she has hepatitis B and the physician does not have documentation of it, "the standard of care is to test for it." (Tr. at 372-373; St. Ex. 4 at 114)

Dr. Cicek testified that, if a patient has hepatitis B, that is a red flag and the physician needs to know how the patient was exposed to that disease "and confirm it wasn't through intravenous drugs." However, she testified that Dr. Demint only documented that Patient 4 had a history of hepatitis B; there was no statement concerning how that had been obtained, diagnosed, treated, or "addressed in terms of risk for prescribing narcotics." Moreover, Dr. Cicek testified that that omission does not reflect a thorough review of the patient's history. (Tr. at 374-375)

135. Dr. Demint stated, "Dr. Cicek's reliance upon an old hepatitis diagnosis is misplaced. The client was not an addict. There were no intravenous drug indications. There was a liver function test. It is not necessary to x-ray to substantiate pain as an x-ray cannot show that subjective symptom. The patient was calling and was really in pain." (Resp. Ex. P)

He further stated:

> **This was an established patient with chart already established in the practice. Dr. Prior stated in his proffer [Board Exhibit A] that as long as it is in the chart it fulfills documentation requirement. All the information was in the chart. A specialist in the area, a [gastroenterologist], no mention of the hepatitis was made and would have been relevant since a colonoscopy was done and hepatitis could be spread by the scope. There was no reason to feel this patient was a drug addict or abuser with his numerous consistent drug screens, OARRS and pill counts.**

(Resp. Ex. P)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings;

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy; and

Allegation 2(h): Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment.

136. Dr. Cicek testified that the type and amount of medication that Dr. Demint prescribed to Patient 4 was not supported by the physical findings or documentation in the chart. Dr. Cicek further testified:

> [T]he patient has some subjective complaints; and we have a physical exam, again, consisting of decreased range of motion all planes of the lumbosacral and T spine, is the physical exam. So there's not a thorough physical exam of what exactly the patient's limitations are in relation to strength, gait, ability to navigate

> up and down from a chair, walk around the room. And there is no note in here of what the patient's pain's actually limiting him from doing.

(Tr. at 375-376)

Dr. Cicek testified that such documentation is part of formulating an individualized treatment plan for the patient, and is therefore required by the standard of care. Dr. Cicek further testified:

> The patient also mentions in the note that he has some stressors in his life of a grandchild dying in his arms and some underlying anxiety. In a situation like that, further exploration before giving large doses of narcotics would be indicated, as well, because of the effect of household stressors or an unstable household in someone who has a large amount of medication.

(Tr. at 376)

137. Dr. Cicek testified that she did not find documentation in Patient 4's chart that Dr. Demint had developed an individualized treatment plan for Patient 4. (Tr. at 376-377)

138. Noting that a number of the patients in this matter had severe limitations and/or multiple surgeries, Dr. Cicek was asked if Dr. Demint still had to document that he had discussed alternative treatments with the patients. Dr. Cicek replied:

> Yes. It's part of the initial visit, what treatments have been tried and been successful or failed. It's, again—Again, there's not data supporting long-term use of narcotics in chronic pain, so the goal is not to put someone on these medications and leave them on forever. The goal is, again, to put someone on the medication, get them to the most functional level that you can at the lowest possible dose of medication so they don't develop opioid hyperalgesia. And incorporating nonmedicinal approaches towards chronic pain is always indicated.
>
> You don't treat a broken leg just by giving a pain medication. You treat a broken leg by fixing it surgically, sending the patient to therapy, teaching them preventive strategies. You don't treat hypertension by just prescribing a medicine; you incorporate diet, lifestyle.

(Tr. at 378-379)

139. Referring to Patient 4's conduct documented by Chillicothe Acute Care, Dr. Cicek testified that it is a red flag when a patient repeatedly calls and becomes rude with office staff: "it doesn't mean the patient's a problem, but it means further exploration is indicated." Dr. Cicek further testified:

> I would review it with the patient because pain contracts almost always specifically state—well, they should state the expectations from the patient. And

> one of the expectations is that the patient behaves in an acceptable manner in the office. And calling people names on the phone isn't an acceptable manner.

(Tr. at 380)

140. Dr. Demint testified that, when he began working for Lance, there were a lot of things that the staff was not doing, and he had to work with the staff there to get them to do the things that he needed them to do. Dr. Demint further explained:

> I had to prioritize these patients, risk manage them, okay; what's the highest risk, what's the lowest risk. So, you know, when I'm—was going through these patients, the ones I was more getting first were the ones that were higher risk.
>
> Here's a man 50 years old with very few risk factors, I felt was a very low risk. He had been consistent. He had previous consistent tests he had previous consistent pill counts, had a consistent pill count with me, and has a consistent OARRS, KASPERs and West Virginia, at least once—let's see, how many—several of them—several of them at least down in here. Let me see how many. Four OARRS were done. All consistent. This man's risk was very low.
>
> We cannot be drug testing everybody every visit or the cost to the system will become so humongous, we won't be able to support it. We have to—What we do in pain management is we try to put risk to people; people at higher risk gets more surveillance, people with less risk gets less surveillance. You know, you try to make it make sense.

(Tr. at 135-137)

141. Dr. Demint testified that he had had objective evidence that supported Patient 4's claims of pain; namely MRIs showing spine abnormalities and disk herniation. Dr. Demint disagreed with Dr. Cicek that those findings were minimal. Dr. Demint further testified that he had diagnosed Patient 4 with GERD and COPD, and that the GERD diagnosis is significant because that limits the patient's ability to tolerate NSAIDs. (Tr. at 716-717, 721-722)

142. Dr. Demint testified that he had assumed the care of Patient 4 at Lance, and first saw him on March 25, 2010. Dr. Demint testified that Patient 4 had indicated a history of hepatitis B, but that Dr. Demint later did a liver function test and found nothing. Dr. Demint speculated:

> He might have been saying that because Percocet's got acetaminophen in it; and if he knows about liver problems and if I say something about aceta- — about it, you know, that I could get off my medication with acetaminophen. Obviously, he wasn't happy being on these two shorter-acting medications,

> which is a good thing, because there's—really probably not a great idea to do it that way, but [some doctors do do it that way].

(Tr. at 123-124)

When asked if a patient lying to him about a condition would "cause him alarm, a red flag," Dr. Demint replied, "A little bit." (Tr. at 124)

143. Dr. Demint disagreed that the amount of oxycodone he prescribed to Patient 4—OxyContin 40 mg twice per day and oxycodone 30 mg every six hours—had been a large amount of medication. Dr. Demint testified that the morphine equivalent dose he prescribed had been either 140 or 220 milligrams per day, depending on whether oxycodone is calculated to have a one-to-one or three-to-two ratio with morphine. Dr. Demint stated that, either way, it was in the neighborhood "of 180 milligram in-the-box treatment. 180 milligram morphine equivalent a day is a moderate dose, not a large dose. So, no, I do not believe this man had an excessive dose." (Tr. at 130-131, 720-721)

    Dr. Demint testified that Patient 4 had already been taking that level of medication, and that he had simply switched Patient 4 from short-acting medications to a long-acting medication supplemented by a short-acting medication for breakthrough pain. (Tr. at 131-132)

144. Dr. Demint disagreed with Dr. Cicek's opinion that he had started Patient 4 on OxyContin 40 mg. He testified that Patient 4's prior physician had started him on that medication. An August 2, 2010, OARRS report confirms that another physician started Patient 4 on OxyContin 40 mg twice per day on or around June 19, 2010. (Tr. at 721; St. Ex. 4 at 22)

145. Dr. Demint testified that he had referred Patient 4 to physical therapy and to various specialists, including a vascular surgeon and a gastroenterologist. (Tr. at 717-720)

146. Dr. Demint disagreed with Dr. Cicek's criticism that he should have started Patient 4 on an NSAID, because Patient 4 had a diagnosis of GERD and NSAIDs would not have been appropriate. (Tr. at 723-724)

147. Dr. Demint stated in his written remand statement:

> **There was enough history documented in the chart including a consult from a neurosurgeon stating to increase pain medication. There were the abnormal MRIs. I did do an exam of the MS spine the first visit which revealed decrease range of motion of the spine. The hearing officer misunderstood my testimony when I was explaining some people can have bad x-rays with no significant pain and that others can have little radiological changes and severe pain. But, in this case when the patient's pain is consistent with the radiological studies it is supportive. Again it is the patient's report of pain which is the most important determining factor.**

(Resp. Ex. P)

Dr. Demint further stated:

> **I did have an individual plan on this patient. It is listed under P. for plan in my SOAP. This patient was referred for PT. He was referred to vascular surgeon and gastroenterologist for non-pain related issues. He had already seen a neurologist prior to me seeing patient and all this was documented in the chart. No other patient has this exact plan. Therefore this is an individual plan based on the physical needs and financial situation of this particular patient. By definition that is individualized.**

(Resp. Ex. P)

Finally, Dr. Demint stated:

> **There were no significant signs of adverse drug effects or abuse in this patient. He has consistent OARRS, Drug tests and pill counts. It is not the patient's fault that a doctor prescribed a medication that his insurance carrier refuses to pay. He is in pain and can not get pain medication [which] can cause him to be a little short with the doctor who refuses to change the medication to something covered by his insurance. If any thing this would be attributed to pseudoaddiction.**[29]

(Resp. Ex. P)

Additional Information

148. Dr. Demint testified that there is no relationship between pain and radiological findings: "Some people can have horrible, horrible looking x-rays and MRIs and have no pain at all; and then other people have nothing, hardly nothing, and have significant pain." (Tr. at 133-134)

<u>Patient 5</u>

149. Dr. Demint assumed the care of Patient 5, a male born in 1959, at Lance on May 21, 2010. At that time, Patient 5 complained of a painful, swollen left knee that was "holding fluid," a painful, swollen right ankle, and back pain. Patient 5 stated that he works as a carpenter. (St. Ex. 5 at 23, 32)

    Patient 5 had last been seen at Lance by another physician on February 19, 2010. (St. Ex. 5 at 33)

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[29] **Dr. Demint testified at the original hearing that pseudoaddiction is a condition whereby a pain patient exhibits aberrant behavior like an addict because the patient's pain is being undertreated. (Tr. at 660-661)**

At Patient 5's first visit, Dr. Demint documented diagnoses of: (1) chronic pain in the knee and ankle, (2) status-post fracture of the knee and ankle, (3) hypertension, and (4) anxiety. (St. Ex. 5 at 32)

At Patient 5's first visit, Dr. Demint noted that he would refill Patient 5's medication, and prescribed Norco 10/325 mg #150, two refills authorized, with instructions to take two tablets every six hours; Valium 10 mg #60, two refills authorized, with instructions to take one-half tablet in the morning, one-half tablet in the evening, and one tablet at bedtime; Motrin 600 mg #90, two refills authorized, with instructions to take one tablet every eight hours; and lisinopril 10 mg #30,[30] two refills authorized, with instructions to take one tablet per day. (St. Ex. 5 at 3, 32)

150. The next time Dr. Demint saw Patient 5 was September 3, 2010. At that visit, Dr. Demint noted the following findings for the musculoskeletal examination: "[Right] knee tender to palpation—very slight swelling noted." (St. Ex. 5 at 30)

151. Patient 5 continued to see Dr. Demint on a regular basis every three months through March 28, 2011, the last visit documented in State's Exhibit 5. During this time, Dr. Demint maintained Patient 5 on the same medication regimen as the first visit except for an increase in the dosage of lisinopril in December 2010. (St. Ex. 5 at 3, 26-30)

152. A urine drug sample submitted by Patient 5 on March 28, 2011, tested positive in-house for opiates and benzodiazepines, which was consistent with Dr. Demint's prescribing. (St. Ex. 5 at 12)

Allegation 2(b): Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records; and

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics.

153. Dr. Cicek acknowledged that Dr. Demint assumed the care of Patient 5 from another provider. Dr. Cicek further testified that the initial visit note includes a history concerning Patient 5's past surgeries and a small social history concerning his alcohol use—the patient told Dr. Demint that he drinks a six-pack of beer per weekend. However, there is no review of what has been done in the past to address his pain, or what non-narcotic therapies were attempted. Dr. Cicek further testified that there is no review concerning the medications that Patient 5 had tried that have been either effective or ineffective. Moreover, Dr. Cicek testified that the musculoskeletal physical examination documented states only that Patient 5 had numerous scars from prior surgeries. Finally, Dr. Cicek testified that Dr. Demint did not obtain an OARRS report or urine toxicology screen at Patient 5's first visit with him; he had had a previous consistent screen in 2008, but Dr. Demint failed to note in the chart that he had reviewed that report. (Tr. at 381-384)

[30] Lisinopril is used to treat hypertension. (MedLine Plus, *Lisinopril*, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a692051.html, accessed December 7, 2012)

154. Dr. Demint testified that, analyzing Patient 5 based on the "four A's": Patient 5 had been on a maintenance dose of analgesic medications; the patient was able to continue working as a carpenter; Patient 5 complained of no adverse effects such as sedation or constipation; and displayed no aberrant behaviors. Dr. Demint testified that Patient 5's OARRS screens were all consistent, his pill counts were consistent, and his toxicology screens were consistent. (Tr. at 151-152)

    Dr. Demint later acknowledged that he did not obtain an OARRS report initially, although he had obtained KASPER and West Virginia Board of Pharmacy reports. Dr. Demint could not recall why but speculated that the OARRS system must have been having problems at the time and he neglected to go back and obtain one. (Tr. at 725-726)

155. Dr. Demint stated: "Dr. Cicek's declaring a patient who drinks a 6 pack of beer on the weekend binges is simply incorrect.[31] (Resp. Ex. Q)

156. Dr. Demint further stated:

> **This was a Lance Practice patient since 10/08/2004 and I had his entire chart available to me. Per Dr. Prior['s] testimony as long as it is in the chart it is documented. At least three other doctors had seen this patient at Lance's and none did an elaborate note as suggested by Dr. Cicek on their first visit with this patient. I did take a history of the cause of pain fracture distal femur, multiple knee surgeries with history of Osteomyelitis.**

(Resp. Ex. Q)

Moreover, Dr. Demint stated that he had obtained OARRS, KASPER, and West Virginia Board of Pharmacy reports on Patient 5 "but Ohio did not come up." In addition, Dr. Demint stated that Dr. Cicek's concerns had been addressed by the previous charting. (Resp. Ex. Q)

Furthermore, with respect to his alleged failure to obtain toxicology screens prior to prescribing narcotics, Dr. Demint gave the same response as he did for this allegation with respect to Patient 2. (Resp. Exs. N and Q)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

157. Dr. Cicek testified that Dr. Demint's prescribing of controlled substances to Patient 5 at Patient 5's first visit had been inappropriate because there was no documentation of any musculoskeletal examination at that visit. (Tr. at 384)

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[31] At the original hearing Dr. Cicek had referred at one point to Patient 5's drinking as "binge" drinking. (Tr. at 386) Dr. Cicek later testified that "binge drinking is greater than -- for a man, greater than, I believe, 14 in a week or something along that line. So the fact that the patient is drinking a couple beers at a time and taking chronic narcotics, I think, needs to be addressed. Perhaps 'binge' isn't the correct term to use there." (Tr. at 500)

158. When asked if Dr. Demint's documentation of his physical examination of Patient 5 met the standard of care, Dr. Cicek replied:

> [T]here's no indication of actually what the patient is or is not able to do functionally besides the fact that it does say he works as a steelworker.[32] But there's no documentation of his limits in his job. It's also not noted if he actually is taking the medication every day or—because I believe it was prescribed as needed. So you would want to know how many times a day is he actually taking the medication, what is the medication allowing him to do, and what is he still not able to do.
>
> And on a physical exam, you would want to document, particularly for the knee, their gait, their ability to sit and stand, if they have crepitus in their joint, if they're tender along the joint line, where are they tender in the knee. And if there's any recent imaging to address further diagnostics, or if there was imaging done in the past referring to it.

(Tr. at 385-386)

159. Dr. Demint testified that he had objective information to support Patient 5's complaint of *left* knee pain, including evidence of a "*right* fib-tib fracture, hardware removed * * *. Also, there's [a left knee] MRI on Page 65 that shows the fracture line. It shows the fracture problem there." (Tr. at 724-725; Emphasis added; St. Ex. 5 at 52, 65)

160. Dr. Demint testified that he had not referred Patient 5 to any non-pharmacological treatment because he had already undergone orthopedic surgery and physical therapy. (Tr. at 725)

161. Dr. Demint believes that his documentation in his first progress note for Patient 5 meets the standard of care, considering that he had assumed the care of the patient and had all the patient's prior treatment records in the file. (Tr. at 146-147)

162. Dr. Demint testified that Patient 5 was not on a high dose of medication, and that his MED had been 50 milligrams. (Tr. at 729)

163. Dr. Demint stated in his written remand statement:

> **The patient was already on opioid therapy when I first saw him. I did not change the dosage he was on. He was able to continue his work while on the medication which he couldn't do without the medication. He had had several surgeries and PT after each surgery. This patient was on a very low dose of opioids at 50mg Morphine Equivalent well below the 180 [mg]**

[32] At his previous visit Patient 5 had told Dr. Demint that he "[w]orks many hours daily as a carpenter." (St. Ex. 5 at 32)

> **ME of in the box treatment and below the new Medical Board Trigger Point. And lower than the 60-80 mg ME that is considered low dose by the panel of 21 physicians from the American Pain Society and American Academy of Pain Medicine. This panel considered high dose of opioids to be over 200 mg ME. So, by all measures this patient was on a very low dose of opioids. Though Dr. Cicek could not come up with any definition of what is low or high dose. She stated about OD's increasing at 150 mg ME indicating that is a very high dose. Yet [according to] the experts in the field this would be considered a moderate dose. This again reveals Dr. Cicek's lack of knowledge in pain management and [shows that she] was not an appropriate expert.**

(Resp. Ex. Q)

Allegation 2(h): Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment

164. Dr. Cicek further testified that, in light of Patient 5's statement that he drinks a six-pack of beer on weekends, "[t]he standard of care would require discussing the risks of prescribing benzodiazepines and narcotics to somebody who drinks and works in a physical job where they could potentially be injured if they're using these medications." (Tr. at 387)

165. Dr. Demint acknowledged that Patient 5 had reported drinking a six-pack of beer on weekends. He further testified, "I'm assuming he had been warned about that in the past and—and that—at the pharmacist about mixing those, but I didn't feel it was excessive." (Tr. at 727)

    When asked about the patient's alcohol consumption of a six-pack of beer on weekends combined with taking Valium, he replied:

    > There are potential side effects, but this patient's been on this same medication, again, since two-thousand- —at least 2006, he's been a patient since 2004. And certainly I—I've warned him when I took his—his drinking history, other doctors have warned him, the pharmacy's warned him about that, they usually put a little sticker on the—on the bottle that says, you know, don't drink and mix with these medications and stuff. He was fully aware of it. He's been on these medications, like I say, at least since 2006. Had no incidents at all.

    (Tr. at 150-151)

166. In his written statement on remand, Dr. Demint stated:

> **This patient did not exhibit any signs of adverse reactions, illegal drug use or abuse and his alcohol use was not excessive [and he was not]**

> **considered an alcoholic. He was on the same dose of medication for years. An addict or abuser request[s] escalation of his medications often, this patient never did. He worked as a union carpenter and was able to continue to work. He could not work with his pain without the medication. This is an activity that was documented in the chart and considered part of the four A's (Activity). Dr. Cicek testified that a physician had to list an activity he couldn't do without the medications. Yet, I list one and it is still not acceptable to Dr. Cicek. No matter what I documented it would not be good enough for Dr. Cicek. (Resp. Ex. Q)**

167. On remand, Dr. Demint presented a printout of a PowerPoint outline from a CME course he attended entitled "Appropriate Prescribing of Controlled Substances for Physician Assistants," offered by the Medical University of South Carolina on May 20, 2014. One of the slides states, in part, that the NIAAA Guidelines define "Risky drinking" for men as "14 drinks per week or 4 drinks per day." (Resp. Ex. EE)

<u>Patient 6</u>

168. Patient 6, a male born in 1976, first saw Dr. Demint on June 8, 2010, at Dr. Demint's practice in Kingston complaining of lower back and right knee pain. At Patient 6's first visit, Dr. Demint documented that Patient 6:

- had two knee surgeries and suffered from lower back pain for six years after falling out of a bucket truck.
- has a history of spondylolisthesis and spondylolysis.
- was previously treated with steroid shots in the back that were no help.
- had previously tried physical therapy that increased pain.
- did not want surgery.
- experienced increased pain with prolonged laying down, standing, and sitting.
- experienced decreased pain with heat, massage, and medication.
- cannot bend or twist (illegible).
- was currently taking oxycodone 10/325 mg, Paxil (illegible) 20 mg once per day, Xanax 1 mg three times per day, and Flexeril.
- has depression and anxiety attacks, is getting a divorce, feels overwhelmed at times, and is trying to obtain SSI disability.

(St. Ex. 6 at 34)

Dr. Demint performed a physical examination and diagnosed: (1) chronic lower back pain, (2) degenerative disk disease of the lumbar spine, (3) lumbar spondylolisthesis, (4) degenerative joint disease of the knee, and (5) depression and anxiety. (St. Ex. 6 at 34)

Dr. Demint prescribed oxycodone/APAP 10/325 mg #120, no refills, with instructions to take one tablet every six hours; Xanax 1 mg #90, no refills, with instructions to take one tablet three times per day; Flexeril 10 mg #90, two refills, with instructions to take one tablet three times per day; naproxen 500 mg #60, two refills, with instructions to take one

tablet twice per day; and Paxil 20 mg #30, two refills, with instructions to take one tablet daily. (St. Ex. 6 at 44-45)

169. Patient 6 signed a medication agreement on June 2, 2010. (St. Ex. 6 at 20-21)

170. Patient 6 continued to see Dr. Demint on a fairly regular basis through March 23, 2011, the last visit documented in State's Exhibit 6. During this time, Dr. Demint maintained Patient 6 on the same regimen of oxycodone/APAP, Xanax, and naproxen, but provided no further prescriptions for Flexeril, switched Patient 6 from Paxil to Cialis in October 2010, and added gabapentin in February 2011. (St. Ex. 6 at 27-28, 31, 41-45)

171. Following his August 4, 2010 visit, Patient 6 did not return to Dr. Demint's practice until October 16, 2010. In his October 16, 2010 progress note, Dr. Demint documented that Patient 6 had been in jail from the last visit until October 10, 2010, based on an OMVI from a "long time ago." Dr. Demint documented that Patient 6 told him that he had unpaid fines that violated his probation. (St. Ex. 6 at 32)

    Later, in his February 23, 2011 progress note, Dr. Demint documented that Patient 6 had been in jail for driving under a suspended license. (St. Ex. 6 at 29)

172. On March 23, 2011, Dr. Demint referred Patient 6 for physical therapy. (St. Ex. 6 at 27)

173. An OARRS report obtained by Dr. Demint on March 30, 2011, shows that Patient 6 was filling on a monthly basis the prescriptions issued by Dr. Demint for oxycodone/APAP. (St. Ex. 6 at 4)

174. A urine sample submitted by Patient 6 on October 16, 2010, and confirmed by a laboratory, tested positive for alprazolam, which is appropriate since he was receiving Xanax. However, it also tested positive for lorazepam,[33] which Dr. Demint did not prescribe, and negative for oxycodone, which Dr. Demint did prescribe. (St. Ex. 6 at 11-14)

    In his progress note for Patient 6's December 16, 2010 visit, Dr. Demint documented: "Discuss Ativan in system. Pt claims he doesn't know how it got there—may have taken mother's by accident. Let pt know not to have another dirty urine." (St. Ex. 6 at 32)

175. Subsequently, a urine sample submitted by Patient 6 on March 23, 2011, and tested in-house yielded a positive result for benzodiazepines, which was appropriate, but a negative result for oxycodone, which was inappropriate. (St. Ex. 6 at 10)

176. Dr. Demint stated in his written testimony on remand that Patient 6's March 23, 2011, urine drug screen lab report confirmed that he did not have oxycodone in his system, but that the report was not added to Patient 6's chart until after he had been discharged because the lab had misspelled the patient's name. Dr. Demint further

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[33] Lorazepam is a benzodiazepine that is sold under the brand name Ativan. (MedLine Plus, *Lorazepam*, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html, accessed December 7, 2012)

stated that on May 2, 2011, he had called Patient 6 in for a pill count; the patient failed to appear and was discharged from the practice. Copies of Dr. Demint's records for Patient 6 submitted on remand corroborate these statements. (Resp. Ex. R)

177. The urine drug screen report for the sample submitted on March 23, 2011, did misspell Patient 6's name, replacing the first letter of the surname with another letter. (St. Ex. 15; Resp. Ex. R)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy

178. Dr. Cicek testified that Dr. Demint's initial visit note for Patient 6 was much more thorough than for some of the other patients in this matter. However, Dr. Cicek testified that Dr. Demint did not document goals for Patient 6's treatment or what the expectations of treatment were. Accordingly, Dr. Demint failed to document the development of an individualized treatment plan for Patient 6. Dr. Cicek further testified: "[E]very patient has an individualized treatment plan based on their past medical history, allergies, drug intolerances, family situations, social situations." Moreover, Dr. Cicek testified that documenting the development of an individualized treatment plan is not just a requirement of the Board's intractable pain rules; it is also required under the standard of care. (Tr. at 388-390)

179. Dr. Demint testified that he did not refer Patient 6 to a specialist prior to prescribing medication but that Patient 6 had undergone previous specialist treatment. (Tr. at 731)

180. Dr. Demint testified that he had ordered physical therapy for Patient 6. (Tr. at 731)

181. Dr. Demint testified that he had administered trigger-point injections to Patient 6. (Tr. at 731; St. Ex. 6 at 25)

182. Dr. Demint testified that he had kept Patient 6 on his then-current medications, oxycodone/APAP and alprazolam, and added naproxen, Flexeril and Paxil "[t]o try to get better control of the pain and not needing to up the opioid dose any." (Tr. at 731-732)

183. Dr. Demint stated that he did have an individualized treatment plan for Patient 6 listed under "P" in his SOAP note, and that no other patient received the same treatment. Dr. Demint further stated that the patient was referred to physical therapy and was taking Paxil, an SSRI. (Resp. Ex. R)

Allegation 2(g): Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports; and

Allegation 2(h): Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any

illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment.

184. Dr. Cicek testified that she had stated in her report that Dr. Demint had not addressed a positive lorazepam result on Patient 6's urine drug screen; however, she acknowledged that he did in fact document a discussion with the patient in the December 16, 2010 progress note. (Tr. at 392-393)

Nevertheless, the patient's excuse that he "may have taken [his] mother's by accident" is a red flag:

> [I]t would indicate the need for a further discussion of safety and medications –
>
> * * *
>
> – keeping the medications separate from someone else who has controlled drugs in the house. If you are having difficulty taking your own medications, using some type of pillbox or reminder system. A discussion of how you're going to avoid that type of event in the future.

(Tr. at 393)

Dr. Cicek testified that no such discussion was documented in the chart, however. (Tr. at 394)

185. With respect to the second inconsistent urine screen in March 2011, Dr. Cicek testified that she found no mention of the test or a confirmation report in the chart. (Tr. at 396-400)

Dr. Cicek further testified that, despite Patient 6's negative in-house result for oxycodone on March 23, 2011, Dr. Demint continued to prescribe the usual dose and quantity of oxycodone/APAP at that visit. Dr. Cicek further testified that the negative result meant that he had gone at least three or four days without taking any of that medication. Moreover, if the patient can go that long without the medication, Dr. Cicek questioned why Dr. Demint prescribed four tablets per day to him. (Tr. at 400-401)

186. Dr. Cicek stated in her report:

> Pain medication for this patient is not inappropriate but there are concerns. His urine toxicology was inappropriately negative for oxycodone, he had consistently high levels of pain but mentions fishing and camping as activities, and he is receiving no mental health care with the exception of daily benzodiazepines. It is not clear how the inappropriate toxicology tests were addressed. It was also not clear the patient was progressing toward any goals.

(St. Ex. 6 at 6-7)

187. Dr. Demint acknowledged that Patient 6's October 2010 urine drug screen report indicated a positive result for Ativan, which he did not prescribe, and a negative result for oxycodone, which he did prescribe. However, Dr. Demint testified that Patient 6 had been in jail for an old OMVI conviction. Dr. Demint testified that the OMVI was a red flag but that you do not necessarily stop seeing a patient based on one red flag. Rather, Dr. Demint testified that it "means you need to increase your surveillance." Dr. Demint testified that he warned Patient 6 to not let it happen again. (Tr. at 165-167)

    Dr. Demint testified that he obtained his next urine drug screen on Patient 6 in March 2011. Dr. Demint noted that the in-house results were positive for benzodiazepines, which was appropriate, but negative for oxycodone, which was not appropriate. Dr. Demint further testified that Patient 6 submitted to a pill count in May 2011, which he failed. Dr. Demint testified that he discharged Patient 6 after the failed pill count. (Tr. at 171-172, 732-733)

188. Dr. Demint disagreed that, because Patient 6 had been able to camp and fish, he should have stopped or altered Patient 6's dose of medication, as Dr. Cicek stated in her report.[34] Dr. Demint testified that he would not stop or alter the dose because the patient had been having problems but was doing better with medication. (Tr. at 734-735)

189. Dr. Demint testified that he had obtained reports concerning Patient 6 from OARRS, KASPER, and the West Virginia Board of Pharmacy. (Tr. at 732)

190. Dr. Demint stated, "The inconsistent tox screen was explained. [Dr. Cicek] is not correct when she says an ITP [individualized treatment plan] requires the doctor state what the drug was prescribed for. 120 pills were prescribed until the report was returned. Her opinion is inconsistent with COT[35] and CLE." (Resp. Ex. R)

191. Dr. Demint further stated:

> **On [Patient 6's] first inconsistent drug test I warned him that he was not to have another dirty test, he stated he may have taken his mother's meds by accident. The second one was not confirmed and misplaced in his chart because of the misspelling of his name by the lab before he was discharged. Therefore, there was not multiple abnormal toxicology reports, very disingenuous to say so. When he did fail to appear for a pill count he was promptly discharged. He had no early refills.**

(Resp. Ex. R)

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[34] This somewhat misstates Dr. Cicek's statement. She questioned how Patient 6 could camp and fish yet consistently report high levels of pain. (St. Ex. 16 at 6)

[35] **"COT" refers to "Chronic Opioid Therapy," and is referenced in the *Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain,* published online by The Journal of Pain, *http://www.jpain.org/article/S1526-5900(08)00831-6/fulltext,* printed on May 4, 2014, submitted by Dr. Demint on remand. (Resp. Ex. BB)**

Dr. Demint's remand exhibits indicate that, by letter dated June 22, 2011, Patient 6 was notified of that he had been discharged from Dr. Demint's practice for failing to appear for a pill count. (Resp. Ex. R)

192. In addition, Dr. Demint noted that he had records from previous treatment providers including two specialists concerning Patient 6's inability to work. Moreover, Dr. Demint stated that he had documented Patient 6's pending divorce. Accordingly, he asserted that he did have sufficient documentation. (Resp. Ex. R)

193. Finally, the Journal of Pain's clinical guidelines for chronic opioid therapy state, in part:

> **Although evidence to guide optimal management strategies is lacking, anecdotal experience of panel members suggests that patients who are not assessed as being at high risk and engage in a relatively nonserious aberrant behavior, such as one or two episodes of unauthorized opioid escalations, can often be managed with patient education and enhanced monitoring.**

(Resp. Ex. BB at 7)

Allegation 2(i): Medical charting was incomplete, often illegible and/or disorganized

194. Dr. Cicek opined that Dr. Demint's medical records for Patient 6 fell below the minimal standard of care based upon the legibility of the records, and a lack of an individualized treatment plan with goals to assess the patient's response to treatment. (Tr. at 398)

195. In his written rebuttal testimony, Dr. Demint repeated the same statement made with respect to this allegation as applied to Patient 1. (Resp. Exs. M, R)

<u>Patient 7</u>

196. On September 14, 2010, Patient 7, a male born in 1960, first visited Dr. Demint at his practice in Kingston. He complained of continuous pain in the neck, back, and legs that resulted from rolling a tractor 15 years earlier. He also complained of being stressed-out all of the time. Dr. Demint documented that Patient 7 had been taking Percocet and Xanax for "many, many years," but that, at that time, Patient 7 had been taking no medication. Patient 7 advised that he had been out of meds since August 31, 2010, about two weeks prior to the visit. (St. Ex. 7 at 27-31)

    Dr. Demint documented that Patient 7 had been discharged from another practice because of a urine sample that tested negative for all prescribed medications, but that Patient 7 stated that he had been taking his medications. (St. Ex. 7 at 27)

    Dr. Demint diagnosed: (1) chronic lower back pain, (2) "CCP," and (3) anxiety. Dr. Demint's plan was for Patient 7 to obtain his old treatment records before his next visit.

In addition, Dr. Demint prescribed Percocet and Xanax and added gabapentin and naproxen, and warned him not to take other people's medication. (St. Ex. 7 at 27)

Finally, Dr. Demint prescribed oxycodone/APAP 10/325 mg #120 with instructions to take one tablet every six to eight hours as needed for pain, Xanax 0.5 mg #90 with instructions to take every eight hours as needed for anxiety, gabapentin 300 #72 to be gradually increased to one tablet three times per day, and naproxen 500 mg #60 with instructions to take one tablet twice per day. No refills were authorized. (St. Ex. 7 at 29)

197. Dr. Demint obtained an OARRS report at Patient 7's first visit. The report indicates that Patient 7 had last filled a prescription from another physician for pain medication on August 31, 2010, when he received a prescription for tramadol 50 mg #112, identified as being a 28-day supply. Prior to that, on August 3, 2010, Patient 7 filled prescriptions from yet another physician for Endocet 10/325 mg #112, tramadol 50 mg #112, and alprazolam 1 mg #84. All the prescriptions were for 28-day supplies. (St. Ex. 7 at 61)

198. A urine drug screen confirmation report for a urine sample submitted by Patient 7 on September 14, 2010, tested positive for oxycodone and oxymorphone and negative for benzodiazepines. (St. Ex. 7 at 9) However, Patient 7 had told Dr. Demint that he had been out of medication for about two weeks. The urine drug screen report states that oxycodone and oxymorphone are detectable in urine for only one to four days following ingestion. (St. Ex. 7 at 10, 28)

199. Patient 7 next visited Dr. Demint on November 3, 2011, and saw him again on December 4, 2010, and January 8, 2011, the last visit documented in State's Exhibit 7. At each visit, Dr. Demint continued the same medications as prescribed at the first visit. (St. Ex. 7 at 21-25)

200. A note dated January 10, 2011, indicates that a pharmacist had contacted Dr. Demint and informed him of an irregularity concerning Patient 7. Dr. Demint noted that the pharmacist told him that Patient 7 had been prescribed oxycodone/APAP 10/325 mg but was mistakenly given a lower strength, 5/325 mg, instead. The pharmacist contacted Patient 7 and told him that if he brought those tablets back to the pharmacy they would replace them with the 10/325 mg tablets. However, Patient 7 was unable to produce the 5/325 mg pills and instead brought a bottle from another pharmacy with a torn label, then told the pharmacist that his girlfriend had stolen the pills. Patient 7 then told the pharmacist not to tell his doctor about it. Dr. Demint noted advising the pharmacist that he would address the problem. (St. Ex. 7 at 2-3)

The chart includes a copy of a letter dated January 28, 2011, that Dr. Demint sent to Patient 7 advising him that he was being dismissed from Dr. Demint's practice. Dr. Demint referenced violations of two paragraphs in his "pain agreement." Dr. Demint told Patient 7 about Dr. Demint's conversation with the pharmacist, and further told him that he had checked an OARRS report and discovered that Patient 7 had been receiving pain medication from other providers. Finally, he advised Patient 7: "You will have to

find a new doctor to treat your pain issues. Once you have established yourself with a new doctor sign a release form and we will forward your records on to them." (St. Ex. 7 at 20)

Allegation 2(b): Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records

201. Dr. Cicek testified that the fact that Patient 7 had been discharged from another physician's practice for an irregular urine screen is a red flag. Dr. Cicek testified that she would provide a records release to the prior physician and ask them over the telephone why the patient had been discharged. (Tr. at 402, 407)

202. Dr. Cicek testified that Patient 7 had been told to obtain his prior medical records in order to continue to receive treatment; however, Dr. Demint prescribed oxycodone to Patient 7 on November 3 and December 4, 2010, prior to receiving the records on December 17, 2010. Dr. Cicek testified that it is okay to "issue a short amount of medication * * * so the patient doesn't go into withdrawal and so you're actually treating the patient." Dr. Cicek further testified that most providers provide their patients with a records release or else fax it to the prior physician themselves. (Tr. at 405-408)

203. Dr. Demint agreed that Patient 7's dismissal from another practice for a failed urine screen had been a red flag. However, Dr. Demint testified that he obtained an OARRS report, performed an appropriate workup, and did his "due diligence." (Tr. at 173-175)

204. Dr. Demint testified that he only saw Patient 7 a few times before he discharged him after being contacted by a pharmacist. Dr. Demint further testified that he did not obtain the prior treatment records for Patient 7 until after he had been discharged. (Tr. at 176-177)

205. Dr. Demint stated, "I took an appropriate H&P which included a Pain evaluation questionnaire * * * which [included] pain levels of 7-10/10 reported and a diagram that shows the location of pain in neck and low back with radiation into the legs and right arm. I did not receive [his] old records till after he was discharged." (Resp. Ex. S)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

206. Dr. Cicek testified that Dr. Demint's documentation of a musculoskeletal examination for Patient 7 at Patient 7's first visit consisted of two lines, one of which referenced the lumbar spine but which Dr. Cicek could not read, and the other which states, "5 out of 5 strength bilateral upper extremities." Dr. Cicek further testified, "So, essentially, there's no physical exam of the musculoskeletal system with the exception of upper extremities strength." Dr. Cicek criticized Dr. Demint for not providing sufficient documentation to support the amount of medication he prescribed to Patient 7 at the first visit. (Tr. at 403-404; St. Ex. 7 at 27)

207. Dr. Demint testified that, when a patient was injured due to trauma, he "usually" ascertains the cause of the trauma. In Patient 7's case, Dr. Demint testified that he had claimed that he had "rolled a tractor on himself" 15 years earlier. (Tr. at 735-736, 742; St. Ex. 7 at 27)

208. Dr. Demint testified that Patient 7 had had great difficulty obtaining his prior treatment records but that he finally produced an MRI report. Dr. Demint further testified that the MRI report confirms that Patient 7 suffered from a condition that could cause pain. (Tr. at 736-737) The report states, under "Impression":

> Minimal diffuse posterior spondylytic [sic] bar with associated minimal diffuse bulging disc, more prominent to the right at the level of C5-C6 with some moderate narrowing of the right C5-C6 neuroforamen and minimal narrowing of the left C5-C6 neuroforamen. No definite soft disc herniation posteriorly. There is also minimal narrowing of the canal at the level of C5-C6.

(St. Ex. 7 at 8)

209. Dr. Demint stated:

> **First, this patient was on a low dose of opioids, 60 mg ME, according to the American Pain Society and American Academy of Pain Medicine. It is well below the 180 mg ME "in the box" and below the 80mg ME trigger point of the new Medical Board's opioid guidelines. I also added gabapentin for his neuropathic pain, the radiating pain, and Naproxen for musculoskeletal pain. Second, he had complaint of significant pain 7-10/10 pain, this is considered severe pain. Third, he had a MRI which revealed several abnormalities.**

(Resp. Ex. S)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy

210. Dr. Cicek testified that she did not find that Dr. Demint had documented an individualized treatment plan for Patient 7. (Tr. at 404-405)

211. Dr. Demint testified that he tried non-pharmacological treatment with Patient 7; namely, osteopathic manipulative therapy ("OMT") on November 3, 2010. Dr. Demint testified Patient 7 experienced good results and had some increased range of motion. (Tr. at 737; St. Ex. 7 at 22)

212. Dr. Demint testified that he had made some changes to the medication regimen that Patient 7 had been taking prior to seeing him. Dr. Demint testified that he continued

oxycodone/APAP 10/325 mg but decreased his alprazolam 1 mg to 0.5 mg, and added naproxen and gabapentin. (Tr. at 738)

213. Dr. Demint stated on remand:

> **P of the SOAP note is for plan. This patient received treatment that was unique for him, this is the definition of individualize treatment. No other patient had this exact treatment. In Pill Mills everyone gets basically the same treatment. He was treated with Naproxen for his musculoskeletal pain and Gabapentin for his neuropathic pain. I was pending records to develop a more individual plan. They did not get to me before he was discharged. This patient was only seen four times.**

(Resp. Ex. S)

Additional Information

214. Dr. Cicek noted that Dr. Demint's chart for Patient 7, like his chart for Patient 6, contains more documentation than some of the other charts. (Tr. at 401)

<u>Patient 8</u>

215. Patient 8, a female born in 1959, first saw Dr. Demint on October 22, 2008, at Dr. Demint's practice in Kingston. At that time, she reported a medical history of having injured her back in 1993 while working as a home health aide when she was helping to turn a 400-pound patient. She suffered severe pain in her back and right leg. As a result, she underwent a partial discectomy in 1993. When she saw Dr. Demint, she indicated she was still suffering from severe pain in her lumbar region and right buttock with occasional pain in her right calf. (St. Ex. 8 at 143, 258)

    Patient 8 continued to see Dr. Demint through July 2009. (St. Ex. 8 at 232-261)

216. In August 2009, Patient 8 began seeing another physician at Chillicothe Acute Care Clinic. She continued to see the other physician until July 2010 when the physician discharged her from that practice. (St. Ex. 8 at 168-232)

    With respect to Patient 8's discharge, office staff at Chillicothe Acute Care Clinic wrote the following note: "Dr. * * * has discharged this patient due to not taking Opana, nor can present them to our office – only had Percocet this last month – no phone call of same or call of pain or Opana not working. This was pt's last visit. She had failed 2 previous urine drug screens." On July 10, 2010, the physician provided Patient 8 with oxycodone/APAP 10/325 mg #70 with instructions for Patient 8 to wean herself from oxycodone over a four-week period. (St. Ex. 8 at 173, 187)

217. Patient 8 returned to Dr. Demint on July 21, 2010. At that time, Dr. Demint documented among other things that her previous physician had prescribed Opana which had caused her to

throw up. Patient 8 claimed she "flushed" the medication and, when she saw the doctor again, she was discharged. She told Dr. Demint that she had previously been prescribed OxyContin but wanted off of it due to the expense of that medication and because BWC will not pay for it. (St. Ex. 8 at 142)

At Patient 8's initial return visit, Dr. Demint prescribed the following: oxycodone 30 mg #120 with instruction to take one tablet four times per day, oxycodone/APAP 10/325 mg #90 with instructions to take one tablet every four to six hours as needed for breakthrough pain, Lyrica 300 mg #60 with instructions to take one tablet twice per day, and Mobic 7.5 mg[36] #60 with instructions to take one tablet twice per day. Dr. Demint authorized two refills on the Lyrica and Mobic prescriptions. The total daily dose of oxycodone prescribed by Dr. Demint, if taken as directed, was 150 milligrams. (St. Ex. 8 at 146)

218. Patient 8 continued to see Dr. Demint on a regular basis through January 8, 2011, the last visit documented in State's Exhibit 8. He obtained one urine drug screen on Patient 8 in September 2010 which yielded consistent results. At that time, Dr. Demint noticed white powder in Patient 8's nose. He referred her for an addiction evaluation with a note that she was "snorting pain medication." (St. Ex. 8 at 3-5, 131-141)

Allegation 2(b): Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records; and

Allegation 2(g): Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports.

219. In her report, Dr. Cicek stated that "[n]o [prior] records appear to have been available at the time of the first visit, although they were requested." (St. Ex. 16 at 8)

220. With respect to "red flags" in Dr. Demint's treatment of Patient 8, Dr. Cicek noted that Dr. Demint's progress note for Patient 8's September 21, 2010 visit indicates he had a discussion with Patient 8 concerning an inconsistent urine screen with a previous provider. Dr. Cicek testified that Dr. Demint had her submit to a drug screen that was consistent with his prescribing. (Tr. at 414; St. Ex. 8 at 135)

Dr. Cicek further testified that there was mention of Patient 8 having problems with her previous provider that were not investigated. (Tr. at 414-415)

221. Dr. Demint testified that he had originally seen Patient 8 in October 2008 at his own practice in Kingston prior to his Board suspension. He testified that, when he was suspended, Patient 8 had seen another physician in Chillicothe. She then returned to him in July 2010 when he reopened his practice. (Tr. at 182-184)

[36] Dr. Cicek testified that Mobic is a nonsteroidal anti-inflammatory medication. (Tr. at 410)

222. Dr. Demint agreed that Patient 8's discharge from the other practice had been a red flag, but testified that he had done "numerous screenings and stuff, what we do when we get red flags, and she was okay. There's all sorts of reasons to have a red flag besides addiction or diversion or misuse." (Tr. at 189-191)

223. Dr. Demint testified that he had obtained two urine drug screens on Patient 8. (Tr. at 746-747)

224. On remand, Dr. Demint stated that he had noticed a white substance in Patient 8's nose during the physical examination on January 8, 2011. He stated that this could indicate aberrant behavior under the 4 A's. Dr. Demint stated that he confronted her and she admitted to snorting her medication. Dr. Demint further stated, "I then weaned her off all her medication and referred her to addictionology. She never returned after this visit." (Resp. Ex. T)

225. Dr. Demint further stated, "I had notes from when I saw her from 10/22/08 till 7/17/09. Which includes H&P from 10/22/08. I took an appropriate H&P on my visit of 7/21/10. In the patient's pain inventory she reported pain levels of worse 9/10, best 3/10, average of 8/10, and current at 8/10." (Resp. Ex. T)

226. Moreover, Dr. Demint stated:

> **All her drug tests and OARRS under me were consistent. I discussed her previous inconsistent drug tests with Dr. Poje. There appears to be a mix up with her tests and all test done after 11/09 was consistent. The first sign of abuse I witness was when I saw the white substance in her nose on 1/18/11 and I immediately weaned her off her medication and referred her to addictionology.**

(Resp. Ex. T)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

227. Dr. Cicek testified that Patient 8's initial visit physical examination was essentially normal with the exception of decreased range of motion in all planes of her lumbar spine. Dr. Cicek further testified, "[T]here's no indication from that physical exam that she needs a drastic increase in medication." (Tr. at 415; St. Ex. 8 at 142)

228. Patient 8 had regularly received from her prior physician Endocet 10/325 mg #90 and OxyContin 40 mg #60, a total daily dose of 110 milligrams of oxycodone. However, at Patient 8's initial visit with Dr. Demint, he prescribed a total of 150 milligrams of oxycodone per day, an increase of 40 milligrams. (St. Ex. 8 at 146-147)

Dr. Cicek characterized Dr. Demint's prescribing at Patient 8's initial visit as a "drastic increase in [the] dose of medication without justification of why that increase was being prescribed." (Tr. at 408-413)

229. Dr. Demint testified that Patient 8 had a history of two failed surgeries and had had bone harvested from her hip. (Tr. at 744)

230. Dr. Demint testified that Patient 8 had already tried surgery and physical therapy before she came to him. Dr. Demint acknowledged that the only referral he had made for Patient 8 had been to an addictionologist at the very end of her treatment. (Tr. at 744-745)

231. Dr. Demint testified that he had increased her dose of oxycodone when she first came to him, from 120 milligrams to 150 milligrams per day. However, he testified that that had still been "in the box." (Tr. at 745-746)

232. Dr. Demint stated on remand:

> **Per the MGH Handbook and Dr. Cicek testimony, "Reports of pain may not correlate with degree of disability or findings on physical exam." Dr. Cicek indicated she agreed to this and added from the MGH handbook, "the most important of these factors is the patient's report." This patient had the levels of pain stated above which is significantly high. She also had abnormal MRI and had spinal surgery twice. Do they do surgery twice on someone without significant findings? I think not. All these findings justify the dose. As far as the increase it was justified by the amount of pain she was experiencing with her current dose and to the fact I was switching her from a long acting opioid to a short acting one. Therefore, an increase to cover the shorter duration and her pain levels was warranted.**

(Resp. Ex. T)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy

233. Dr. Cicek testified that Dr. Demint failed to document an individualized treatment plan for Patient 8. (Tr. at 413-414)

234. On remand, Dr. Demint stated that the patient had received treatment that was unique for her, which he testified is the definition of individualized treatment. He further stated that no other patient had the exact same treatment. Dr. Demint further stated that Patient 8 had been given Celexa, an SSRI; Mobic, an NSAID; Zanaflex, a muscle relaxer; and Lyrica, an anticonvulsant. He further stated that Patient 8 had had physical therapy in the past. (Resp. Ex. T)

Allegation 2(i): Medical charting was incomplete, often illegible and/or disorganized

235. Dr. Cicek found overall that Dr. Demint's medical chart for Patient 8 fell below the minimal standard of care. (Tr. at 416)

236. On remand, Dr. Demint responded to this allegation concerning Patient 8 as he had for Patient 1. (Resp. Exs. M, T)

Additional Information

237. Dr. Cicek noted that Dr. Demint had performed a urine drug screen at Patient 8's initial visit which was consistent with the medications she had been prescribed. (Tr. at 413)

238. Dr. Cicek noted that Dr. Demint had obtained an OARRS report the day before Patient 8 first came back to his office, which is a good thing to do. (Tr. at 409)

239. With regard to long-acting versus short-acting medications, Dr. Demint testified that it is advisable to keep chronic pain patients on long-acting medications as their treatment, and possibly use short-acting medication for breakthrough pain. The idea is to keep the patient's medication level as steady as possible. The short-acting breakthrough medication helps patients who experience pain between the time after one dose of long-acting medication begins to wear off and before the next dose of medication takes effect. Dr. Demint testified that maintaining chronic pain patients on short-acting medications only causes them to go through numerous "peaks and valleys" of pain relief. (Tr. at 748-749)

240. Dr. Demint testified that he had prescribed Xanax to Patient 8 because she was experiencing a lot of stressors in her life and had asked for something. Dr. Demint testified that he had prescribed Xanax at a very low dose, 0.25 milligrams. (Tr. at 193-195)

<u>Patient 9</u>

241. Patient 9, a male born in 1954, first saw Dr. Demint at his Kingston practice on July 17, 2010, for chronic pain in his back and neck. Patient 9 indicated that he had been injured in 1990 when, as a pedestrian, he was struck by a car. On Patient 9's history form, Dr. Demint noted that Patient 9 had "[t]oo many surgeries to mention" including two neck surgeries, a left leg amputation, and had a plate in his jaw. He suffered from, among other things, chronic obstructive pulmonary disease ("COPD"), emphysema, and congestive heart failure ("CHF"). His current medications included oxygen (2 liters), albuterol inhaler, Combivent inhaler, Advair, Remeron, gabapentin 600mg three times per day, OxyContin 40 mg twice per day, oxycodone/APAP 10/325 mg for breakthrough pain,[37] and Xanax 1 mg.[38] (St. Ex. 9 at 50-52)

[37] The dosing frequency is illegible to the Hearing Examiner. (St. Ex. 9 at 51)
[38] No dosing frequency was documented. (St. Ex. 9 at 51)

At Patient 9's first visit, Dr. Demint prescribed OxyContin 60 mg #60 with instructions to take one tablet twice per day, and oxycodone/APAP 10/325 mg #120 to take one tablet every four to six hours as needed for breakthrough pain. (St. Ex. 9 at 54)

242. Patient 9 continued to see Dr. Demint on a regular basis through March 29, 2011. During this time, Dr. Demint continued prescribing, among other things, OxyContin and oxycodone IR. In addition, at Patient 9's September 16, 2010 visit, he added Xanax 1 mg with instructions to take one tablet twice per day. (St. Ex. 9 at 32-49)

243. At Patient 9's final visit on March 29, 2011, Dr. Demint dismissed Patient 9 from his practice for having failed three urine drug tests. However, Dr. Demint provided Patient 9 with a prescription for, among other things, oxycodone 30 mg #74 with instructions to taper the dose to wean himself off the medication. (St. Ex. 9 at 30-32)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

244. Dr. Cicek noted that Patient 9 had a lot of chronic medical problems, and that Dr. Demint diagnosed chronic low back pain, chronic cervical pain, degenerative disc disease, COPD, and hypertension. Moreover, Dr. Demint documented that Patient 9 had had numerous surgeries including amputation of his left leg. Nevertheless, Dr. Cicek found that Dr. Demint's documentation did not support the medication he prescribed. She explained:

> On this patient for the physical exam there's decreased range of motion in [the] lumbar and cervical spine; reflexes two out of four, that's considered normal; five out of five strength is considered normal, bilateral upper extremity—I can't read the next word.
>
> So, again, we don't have a picture of the patient's function. Is the patient ambulating with a prosthesis? Is the patient wheelchair-bound? There's not an indication of—I can't read this physical exam and picture the patient.
>
> * * *
>
> If he's ambulating, if he's in a wheelchair, what his actual level of function is. Because if you look at his history, his function could be sitting in a reclining chair, but it could be going to the grocery store. So without having any kind of physical exam or indication of what his treatment objectives are, it's hard to even know what—well, you can't know what this patient's functional status is.
>
> * * *
>
> There is a lack of subjective data—or, objective data to support the medication he's receiving.

(Tr. at 420-421)

245. Dr. Demint testified that in the past Patient 9 was severely injured in a motorcycle accident, and had undergone a left leg amputation and two cervical spine fusions. Dr. Demint further testified that he also suffered from phantom pain from the amputation. (Tr. at 749-750)

246. Dr. Demint stated on remand, "[Patient 9] had a below knee amputation, two cervical spine surgeries, had a plate in his jaw. Is not this significant medical history? He complained of pain in the range of 6-9/10. One goal of PM is to get pain down to a 3-4/10 range if possible." (Resp. Ex. U)

Allegation 2(d): Dr. Demint inappropriately prescribed high doses of narcotics despite diagnoses of underlying Chronic Obstructive Pulmonary Disease

247. Dr. Cicek further criticized Dr. Demint for failing to document taking into account Patient 9's serious respiratory problems when prescribing large doses of opiate medications. Dr. Cicek testified that opiates have a side effect of respiratory depression. Dr. Cicek was apprised of Dr. Demint's testimony that Patient 9 had developed a tolerance to the opiate medication which reduced the risk of respiratory depression, and that he had performed breathing exams which showed that Patient 9 did not have depressed respiration. However, even if that had occurred,[39] Dr. Cicek testified that respiration rate is "just one part of the assessment of [patients'] respiratory function." Dr. Cicek stated: "[Y]ou could have * * * arterial blood gases. You could have a report from a pulmonologist that tells you what stage of COPD the patient's at; if they're a CO2 retainer or not. The different things you worry about in suppressing respirations in a patient." (Tr. at 421-424)

248. As stated above, on July 17, 2010, Dr. Demint provided Patient 9 with prescriptions for OxyContin 60 mg #60 to take one tablet twice per day, and oxycodone/APAP 10/325 mg #120 to take one tablet every four to six hours as needed for breakthrough pain. Assuming Patient 9 took the maximum dose over the course of thirty days, his daily dose of oxycodone would have been 160 milligrams. However, according to an OARRS report obtained by Dr. Demint at Patient 9's initial visit, during the three months prior to his first visit, from April through June 2010, Patient 9 had received only two prescriptions for hydrocodone/APAP 5/500 mg #30.[40] In fact, Patient 9 had not received any large doses of opiates since March 26, 2010, when he filled prescriptions for OxyContin 40 mg #28 and Endocet 10/325 mg #42 that were written for a 14-day supply. (St. Ex. 9 at 54-55)

    Dr. Cicek testified that going from small doses of opiates to the dose Dr. Demint prescribed at Patient 9's first visit "in a patient with COPD severe enough to require oxygen is very concerning." She further testified that it fell below the minimal standard of care. (Tr. at 424-425)

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[39] In Patient 9's chart, Dr. Demint regularly documented his temperature, blood pressure, and heart rate but documented his respiration rate only once; on March 15, 2011, his respiration rate was 16. (St. Ex. 9 at 32, 34-35, 40-41, 50)

[40] The total oxycodone content of each of those prescriptions was 150 milligrams, ten milligrams less than the daily dose prescribed by Dr. Demint.

249. **Dr. Cicek testified that she did not criticize Dr. Demint for treating a patient who had COPD with narcotics, per se.** Dr. Cicek testified: "I want him to discuss with the patient the risks of high-dose opioids and respiratory depression with his underlying lung disease; that he's had that discussion, that this patient is a high-risk patient for receiving opioids because of his COPD, and what's going to be done to monitor that for the patient's safety." (Tr. at 541-542) (**Emphasis added on remand**)

250. Dr. Demint testified that he had sought confirmation through medical literature that he was doing the right thing with respect to Patient 9. He referenced two Medscape.com articles, the first entitled *Opioids Underprescribed for Refractory COPD, per Small Study,* dated April 28, 2012, and the second entitled *Opioids Underused in Advanced COPD,* dated September 14, 2009. Dr. Demint testified that those articles support his decision to treat this patient with opioids.[41] (Tr. at 677-679; Resp. Ex. I)

251. Dr. Demint stated that Dr. Cicek's opinion to not use opioids in patients with COPD "is contrary to all other authority." (Resp. Ex. U)

252. Dr. Demint further stated:

> **Patient on chronic opioid therapy will develop tolerance to the respiratory depression of opioids. The consent form which the patient read and signed stated it can slow breathing, ergo the patient was given notice. The patient was hospitalized for Pulmonary problems prior to seeing me and then after he was discharged. He never needed hospitalization while under my care. Reason I saw him monthly which allowed to monitor his COPD and treated him early when he had issues as can be seen in my notes.**

(Resp. Ex. U)

253. Dr. Frazier stated in his affidavit that patients with COPD can be treated with opioids. (Resp. Ex. AA)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy

254. Dr. Cicek testified that Dr. Demint failed to develop or document developing an individualized treatment plan for Patient 9. (Tr. at 421)

255. Dr. Demint acknowledged that he did not refer Patient 9 to physical therapy, but testified that Patient 9 had already been through surgeries and physical therapy on multiple occasions. Dr. Demint further testified that Patient 9 suffered from COPD and appeared

[41] Obviously, Dr. Demint could not have relied upon the first article, dated April 28, 2012, in his treatment decision because the article post-dates the time period relevant to this matter.

much older than he actually was, and Dr. Demint believes that Patient 9 would have had difficulty participating in physical therapy. (Tr. at 750-751)

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics;

256. On remand, Dr. Demint gave the same response to this allegation that he gave in reference to Patient 2. (Resp. Exs. N, U)

Allegation 2(g): Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports; and

Allegation 2(h): Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment.

257. Dr. Cicek noted that, on his initial visit note, Dr. Demint documented that Patient 9 had been discharged from his prior physician's practice because he could not produce a urine sample. Patient 9 told Dr. Demint that that was because he was suffering from pneumonia at the time and had been dehydrated. However, Dr. Cicek testified it is standard practice that, "[w]hen a patient is unable to give a urine specimen, * * * they're given a glass of water or something to drink so they can give the specimen."[42] (Tr. at 418)

258. Dr. Cicek testified that Patient 9 submitted to four urine drug screens while under the care of Dr. Demint. The first was done in September 2010, two months after Dr. Demint initiated care. The result was positive for oxycodone and oxymorphone, which is appropriate, but also positive for morphine, which Dr. Demint did not prescribe. Dr. Demint documented that Patient 9 told him that he had been using cough syrup containing codeine.[43] Dr. Cicek testified that it is good that Dr. Demint documented that; however, the medication contract forbade Patient 9 from obtaining narcotics from other people. (Tr. at 425-427; St. Ex. 9 at 19, 40)

Patient 9 next submitted a urine sample on January 15, 2011. The sample tested positive for oxycodone but negative for alprazolam and gabapentin, which was inconsistent with Dr. Demint's prescribing. In his progress note for February 2010, Dr. Demint documented that Patient 9 told him that he had stopped taking Xanax for one week the previous month. Dr. Cicek testified that this statement raises a question because abruptly stopping Xanax after having taken two milligrams per day for months put Patient 9 at risk for seizures. However, Dr. Cicek testified that the issue was not addressed. Dr. Cicek further testified: "If he was not needing them for a week, I think the discussion of decreasing the dose would

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[42] **On remand, Dr. Demint stated that Dr. Cicek's statement was incorrect that "drinking water was required to obtain a urine sample because extreme dehydration cannot be hydrated enough to produce a sample." (Resp. Ex. U)**

[43] Morphine is detectable in urine as a metabolite of codeine. (St. Ex. 9 at 20)

be very appropriate here, and the discussion of the harm of abruptly stopping benzodiazepines, as well." However, Dr. Demint did note a discussion with the patient that, if he wants to wean off of Xanax, it has to be done gradually. Dr. Demint further noted that he would refill Patient 9's medications but would keep a close eye on him. (Tr. at 427-428; St. Ex. 9 at 17, 34-35, 53)

259. Also in his February 2010 progress note, Dr. Demint documented that Patient 9 expressed concern that his wife "was snorting her meds." Dr. Cicek testified that such information would require "a pretty serious discussion about keeping medications locked and in an appropriate place, because this is a family that's at very high risk for a negative outcome from potentially taking this patient's medications." (Tr. at 429; St. Ex. 9 at 34)

260. Dr. Demint testified that a prescription is not necessary to obtain cough syrup with codeine in Ohio; the patient simply has to go to a pharmacy and sign for it. Dr. Demint further testified that codeine ingestion can cause a positive result for morphine on a urine drug screen. (Tr. at 206)

261. Dr. Demint testified that he had performed urine drug screens on Patient 9. One, from January 2011, was confirmed to be negative for benzodiazepines even though Dr. Demint had been prescribing Xanax. Dr. Demint explained the result:

> Well, he—he had given me the explanation that he was trying to see if he could, you know, take himself off of it, but as most people who try to take themselves off this medication, he found he couldn't, either because of rebound anxiety—probably for rebound anxiety, you know. He thought he needed it and then he restarted it.

(Tr. at 752)

Dr. Demint testified that, when a second in-house screen tested positive for buprenorphine, he questioned Patient 9. Dr. Demint testified that Patient 9 gave him some story about eating a "funny piece of candy," then told him that some of his family members were on Suboxone. Dr. Demint further testified that, since he could not make a diagnosis based only on an in-house screen, he gave Patient 9 a two-week supply of medication and sent the urine sample to a lab for confirmation. When the positive buprenorphine result was confirmed, he referred Patient 9 to an addictionologist and discharged him from the practice. (Tr. at 752-753; St. Ex. 9 at 30, 32)

262. Dr. Demint testified that Patient 9 had been taking Xanax for anxiety prior to seeing him. (Tr. at 754)

263. Dr. Demint stated on remand that he acted on each abnormal urine drug screen. He further stated, "This patient was discharged after I received the first UDT which showed suboxone but after I got confirmation of the first UDS. This is an error by the Hearing Officer to state I didn't discharge till after a second UDT revealed suboxone." (Resp. Ex. U)

264. As stated in Paragraph 261 above, the sentence that states, "Dr. Demint testified that, when a second in-house screen tested positive for buprenorphine, he questioned Patient 9" could have been worded more clearly. It was meant to state that when the last urine screen was abnormal, which on this occasion showed the presence of buprenorphine (the previous abnormal screen showed an absence of benzodiazepines), Dr. Demint questioned Patient 9. There were other abnormal screens, but only the last showed buprenorphine. Dr. Demint discharged Patient 9 and referred him to an addictionologist following lab confirmation of the presence of buprenorphine in the last abnormal screen. (Tr. at 752-753; St. Ex. 9 at 30, 32; Resp. Ex. U)

<u>Patient 10</u>

265. Patient 10, a male born in 1975, first visited Dr. Demint's Kingston office on September 16, 2010. At that time, he reported lower back pain since 2006. He claimed that a 2007 MRI showed a bulging disc at L4-L5. Patient 10 identified his current medications as oxycodone 15 mg four times per day, Percocet 5 mg three times per day, Claritin, an unnamed muscle relaxer, and gabapentin. Dr. Demint diagnosed chronic low back pain, degenerative disc disease of the lumbar spine by history, and an illegible reference to a dysfunction of the lumbar spine. Dr. Demint's plan included osteopathic manipulative therapy, obtaining a new MRI, and obtaining Patient 10's old medical records. Dr. Demint prescribed oxycodone/APAP 10/325 mg #120, one tablet every six to eight hours as needed for pain up to a maximum of four tablets per day; naproxen 500 mg #60, one tablet twice per day; and gabapentin 300 mg gradually increased to one tablet three times per day. (St. Ex. 10 at 37-39)

266. A November 9, 2010 MRI ordered by Dr. Demint provided the following impressions:

    1. Right paracentral disk protrusion at L5-S1 extending into and severely effacing the right lateral recess with marked mass effect upon the right S1 nerve root within the right lateral recess. There is mild right neural foraminal narrowing as well.
    2. Focal left paracentral disk protrusion at L4-5 without significant central canal stenosis or neural foraminal narrowing present.

    (St. Ex. 10 at 11)

267. Patient 10 continued to see Dr. Demint on a regular basis through March 23, 2011, the last visit documented in State's Exhibit 10. During this time, Dr. Demint continued to prescribe naproxen and gabapentin to Patient 10. He added tramadol 50 mg #90 in January 2011. In addition, Dr. Demint increased the amount of oxycodone Patient 10 received to oxycodone 15 mg #120. (St. Ex. 10 at 27-36)

268. Dr. Demint stated that he discharged Patient 10 from his practice on June 23, 2011, because Patient 10 refused a drug test. (Resp. Ex. V)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

269. Dr. Cicek testified:

> OARRS report was done * * *. Physical exam was normal at all visits, including reflexes and lower extremity strengths—strength. I believe there was not a straight-leg test that I could read documented as positive.
>
> So my assessment was that the patient's care—the patient had received large amounts of medication considering an essentially normal physical exam. The patient wasn't being treated, as one would expect with this type of pain, with nonsteroidal anti-inflammatories and gabapentin or Lyrica with small amounts of narcotic pain prescribed for exacerbations.

(Tr. at 431)

Dr. Cicek further testified that Patient 10 told Dr. Demint at the first visit that he was taking oxycodone and Percocet, but the chart includes reports from the West Virginia Board of Pharmacy, KASPER, and OARRS that were all negative for any narcotics except for those prescribed by Dr. Demint.[44] In addition, a urine drug test on a sample submitted by Patient 10 at his first visit was confirmed by a lab to be negative for all substances. Based on that information, Dr. Cicek testified that Patient 10 went from no medication to receiving 40 milligrams of oxycodone per day from Dr. Demint at his first visit. Moreover, Dr. Cicek testified that it had been below the minimal standard of care for Dr. Demint to prescribe that amount of medication to Patient 10 at his first visit. (Tr. at 431-433; St. Ex. 10 at 12-15, 17, 38)

270. Dr. Cicek testified that, if a patient reports that he is taking oxycodone and Percocet but other evidence indicates he is not, the standard of care requires that the physician address this issue with the patient. Dr. Cicek testified that a "miscommunication at the best and a lie at the worst is a huge red flag for writing of narcotics." (Tr. at 435-436)

271. Dr. Demint testified that he had ordered an MRI for Patient 10 that revealed "a protrusion that extends to and then severely effaces the right lateral recess with marked mass effect upon the right S1 nerve root within the right lateral recess. There is mild right foraminal narrowing as well." Dr. Demint testified that those findings substantiate Patient 10's pain complaint. (Tr. at 754-755; St. Ex. 10 at 10)

272. Dr. Demint testified that he had used non-pharmacological therapies in treating Patient 10. Dr. Demint testified that he had performed OMT on September 16, 2010, and referred him to physical therapy. (Tr. at 755-756; St. Ex. 10 at 30, 37)

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[44] These reports were not obtained by Dr. Demint until January 2011. (St. Ex. 10 at 12-15)

273. Dr. Demint testified that he had started Patient 10 on 30 to 40 milligrams of oxycodone per day, which was a decrease from the 75 milligrams per day that he had been taking. Dr. Demint testified that his prescribing had been well within "the box." (Tr. at 756-757)

274. Dr. Demint acknowledged that he had believed Patient 10 at the initial visit when Patient 10 told him that he had been taking oxycodone 15 milligrams four time per day and Percocet 5/325 milligrams three times per day, among other things. However, Dr. Demint acknowledged that reports from KASPER, the West Virginia Board of Pharmacy, and OARRS do not show that Patient 10 had filled any prescriptions for controlled substances prior to seeing Dr. Demint. Dr. Demint testified that he eventually received records from Columbus Southern Medical Center that indicated Patient 10 had been taking opioids. (Tr. at 221-224)

    Dr. Demint added that he takes patients at their word "until proven otherwise." Dr. Demint testified that he believes, and was taught in medical school, that most patients tell the truth. Dr. Demint further testified: "I believe the vast majority are having legitimate pain. Do some lie to me? Yes. I mean, that's—but I'm going to tell you people lie to me about their cholesterol, and their diets, and everything else, too." (Tr. at 224)

275. Dr. Demint was asked whether he had had any evidence at Patient 10's initial visit that Patient 10 had been taking the medications he claimed to have been taking. Dr. Demint acknowledged that he had not known at that time what Patient 10 had been taking. (Tr. at 795-798; St. Ex. 10 at 12-15, 17, 38-39)

    Dr. Demint was asked whether, in light of the evidence of the state pharmacy board reports and Patient 10's urine screen, whether Patient 10 had lied to him when he told him that he had been taking oxycodone. Dr. Demint replied that he may not necessarily have been lying. Dr. Demint testified that patients sometimes will report the medications they had been taking the last time that they were prescribed medication, even if they had not been taking them for a while. Dr. Demint further testified that the patient may not have actually been lying. (Tr. at 798-799)

276. Dr. Demint stated, "Again the most important determining factor is the patient's complaint, which in this case was 7-9/10. Both MGH handbook and Dr. Cicek stated this fact. This patient had a MRI which showed significant abnormalities * * *." (Resp. Ex. V)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy

277. When asked whether Dr. Demint had documented an individualized treatment plan for Patient 10, Dr. Cicek replied: "There are no goals for what they are attempting to achieve with his function, what he is not able to do that he wants to do, or what the goals for treating the pain to—what the improved functional goals are, which would be the individual treatment plan." (Tr. at 434-435)

278. Dr. Demint stated, "This patient was sent for a MRI, physical therapy and received OMT from myself. This patient was given, along with opioids, NSAIDs and a SSRI. Again this patient was treated differently than any other patient this by definition [is] individualize[d] treatment plan." (Resp. Ex. V)

<u>Patient 11</u>

279. Patient 11, a male born in 1974, first visited Dr. Demint at his Kingston practice on June 5, 2010, complaining of lower back, hip and leg pain. He stated that he was allergic to hydrocodone. Among other things, Patient 11 told Dr. Demint that he had been released by his previous physician.[45] Dr. Demint also noted that Patient 11 had been to Adena Pain Management which "wanted to do injections" but did not have any openings for two months. The next statement in the notes indicates that Patient 11 works from 4:30 a.m. to 4:30 p.m. and that he cannot miss any work. (St. Ex. 11 at 20-25)

    At Patient 11's initial visit, Dr. Demint prescribed oxycodone/APAP 10/325 mg #90 to take one tablet three times per day, methocarbamol 500 mg #120 to take one tablet four times per day, naproxen 500 mg #60 to take one tablet twice per day, gabapentin 300 mg #72 to gradually increase to three times per day, and Effexor XR 75 mg #30 to take one tablet per day. (St. Ex. 11 at 22-23)

280. An OARRS report obtained by Dr. Demint on July 10, 2010, indicates that Patient 11 had for some time been prescribed the same dose of oxycodone/APAP prescribed by Dr. Demint at Patient 11's first visit. (St. Ex. 11 at 18)

281. Patient 11 saw Dr. Demint on four more occasions until October 9, 2010, the last visit documented in State's Exhibit 11. Dr. Demint maintained Patient 11 on the same level of oxycodone/APAP throughout his care until the October 2010 visit, when he prescribed 21 tablets with instructions for Patient 11 to wean himself from that medication. (St. Ex. 11 at 10-16)

282. A urine drug screen report dated September 15, 2010, concerning a sample Patient 11 submitted on September 9, 2010, indicates that Patient 11 tested positive for alprazolam, hydrocodone, and hydromorphone, which Dr. Demint had not prescribed.[46] It was also positive for carboxy THC. (St. Ex. 11 at 4)

Allegation 2(b): Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records

283. Dr. Cicek testified that, although Dr. Demint documented in his initial visit note that Patient 11 had been released from his prior physician's practice, he did not document any

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[45] Patient 11's prior medical records, which appear to have been received by Dr. Demint on June 10, 2010, include a urine drug screen report for a urine sample Patient 11 submitted on March 11, 1010, that tested positive for cocaine metabolites and marijuana metabolites. (St. Ex. 11 at 30, 44-45)

[46] As indicated above, Patient 11 had told Dr. Demint that he is allergic to hydrocodone. (St. Ex. 11 at 4, 21)

reason why that had happened. Dr. Cicek testified that Dr. Demint's failure to document exploring that issue constituted inadequate medical documentation. (Tr. at 437-439)

284. Dr. Demint testified that he had originally seen Patient 11 on June 5, 2010, and received his medical records on June 10, 2010. Dr. Demint further testified that the fax machine-imprinted date of May 31, 2010, on the fax cover sheet that Dr. Cicek referenced was erroneous. (Tr. at 765-767; St. Ex. 11 at 20, 30)

285. Dr. Demint stated:

> **I did do an appropriate H&P on this patient. I address the reason for his discharge from previous physician when I did get the old records and saw the abnormal toxicology test by ordering another [one] which was consistent. I had several patients that had seen Dr. Patterson and told me there was a questions on how the urines were collected and labeled.**
>
> **As far as not doing a Straight Leg Raise[47] the patient did not complain of radiation of pain into his leg.[48] Also, a MRI was already done which is a more definitive test for nerve impingement. The reason for many PE tests is to determine what further testing is needed. If that more definitive test has been done the PE test is unnecessary.**

(Resp. Ex. W)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

286. Dr. Cicek described the physical examination documented by Dr. Demint at Patient 11's initial visit on June 5, 2010:

> [T]his patient has on his physical exam pain with range of motion, tenderness LS spine with palpation, **a straight—positive straight leg on the right**, normal reflexes. I don't see strength on here. In his history, he complains of the low back pain raiding—radiating to his leg, and a couple of things that make it worse, like twisting and bending.
>
> So there is a small discussion of what he had done in the past and being referred for injections. I don't see any indication of previous medications tried and what worked and what didn't.

(Tr. at 439-440) **(Emphasis added on remand)**

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[47] Dr. Cicek <u>did</u> state that Dr. Demint performed and documented a straight leg raise. See her testimony as quoted in the next paragraph. (Tr. at 439)
[48] Dr. Demint's June 5, 2010 initial visit note states, near the middle of the page, "Pain radiates down [right] leg." (St. Ex. 11 at 20)

287. Dr. Demint stated:

> **This patient was complaining of pain in the range of 5 (the least) to 9/10 with an average of 8/10 well above the 3/10 which is considered the goal, if possible, by pain management physicians. The pain interfered with various aspects of his life with scores of 7-10/10. As stated before both the MGH and Dr. Cicek stated that the description of pain is the main factor when determining need for treatment with opioids.**

(Resp. Ex. W)

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics

288. Dr. Cicek testified that Dr. Demint did not obtain a urine sample for drug testing at Patient 11's initial visit. She further testified that the standard of care required Dr. Demint to obtain a urine screen, "[e]specially if he were discharged from another provider." (Tr. at 440)

289. On remand, Dr. Demint gave the same response to this allegation that he gave in reference to Patient 2. (Resp. Exs. N, W)

Allegation 2(g): Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports

290. Patient 11's September 2010 urine drug screen tested positive for alprazolam, hydrocodone, hydromorphone, and THC. Dr. Cicek noted that, at Patient 11's next visit on October 9, 2010, Dr. Demint referred Patient 11 to an addictionologist and weaned him off of oxycodone, which she stated was "[a]bsolutely" appropriate. (Tr. at 440-442; St. Ex. 11 at 4)

    In fact, Dr. Cicek testified that she finds no fault with Dr. Demint's reaction when Patient 11 turned in a dirty urine sample. (Tr. at 442) The problem is, Dr. Demint should have avoided that situation at the outset:

    > Had the subjective, being discharged from a previous provider, been explored in more detail initially, giving the patient a small amount of medications while you have the chance to review the old records or get the old records or speak with the previous provider, this wouldn't have gone on for, what, five months, four months, before the patient was—ended up being discharged for illicit drug use.

    (Tr. at 442-443)

291. Dr. Demint acknowledged that Patient 11 had had a bad urine screen on May 6, 2010, while being treated by another provider, and tested positive for cocaine, marijuana, and Xanax. Dr. Demint testified that he did not have this information available at Patient 11's initial visit. However, he testified that, after obtaining this information later in June 2010, he increased his surveillance of the patient. (Tr. at 234-235)

292. Dr. Demint testified that Patient 11 never returned to his office after he referred him for an addiction evaluation. (Tr. at 243-244)

293. Dr. Demint reiterated that he does not deny treatment based upon marijuana use alone because he is aware of no drug interaction or lethality between THC and opioids. (Tr. at 768)

294. Dr. Demint stated on remand, "This patient was given a UDS with confirmation after I received the old records which showed a previous inconsistent drug test result. That UDT was consistent to my treatment. I did another drug test which when I received confirmation I referred to addictionology. This is the appropriate actions in this case." (Resp. Ex. W)

<u>Patient 12</u>

295. On April 5, 2010, at the Lance practice, Dr. Demint took over the care of Patient 12, a male born in 1949. At that time, Patient 12 complained of pain in his neck, back, feet, and left shoulder. He also complained of a cough. Dr. Demint documented among other things that Patient 12 did not drink alcohol or take drugs. He diagnosed chronic lower back pain and chronic cervical pain, degenerative disc disease of the lumbar and lumbosacral spine, anxiety, and acute bronchitis. (St. Ex. 12 at 41-42)

    At Patient 12's initial visit, Dr. Demint prescribed Norco 10/325 #180, one refill authorized, to take one tablet every four hours as needed; and Xanax 1 mg #60, one refill authorized, to take one tablet every six hours as needed. (St. Ex. 12 at 3)

296. At Patient 12's next visit, on May 21, 2010, Dr. Demint changed the bronchitis diagnosis to emphysema. (St. Ex. 12 at 41)

297. Patient 12 submitted a urine sample on October 1, 2010, that tested positive for marijuana. Dr. Demint stated in his progress note dated October 25, 2010, that Patient 12 had admitted smoking one to two joints per day, and that Dr. Demint had discussed Ohio marijuana laws with Patient 12. In a later progress note, dated March 21, 2011, Dr. Demint again discussed marijuana with Patient 12 and told him to stop smoking it. (St. Ex. 12 at 13, 15, 35, 39)

298. Patient 12 continued to see Dr. Demint on a regular basis through March 21, 2011, the last visit documented in State's Exhibit 12. During this time, Dr. Demint maintained Patient 12 on the same levels of Norco and Xanax and briefly added cyclobenzaprine 10 mg three times per day and an ipratropium inhaler. (St. Ex. 12 at 3, 33, 35-42)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings; and

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy.

299. Dr. Cicek testified as follows concerning Patient 12's first visit:

> [T]here's a brief review of the patient's past medical, surgical history. There is not any review of what modalities of pain management have been attempted in the past and if they worked. There's not a review of the patient's current level of function or the functional goals, and there's not an individualized treatment plan.

(Tr. at 444)

300. Dr. Demint testified that he had objective evidence to support Patient 12's pain complaints. Dr. Demint testified that Patient 12 "had fracture of hip, dislocated shoulder due to a four-wheeler accident which resulted in him having surgery, open reduction, internal fixation of the left hip and the left arm." (Tr. at 769)

Dr. Demint further testified that imaging reports evidenced moderate degenerative changes in the cervical spine, along with evidence of old fractures to the left femur and hip joint. Moreover, Dr. Demint testified that there was evidence of herniated nucleus pulposus in the cervical spine and minimal bulging of two disks in the lumbar spine. (Tr. at 770-771)

301. Dr. Demint testified that he had prescribed a morphine equivalent dose of 60 milligrams to Patient 12, which he testified was only one-third of the 180 milligram "morphine equivalent of being in-the-box prescribing." (Tr. at 248)

302. Dr. Demint testified that his prescribing had been supported by the patient's history and examination findings. Dr. Demint further testified that he had not prescribed an excessive amount of medication to Patient 12. (Tr. at 774)

303. Dr. Demint stated on remand, "This patient had multiple abnormalities on MRI * * *. These are very significant findings and his complain[t] of pain being in 9/10 at its worse without medication is also significant. His pain has gone down to 3-4/10 which is the goal in PM." (Resp. Ex. X)

304. With respect to the allegation that he had not developed an individualized treatment plan for Patient 12, Dr. Demint stated, "This patient's plan was individualized and no other patient was treated this same way. He was on a very low dose of opioids and that gave him significant pain relief." (Resp. Ex. X)

Allegation 2(d): Dr. Demint inappropriately prescribed high doses of narcotics despite diagnoses of underlying Chronic Obstructive Pulmonary Disease

305. Dr. Cicek stated that it had been below the minimal standard of care for Dr. Demint to prescribe "high doses of narcotics to someone with underlying COPD." (St. Ex. 16 at 11)

306. Dr. Demint stated on remand:

> **First 40 mg ME is a very low dose per ASP and AAPM consensus. According to ASP and AAPM 60-80 mg ME is low dose. Second, as I presented before patient's develop tolerance to the respiratory depression of opioids. This patient has been on this dose since at least 2007. This patient has develop[ed] tolerance long before I first saw him. This is another example of Dr. Cicek['s] ignorance of chronic pain management, she doesn't know low from high dose opioid therapy and she doesn't understand the development of tolerance to opioid adverse events with time.**

(Resp. Ex. X)

307. Dr. Frazier stated in his affidavit that patients with COPD can be treated with opioids. (Resp. Ex. AA)

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics

308. The chart indicates that Dr. Demint began seeing Patient 12 on April 5, 2010, but did not obtain a urine drug screen until October 2010. (St. Ex. 12 at 13-15, 41-42)

309. On remand, Dr. Demint gave the same response to this allegation that he gave in reference to Patient 2. (Resp. Exs. N, X)

Allegation 2(g): Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports

310. With respect to Patient 12's October 2010 urine screen that tested positive for THC, Dr. Cicek noted that Dr. Demint documented a discussion with Patient 12 in his October 25, 2010 progress note and that the patient admitted to using one or two "joints" per day. Dr. Cicek testified that, in Ohio, marijuana is an illegal drug that is not used medically, and that "using it would imply you're abusing it." She further testified that Patient 12 had signed a medication agreement wherein he agreed not to use illicit drugs. Dr. Cicek testified that the appropriate thing for Dr. Demint to have done pursuant to the intractable pain rules would have been to refer Patient 12 for an addiction evaluation. Moreover, she testified that his failure to do so violated the standard of care. (Tr. at 445-447; St. Ex. 12 at 9-10, 13, 39)

311. Dr. Cicek testified that it is concerning that Patient 12 lied at the first visit saying that he did not use drugs when, in fact, he used marijuana daily. (Tr. at 449-450)

312. Dr. Demint acknowledged that Patient 12's marijuana use had violated his medication contract. However, Dr. Demint testified that Patient 12 had otherwise been compliant, and that Dr. Demint did not believe that Patient 12 had "a true addiction problem." Dr. Demint further testified that there are many other physicians who do not routinely discharge patients simply for smoking marijuana. (Tr. at 263-264)

313. Dr. Demint stated that the only inconsistency on Patient 12's urine drug screen was the presence of THC. He further stated:

> **[Patient 12] stated that THC help[s] with his pain and that is why he used it. I presented several articles which show that marijuana helps with chronic pain. [Patient] was told to quit since there is no medical marijuana laws in Ohio. His previous physician did not mention it or discharged him when he tested positive for THC in 10/2008. Many physicians recognize that marijuana helps with pain and will not stop treatment if that is the only illicit drug in the patient's system. I presented articles on this fact.**

(Resp. Ex. X)

314. In addition, Dr. Demint stated:

> **This patient had consistent OARRS, Pill Counts, had no early refills. The only thing inconsistent in his toxicology tests was the presence of THC. As stated earlier this patient stated that marijuana helped with his pain. I presented several articles to the fact that it does help with pain and many pain specialist[s] don't discharge for that alone. One of the articles stated that marijuana decreases the amount of opioids needed to control pain. That may explain why he needed such a low dose of opioids, 40 mg MEQ, to control his pain. Well below both the 180 mg "in the box" prescribing and the Medical Boards new 80mg MEQ trigger point.**

(Resp. Ex. X)

315. In his Affidavit, Dr. Frazier stated, "There is no medical standard of care that requires a physician to discharge a substance abuse patient who tests positive for marijuana. The requirement is to refer him or counsel him." (Resp. Ex. AA)

Allegation 2(i): Medical charting was incomplete, often illegible and/or disorganized

316. Dr. Cicek testified that she found Dr. Demint's chart for Patient 12 to be poorly organized, hard to read, and difficult to determine Patient 12's physical findings without reviewing old records. (Tr. at 449)

317. Dr. Demint responded to this allegation in the same manner as he did for the same allegation with respect to Patient 1. (Resp. Exs. M, X)

<u>Patient 13</u>

318. On March 15, 2010, at the Lance practice, Dr. Demint assumed the care of Patient 13, a female born in 1957. At that time, she advised that an increase in pain medication that she had received at her previous visit was giving her pain relief. She also advised that she wakes up on occasion with the fingers on her right hand numb, and that the numbness lasts from ten minutes to an hour. She further advised that she had no insurance and could not afford any tests. Dr. Demint noted among other things that she had pain in her thoracic and lumbosacral spine and ankle; the note is difficult to read but it does not appear that he specified which ankle was painful or whether both ankles were painful. Dr. Demint diagnosed chronic low back pain, degenerative disk disease of the lumbosacral spine, and depression with anxiety. (St. Ex. 13 at 29, 42)

    On March 15, 2010, Dr. Demint prescribed oxycodone 30 mg #120 with instructions to take one tablet every six hours, no refills; clonazepam 0.5 mg # 90 with instructions to take one tablet three times per day, two refills authorized; and Zoloft 25 mg #30 with instructions to take one tablet each day, two refills authorized. These were all continuations of prescriptions previously issued to Patient 13 by her previous provider. (St. Ex. 12 at 3, 42)

319. Patient 13 continued seeing Dr. Demint on a regular basis through December 6, 2010, the last visit documented in State's Exhibit 13. He continued Patient 13 on the same level of oxycodone and clonazepam through November 5, 2010, and increased Patient 13's Zoloft prescription to 100 milligrams per day by July 2010. (St. Ex. 13 at 3, 33-42)

320. Patient 13 submitted urine samples on three occasions during the time Dr. Demint treated her. Her first, submitted on October 4, 2010, tested positive for oxycodone, oxymorphone, and 7-aminoclonazepam, which is appropriate since she was being prescribed oxycodone and clonazepam, but it also tested positive for oxazepam, which Dr. Demint had not prescribed. The lab result was received by Dr. Demint's office on October 7, 2010. (St. Ex. 13 at 18)

321. On October 8, 2010, following her first inconsistent urine drug screen, Dr. Demint ordered that Patient 13 be called in for a "pill count, OARRS, and addiction evaluation." The chart indicates that Patient 13 was called on October 13, 2010, but told Dr. Demint's staff that her medication was stored in a locked box at her mother's house and that her mother was at work. The note further states that "[s]he was told to get meds as soon as possible or it would count as failed pill count. She was to take them to the pharmacy. She later called crying cause she could not get her pills as her mom was not home all day." The chart indicates that Patient 13 was subsequently called in for a pill count on October 27, 2010, and passed, with the note that she "has some extra" oxycodone. (St. Ex. 13 at 21, 23)

322. Patient 13's second urine sample, submitted on November 5, 2010, tested positive in-house for benzodiazepine, oxycodone, and cocaine. AIT Laboratories confirmed positive results for oxycodone and oxymorphone, and also confirmed a positive result for benzoylecgonine, a cocaine metabolite, at a level of 2018 ng/ml, well above the cutoff level of 30 ng/ml. In addition, the sample was confirmed negative for benzodiazepines, which, along with the positive cocaine result, was inappropriate. The lab report was received in Dr. Demint's office on November 17, 2010. (St. Ex. 13 at 14-16)

323. Finally, Patient 13's third urine sample, submitted on December 6, 2010, tested positive in-house for cocaine and opiates; the results sheet indicates the sample was not tested for benzodiazepines or oxycodone. Dr. Demint issued no prescriptions to Patient 13 at her December 6, 2010, visit following the positive screen. A lab report received by Dr. Demint's office on December 29, 2010, confirms a positive result for benzoylecgonine at a level of 864 ng/ml, along with positive results for oxycodone, oxymorphone, and 7-aminoclonazepam. A note on the lab report dated December 31, 2010, indicates that Patient 13 needs "[d]rug addiction evaluation & treatment." (St. Ex. 13 at 11-13)

Allegation 2(b): Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records; and

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings.

324. Dr. Cicek testified that Dr. Demint's physical examination addressed Patient 13's range of motion in her lumbosacral spine but did not address her complaints concerning her hands, ankle, or thoracic spine. Dr. Cicek further testified: "Again, there is not any review here of the previous treatments from the patient's previous provider, what's been tried, what worked, what didn't work, tests that had been done and what they showed, and then what the goals for the patient's function were." Moreover, Dr. Cicek testified that the physical examination findings did not support the patient's claimed pain level. (Tr. at 451-452)

325. Dr. Demint testified that an MRI report concerning Patient 13's lumbar spine confirmed her pain complaint. Dr. Demint described the results:

> [A]n MRI of the lumbar spine * * * shows degenerative disk disease, disk protrusion, disk protrusion that abuts S1—the right S1 nerve root, annular tear with protrusion at S-—that's at S1 nerve root. It talks about could elicit focal neuritis due to local inflammation. She also had mild bilateral neural foramen stenosis, right disk bulge, abuts to the L5 nerve root. Bulge at L4-L5. And then there's this [syringohydromelia] * * * of the distal conus measuring 2 millimeters.

(Tr. at 777)

326. Dr. Demint opined that he had performed an appropriate physical examination for a patient that had been established at the practice where he had assumed her care. (Tr. at 781-782)

327. Dr. Demint stated that Patient 13 was an established patient at Lance and that he had her entire chart available. Dr. Demint further stated that her MRI and surgical history were part of the chart. Dr. Demint further noted that, according to Dr. Prior's testimony, the information is documented as long as it is somewhere in the chart. (Resp. Ex. Y)

328. Dr. Demint further stated:

> **This patient was complaining of significant pain (up to 9/10 and average 5-6/10 with medication). This patient had an MRI which showed very significant changes * * *. This patient also was seen by another doctor prior to me (Dr. Puje) who also limited part of her practice to Pain Management. Therefore, according to 4731-21-02 "a practitioner 'specializes' if the practitioner limits the whole or part of his or her practice, and is qualified by advance training or experience." Therefore Dr. Puje qualifies as a specialist in pain management. It was this doctor who had her initially on these medication and dosage. I did not increase the opioid on this patient.**

(Resp. Ex. Y)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy;

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics;

Allegation 2(g): Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports; and

Allegation 2(h): Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment.

329. Dr. Cicek testified that Patient 13's inconsistent urine drug screen report and failure to come in for a pill count in October 2010 were red flags. Dr. Cicek further testified that, despite the red flags, Dr. Demint did not alter his prescribing to Patient 13. (Tr. at 453-454)

330. Dr. Cicek acknowledged that Dr. Demint referred Patient 13 for an addiction evaluation around December 6, 2010, and that that had been appropriate. A note on the copy of the referral form states that Patient 13 refused the referral and never returned to Dr. Demint's office. (Tr. at 454-456; St. Ex. 13 at 32)

331. Dr. Cicek noted that a previous provider had determined on February 2, 2009, that Patient 13 was positive for hepatitis C. She testified that that should have been documented on Dr. Demint's initial history, but was not. (Tr. at 456; St. Ex. 13 at 51)

332. Dr. Demint testified that Patient 13 suffered from some psychological issues and that he had documented her counseling with Catholic Social Services. Dr. Demint noted that she was suffering from depression and had a lot of issues with her family. Dr. Demint further testified that he had increased her Zoloft prescription when she first came to see him. (Tr. at 778-779)

333. Dr. Demint testified that he stopped Patient 13's medication and referred her to an addictionologist following repeated aberrant behavior, including failed urine screens. Dr. Demint testified that she never returned to his practice. (Tr. at 280-281, 779-781)

334. Dr. Demint stated that Patient 13 "received treatment that was unique for her, this is the definition of individualize[ed] treatment. No other patient had this exact treatment. This patient was on the SSRI Zoloft. She was receiving [counseling]. She was referred to Addictionology after the second confirmed inconsistent drug test." (Resp. Ex. Y)

335. Dr. Demint stated on remand:

> **This patient only received one early refill because she drop[ped] her medication in the toilet and it was only three days early. I documented in the chart that I [counseled] her it was her responsibility to take care of her medication and she would not get another early refill. On her first inconsistent confirmed drug test I discuss[ed] with her that she can't have another [sic] drugs in her system and if it occurs again she will be discharged from the practice. When I got the second confirmed inconsistent test I referred her to addictionology and she never returned. Therefore, I did address addiction signs and symptoms appropriately. To say otherwise is just [disingenuous].**

(Resp. Ex. Y)

336. Moreover, Dr. Demint stated:

> **I did question her about her home situation. She had issues with a daughter that was causing emotional issues and on further investigation I found out this daughter was actually her granddaughter she was rearing. Numerous notes documented my discussions with her about her home situation. To say otherwise is just [disingenuous].**

(Resp. Ex. Y)

Patient 14

337. On March 15, 2010, Dr. Demint assumed the care of Patient 14 at Lance, who was a male born in 1971. Dr. Demint's progress note indicates that Patient 14 had undergone a laminectomy, decompression, and fusion on November 13, 2009, and was experiencing more back pain than he had prior to the surgery. Dr. Demint diagnosed a herniated disk at L5-S1. He continued the patient's medication from his previous visit and had Patient 14 continue with physical therapy. (St. Ex. 14 at 50)

    At the initial visit on March 15, 2010, Dr. Demint continued the medication and dosages that Patient 14 had been prescribed the previous month: MS Contin 30 mg #60 to take one tablet twice per day, Norco 10/325 mg #120 to take one tablet four times per day as needed for breakthrough pain, Valium 10 mg #90 to take one-half to one pill three times per day, and Soma 350 mg #120 to take one tablet four times per day as needed for spasms. (St. Ex. 14 at 2)

338. Patient 14 continued to see Dr. Demint on a regular basis through March 28, 2011, the last visit documented in State's Exhibit 14. During this time, Dr. Demint continued to prescribe the same medications and dosages with the following exceptions: in July 2010, Dr. Demint increased Patient 14's MS Contin prescription from 30 mg to 60 mg #60 with instructions to take one tablet twice per day, and added Effexor 25 mg #90 to take one tablet three times per day. (St. Ex. 14 at 2, 34-50)

339. A urine sample submitted by Patient 14 on October 4, 2010, tested appropriately for the medications he had been prescribed. (St. Ex. 14 at 10)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings; and

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy.

340. Dr. Cicek commented on Dr. Demint's documentation for his first visit with Patient 14:

> So, again, the initial visit doesn't—it reviews the surgery date and just pain worse since surgery. We don't have a past medical history, thorough past surgical history, a social history, or a family history here.
>
> The musculoskeletal exam on this patient documents the range of motion, but not strength, sensation, gait.
>
> And then the assessment is just a herniated disk status post-surgery and see med list, continue PT.
>
> So not thorough documentation for an initial visit. Not an individualized treatment plan. The only treatment plan is the medications and the PT.

> There's no statement of goals or what you're hoping to achieve with pain management.

(Tr. at 457-458)

Dr. Cicek further testified that it is important for a physician who assumes the care of a patient to review this information at the first visit "so you are not prescribing things that could possibly harm the patient. If you don't know their past medical history, for instance, someone with hepatitis C, you wouldn't want to give large doses of Tylenol. So you have to be aware of their comorbidities to treat the patient appropriately." (Tr. at 458)

Moreover, Dr. Cicek testified that just knowing that information is not enough; it must be documented. Dr. Cicek testified that "if it's not documented, it's not done." She added: "There's no way to know if those—the past history was addressed or reviewed because it doesn't say anywhere it was addressed or reviewed." She also stated that "you can't assume something when you're providing care. * * * We, as providers, don't assume something was done." (Tr. at 458-459)

341. Dr. Cicek further testified that the medications that Dr. Demint prescribed for Patient 14 were not supported by testing or the medical records:

> [W]e have the physical exam, which essentially doesn't give us a lot of idea of the patient's function. It does mention the patient is very—is having pain from stimuli that shouldn't cause pain. And the patient is prescribed MS Contin or morphine 60 milligrams twice a day;[49] in addition, hydrocodone, a total of 40 milligrams a day; Valium a total of 30 milligrams a day; and Soma, which is a muscle relaxer that metabolizes to a barbiturate, a total of at least—well, four pills a day of that, as well.

(Tr. at 460)

342. Dr. Cicek testified that Patient 14 had "continually escalating doses of narcotics"[50] while being treated by Dr. Demint although they did not seem to improve Patient 14's pain or ability to function. She further testified that Dr. Demint failed to obtain a urine drug screen at the initiation of his care despite Patient 14's history of being dropped by a previous physician for a failed toxicology screen. Moreover, Dr. Cicek testified that Dr. Demint had failed to summarize a plan when he assumed the care of Patient 14, and documented nothing to measure Patient 14's improvement of function. (Tr. at 461-462)

343. Dr. Demint testified that Patient 14 came to him four months after having had a laminectomy, decompression, and fusion of his lumbar spine. Dr. Demint further testified

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[49] Dr. Demint initially prescribed MS Contin *30 milligrams* twice per day. He increased the dose to 60 milligrams twice per day in July 2010. (St. Ex. 14 at 2)

[50] As stated above, Dr. Demint increased Patient 14's morphine dose only once, although it was doubled at that time from 60 milligrams per day to 120 milligrams per day. (St. Ex. 14 at 2)

that his surgeon was managing everything in Patient 14's his post-surgical recovery except for medication management. Dr. Demint testified that Patient 14 came to him taking MS Contin 30 mg twice per day, hydrocodone/APAP 10/325 four times per day as needed for breakthrough pain, Valium 10 mg, and Soma 325 mg as needed for spasm. (Tr. at 783-784)

344. Dr. Demint testified that he did not particularly like the combination of medication he prescribed to Patient 14, but that the patient had been taking those medications for some time and they were effective for him. Dr. Demint testified:

> [T]his patient is on a combination of medicine I don't particularly like to give. I don't like Soma very much, and as you know this is the only patient I have on Soma, but he had tried several other muscle relaxants and—and other adjuncts and could not tolerate them. So this was, you know, the exception that he use that drug.
>
> You know, I did use Effexor on him for his neuropathic pain. I had tried gabapentin, and that was the second or third time he had been tried on gabapentin, but he could not tolerate it due to the side effects.
>
> So, you know, sometimes you prescribe medicines you don't particularly like because the one you like just doesn't work or they can't tolerate them, you know. You know, that's—that's part of the practice of medicine.

(Tr. at 295-296)

345. Dr. Demint testified that he had utilized non-narcotic adjunctive medication in his treatment of Patient 14. He attempted gabapentin but Patient 14 could not tolerate it. He then placed Patient 14 on Effexor to treat his neuropathic pain. (Tr. at 784-785)

346. In response to the allegation that the amount or type of narcotics prescribed was not supported by history, physical examination, or test findings, Dr. Demint stated:

> **Really! This patient had numerous MRIs showing his herniated disc and DDD and he was seen by an orthopedic surgeon and had surgery. His overall care was being directed by his orthopedic surgeon. This patient had surgery just about 6-7 months before seeing me and was seeing the surgeon the whole time I was seeing him. To have this finding is just [disingenuous].**

(Resp. Ex. Z)

347. In response to the allegation that Dr. Demint failed to develop an individualized treatment plan, he stated:

> **First, [his] care was being directed by Dr. Todd see all his progress notes. If you look at his progress notes.[51] He had both PT and OT. He had surgery. He was placed on an NSRI for his neuropathic pain. Here is another area that shows Dr. Cicek's lack of Pain Management knowledge. SSRI's do not help with pain. They help with depression but not pain. NSRI's help with neuropathic pain. But, apparently she was ignorant of this fact. Again why she was not qualified to be an expert witness in this case. She is just a FP without any additional training in PM. This in itself appears very disingenuous. Second, the P in SOAP note means plan. No other patient received the same treatment, this by definition is individualize[d]. Dr. Cicek testified to some elaborate note on the plan yet neither Dr. Poje nor Dr. Todd had such a note. So, if Dr. Cicek is correct then all these other doctors were also wrong. It seems more likely the rest of us physicians are correct and Dr. Cicek is again making up her own standards.**

(Resp. Ex. Z)

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics

348. Dr. Cicek testified that it was below the minimal standard of care for Dr. Demint to wait seven months prior to obtaining a urine drug screen on Patient 14. Dr. Cicek further testified that, for an individualized treatment plan, Dr. Demint should have noted when the urine drug screen would be repeated. (Tr. at 459-460)

349. Dr. Demint testified that he had had reports concerning Patient 14 from OARRS, KASPER, and West Virginia Board of Pharmacy. Dr. Demint further testified that he obtained urine screens from Patient 14 that were all consistent. (Tr. at 785-786)

350. On remand, Dr. Demint stated:

> **In all my training in [pain management] and all the courses I took I never heard [of] the requirement of initial drug tests. Neither the old guidelines nor the new guidelines require a drug tests [sic] before starting opioid therapy. Per [Ohio Administrative Code Chapter] 4731-21, "Based on evidence or behavioral indications of addiction or drug abuse, the practitioner *may* obtain a drug screen on the patient." This was the guideline at the time of these visits. The new guidelines state that after treating for longer [than] 3 months with opioids, "*Consider* a patient pain treatment agreement that *may* include: . . . drug screens . . ." So, even the Board's guidelines don't require an initial drug test before starting opioid therapy. This is a just a made up standard by Dr. Cicek.**

(Resp. Ex. Z) (Italics substituted for original bold emphasis)

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[51] Records from Dr. Todd appear to begin in State's Exhibit 14 at page 83, and continue through page 113. Additional documents from Dr. Todd can be found in State's Exhibit 14 at pages 129-131 and 133-134.

Conclusions of Dr. Cicek

351. Dr. Cicek summarized her opinion concerning Dr. Demint's care and treatment of Patients 1 through 14:

> [I]n terms of the drug treatment of intractable pain guidelines from the Board, we're required to make an assessment of the impact of pain on a patient's physical and psychological functions, as well as reviewing previous diagnostic studies, previous utilized therapies, coexisting illnesses, and an appropriate physical exam, which in almost all the charts we reviewed was lacking.
>
> Medical diagnoses should be established when possible. Back pain is a symptom, it's a diagnosis—if you can't find a cause for it, more appropriate than back pain would be what's—the diagnosis of what's actually causing the back pain so you know how to treat it appropriately.
>
> The individual treatment plan shall be formulated and documented in the patient's medical record. Again, the individual treatment plans were essentially prescriptions. There is no mention of goals that are desirable for the patient in terms of function, mobility, what they're able to do. And there's not regular assessments of what the patients are and are not able to do that they should be able to do or want to do because of their pain.
>
> So, again, the subjective, it clearly states that some patients' intractable pain are at risk of developing increasing prescription drug consumption without improvement in functional status. Subjective reports by the patient should be supported by objective data. And that needs to be an ongoing assessment. And if the patient is continually needing elevations in their drugs, they should be referred to an appropriate specialist to further evaluate them, which was not done on a regular basis.
>
> The patients were consistently given large—a month's supply of medication at their first visit without having a urine toxicology done most of the time. Then when urine tox screens were inconsistent, patients should—the frequency of visits should have been increased so the patient was being seen more frequently or that was being addressed in some manner with the patient.

(Tr. at 462-464)

When asked about her comments in her written report concerning long-acting versus short-acting medications, Dr. Cicek testified:

> [T]he standard of care for treating intractable pain is that you put a patient—when you can determine their dosage, put them on a long-acting narcotic which gives them consistent pain control over a longer period of time, as

> opposed to frequent dosing of a short-acting medication, and they have a certain amount of medication for breakthrough pain.
>
> If a patient is on a long-acting narcotic and taking their breakthrough pain medication every four hours, then you need to assess why the long-acting narcotic isn't working and if it needs to be increased or changed. And, again, if you're continually escalating that dose and not seeing improvements in function, then it's the inappropriate therapy for the patient or you need to get a specialist's opinion.
>
> There were a couple of people on long-acting medications, but the majority had high dosages of short-acting medications. And when they were on long-acting medications, they often had large amounts of short-acting medications for breakthrough pain; 112, 120 of 5 or 10 milligram oxycodones in addition to their long-acting medication.

(Tr. at 464-465)

352. Dr. Cicek testified that she had not had "enough information in the notes to actually paint a picture" of the patients because there was insufficient information documented in the charts. (Tr. at 482-483)

353. Dr. Cicek testified that in six years of practice she discharged about 10 to 20 patients for violating their medication contract. When asked why so few, Dr. Cicek replied that she screens patients at their initial visits: "[I]f there is a patient who comes in who has a prior discharge from someone or an OARRS report that's not reflecting what they're telling me, I don't take them on as a chronic pain patient." (Tr. at 466-467)

354. Dr. Cicek testified that, if a patient who receives prescriptions for narcotics and benzodiazepines tells the physician that he or she drinks a couple beers at a time, the physician needs to address that with the patient and counsel the patient concerning the potentiating or addictive effects of combining alcohol with those medications. Dr. Cicek added that "people typically underreport their alcohol intake." Moreover, Dr. Cicek testified that that discussion needs to be documented in the patient's chart. (Tr. at 499-502)

355. Dr. Cicek testified that it is necessary for a physician to sign off on initial patient documentation coming in from another source, such as imaging reports or prior treatment records, that the physician has reviewed. When asked why, she replied: "The same reason we write a physical exam for a patient or we take a medical history; because it shows that we've reviewed the previous information and incorporated it into the current plan of care." Moreover, Dr. Cicek testified that "[e]very practice institution I have trained at and worked in in Ohio and other states, it is standard of care to sign off on something you've received and reviewed." She further testified that, if it is not signed off on, it is possible that it was still reviewed but that that cannot be assumed. (Tr. at 505-511)

356. Dr. Cicek testified that medication contracts are the standard of care. Dr. Cicek testified that they should be entered into at the same time narcotic medication is initiated. Moreover, she testified that if care of the patient is transferred to a new provider then the contract should be reviewed and re-signed with the new provider to document that the contract was addressed. (Tr. at 523-524)

357. When asked if it is okay if a physician, upon being told by his patient that the patient smokes marijuana in violation of the medication contract, tells the patient to stop smoking marijuana but agrees to continue to prescribe controlled substances, Dr. Cicek replied, "I wouldn't prescribe that person narcotics if they admitted to smoking an illegal substance." When asked if the "millions of Americans" who have pain and smoke marijuana have to be refused care because they use an illegal drug, Dr. Cicek replied: "If they're using an illegal drug, then they need an addiction assessment prior to receiving chronic narcotics from a primary care provider. Again, that obligates you to getting a specialist's input." Finally, Dr. Cicek noted that medical marijuana is not legal in Ohio. (Tr. at 525-527)

358. With respect to the established patients that Dr. Demint took over at the Lance practice, Dr. Cicek testified that Dr. Demint had a responsibility to treat them like they were new patients. She noted that they were "brand new to him." (Tr. at 530-531)

359. Dr. Cicek was asked what a physician is supposed to document as the patient's individualized goals. Dr. Cicek testified:

> What the patient hopes to achieve by controlling their pain. Do they want to be able to work full time? Do they want to be able to go to the grocery store? Do they want to be able to care for their children? What activities in their life are they unable to do because of the pain and what would they like to achieve with control of their pain? How else are you going to objectively – [measure their progress?]

(Tr. at 538-539)

360. Dr. Cicek testified that writing "See Rx" does not constitute a sufficient treatment plan. Dr. Cicek testified that, patients should be treated with non-narcotic modalities first, and, when they are treated with narcotics, it is "a multimodal approach. So 'See Rx' as the plan is not an individualized treatment plan, and we—we know that because that's what the plan is for every chart that I reviewed, is 'See Rx.'" (Tr. at 540-541)

361. Dr. Cicek acknowledged that there is some lag in OARRS reports between what is reported and the most recent transactions. For example, and OARRS report might not have last week's prescriptions on it. (Tr. at 549)

<u>Dr. Demint's Conclusions</u>

362. Dr. Demint testified that he follows accepted methodology when he performs his initial evaluations of patients. Dr. Demint testified that he follows the SOAP form of

recordkeeping, whereby the patients' subjective complaints are documented, he documents objective findings during examinations, he assesses the patients' problems, documents diagnoses, and he documents plans. (Tr. at 620-621)

Dr. Demint testified that he believes that the SOAP notes, four A's, and the brief pain inventory together provide him sufficient information to diagnose and treat his patients. (Tr. at 624-625)

363. Dr. Demint testified that there is no correlation between a patient's subjective sensation of pain and the results of imaging studies:

> I have seen patients with the worst-looking x-rays and have no—or MRIs, not complain of any pain at all of any significance. And then I have others that had not had what was considered any significant abnormality and have almost debilitating pain. Again, as I said, fibromyalgia is one of the—one of those—those conditions.

(Tr. at 625)

364. Dr. Demint testified that he gives his patients individualized treatment, and that he tailors the treatment he gives to the individual needs of each patient. Dr. Demint further testified that his treatment of the patient evolves over time. Moreover, Dr. Demint testified:

> Where we evolve during the times you see the patient, you know, I think that's one of the things that I think you can tell a pill mill from someone who's trying to do a good job. Pill mill doesn't give individual treatment. They give the same medications all the time, you know. They always give an opioid of choice, whichever opioid that is; they give a benzodiazepine of choice, usually Xanax; and then they give Soma. And everyone gets that. So that's not individualized.
>
> If you look at these patients, none of these patients have the same medications, because I not only use the opioids, but I use the adjunctive medications; the gabapentins, the Lyricas, the SNRIs such as Cymbalta and Effexor.

(Tr. at 626-627)

365. With respect to documenting his review of patients' prior medical records, Dr. Demint acknowledged that he does not always sign the old records. Dr. Demint further testified:

> I may not say, "Oh, reviewed records," but you can see that by my diagnoses or something that I had to have gotten that from the—the records.

> You know, that would have been something I wouldn't have gotten from the patient, and to me that proves I must have looked at the records. Otherwise, how would I have come up with that information?

(Tr. at 631-632)

Dr. Demint further testified that he believes that the standard of care requires only that his note references a prior treatment record. Moreover, Dr. Demint testified that he is unaware of any written requirement that he must sign prior treatment records. (Tr. at 632)

366. Dr. Demint testified that he disagreed with Dr. Cicek's opinion that a physician should start a new pain patient on the minimum dose of medication:

> Because the minimum dose may not provide enough pain relief for their situation, and so the patient's continuing to suffer from pain. And this is very troublesome when you have people in acute pain, and like I say, most of her discussion really applied more to acute pain than chronic pain. But if you don't get adequate control of acute pain, it can tend to become chronic pain and now we got a big bugaboo. I think that's part of the problem that got us where we are now, you know, and the whole opioid—is that if people would have treated a lot of these people's patient—pain effectively initially, they never would have been chronic pain patients.

(Tr. at 673-674)

367. Dr. Demint testified that, with respect to urine drug screens, the intractable pain rules state that if he becomes suspicious about a patient he *may* do a urine screen. He further testified that the rule requires that a patient be referred for addiction services should he or she refuse to consent to the screen. (Tr. at 632-633)

Dr. Demint further testified that the standard of care does not require action based simply on a *screen*, and that the physician must get *confirmation*. Dr. Demint testified that the in-office screens are too unreliable to serve as a basis for medical decisions, although a medical decision could sometimes be made on an initial screen that is totally negative. (Tr. at 634)

Dr. Demint believes that a physician should not alter a patient's medication regimen based on an inconsistent in-house urine screen. He further testified that physicians have faced lawsuits for such action when the laboratory report following an inconsistent in-house screen was confirmed to be okay. Therefore, Dr. Demint testified, he feels obligated to continue the patient's medication until he receives laboratory confirmation. (Tr. at 636)

368. Dr. Demint was questioned concerning Dr. Cicek's opinion that, faced with an inconsistent in-house urine screen result, a physician should only prescribe enough medication to last until the physician receives the laboratory confirmation. He testified that the typical one-month supply of medication that he prescribes is reasonable because delays in receiving the lab reports are not unusual. Dr. Demint further testified that he practices in an area where a lot of people are

economically disadvantaged and that it would be a hardship for the patient to return in two weeks. (Tr. at 636-638)

Dr. Demint opined that the standard of care does not require any particular maximum period of time to prescribe medication pending lab confirmation of an inconsistent in-house urine drug screen result. (Tr. at 638-639) In support of his opinion, Dr. Demint presented a letter he received dated June 8, 2012, from AIT Laboratories. The letter states, in pertinent part:

> Immunoassay tests, whether they are a point of care device, such as an instant cup, or a dipstick test or even a laboratory initial screening test, are based on the principle that antibodies are able to recognize and bind to the drug of interest. These antibodies are designed to be highly selective, which means they preferentially bind to the drug of interest. In the absence of the drug, this binding does not eliminate the possibility of binding to other drugs that have similar chemical characteristics (i.e. similar chemical structure). This secondary binding is commonly called a "false positive" result. It is not possible to design an antibody that binds to a single drug exclusively. Additionally, given the vast number of drugs available on the market (illicit, prescription and over-the-counter) and the vast number of metabolites produced by the body, it is also not possible to evaluate all possible "false positives." As an example, the target drugs in the amphetamine immunoassay screening analysis in the laboratory are Amphetamine, Methamphetamine, and MDMA. Other amphetamine-like drugs, such as Ephedrine (Ephedra), Pseudoephedrine (Sudafed/Actifed), and Phentermine (Adipex), as well as the acid-reflux medication, Ranitidine (Zantac), and the antidepressant, Trazodone (Desyrel), can cross react (if present in a specific amount) and cause a positive result leading to a "false positive." As another example, the target drug in the cannabinoid immunoassay screening analysis is Carboxy THC, the main urinary metabolite of THC, the primary psychoactive ingredient in cannabis. The acid-reflex medication, Pantoprazole (Protonix), and the antiretroviral drug, Efavirenz (Sustiva), can cross react and cause a ''false positive."
>
> While the POC screening testing is valuable, the possibility of the "false positive" result is the underlying reason that no medical decision be made on the POC screening result on its own. A confirmatory test, typically either gas chromatography with mass spectrometry (GC/MS) or liquid chromatography with tandem mass spectrometry (LC/MS/MS), is needed for unequivocal identification of the drug or metabolites present.

(Resp. Ex. H)

369. Dr. Demint further testified that his position is supported by a book entitled *The Massachusetts General Hospital Handbook of Pain Management, Third Edition* ("MGH Handbook"), edited by Jane C. Ballantyne, M.D.[52] Dr. Demint testified that Massachusetts

[52] The third edition was copyrighted in 2006. (Resp. Sub. Ex. A at iv)

General Hospital is the training facility for the Harvard University College of Medicine and that Dr. Ballantyne is a highly respected pain specialist. Dr. Demint further testified that the MGH Handbook sets forth appropriate knowledge and the standards one needs to follow practicing pain management. (Tr. at 655-656, 663-664; Respondent's Substitute Exhibit ("Resp. Sub. Ex.") A)

With respect to urine drug screens, the MGH Handbook states, in pertinent part:

> Unfortunately, routine urine assays provide only qualitative results (i.e., the presence or absence of a representative from a specific drug class, e.g., opioid and benzodiazepine). This is simply a screening method, which needs to be followed by a second confirmatory test. The preliminary test result must be validated when the consequences of a false-positive result are crucial, such in the case of ongoing litigation.

(Tr. at 675-677; Resp. Sub. Ex. A at 520)

370. Dr. Demint testified that there is no rule that states that a physician cannot treat a pain patient who admits to smoking marijuana, even if that violates their medication contract. Dr. Demint testified that the physician must counsel the patient, but it is not necessary to discharge the patient even if the patient had previously lied about his or her use of illicit drugs. (Tr. at 644-646)

Dr. Demint further testified that he does not believe there is a requirement to refer a patient to an addictionologist simply because the patient admits using marijuana. Moreover, Dr. Demint testified that he does not believe that marijuana use per se constitutes drug abuse or addiction. (Tr. at 648-649)

371. When asked about a responsibility to counsel a patient who states that he drinks a six-pack of beer on weekends, Dr. Demint replied:

> Well, I usually, you know, patients [who are] totally new to me, you know, I—I probably mention something, but I may not particularly document it in the chart. But also I know he's going to get counseling at the pharmacy when he picks up his medications. Actually, the pharmacist often knows that—you know, the interactions and stuff better than we do.

(Tr. at 649-650)

372. Dr. Demint testified that medication contracts are not required by any government rule but are considered to be the standard of care. However, he testified that he is unaware of any standard concerning the contents of such contracts. Dr. Demint testified that he obtained the contract he uses from the American Academy of Pain Management and modified it to suit his practice. He further testified that they are available in textbooks and from other sources. (Tr. at 646-647)

373. Dr. Demint does not believe that his handwriting in his medical charts is illegible. Dr. Demint further testified that he has never had any complaints prior to Dr. Cicek that his charts are unreadable. Moreover, Dr. Demint testified that he has had pharmacy technicians and nurses comment to him how much better his handwriting is compared to other physicians. (Tr. at 650)

374. Dr. Demint presented a statistical compilation from AIT Laboratories that he says demonstrates that his patients' compliance rate is higher than that reported by AIT labs in general. (Tr. at 685-688; Resp. Ex. K)

375. Addressing the issue of new patients who have previously been discharged from other physicians' practices, Dr. Demint testified that he does not believe that there is any particular action that can be called "the standard of care" under such circumstances, nor does he believe that he must withhold treatment until he obtains a urine drug test. He further testified that a prior discharge does not automatically form a basis to deny treatment. He stated that each patient's situation must be looked at individually to determine whether to treat or deny treatment to that patient. (Tr. at 643-644)

376. Dr. Demint testified concerning the reasons why he is willing to take patients who were discharged from other physicians' practices:

> [T]he biggest reason for a misuse is not addiction like most people think, but the studies show that the biggest reason for misuse is undertreatment of pain and using drugs to treat their pain. And so I'm willing to give someone a chance to—to relieve their pain.
>
> You know, again, they have to go through a new contract with me, they know—I mean, after a while, when you kick out enough patients, the word gets around that, you know, Dr. Demint will kick you out. You know, will I give them a chance because I know I would do the proper screening, risk evaluation, and—and such.
>
> If you notice as we've gone through here, you know, not everybody got screened the same way. That's because I do a risk management, you know. That's how we're going to—you know, if I did—you know, if we did drug screens on every patient every day—every time they came in the office, if we did an OARRS every time they came to the office, did the pill count once a month, logistically, it would be impossible. We—you know, the logistics of it would be impossible. The cost of it would be such a burden on the system.
>
> * * *
>
> * * * The health care system couldn't afford it. You know, I mean, you've got to think about all those costs if you add up. You know, it's—so you have to do a risk stratification, you know. You know, the risk factors, you know.
>
> And according to those risk factors, you stratify them, and then you do your monitoring or surveillance per those risks. So those with higher risk get more

> monitoring, as you noticed for some of these patients, where I did maybe a drug screen again in—you know, on the next visit or the visit after, where others would go a long time. I mean, I think that's the whole purpose why that law said [you may].

(Tr. at 790-792)

377. Dr. Demint testified concerning Respondent's Exhibit E, a collection of continuing medical education certificates for "hundreds of hours" of courses he completed since 2006. Dr. Demint testified that he is required to take a certain number of hours to maintain his status of diplomate in the American Academy of Pain Management, and testified that he has completed "much more than is required." (Resp. Ex. E; Tr. at 615-617)

Dr. Cicek – Response to MGH Handbook

378. Dr. Cicek testified that she is not familiar with *Pain Medicine, a Comprehensive Review,* by Raj; or *The Massachusetts General Hospital Handbook of Pain Management*. She acknowledged that they may be authoritative sources but that she does not refer to them. Dr. Cicek testified that she mainly relies upon online resources. (Tr. at 475-476)

379. Dr. Cicek was asked whether she agrees with a statement in *The Massachusetts General Hospital Handbook of Pain Management* ("MGH Handbook"), in a chapter entitled Assessment of Pain, that states, in bold print, "**There is no objective measure of pain.**" Dr. Cicek indicated that she disagreed with that statement, stating that there are some objective measures of pain such as "[e]levated blood pressure, elevated pulse, facial expressions, [and] someone's ability to walk, sit, stand." (Resp. Sub. Ex. A at 58; Tr. at 479)

    Dr. Cicek was also asked whether she agrees with another statement from the MGH Handbook that says: "Reports of pain may not correlate with the degree of disability or findings on physical examination." Dr. Cicek indicated agreement but referenced an additional statement in the same paragraph that says: "The most important of these factors [to be considered in combination by a physician assessing pain] is the patient's report of pain, but other factors such as personality and culture, psychological status, the existence of secondary gain, and drug-seeking behavior should also be considered." (Resp. Sub. Ex. A at 58; Tr. at 480-481)

380. Dr. Cicek indicated agreement with the following statement in the MGH Handbook:

> Opioids are the core pharmacologic treatment of pain. They are the mainstay for treatment of both acute pain and cancer pain, and although controversy still exists over their use in chronic nonterminal pain (CNTP), they are increasingly used for this indication also. Opioids are the only pain medications that have no ceiling effect and are therefore the only systemic treatment that can be used to treat severe accelerating pain.

(Resp. Sub. Ex. A at 105; Tr. at 485-486)

381. A statement in the MGH Handbook states, with respect to medication contracts for pain patients receiving opioids: "[A]lthough there is limited scientific evidence to support success with contracts in the pain population, the practice seems to be widespread." (Resp. Sub. Ex. A at 521-523) Dr. Cicek testified that she disagrees with that statement:

> I think a contract states to the patient what they can expect from the provider and what the provider expects from them. It's—makes clear at the outset what the expectations are. If you're going to go to a job, you get a contract that states what the expectations of your performance are and what you can expect from your employer.

(Tr. at 498)

Additional Testimony of Dr. Demint

382. Dr. Demint testified that patients in chronic pain appear differently on examination from patients in acute pain, because the nervous system of chronic pain patients undergoes changes due to a process he called neuroplasticity. Dr. Demint further testified that the result of these changes is called neuropathic pain. Moreover, Dr. Demint testified that, unlike acute pain, neuropathic pain does not respond well to nonsteroidal anti-inflammatory drugs, but is better treated with gabapentin or a serotonin–norepinephrine reuptake inhibitor ("SNRI") such as Effexor or Cymbalta. (Tr. at 640-641)

Dr. Demint testified that patients in chronic pain do not exhibit the same objective characteristics shown by patients in acute pain whose blood pressure and pulse can be elevated. Moreover, Dr. Demint testified that Dr. Cicek demonstrated "ignorance of pain management" by not differentiating between the presentations of acute pain and chronic pain. (Tr. at 642)

Dr. Demint testified that a statement in Chapter 6 of the MGH Handbook, "Reports of pain may not correlate with the degree of disability or findings on physical examination," supports his testimony. (Tr. at 657; Resp. Sub. Ex. A at 58)

Affidavit of Ellis Frazier, M.D.

383. On remand, Dr. Demint presented the expert opinion of Ellis Frazier, M.D., via Affidavit dated May 20, 2014. In his affidavit, Dr. Frazier stated, among other things:

> **6. It is my considered opinion and when necessary, it is to a reasonable degree of medical certainty as follows:**
>
> **A. The patient files are substantially legible. I had no personal difficulty in deciphering them to render my opinion.**
> **B. I do not believe that there is a standard of care that requires a physician to note in the patient file at each consultation that the physician has reviewed the file.**

C. I do not believe that there is a standard of care known as "not written, not done."
D. I do not believe that there is a standard of care that requires a physician to specifically state what each drug prescribed is meant to treat so long as the entire record shows a specific diagnosis and the prescribed drug is a known treatment for it. Only when a drug does not fit the diagnosis should the reason be stated.
E. My examination of the patient files shows me that Dr. Demint is using the four As and SOAP techniques for evaluation, diagnosis and treatment plan.
F. It is my belief that proper use of the four As and SOAP constitutes the requirement to set forth an individual treatment plan.
G. An ITP is tied to functionality and not to its specific activity. That is, if a carpenter comes in complaining of pain prohibiting him from performing his activities, the ITP should get him to the point where he can return to work. It is not necessary to state, for example, use a nail gun.
H. For proper diagnosis and ITP, it is not necessary to perform a full physical examination upon each visit. To do so is excessive and not appropriate.
I. It is not a standard of care to document a subjective complaint of pain to a particular physical movement. A patient complaint of increased pain is a subjective diagnosis. A medical report showing the nature of the injury is enough. Visible indications of surgery are enough.
J. There is no medical standard of care that requires a physician to discharge a substance abuse patient who tests positive for marijuana. The requirement is to refer him or counsel him.
K. There is no standard of care that requires a physician to discharge a patient with an inconsistent toxicology screen so long as the inconsistency is reasonably explained.
L. A physician may, or may not, run an OARRS or a toxicology screen and in making that decision, a physician may rely upon the fact that the patient is an established patient who has garnered the physician's trust and confidence.
M. There is no standard of care that states a physician cannot prescribe medicines until and unless he receives the patient's old medical records.
N. There is no medical standard of care that states a physician cannot prescribe drugs on the first visit if the patient has been discharged from another's care until and unless a toxicology screen is received.
O. There is no medical standard of care that says discharge is automatic if a term or condition of the contract is breached by the patient.
P. There is no medical standard of care that says that a new patient must be prescribed the minimum dose of a drug. It is acceptable to prescribe the drug in the dosage previously prescribed or in accordance with the complaints.

Q. There is no medical standard of care that sets forth for how long medicine can be prescribed until records are received, OARRS is received and/or a tox report is received. Two weeks is probably too short. Thirty days is certainly acceptable.
R. In regard to diagnosing fibromyalgia, the presence or absence of tender points are common but not required. That disease may be treated with narcotics.
S. While recognized to be acceptable, a pain management contract which documents patient and clinician responsibilities and expectations and which assists in patient education has not been shown to be of significant value.
T. Chronic Non-Cancer Pain can be treated with an initial course of treatment with opioids with the therapeutic trial lasting from several weeks to several months.
U. Opioids have no maximum or ceiling dose. There is little evidence to guide safe and effective prescribing at higher doses and there is no standardized definition of what constitutes a "high dose." A reasonable definition for high dose opioid therapy is more than 200 mg daily. A low daily dose would be 60-80 mg daily of morphine (or equivalent).
V. COPD can be treated with opioids.[53]
W. The proper standard for a failed urine screen is to question but not act until there is been confirmation.

7. I would not conclude that a patient who disclosed to me that he consumed a 6 pack of beer in a weekend was a binge drinker.

8. It is my considered medical opinion to a reasonable degree of medical certainty that Dr. Demint did not fall below a reasonable standard of care for any patient 1 through 14.

(Resp. Ex. AA)

<u>Testimony of Barry Bennett</u>

384. Barry Bennett testified that he is the Executive Director of Pickaway Area Recovery Services ("PARS"), Fayette Recovery Center, and Washington Courthouse Women's Residential Program. Mr. Bennett testified that PARS is a substance abuse outpatient counseling center that is licensed by the Ohio Department of Alcohol and Drug Addiction Services. (Tr. at 544)

385. Mr. Bennett testified that he is familiar with Dr. Demint. Mr. Bennett testified that Dr. Demint has referred Suboxone patients to PARS who suffer from anxiety or depression.

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[53] The Hearing Examiner interprets this statement to mean that a patient who has been diagnosed with COPD can be treated for pain with opioids.

Mr. Bennett testified that PARS has staff who are qualified to treat such patients. He testified that many other physicians refer patients to PARS as well. However, Mr. Bennett testified that "Dr. Demint and Children's Hospital are the two that follow up the most with their clients." (Tr. at 545)

Testimony of Stephen G. Allen

386. Stephen G. Allen testified that he is a registered pharmacist in the State of Ohio and works at Allen's Medical Pharmacy in Chillicothe. Mr. Allen testified that he is familiar with Dr. Demint through Dr. Demint's prescriptions and that he has known Dr. Demint for about 20 years. Mr. Allen testified that Dr. Demint seems very concerned about the problem of drug diversion, and frequently calls his pharmacy asking questions about patients. Likewise, Mr. Allen testified that he has contacted Dr. Demint about suspect prescriptions and that Dr. Demint has always been cooperative in that regard. He further testified that Dr. Demint appears to be "very active in pursuing that things are being done legitimately." (Tr. at 570-572)

387. Mr. Allen testified that he is very familiar with the prevalence of drug abuse and diversion in his area and stated that it is a huge problem. Mr. Allen further testified:

> Even if—if you have a patient that maybe has a legitimate problem, I think even many times they are taking part of it, selling part of it.
>
> A lot of physicians have become very prudent in doing drug screens, and if they don't find any showing up in the urine test, then they're out. I am seeing physicians quicker to let people go than they used to be. But we have a long, long, long, long way to go.
>
> And it seems like when you solve one thing, something else pops up. You know, there used to be a time when marijuana was a problem. Now it seems like something very minor. But now we have kids—people growing up with meth and all their teeth are falling out. And you can almost tell some of the people that come in the store that—you can almost tell they're meth'd up, as we call them.
>
> It's a terrible industry. It's a terrible, terrible thing. And in my time left in this profession, I don't see it being totally solved, but I would like to see steps going that direction. I think we're—we're turning that direction.

(Tr. at 580-583)

388. Mr. Allen testified concerning OARRS that there is a lag time between prescriptions being issued and the prescriptions appearing on OARRS reports. He further testified that the information in OARRS is not perfect and that sometimes patients are misidentified. Also, when patients fail to pick up a prescription that has been filled, there is no way of reversing the information input into OARRS short of writing a letter. In addition, Mr. Allen testified

that OARRS uses ZIP codes to search; "[i]f the patient would give me as little misleading information as their ZIP code and I search the wrong ZIP code, that will not come up." Finally, Mr. Allen testified, "OARRS is a wonderful thing, but it has a ways to go." (Tr. at 575-579)

Testimony of Phillip Prior, M.D.

389. Phillip Prior, M.D., testified that he is an addictionologist and that he practices at the Veterans Administration hospital in Chillicothe. Dr. Prior testified that he is board-certified in family medicine and in addiction medicine. Dr. Prior further testified that he has been an addictionologist for about ten years. (Tr. at 588, 595)

390. Dr. Prior testified that he is Dr. Demint's monitoring physician for purposes of Dr. Demint's consent agreement with the Board. As Dr. Demint's monitoring physician, Dr. Prior performs periodic reviews of Dr. Demint's patient records to ensure that he is practicing medicine in accordance with the minimal standard of care. Moreover, Dr. Prior provides a general assessment of the quality of Dr. Demint's recovery program. (Tr. at 588-589)

Dr. Prior testified that, in his capacity as Dr. Demint's monitoring physician, he has not had any problems with Dr. Demint's medical charts with respect to their legibility. Dr. Prior further testified:

- As part of the chart review process, Dr. Prior determines whether or not the care provided to the patient appeared to be appropriate.

- He has not been concerned that Dr. Demint's initial visit notes were so brief that he could not ascertain the purpose of the patient's visit. Dr. Prior further testified that he believes that Dr. Demint's initial visit notes are appropriate.

- Dr. Prior testified that an initial treatment plan "consists of a diagnosis and whatever therapeutic measures are going to be undertaken to deal with that diagnosis." Dr. Prior testified that he believes from his reviews of Dr. Demint's charts that Dr. Demint has an initial treatment plan for each patient.

- Dr. Prior does not believe that all of the information a physician needs to make a decision has to be in one particular place in the file. Dr. Prior testified, "the standard of care would be for the information that you're seeking to be somewhere in the chart"

- Dr. Prior testified that the patient's report of pain does not always correlate with the patient's degree of disability or the examination findings.

(Tr. at 591-594)

391. On remand, at Dr. Demint's request and with no objection from the State, Board Exhibit A was admitted to the hearing record and may now be reviewed and

considered by the Hearing Examiner and the Board. Board Exhibit A states, in pertinent part:

Q. [By Mr. Kingsley] Do you believe an initial treatment plan requires you to identify at each visit an objective activity or function that's affected?

And let me give you an example. The State's expert said you should identify something like, well, you need -- you'd like to vacuum your house but you can't and, therefore, you can -- you can use that as a standard to see if you've met it. Is that necessary?

A. [By Dr. Prior] I wouldn't say that it would need to be that specific.

Q. All right. Do you rely in total -- in -- You know what OARRS are -- is?

A. Yes.

Q. Do you -- Do you believe that OARRS is foolproof?

A. No.

Q. Do you -- Have you experienced mistakes in OARRS?

A. I have experienced deficiencies that -- wherein the report was not completely accurate.

Q. In regard to medical records that you received from a prior doctor, prior treatment, put them in the folder here, do you believe that you have to personally sign off on those records when you put them into the file?

A. No.

Q. Do you believe that you have to sign off on the record in the file or if you review it and intend to make a note in the present consultation?

A. I -- Could you repeat the question?

Q. You're going to make a mental note that you referred back to those records that you've got here. "He told me that he was in a car accident," or "The records show that he had an IME." Do you believe that you have to initial the record that you referred to to show that you looked at the prior record?

A. No.

Q. Do you do urine screens on your patients?

A. Yes.

Q. Do you believe that urine screen is a mandatory requirement on the initial consultation for each drug patient?

A. For what class of drugs?

Q. Opiates. Well, if we -- somebody comes in, just wants to treat you, you want treatment, initial consultation, do you believe that a urine screen is -- is a standard of care that's required?

A. No.

Q. Do you believe a urine screen is required every time that you see a patient you know is receiving opiates?

A. No.

Q. Do you rely on a screening urine test to make a medical decision?

A. At times.

Q. Do you believe -- Do you believe that you should discharge a patient on a screen versus a confirmation?

A. No.

Q. Do you know what -- what is the standard of care of a doctor acting on a screen versus a confirmation test, making a medical decision?

A. A screen is referred to as a screen for a reason; is the fact that it is an initial diagnostic test that should be followed up by confirmation.

Q. What is the -- Do you believe the -- What is the standard of care -- Let me rephrase that. Is it necessary for a drug to -- a doctor to write in the chart the purpose of the drug that he prescribed?

A. What part of the chart?

Q. Well, I guess anywhere in the chart.

A. I think in some cases that's implied, that there are certain medications that are used only for one reason, one indication. And so under those circumstances, I -- I wouldn't have -- feel the need to specifically state

that this drug is for this condition, because it may be that there is only a single condition for which that drug is indicated.

Q. Do you use contracts?

A. Yes.

Q. Does your contract provide that the patient shall not use illicit drugs?

A. Yes.

Q. What is the standard of care if the patient lied to you and you discovered in a urine test later that he used marijuana?

A. I don't believe that standard of care has been established.

Q. It is not mandatory that he be discharged for lying?

A. No.

Q. It's not mandatory that he be discharged for marijuana use?

A. No.

Q. If a person is being prescribed an opiate and he tells you that he drinks a six-pack of beer on a weekend, do you believe it's necessary to note in the file a precaution that he should not be drinking and taking the medicine?

A. I would advise him of that and probably note that.

Q. Is there any -- What is your opinion on the doctor relying on the disclaimer by the pharmacy in place of the note in the file? Can that -- Is that reasonable?

A. I think I would not say that I would specifically counsel somebody at the onset of medication therapy that there is abs- -- that -- I would -- no, I don't think I would under every circumstance tell a patient, "Do not drink with this medication," if I was absolutely certain that that warning would be part of the prescriptive process at the pharmacy.

Q. Is it appropriate to treat fibromyalgia with a opioid?

A. No.

Q. Ever?

A. Not to my knowledge.

Q. All right.

A. There may be some controversy in the literature regarding that, but from an addictionologist's standpoint, no.

Q. And a person with chronic COPD, is it appropriate to give him opioids?

A. Not unreasonable.

Q. It's, under some circumstances, proper?

A. Yeah.

MR. KINGSLEY: All right. I have no further questions.

(Bd. Ex. A)

Additional Information

392. The parties stipulated to the following with respect to an OARRS report received by Dr. Demint: "On April 17, 2014, Respondent prescribed medicine[54] to a patient. It did not appear on the OARRS report dated May 14, 2014." (Resp. Substitute Ex. DD)

393. Dr. Demint presented a May 30, 2014 Affidavit of Juni Johnson. Ms. Johnson is the Executive Director of Paint Valley Alcohol, Drug Addiction and Mental Health Services Board ("ADAMH") serving Fayette, Highland, Pickaway, Pike, and Ross Counties. Ms. Johnson stated, "There is a shortage of physicians willing to provide Medication Assisted Treatment for addicted persons in our area following appropriate guidelines." She further stated that her office and staff "have complete confidence in [Dr. Demint] and in his ability to professionally and responsibly treat substance abuse patients." Moreover, she stated that Dr. Demint "is one of the few physicians in our area that responsibly provide Medication Assisted Treatment following a low dose protocol, referring to certified substance abuse counseling agencies, and follows up to assure his patients are attending the required treatment meetings." (Resp. Ex. HH)

FINDINGS OF FACT

1. On or about August 12, 2009, Franklin Donald Demint, D.O., entered into a Step I Consent Agreement with the Board in lieu of formal proceedings based upon violations of Sections 4731.22(B)(26), (5), (10), and (20), Ohio Revised Code. The Step I Consent Agreement

[54] The medication was Suboxone.

was based upon Dr. Demint's dependence on and excessive and habitual use of marijuana, and his admission of having possessed and dispensed generic Tylenol #3 tablets to a family member under circumstances not constituting an emergency, without performing and documenting an examination and without maintaining patient records.

Subsequently, on or about March 10, 2010, Dr. Demint entered into a Step II Consent Agreement with the Board, pursuant to which his Ohio certificate to practice osteopathic medicine and surgery was reinstated, subject to certain terms, conditions, and limitations.

To date Dr. Demint remain subject to all terms, conditions and limitations of the Step II Consent Agreement, as modified by the Board, including Paragraph 1, which requires that you obey all federal, state, and local laws, and all rules governing the practice of osteopathic medicine in Ohio.

2. During the time period of March 2010 to in or about April 2011, Dr. Demint provided care in the routine course of his practice for Patients 1 through 14 as identified in a confidential Patient Key.

   In his treatment of Patients 1 through 14, Dr. Demint practiced below minimal standards of care, including, but not limited to, the following:

   a. Dr. Demint inappropriately prescribed narcotics to Patient 1 for treatment of diagnosed fibromyalgia. Although Dr. Demint and Dr. Frazier opined on remand that fibromyalgia may be treated with narcotics, this is not persuasive. Furthermore, it is contradicted by other evidence submitted by Dr. Demint on remand; specifically, the testimony of Dr. Prior and the article from the Journal of the American Osteopathic Association.

   b. With respect to Patients 3 through 5, 7, 8, 11, and 13, Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records.

      Dr. Cicek persuasively opined that physicians must review and document their review of patients' histories and prior medical records. The documentation can be as brief as "medical history reviewed and updated." She further testified that the importance of documentation and the adage that, if it is not documented, it was not done is common knowledge in the physician community. Dr. Demint's suggestion from the original hearing that one can tell from his diagnoses that he had reviewed histories or records is unpersuasive—medical records should clearly and accurately reflect what the physician did, and the burden of including a short note to that effect is not too great. Moreover, Dr. Demint presented no persuasive evidence to the contrary on remand.

   c. With respect to Patients 1 through 5, and 7 through 14, the amount and/or type of narcotics prescribed by Dr. Demint was not supported by history, physical exam and/or test findings.

Dr. Cicek opined there was a lack of physical examination findings documented to support the level of narcotic prescribing for each of these patients. She noted that the musculoskeletal examinations were incomplete and failed to include all of the necessary elements such as range of motion, reflex testing, strength, sensation, and muscle atrophy or asymmetry. Moreover, Dr. Demint failed to evaluate patients' ability to stand, walk, and sit. None of the patient records for Patients 1 through 5, and 7 through 14, include all, or even most, of those elements. For example, Dr. Cicek noted, with respect to Patient 9, who had had a leg amputated, that there was not enough information to present a picture of that patient's functioning, including whether he ambulated with a prosthesis or used a wheelchair.

Dr. Demint noted that some of these patients had had radiological studies that supported their pain complaints. However, as Dr. Demint himself persuasively opined, there is no direct relationship between radiological findings and patients' subjective reports of pain—patients with terrible radiological studies can be pain free and patients in terrible pain can have normal radiological studies. As useful as radiological studies may be, it is the physician's responsibility to determine the patients' level of pain via examination, pain inventories, and histories. Accordingly, Dr. Cicek's opinion is deemed more credible.

d. With respect to Patients 9 and 12, Dr. Demint inappropriately prescribed high doses of narcotics despite diagnoses of underlying Chronic Obstructive Pulmonary Disease.

Dr. Cicek persuasively opined that Dr. Demint should have documented discussions with these patients concerning their increased risks of respiratory depression and his plans for monitoring them. On remand, Dr. Demint and Dr. Frazier criticized Dr. Cicek for opining that patients with COPD can never be prescribed narcotics; however, this misconstrues her testimony. Dr. Cicek did not criticize Dr. Demint for using narcotics to treat patients with COPD, per se. What Dr. Cicek *did* say was that Dr. Demint should have discussed with the COPD patients the risks of taking high-dose opioids due to respiratory depression and documented those discussions, as well as what would be done to monitor the patients. Those discussions were not documented in the medical records for Patients 9 and 12.

e. With respect to Patients 1, 2, 4, 6 through 10, and 12 through 14, Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, selective serotonin reuptake inhibitors, and/or physical therapy.

Dr. Demint argued that he had not simply prescribed the same medications to every patient, and that he had utilized non-narcotic adjunctive medications such as gabapentin, antidepressants, and NSAIDs in his treatment of his patients. Moreover, the records indicate that Dr. Demint referred some of his patients for mental health treatment and physical therapy. However, Dr. Cicek testified persuasively that no *plan* was documented for these patients. There was no documented attempt to determine how therapy would be used to assist the patients to achieve improvements

in functioning, or monitoring to assess whether those goals were being met. Dr. Cicek never testified that the goals had to be as specific as, for example, a carpenter being able to use a nail gun, as suggested by Dr. Frazier on remand. Instead, Dr. Cicek opined that there needed to be documentation of assessments of what the patients needed to do in their everyday lives that they are not able to do, and establish measurable goals to hopefully get the patient back to that level of functioning. The records for these patients do not show that that was done.

On remand, Dr. Demint presented evidence that SSRIs are not effective in treating pain, but that SNRIs are. This Board, as a panel of experts, is qualified to determine whether that is true and what effect, if any, that has on this finding.

f. See Finding of Fact 3, below.

g. With respect to Patients 3, 6, 8, 9, 11, 12, and 13, Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports.

With respect to Patient 3, Dr. Demint established on remand that he had dismissed Patient 3 from his practice on April 7, 2011, following confirmation of the presence of buprenorphine in the patient's urine sample on March 26, 2011, as well as Patient 3's failure to appear for a pill count. This was appropriate. However, Dr. Cicek persuasively testified at the original hearing that Dr. Demint should have limited his controlled substance prescription to a ten-day supply based upon the inconsistent in-house screen on March 26, 2011. Instead, Dr. Demint prescribed a full month's supply of oxycodone at that visit. Accordingly, the evidence is sufficient to support this finding with respect to Patient 3.

Similarly, with respect to Patient 6, Dr. Demint established on remand that he had dismissed Patient 6 from his practice following lab confirmation of an inconsistent in-house screen on March 23, 2011, that was negative for oxycodone, which Dr. Demint had prescribed. There was a delay in the lab result being placed in the patient's file because the lab had misspelled Patient 6's last name. It was appropriate for Dr. Demint to dismiss this patient following confirmation of the inconsistent in-house screen. However, the issue with this patient is similar to the issue with Patient 3: Dr. Demint prescribed the usual dose and quantity of oxycodone to Patient 6 on March 23, 2011, even though the in-house screen was negative for that medication. Accordingly, the evidence is sufficient to support this finding with respect to Patient 6.

h. With respect to Patients 3 through 6, 9, and 13, Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment.

i. The evidence overwhelmingly supports a finding that, with respect to Patients 1 through 3, 6, 8, and 12, Dr. Demint's medical charting was incomplete and sometimes illegible.

Despite the foregoing, Dr. Demint established at the original hearing and on remand that he had provided his patients with actual medical care; this is not a "pill-mill" situation. Despite any shortcomings in his treatment of these patients, it is evident that Dr. Demint cares about his patients' well-being and he did not place his own needs, i.e. financial needs, ahead of the needs of his patients.

3. The evidence is insufficient to support a finding that Dr. Demint practiced below the minimal standard of care by failing to obtain toxicology screens prior to prescribing narcotics to Patients 2, 5, 9, and 11 through 14.

On remand, Dr. Demint asserted that there is no standard of care that requires a physician to obtain an initial drug test prior to initiating opioid therapy, and noted that the Board's intractable pain rules do not include such a requirement. Specifically, Ohio Administrative Code Rule ("Rule") 4731-21-02(B)(3) states, in pertinent part:

> 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.

(Rule 4731-21-02[B][3]) (Emphasis added)

Based upon the language of Rule 4731-21-02(B)(3), the Hearing Examiner finds Dr. Demint's opinion to be persuasive. Accordingly, the evidence is insufficient to support this finding.

4. The evidence is insufficient to support a finding that Dr. Demint practiced below the minimal standard of care by failing to obtain a toxicology screen on Patient 1 prior to prescribing narcotic medication. Dr. Demint's medical record for Patient 1 establishes that he did obtain an in-house urine screen on Patient 1 at her initial visit.

5. The evidence is insufficient to support a finding that Dr. Demint practiced below the minimal standard of care by failing to appropriately evaluate, or document the appropriate evaluation of Patient 2's situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment. The evidence establishes that Dr. Demint appropriately referred Patient 2 to a psychiatrist in October 2010, although the patient did not follow through for lack of insurance coverage.

CONCLUSIONS OF LAW

1. The acts, conduct, and/or omissions of Franklin Donald Demint, D.O., as described in Findings of Fact 2, 2.a through 2.e, and 2.g through 2.i, 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 R.C. 4731.22(B)(2).

2. Dr. Demint's acts, conduct, and/or omissions as described in Findings of Fact 2, 2.a through 2.e, and 2.g through 2.i, 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 R.C. 4731.22(B)(6).

3. Dr. Demint's acts, conduct, and/or omissions as described in Findings of Fact 1, 2, 2.a through 2.e, and 2.g through 2.i, above, individually and/or collectively, constitute a "[v]iolation of the conditions of limitation placed by the board upon a certificate to practice," as that clause is used in R.C. 4731.22(B)(15), Ohio Revised Code. This is based solely on the violations of the Medical Practice Act set forth herein in Conclusions of Law 1, 2, and 4.

4. Dr. Demint's acts, conduct, and/or omissions as described in Findings of Fact 2, 2.a through 2.e, and 2.g through 2.i, 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 R.C. 4731.22(B)(20), to wit: Rule 4731-21-02, Utilizing Prescription Drugs for the Treatment of Intractable Pain. Furthermore, pursuant to Rule 4731-21-05, violation of Rule 4731-21-02 also constitutes violation of R.C. 4731.22(B)(2) and 4731.22(B)(6).

RATIONALE FOR THE PROPOSED ORDER ON REMAND

This matter concerns Dr. Demint's care and treatment of pain management patients. According to Dr. Demint, he is no longer practicing pain management. However, the evidence in this matter concerns problems with Dr. Demint's practice of medicine that could carry over into other fields of medicine. Additional evidence presented by Dr. Demint on remand was largely unpersuasive except with regard to the issue set forth in paragraph 2(f) of the Notice; however, even with that issue removed from consideration, the Hearing Examiner finds that the Board's original Order of April 10, 2013, is appropriate.

Accordingly, the Proposed Order on Remand would suspend Dr. Demint's medical license for a minimum of 180 days following a 30-day period to wind down his practice. Prior to reinstatement, Dr. Demint must complete a medical records course as well as the Annual ACOFP Intensive Update and Board Review in Osteopathic Medicine. Following reinstatement,

Dr. Demint's practice would be subject to a practice plan in addition to other appropriate probationary conditions.

In addition, the Proposed Order on Remand supersedes and replaces Dr. Demint's March 2010 Step II Consent Agreement.[55] During a February 12, 2013, teleconference with the Hearing Examiner and counsel for the parties, Dr. Demint, through counsel, agreed to waive objection to the inclusion of impairment-related requirements in the Proposed Order.[56] Accordingly, the Proposed Order carries forward the impairment-related monitoring requirements from Dr. Demint's March 2010 Step II Consent Agreement.

PROPOSED ORDER ON REMAND

It is hereby ORDERED that:

A. **SUSPENSION OF CERTIFICATE**: Commencing on the thirty-first day following the date on which this Order becomes effective, the certificate of Franklin Donald Demint, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than 180 days. During the thirty-day interim, Dr. Demint shall not undertake the care of any patient not already under his care.

B. **INTERIM MONITORING**: During the period that Dr. Demint's certificate to practice osteopathic medicine and surgery in Ohio is suspended, Dr. Demint shall comply with the following terms, conditions, and limitations:

1. **Obey the Law**: Dr. Demint shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

2. **Declarations of Compliance**: Dr. Demint shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the date his quarterly declaration would have been due pursuant to his March 2010 Step II Consent Agreement. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Demint shall appear in person for interviews before the Board or its designated representative. The first such appearance shall take place on

[55] It is unnecessary to supersede the Board's April 2013 Order because that Order was vacated by the court.
[56] In *In re Eastway* (1994), 95 Ohio App.3d 516, 642 N.E.2d 1135, cert. denied, the Franklin County Court of Appeals held that the Board could not require psychiatric treatment as a condition of probation when it had not charged a physician with being mentally impaired. In such a situation, a Board order that includes such sanctions is not supported by reliable, probative, and substantial evidence and is not in accordance with the law. See also *Lawrence S. Krain, M.D. v. State Medical Board of Ohio* (Oct. 29, 1998), Franklin App. No. 97APE08-981, unreported. However, a respondent may waive his or her objection to a Board order that includes such sanctions.

or before the date his appearance would have been scheduled pursuant to his March 2010 Step II Consent Agreement. Subsequent personal appearances shall occur every three months thereafter, and/or as otherwise directed by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

4. **Absences from Ohio:** Dr. Demint shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have the discretion to grant a waiver of part or all of the probationary terms set forth in this Order for occasional periods of absence of fourteen days or less.

   In the event that Dr. Demint resides and/or is employed at a location that is within fifty miles of the geographic border of Ohio and any of its contiguous states, Dr. Demint may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Demint is able to otherwise maintain full compliance with all other terms, conditions and limitations set forth in this Order.

5. **Ban on Administering, Furnishing, or Possessing Controlled Substance; Log**: Dr. Demint shall not, without prior Board approval, administer, personally furnish, or possess (except as allowed under Paragraph B.6.a) any controlled substances as defined by state or federal law.

   In the event that the Board agrees at a future date to modify this Order to allow Dr. Demint to administer or personally furnish controlled substances, Dr. Demint shall keep a log of all controlled substances prescribed, administered or personally furnished. Such log shall be submitted in the format approved by the Board and shall be submitted to the Board no later than the date upon which Dr. Demint's declarations of compliance quarterly declaration is due, or as otherwise directed by the Board. Further, Dr. Demint shall make his patient records with regard to such prescribing, administering, or personally furnishing available for review by an agent of the Board immediately upon request.

6. **Sobriety**

   a. **Abstention from Drugs**: Dr. Demint shall abstain completely from the personal use or personal possession of drugs, except those prescribed, dispensed or administered to him by another so authorized by law who has full knowledge of Dr. Demint's history of chemical dependency. Further, in the event that Dr. Demint is so prescribed, dispensed or administered any controlled substance, carisoprodol, or tramadol, Dr. Demint shall notify the Board in writing within

seven days, providing the Board with the identity of the prescriber; the name of the drug Dr. Demint received; the medical purpose for which he received said drug; the date such drug was initially received; and the dosage, amount, number of refills, and directions for use. Further, within thirty days of the date said drug is so prescribed, dispensed, or administered to him, Dr. Demint shall provide the Board with either a copy of the written prescription or other written verification from the prescriber, including the dosage, amount, number of refills, and directions for use.

b. **Abstention from Alcohol**: Dr. Demint shall abstain completely from the use of alcohol.

7. **Drug and Alcohol Screens/Drug Testing Facility and Collection Site**: Dr. Demint shall submit to random urine screenings for drugs and alcohol at least two times per month, or as otherwise directed by the Board. Dr. Demint shall ensure that all screening reports are forwarded directly to the Board on a quarterly basis. The drug testing panel utilized must be acceptable to the Secretary of the Board, and shall include Dr. Demint's drug(s) of choice.

Dr. Demint shall abstain from the use of any substance and the consumption of poppy seeds or any other food or liquid that may produce a low level positive result in a toxicology screen. Dr. Demint shall be held to an understanding and knowledge that the consumption or use of such substances, including but not limited to substances such as mouthwash or hand cleaning gel, may cause a positive drug screen that may not be able to be differentiated from intentional ingestion, and therefore such consumption or use is prohibited under this Order.

All such urine screenings for drugs and alcohol shall be conducted through a Board-approved drug testing facility and collection site pursuant to the global contract between said facility and the Board, that provides for the Board to maintain ultimate control over the urine screening process and to preserve the confidentiality of all positive screening results in accordance with Section 4731.22(F)(5), Ohio Revised Code, and the screening process shall require a daily call-in procedure. Further, in the event that the Board exercises its discretion, as provided in Paragraph B.8 below, to approve urine screenings to be conducted at an alternative drug testing facility and/or collection site or a supervising physician, such approval shall be expressly contingent upon the Board retaining ultimate control over the urine screening process in a manner that preserves the aforementioned confidentiality of all positive screening results.

Dr. Demint shall submit, at his expense and on the day selected, urine specimens for drug and/or alcohol analysis. All specimens submitted by Dr. Demint shall be negative, except for those substances prescribed, administered, or dispensed to him in conformance with the terms, conditions and limitations set forth in this Order. Refusal to submit such specimen, or failure to submit such specimen on the day he is

selected or in such manner as the Board may request, shall constitute a violation of this Order.

Further, within thirty days of the effective date of this Order, Dr. Demint shall enter into the necessary financial and/or contractual arrangements with the Board-approved drug testing facility and/or collection site in order to facilitate the urine screening process in the manner required by this Order. Further, Dr. Demint shall promptly provide to the Board written documentation of completion of such arrangements, including a copy of any contract entered into between Dr. Demint and the Board-approved drug testing facility and/or collection site. Dr. Demint's failure to timely complete such arrangements, or failure to timely provide written documentation to the Board of completion of such arrangements, shall constitute a violation of this Order.

Dr. Demint shall ensure that the urine screening process performed through the Board-approved drug testing facility and/or collection site requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Demint and the Board-approved drug testing facility and collection site shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

Dr. Demint shall ensure that the Board-approved drug testing facility and/or collection site provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Order, and whether all urine screens have been negative.

In the event that the Board-approved drug testing facility and/or collection site becomes unable or unwilling to serve as required by this Order, Dr. Demint must immediately notify the Board in writing, and make arrangements acceptable to the Board pursuant to Paragraph B.8 below, as soon as practicable. Dr. Demint shall further ensure that the Board-approved drug testing facility and/or collection site also notifies the Board directly of its inability to continue to serve and the reasons therefore.

The Board expressly reserves the right to withdraw its approval of any drug testing facility and/or collection site in the event that the Secretary and Supervising Member of the Board determine that the drug testing facility and/or collection site has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

8. **Alternative Drug-testing Facility and/or Collection Site**: It is the intent of this Order that Dr. Demint shall submit his urine specimens to the Board-approved drug testing facility and collection site chosen by the Board. However, in the event that utilizing said Board-approved drug testing facility and/or collection site creates an extraordinary hardship upon Dr. Demint, as determined in the sole discretion of the Board, then subject to the following requirements, the Board may approve an

alternate drug testing facility and/or collection site, or a supervising physician, to facilitate the urine screening process for Dr. Demint:

a. Within thirty days of the date upon which Dr. Demint is notified of the Board's determination that utilizing the Board-approved drug testing facility and/or collection site constitutes an extraordinary hardship upon Dr. Demint, he shall submit to the Board in writing for its prior approval the identity of either an alternate drug testing facility and collection site, or the name of a proposed supervising physician, to whom Dr. Demint shall submit the required urine specimens. In approving a facility, entity, or an individual to serve in this capacity, the Board will give preference to a facility located near Dr. Demint's residence or employment location, or to a physician who practices in the same locale as Dr. Demint. Dr. Demint shall ensure that the urine screening process performed through the alternate drug testing facility and/or collection site, or through the supervising physician, requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Demint acknowledges that the alternate drug testing facility and collection site, or the supervising physician, shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

b. Dr. Demint shall ensure that the alternate drug testing facility and/or collection site, or the supervising physician, provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Order, and whether all urine screens have been negative.

c. In the event that the designated alternate drug testing facility and/or collection site, or the supervising physician, becomes unable or unwilling to so serve, Dr. Demint must immediately notify the Board in writing. Dr. Demint shall further ensure that the previously designated alternate drug testing facility and collection site, or the supervising physician, also notifies the Board directly of the inability to continue to serve and the reasons therefore. Further, in order to ensure that there will be no interruption in his urine screening process, upon the previously approved alternate drug testing facility, collection site, or supervising physician becoming unable to serve, Dr. Demint shall immediately commence urine screening at the Board-approved drug testing facility and collection site chosen by the Board, until such time, if any, that the Board approves a subsequent alternate drug testing facility, collection site, or supervising physician, if requested by Dr. Demint.

d. The Board expressly reserves the right to disapprove any entity or facility proposed to serve as Dr. Demint's designated alternate drug testing facility and/or collection site, or any person proposed to serve as his supervising physician, or to withdraw approval of any entity, facility or person previously

approved to so serve in the event that the Secretary and Supervising Member of the Board determine that any such entity, facility or person has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

e. In the event that the Board approved an alternate drug testing facility and/or collection site, or a supervising physician, pursuant to the March 2010 Step II Consent Agreement between Dr. Demint and the Board, the entity, facility or person previously approved by the Board to so serve pursuant to the March 2010 Step II Consent Agreement may, in the sole discretion of the Board, be approved to continue as Dr. Demint's designated alternate drug testing facility and collection site or as his supervising physician under this Order.

9. **Reports Regarding Drug and Alcohol Screens**: All screening reports required under this Order from the Board-approved drug testing facility and/or collection site, or from the alternate drug testing facility and/or collection site or supervising physician, must be received in the Board's offices no later than the due date for Dr. Demint's quarterly declaration. It is Dr. Demint's responsibility to ensure that reports are timely submitted.

10. **Additional Screening Without Prior Notice**: Upon the Board's request and without prior notice, Dr. Demint shall provide a specimen of his blood, breath, saliva, urine, and/or hair for screening for drugs and alcohol, for analysis of therapeutic levels of medications that may be prescribed for Dr. Demint, or for any other purpose, at Dr. Demint's expense. Dr. Demint's refusal to submit a specimen upon the request of the Board shall result in a minimum of one year of actual license suspension. Further, the collection of such specimens shall be witnessed by a representative of the Board, or another person acceptable to the Secretary and Supervising Member of the Board.

11. **Rehabilitation Program**: Dr. Demint shall maintain participation in an alcohol and drug rehabilitation program, such as A.A., N.A., C.A., or Caduceus, no less than twice per week with a minimum of ten per month. At least one of the abovementioned meetings shall be a Caduceus meeting. Substitution of any other specific program must receive prior Board approval.

    Dr. Demint shall submit acceptable documentary evidence of continuing compliance with this program, including submission to the Board of meeting attendance logs, which must be received in the Board's offices no later than the due date for Dr. Demint's quarterly declarations.

12. **Comply with the Terms of Aftercare Contract**: Dr. Demint shall maintain continued compliance with the terms of the aftercare contract entered into with a Board-approved treatment provider, provided that, where terms of the aftercare contract conflict with terms of this Order, the terms of this Order shall control.

13. **Releases**: Dr. Demint shall provide authorization, through appropriate written consent forms, for disclosure of evaluative reports, summaries, and records, of whatever nature, by any and all parties that provide treatment or evaluation for Dr. Demint's chemical dependency or related conditions, or for purposes of complying with this Order, whether such treatment or evaluation occurred before or after the effective date of this Order. To the extent permitted by law, the above-mentioned evaluative reports, summaries, and records are considered medical records for purposes of Section 149.43 of the Ohio Revised Code and are confidential pursuant to statute. Dr. Demint shall also provide the Board written consent permitting any treatment provider from whom he obtains treatment to notify the Board in the event he fails to agree to or comply with any treatment contract or aftercare contract. Failure to provide such consent, or revocation of such consent, shall constitute a violation of this Order.

14. **Required Reporting of Change of Address**: Dr. Demint shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

C. **CONDITIONS FOR REINSTATEMENT OR RESTORATION**: The Board shall not consider reinstatement or restoration of Dr. Demint's certificate to practice medicine and surgery until all of the following conditions have been met:

1. **Application for Reinstatement or Restoration**: Dr. Demint shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.

2. **Compliance with Interim Conditions**: Dr. Demint shall have maintained compliance with all the terms and conditions set forth in Paragraph B of this Order.

3. **Controlled Substances Prescribing Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide acceptable documentation of successful completion of a course or courses dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

   In addition, at the time Dr. Demint submits the documentation of successful completion of the course(s) dealing with the prescribing of controlled substances, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

4. **Medical Records Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide

acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Demint submits the documentation of successful completion of the course(s) on maintaining adequate and appropriate medical records, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

5. **ACOFP Course**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide acceptable documentation of successful completion of the Annual ACOFP Intensive Update and Board Review in Osteopathic Medicine. This course shall be taken in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) during which it is completed.

   In addition, at the time Dr. Demint submits the documentation of successful completion of the ACOFP course, he shall also submit to the Board a written report describing the course, setting forth what he learned from the course, and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

6. **Additional Evidence of Fitness To Resume Practice**: In the event that Dr. Demint has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

D. **PROBATION**: Upon reinstatement or restoration, Dr. Demint's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:

1. **Terms, Conditions, and Limitations Continued from Suspension Period**: Dr. Demint shall continue to be subject to the terms, conditions, and limitations specified in Paragraph B of this Order.

2. **Practice Plan and Monitoring Physician**: Within 30 days of the effective date of Dr. Demint's reinstatement or restoration, or as otherwise determined by the Board, Dr. Demint shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan will be directly supervised and overseen by a monitoring physician approved by the Board. Dr. Demint shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

At the time Dr. Demint submits his practice plan, he shall also submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Demint and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Demint and his medical practice, and shall review Dr. Demint's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Demint and his medical practice, and on the review of Dr. Demint's patient charts. Dr. Demint shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Demint's declarations of compliance.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Demint shall immediately so notify the Board in writing. In addition, Dr. Demint shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Demint shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Demint's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Demint's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

E. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Demint's certificate will be fully restored.

F. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training, and the Chief of Staff

at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Demint shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments.

In the event that Dr. Demint provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.

These requirements shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Administration, through which he currently holds any professional license or certificate. Also, Dr. Demint shall provide a copy of this Order at the time of application to the proper licensing authority of any state or jurisdiction in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

3. **Required Reporting to Treatment Providers/Monitors**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to all persons and entities that provide chemical dependency/abuse treatment to or monitoring of Dr. Demint. This requirement shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

4. **Required Documentation of the Reporting Required by Paragraph F**: Dr. Demint shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (a) the return receipt of certified mail within 30 days of receiving that return receipt, (b) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (c) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (d) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

G. **VIOLATION OF THE TERMS OF THIS ORDER**: If Dr. Demint violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

H. **SUPERSEDE PREVIOUS CONSENT AGREEMENT**: Upon becoming effective, this Order shall supersede the terms and conditions set forth in the March 2010 Step II Consent Agreement between Dr. Demint and the Board.

EFFECTIVE DATE OF ORDER: This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

R. Gregory Porter
Hearing Examiner

State Medical Board of Ohio

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

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EXCERPT FROM THE DRAFT MINUTES OF NOVEMBER 5, 2014

REPORT AND RECOMMENDATION ON REMAND

FRANKLIN DONALD DEMINT, D.O.

Dr. Ramprasad announced that the Board would now consider the Report and Recommendations on Remand appearing on its agenda.

Dr. Ramprasad 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 matter of Franklin Donald Demint, D.O.

A roll call was taken:

ROLL CALL:	Dr. Bechtel	- aye
	Dr. Saferin	- aye
	Dr. Rothermel	- aye
	Dr. Steinbergh	- aye
	Mr. Kenney	- aye
	Dr. Ramprasad	- aye
	Dr. Soin	- aye
	Dr. Schachat	- aye
	Mr. Gonidakis	- aye
	Mr. Giacalone	- aye

Dr. Ramprasad 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 the matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Dr. Bechtel	- aye
	Dr. Saferin	- aye
	Dr. Rothermel	- aye
	Dr. Steinbergh	- aye
	Mr. Kenney	- aye
	Dr. Ramprasad	- aye
	Dr. Soin	- aye
	Dr. Schachat	- aye
	Mr. Gonidakis	- aye
	Mr. Giacalone	- aye

Dr. Ramprasad 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 any disciplinary matters. In this matter, Dr. Bechtel served as Secretary and Dr. Saferin served as Supervising Member.

Dr. Ramprasad directed the Board's attention to the matter of Franklin Donald Demint, D.O. Dr. Ramprasad stated that on April 18, 2013, the Medical Board entered an Order that suspended Dr. Demint's certificate for at least 180 days, set forth interim monitoring conditions and requirements for reinstatement, followed by probationary terms and conditions for at least three years. Dr. Demint appealed the Board's decision to the Franklin County Court of Common Pleas. On August 8, 2013, the Court reversed the Board's Order and remanded the case to the Board for a new hearing. The basis for the court's decision was that Dr. Demint should have been afforded additional time to obtain an expert witness prior to the hearing.

Dr. Ramprasad continued that an informal presentation of additional evidence took place on June 2, 2014, and the matter is now before the Board. Objections to Mr. Porter's Report and Recommendation on Remand have been filed by Dr. Demint and were previously distributed to Board members.

Dr. Steinbergh moved to approve and confirm the Proposed Findings of Fact, Conclusions of Law, and Order in the matter of Dr. Demint. Dr. Soin seconded the motion.

Dr. Ramprasad stated that he will now entertain discussion in the above matter.

Dr. Ramprasad stated that the matter of Dr. Demint was initially brought to the attention of the Board due to his treatment of 14 patients with pain medications. Patient 1, who came to the practice with a possible history of misusing pain medications, was diagnosed by Dr. Demint with fibromyalgia. However, Dr. Demint failed to document any evidence to support this diagnosis. Previously, the Board had indicated that Dr. Demint should have used pressure points to confirm the diagnosis. Dr. Ramprasad acknowledged that one month after Patient 1's initial visit, the American College of Rheumatology (ACR) changed its recommendations and no longer required pressure points for diagnosis of fibromyalgia. However, the ACR guidelines still indicate that there should be a widespread pain index of more than seven and a systemic severity scale of more than five; Dr. Demint did not follow these guidelines when diagnosing Patient 1 with fibromyalgia. Consequently, Dr. Ramprasad reiterated that Dr. Demint's diagnosis was not in accordance with ACR guidelines and pain medications were prescribed to Patient 1 earlier than necessary.

Dr. Ramprasad continued to Patient 2, who presented to Dr. Demint with back pain and thoracic pain. Patient 2 had stated that Neurontin upset her stomach, Lyrica caused her to swell, and she had no insurance. Dr. Ramprasad stated that Patient 2 was able to pay for her visits and Dr. Demint simply ignored the red flags indicating possible medication abuse.

Patient 3 suffered from anxiety and depression. Patient 3 indicated that the only medication that worked

for his pain was OxyContin. Dr. Ramprasad noted that this statement should have been seen as a red flag. An MRI showed no meniscus tear, but it did show degenerative joint disease for which morphine, oxycodone, fluoxetine, Xanax, and other medications were prescribed. Dr. Ramprasad stated although some patients have symptomology that is not consistent with imaging tests, there was no documented evidence of severe disease with Patient 3. A urine screen did not show hydrocodone, which had been prescribed, but did show benzodiazepines, which had not been prescribed. Although these results were confirmed by a subsequent urine screen, Dr. Demint considered these results to be false.

Patient 4 suffered from back ache and was prescribed morphine, oxycodone, OxyContin, and alprazolam. Another treating physician had discharged Patient 4, but Dr. Demint continued to treat him. An MRI was obtained and documented to be normal. Dr. Demint prescribed morphine equivalent doses (MED) for Patient 4 which varied from 140 to 220.

Patient 6 had a urine screen which was negative for oxycodone, which had been prescribed, and positive for alprazolam and lorazepam, which had not been prescribed. Dr. Ramprasad commented that Patient 7 had very similar findings.

Patient 9, who was on oxygen and had chronic obstructive pulmonary disease (COPD), was prescribed OxyContin and oxycodone by Dr. Demint. Dr. Ramprasad stated that, while was not a fatal mistake, physicians must be very careful when prescribing these medications because of possible respiratory depression.

Dr. Ramprasad further commented that for Patients 1 through 5 and 7 through 14, the amounts and types of narcotics prescribed were not supported by patient history, physical examination, or test results.

Dr. Ramprasad stated that many of these patients had significant red flags, which Dr. Demint basically ignored and prescribed higher-than-usual doses of medications. Dr. Ramprasad stated that he agrees with the Hearing Examiner's Findings of Fact. Dr. Ramprasad stated that Dr. Demint had inappropriately prescribed narcotics to Patients 1, 3, 4, 5, 7, 8, 11, and 13, and failed to obtain appropriate review of patient histories and medical records. Regarding Patients 3, 6, 8, 9, 11, 12, and 13, Dr. Ramprasad stated that Dr. Demint failed to appropriately act or properly document appropriate actions when presented with signs of drug abuse or diversion, including early refills and multiple abnormal toxicology results. Although Dr. Demint argued that he had done the right thing, Dr. Ramprasad agreed with the Hearing Examiner that there was no persuasive evidence on remand that was contrary to the Board's initial interpretation.

Dr. Ramprasad stated that Dr. Demint presented evidence on remand that selective serotonin reuptake inhibitors (SSRI) were not effective in treating pain. Dr. Ramprasad stated that this is not true and noted that the Medical Board, as a panel of experts, is qualified to determine whether that is true.

Dr. Ramprasad stated that it is very clear that Dr. Demint did not follow proper procedures, although he did not do this purposely for financial reasons. Dr. Ramprasad did not understand why Dr. Demint prescribed these medications even on initial visits in such high doses for conditions which did not require

them. Dr. Ramprasad noted that the diagnoses between patients did not vary, very minimal changes were seen on MRI, and almost the same medication combinations were used in high doses.

Dr. Ramprasad stated that Dr. Demint did take proper actions in some instances. Notably, Dr. Demint discharged Patient 8 after seeing white powder in his nose, discharged Patient 9 after he tested positive for Suboxone, and discharged Patient 10 when he refused a drug test. Dr. Demint also referred Patient 13 to an addictionologist after she tested positive for cocaine.

Dr. Ramprasad stated that he concurs with the Hearing Examiner's Proposed Order.

Dr. Soin noted irregularities with Dr. Demint's practice, most notably that it was a cash-pay practice, visits cost $200.00, and patients had a 99% chance of being prescribed controlled substances. Dr. Soin stated that, according to a Medicare profile of physicians, 74% of pain management physicians wrote at least one prescription for a scheduled substance that year. Dr. Soin therefore found it very concerning that Dr. Demint, who was not a pain management physician, prescribed scheduled substances for 99% of his patients.

Having reviewed the hearing record, Dr. Soin stated that he did not agree with certain aspects of the expert witness testimony. Dr. Soin agreed with Dr. Ramprasad that Dr. Demint did some things well, but still opined that Dr. Demint did not "get it" when it comes to pain medications. Dr. Soin noted that due to the passage of House Bill 93, Dr. Demint has decided to stop practicing pain management and drop the number of pain patients he sees to approximately 11. Dr. Soin opined that Dr. Demint could still offer good service to his patients, but not in the field of pain management.

Dr. Soin proposed an amendment to the Hearing Examiner's Proposed Order. Dr. Soin's proposed amendment would reduce the minimum length of Dr. Demint's license suspension from 180 days to 90 days. Dr. Soin commented that the main purpose of the Board is to prevent Dr. Demint from harming the public and opined that this can be accomplished with a shorter period of suspension. Dr. Soin's proposed amendment also added a permanent limitation/restriction, as follows:

1. Dr. Demint shall not prescribe, administer, dispense or otherwise provide any narcotic analgesics including but not limited to single entity or combination products containing oxycodone, hydrocodone, hydromorphone, oxymorphone or codeine.

2. This limitation shall not apply to buprenorphine-containing products or any other products that are approved to treat drug addiction, provided that they are prescribed, administered, dispensed or otherwise provided in accordance with FDA-approved labeling and other federal and state requirements.

Dr. Soin moved to amend the Proposed Order to read as follows:

It is hereby ORDERED that:

A. **SUSPENSION OF CERTIFICATE**: Commencing on the thirty-first day following the date on which this Order becomes effective, the certificate of Franklin Donald Demint, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than 90 days. During the thirty-day interim, Dr. Demint shall not undertake the care of any patient not already under his care.

B. **PERMANENT LIMITATION/RESTRICTION**: Upon reinstatement or restoration of Dr. Demint's certificate to practice osteopathic medicine and surgery in the State of Ohio, said certificate shall be permanently LIMITED and RESTRICTED as follows:

1. Dr. Demint shall not prescribe, administer, dispense or otherwise provide any narcotic analgesics including but not limited to single entity or combination products containing oxycodone, hydrocodone, hydromorphone, oxymorphone or codeine.

2. This limitation shall not apply to buprenorphine-containing products or any other products that are approved to treat drug addiction, provided that they are prescribed, administered, dispensed or otherwise provided in accordance with FDA-approved labeling and other federal and state requirements.

C. **INTERIM MONITORING**: During the period that Dr. Demint's certificate to practice osteopathic medicine and surgery in Ohio is suspended, Dr. Demint shall comply with the following terms, conditions, and limitations:

1. **Obey the Law**: Dr. Demint shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

2. **Declarations of Compliance**: Dr. Demint shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the date his quarterly declaration would have been due pursuant to his March 2010 Step II Consent Agreement. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Demint shall appear in person for interviews before the Board or its designated representative. The first such appearance shall take place on or before the date his appearance would have been scheduled pursuant to his March 2010 Step II Consent Agreement. Subsequent personal appearances shall occur every three months thereafter, and/or as otherwise directed by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

4. **Absences from Ohio:** Dr. Demint shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have the discretion to grant a waiver of part or all of the probationary terms set forth in this Order for occasional periods of absence of fourteen days or less.

   In the event that Dr. Demint resides and/or is employed at a location that is within fifty miles of the geographic border of Ohio and any of its contiguous states, Dr. Demint may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Demint is able to otherwise maintain full compliance with all other terms, conditions and limitations set forth in this Order.

5. **Ban on Administering, Furnishing, or Possessing Controlled Substance; Log**: Dr. Demint shall not, without prior Board approval, administer, personally furnish, or possess (except as allowed under Paragraph C.6.a) any controlled substances as defined by state or federal law.

   In the event that the Board agrees at a future date to modify this Order to allow Dr. Demint to administer or personally furnish controlled substances, Dr. Demint shall keep a log of all controlled substances prescribed, administered or personally furnished. Such log shall be submitted in the format approved by the Board and shall be submitted to the Board no later than the date upon which Dr. Demint's declarations of compliance quarterly declaration is due, or as otherwise directed by the Board. Further, Dr. Demint shall make his patient records with regard to such prescribing, administering, or personally furnishing available for review by an agent of the Board immediately upon request.

6. **Sobriety**

   a. **Abstention from Drugs**: Dr. Demint shall abstain completely from the personal use or personal possession of drugs, except those prescribed, dispensed or administered to him by another so authorized by law who has full knowledge of Dr. Demint's history of chemical dependency. Further, in the event that Dr. Demint is so prescribed, dispensed or administered any controlled substance, carisoprodol, or tramadol, Dr. Demint shall notify the Board in writing within seven days, providing the Board with the identity of

the prescriber; the name of the drug Dr. Demint received; the medical purpose for which he received said drug; the date such drug was initially received; and the dosage, amount, number of refills, and directions for use. Further, within thirty days of the date said drug is so prescribed, dispensed, or administered to him, Dr. Demint shall provide the Board with either a copy of the written prescription or other written verification from the prescriber, including the dosage, amount, number of refills, and directions for use.

b. **Abstention from Alcohol**: Dr. Demint shall abstain completely from the use of alcohol.

7. **Drug and Alcohol Screens/Drug Testing Facility and Collection Site**: Dr. Demint shall submit to random urine screenings for drugs and alcohol at least two times per month, or as otherwise directed by the Board. Dr. Demint shall ensure that all screening reports are forwarded directly to the Board on a quarterly basis. The drug testing panel utilized must be acceptable to the Secretary of the Board, and shall include Dr. Demint's drug(s) of choice.

Dr. Demint shall abstain from the use of any substance and the consumption of poppy seeds or any other food or liquid that may produce a low level positive result in a toxicology screen. Dr. Demint shall be held to an understanding and knowledge that the consumption or use of such substances, including but not limited to substances such as mouthwash or hand cleaning gel, may cause a positive drug screen that may not be able to be differentiated from intentional ingestion, and therefore such consumption or use is prohibited under this Order.

All such urine screenings for drugs and alcohol shall be conducted through a Board-approved drug testing facility and collection site pursuant to the global contract between said facility and the Board, that provides for the Board to maintain ultimate control over the urine screening process and to preserve the confidentiality of all positive screening results in accordance with Section 4731.22(F)(5), Ohio Revised Code, and the screening process shall require a daily call-in procedure. Further, in the event that the Board exercises its discretion, as provided in Paragraph C.8 below, to approve urine screenings to be conducted at an alternative drug testing facility and/or collection site or a supervising physician, such approval shall be expressly contingent upon the Board retaining ultimate control over the urine screening process in a manner that preserves the aforementioned confidentiality of all positive screening results.

Dr. Demint shall submit, at his expense and on the day selected, urine specimens for drug and/or alcohol analysis. All specimens submitted by Dr. Demint shall be negative, except for those substances prescribed, administered, or dispensed to him in conformance with the terms, conditions and limitations set forth in this Order. Refusal

to submit such specimen, or failure to submit such specimen on the day he is selected or in such manner as the Board may request, shall constitute a violation of this Order.

Further, within thirty days of the effective date of this Order, Dr. Demint shall enter into the necessary financial and/or contractual arrangements with the Board-approved drug testing facility and/or collection site in order to facilitate the urine screening process in the manner required by this Order. Further, Dr. Demint shall promptly provide to the Board written documentation of completion of such arrangements, including a copy of any contract entered into between Dr. Demint and the Board-approved drug testing facility and/or collection site. Dr. Demint's failure to timely complete such arrangements, or failure to timely provide written documentation to the Board of completion of such arrangements, shall constitute a violation of this Order.

Dr. Demint shall ensure that the urine screening process performed through the Board-approved drug testing facility and/or collection site requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Demint and the Board-approved drug testing facility and collection site shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

Dr. Demint shall ensure that the Board-approved drug testing facility and/or collection site provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Order, and whether all urine screens have been negative.

In the event that the Board-approved drug testing facility and/or collection site becomes unable or unwilling to serve as required by this Order, Dr. Demint must immediately notify the Board in writing, and make arrangements acceptable to the Board pursuant to Paragraph C.8 below, as soon as practicable. Dr. Demint shall further ensure that the Board-approved drug testing facility and/or collection site also notifies the Board directly of its inability to continue to serve and the reasons therefore.

The Board expressly reserves the right to withdraw its approval of any drug testing facility and/or collection site in the event that the Secretary and Supervising Member of the Board determine that the drug testing facility and/or collection site has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

8. **Alternative Drug-testing Facility and/or Collection Site**: It is the intent of this Order that Dr. Demint shall submit his urine specimens to the Board-approved drug testing

facility and collection site chosen by the Board. However, in the event that utilizing said Board-approved drug testing facility and/or collection site creates an extraordinary hardship upon Dr. Demint, as determined in the sole discretion of the Board, then subject to the following requirements, the Board may approve an alternate drug testing facility and/or collection site, or a supervising physician, to facilitate the urine screening process for Dr. Demint:

a. Within thirty days of the date upon which Dr. Demint is notified of the Board's determination that utilizing the Board-approved drug testing facility and/or collection site constitutes an extraordinary hardship upon Dr. Demint, he shall submit to the Board in writing for its prior approval the identity of either an alternate drug testing facility and collection site, or the name of a proposed supervising physician, to whom Dr. Demint shall submit the required urine specimens. In approving a facility, entity, or an individual to serve in this capacity, the Board will give preference to a facility located near Dr. Demint's residence or employment location, or to a physician who practices in the same locale as Dr. Demint. Dr. Demint shall ensure that the urine screening process performed through the alternate drug testing facility and/or collection site, or through the supervising physician, requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Demint acknowledges that the alternate drug testing facility and collection site, or the supervising physician, shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

b. Dr. Demint shall ensure that the alternate drug testing facility and/or collection site, or the supervising physician, provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Order, and whether all urine screens have been negative.

c. In the event that the designated alternate drug testing facility and/or collection site, or the supervising physician, becomes unable or unwilling to so serve, Dr. Demint must immediately notify the Board in writing. Dr. Demint shall further ensure that the previously designated alternate drug testing facility and collection site, or the supervising physician, also notifies the Board directly of the inability to continue to serve and the reasons therefore. Further, in order to ensure that there will be no interruption in his urine screening process, upon the previously approved alternate drug testing facility, collection site, or supervising physician becoming unable to serve, Dr. Demint shall immediately commence urine screening at the Board-approved drug testing

facility and collection site chosen by the Board, until such time, if any, that the Board approves a subsequent alternate drug testing facility, collection site, or supervising physician, if requested by Dr. Demint.

d. The Board expressly reserves the right to disapprove any entity or facility proposed to serve as Dr. Demint's designated alternate drug testing facility and/or collection site, or any person proposed to serve as his supervising physician, or to withdraw approval of any entity, facility or person previously approved to so serve in the event that the Secretary and Supervising Member of the Board determine that any such entity, facility or person has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

e. In the event that the Board approved an alternate drug testing facility and/or collection site, or a supervising physician, pursuant to the March 2010 Step II Consent Agreement between Dr. Demint and the Board, the entity, facility or person previously approved by the Board to so serve pursuant to the March 2010 Step II Consent Agreement may, in the sole discretion of the Board, be approved to continue as Dr. Demint's designated alternate drug testing facility and collection site or as his supervising physician under this Order.

9. **Reports Regarding Drug and Alcohol Screens**: All screening reports required under this Order from the Board-approved drug testing facility and/or collection site, or from the alternate drug testing facility and/or collection site or supervising physician, must be received in the Board's offices no later than the due date for Dr. Demint's quarterly declaration. It is Dr. Demint's responsibility to ensure that reports are timely submitted.

10. **Additional Screening Without Prior Notice**: Upon the Board's request and without prior notice, Dr. Demint shall provide a specimen of his blood, breath, saliva, urine, and/or hair for screening for drugs and alcohol, for analysis of therapeutic levels of medications that may be prescribed for Dr. Demint, or for any other purpose, at Dr. Demint's expense. Dr. Demint's refusal to submit a specimen upon the request of the Board shall result in a minimum of one year of actual license suspension. Further, the collection of such specimens shall be witnessed by a representative of the Board, or another person acceptable to the Secretary and Supervising Member of the Board.

11. **Rehabilitation Program**: Dr. Demint shall maintain participation in an alcohol and drug rehabilitation program, such as A.A., N.A., C.A., or Caduceus, no less than twice per week with a minimum of ten per month. At least one of the abovementioned

meetings shall be a Caduceus meeting. Substitution of any other specific program must receive prior Board approval.

Dr. Demint shall submit acceptable documentary evidence of continuing compliance with this program, including submission to the Board of meeting attendance logs, which must be received in the Board's offices no later than the due date for Dr. Demint's quarterly declarations.

12. **Comply with the Terms of Aftercare Contract**: Dr. Demint shall maintain continued compliance with the terms of the aftercare contract entered into with a Board-approved treatment provider, provided that, where terms of the aftercare contract conflict with terms of this Order, the terms of this Order shall control.

13. **Releases**: Dr. Demint shall provide authorization, through appropriate written consent forms, for disclosure of evaluative reports, summaries, and records, of whatever nature, by any and all parties that provide treatment or evaluation for Dr. Demint's chemical dependency or related conditions, or for purposes of complying with this Order, whether such treatment or evaluation occurred before or after the effective date of this Order. To the extent permitted by law, the above-mentioned evaluative reports, summaries, and records are considered medical records for purposes of Section 149.43 of the Ohio Revised Code and are confidential pursuant to statute. Dr. Demint shall also provide the Board written consent permitting any treatment provider from whom he obtains treatment to notify the Board in the event he fails to agree to or comply with any treatment contract or aftercare contract. Failure to provide such consent, or revocation of such consent, shall constitute a violation of this Order.

14. **Required Reporting of Change of Address**: Dr. Demint shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

D. **CONDITIONS FOR REINSTATEMENT OR RESTORATION**: The Board shall not consider reinstatement or restoration of Dr. Demint's certificate to practice medicine and surgery until all of the following conditions have been met:

1. **Application for Reinstatement or Restoration**: Dr. Demint shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.

2. **Compliance with Interim Conditions**: Dr. Demint shall have maintained compliance with all the terms and conditions set forth in Paragraph C of this Order.

3. **Controlled Substances Prescribing Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint

shall provide acceptable documentation of successful completion of a course or courses dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Demint submits the documentation of successful completion of the course(s) dealing with the prescribing of controlled substances, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

4. **Medical Records Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

   In addition, at the time Dr. Demint submits the documentation of successful completion of the course(s) on maintaining adequate and appropriate medical records, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

5. **ACOFP Course**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide acceptable documentation of successful completion of the Annual ACOFP Intensive Update and Board Review in Osteopathic Medicine. This course shall be taken in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) during which it is completed.

   In addition, at the time Dr. Demint submits the documentation of successful completion of the ACOFP course, he shall also submit to the Board a written report describing the course, setting forth what he learned from the course, and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

6. **Additional Evidence of Fitness To Resume Practice**: In the event that Dr. Demint has not been engaged in the active practice of medicine and surgery for a period in excess

of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

E. **PROBATION**: Upon reinstatement or restoration, Dr. Demint's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:

1. **Terms, Conditions, and Limitations Continued from Suspension Period**: Dr. Demint shall be subject to the terms, conditions, and limitations specified in Paragraphs B and C of this Order.

2. **Practice Plan and Monitoring Physician**: Within 30 days of the effective date of Dr. Demint's reinstatement or restoration, or as otherwise determined by the Board, Dr. Demint shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan will be directly supervised and overseen by a monitoring physician approved by the Board. Dr. Demint shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

   At the time Dr. Demint submits his practice plan, he shall also submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Demint and who is engaged in the same or similar practice specialty.

   The monitoring physician shall monitor Dr. Demint and his medical practice, and shall review Dr. Demint's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

   Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Demint and his medical practice, and on the review of Dr. Demint's patient charts. Dr. Demint shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Demint's declarations of compliance.

   In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Demint shall immediately so notify the Board in writing. In addition, Dr. Demint shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Demint shall further ensure that the previously designated monitoring

physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Demint's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Demint's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

F. **TERMINATION OF PROBATION; PERMANENT LIMITATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Demint's certificate will be restored, but shall thereafter be permanently LIMITED and RESTRICTED as specified in Paragraph B, above.

G. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training, and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Demint shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments.

   In the event that Dr. Demint provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.

   These requirements shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug

Enforcement Administration, through which he currently holds any professional license or certificate. Also, Dr. Demint shall provide a copy of this Order at the time of application to the proper licensing authority of any state or jurisdiction in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

3. **Required Reporting to Treatment Providers/Monitors**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to all persons and entities that provide chemical dependency/abuse treatment to or monitoring of Dr. Demint. This requirement shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

4. **Required Documentation of the Reporting Required by Paragraph G**: Dr. Demint shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (a) the return receipt of certified mail within 30 days of receiving that return receipt, (b) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (c) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (d) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

H. **VIOLATION OF THE TERMS OF THIS ORDER**: If Dr. Demint violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

I. **SUPERSEDE PREVIOUS CONSENT AGREEMENT**: Upon becoming effective, this Order shall supersede the terms and conditions set forth in the March 2010 Step II Consent Agreement between Dr. Demint and the Board.

EFFECTIVE DATE OF ORDER: This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

Mr. Giacalone seconded the motion.

Dr. Ramprasad stated that he will now entertain discussion of the proposed amendment.

Mr. Giacalone stated that there are many questions regarding Dr. Demint. Mr. Giacalone stated that a typical "pill mill" pattern would be to prescribe the same regiment for every patient, whereas Dr. Demint's

prescriptions varied between patients. However, Mr. Giacalone stated that it was very apparent that Dr. Demint overprescribed and that his prescription habits do not necessarily fit within proper parameters. Mr. Giacalone further stated that Dr. Demint failed to recognize red flags that are indicative of abuse or diversion, including urine screens that are negative for prescribed medications and positive for medications that have not been prescribed. Mr. Giacalone stated that all of this raises questions about Dr. Demint's competency in relation to prescribing controlled substances.

Mr. Giacalone opined that, based on the arrogance of Dr. Demint's testimony and the forthrightness of his convictions, it is possible that following a suspension he will return to his previous prescribing habits. Mr. Giacalone approved of Dr. Demint's current practice of prescribing Suboxone as an addiction management physician, but wanted to ensure that he does not return to pain management because he has proven incapable or unwilling to prescribe narcotic analgesics appropriately. Mr. Giacalone supported Dr. Soin's proposed amendment because it permanently prohibits Dr. Demint from prescribing narcotic analgesics. Mr. Giacalone stated that Dr. Demint may still provide value to society by treating addiction with Suboxone, and may also prescribe other medications such as antibiotics. Mr. Giacalone also agreed with Dr. Soin regarding reducing the minimum time of suspension from 180 days to 90 days.

Dr. Steinbergh noted that the proposed amendment will still impose conditions for reinstatement of Dr. Demint's medical license, including the requirement that he take a course in prescribing controlled substances. Dr. Steinbergh agreed with this requirement because, even with the permanent limitation/ restriction proposed by Dr. Soin, Dr. Demint will still be prescribing some controlled substances. Dr. Demint will also be required to take a medical record-keeping course. Dr. Steinbergh further commented that the required Intensive Update and Board Review course, administered by the American College of Osteopathic Family Physicians (ACOFP), will give Dr. Demint an opportunity to update himself on family medicine. Upon reinstatement, Dr. Demint will be required to have a practice plan with a monitoring physician. Dr. Steinbergh opined that this proposal provides the necessary patient protection measures.

A vote was taken on Dr. Soin's motion to amend:

ROLL CALL:	Dr. Bechtel	- abstain
	Dr. Saferin	- abstain
	Dr. Rothermel	- aye
	Dr. Steinbergh	- aye
	Mr. Kenney	- aye
	Dr. Ramprasad	- aye
	Dr. Soin	- aye
	Dr. Schachat	- aye
	Mr. Gonidakis	- aye
	Mr. Giacalone	- aye

The motion to amend carried.

Dr. Steinbergh moved to approve and confirm the Proposed Findings of Fact, Conclusions of Law, and Order, as amended, in the matter of Dr. Demint. Dr. Soin seconded the motion. A vote was taken:

ROLL CALL:	Dr. Bechtel	- abstain
	Dr. Saferin	- abstain
	Dr. Rothermel	- aye
	Dr. Steinbergh	- aye
	Mr. Kenney	- aye
	Dr. Ramprasad	- aye
	Dr. Soin	- aye
	Dr. Schachat	- aye
	Mr. Gonidakis	- aye
	Mr. Giacalone	- aye

The motion to approve carried.

IN THE COURT OF COMMON PLEAS OF FRANKLIN COUNTY, OHIO
CIVIL DIVISION

Franklin D. Demint, D.O.,	:	
Appellant,	:	**Case No. 13CVF-4850**
vs.	:	**JUDGE SERROTT**
State Medical Board of Ohio,	:	
Appellee.	:	

OPINION AND FINAL JUDGMENT ENTRY

Rendered this 8th day of August, 2013

SERROTT, J.

I. PRELIMINARY STATEMENT

This matter is before the Court upon Appellant's timely administrative appeal of Appellee State Medical Board of Ohio's (the "Board") six month to an indefinite suspension of his license to practice medicine. Appellant's first assignment of error is dispositive of the case and renders the additional assignments of error moot. The Court finds that the first assignment of error should be sustained. The Court finds that the hearing officer abused his discretion in failing to continue the hearing at Appellant's request. Therefore, it is Ordered, Adjudged, and Decreed that this case is REVERSED and REMANDED to the Board for a new hearing. The reasons for the reversal are more fully set forth herein.

II. FACTS AND ANALYSIS

The Board charged Appellant on March 14, 2012, and he received notice of the charges on March 16, 2012. The Board charged Appellant with numerous counts relating to 14 patients, including but not limited to failing to conform to minimal

standards of care, a departure from minimum standards of care applicable to the administration of drugs, and failing to comply with rules regarding using prescription drugs to treat intractable pain. The nature of the allegations mandated the use of an expert witness on behalf of the Board and most certainly any real defense of the charges would call for an expert to testify on behalf of Appellant.

The Appellant timely requested a hearing, and a hearing date was set for September 4, 2012. Appellant hired counsel Elizabeth Collins, who entered her appearance on May 3, 2012. A hearing officer issued a pre-trial order. The order and O.A.C. 4731-12-18 require the timely exchange of witness lists, documents, and expert witness reports. The failure to timely identify an expert witness and to exchange expert reports can lead to exclusion of the expert testimony.

On August 3, 2012, Appellant's counsel filed a "Notice of Withdrawal" of counsel with no explanation nor a request for permission to withdraw. Appellant was left without counsel less than 32 days before the hearing. The hearing officer could have refused counsel's request to withdraw. Appellant's prior counsel did not name any expert witnesses nor did she exchange any reports within the deadlines. Nothing is contained in the record which would establish Appellant was at fault, or responsible, for the withdrawal of his counsel. Thus, 32 days prior to the hearing, Appellant was without counsel and had no expert witness he could present because of non-compliance with the pre-trial order governing exchange of reports and witness lists.

Appellant hired new counsel who appeared as counsel of record on August 16, 2012, requesting a continuance on that same date. The basis for the request for a continuance was to allow "new counsel to prepare which includes identifying and [sic] expert witness which former counsel failed to do." The State opposed the Motion, and

the hearing officer denied the request in an order dated August 24, 2012. In the denial order, the hearing officer set forth the parties positions regarding the continuance request:

> **[Dr. Demint argues that] (1) through no fault of Dr. Demint; his prior counsel withdrew approximately one month prior to commencement of the hearing; (2) prior counsel had been unable to secure an expert witness to testify on Dr. Demint's behalf, and he and new counsel required additional time to complete that task; and (3) new counsel required additional time to gather evidence for defense and mitigation. Dr. Demint further argued that his right to due process will be violated if he does not obtain a continuance.**
>
> **In its memorandum opposing Dr. Demint's motion, the State argued among other things: (1) Dr. Demint had been afforded ample time to secure an expert witness and prepare a defense; (2) the State's expert witness had adjusted her calendar to appear at the hearing as scheduled; (3) a schedule had been established for the prehearing exchange of witness lists and documents, and, pursuant to Board rule, the failure of a party to identify a witness in compliance with the terms of an exchange order shall result in the exclusion of that witness' testimony at hearing; and (4) the requested delay in the hearing process would cause a risk of potential harm to the public. The State further argued that Dr. Demint's right to due process will not be violated if his motion for continuance is denied.**

In denying the continuance, the hearing officer expressed:

> **The hearing examiner finds that Dr. Demint has been given sufficient time to identify his expert witness and provide a report. The extended deadline to comply with that order**

> **was August 9, 2012; however, no expert witness was identified and no expert report was provided. In the absence of extraordinary circumstances, the failure of a party to identify an expert witness and provide an expert witness report "shall result in the exclusion of the witness' expert testimony at hearing." Ohio Adm. Code 4731-13-18(D)(3). <u>Dr. Demint has failed to demonstrate that extraordinary circumstances exist that would justify delaying the hearing to allow Dr. Demint to continue to seek an expert witness.</u> In addition, the allegations in this matter concern medical practice issues; therefore, potential risk to the public from delay is relevant to this determination.**
>
> **Accordingly, Dr. Demint's motion to continue the hearing is denied, and the hearing shall proceed as previously scheduled.**

The hearing officer apparently denied the request for a continuance based upon faulty circular reasoning and the erroneous legal conclusion that Appellant had to establish "extraordinary circumstances" for the continuance. In other words, the hearing officer denied a continuance and then ruled that because experts had not been timely named, Appellant could not call an expert witness.

Had the hearing officer granted a short 60 day continuance, new deadlines could have been established for exchange of reports and witness lists. A short continuance would not have prejudiced the Board. No prior continuances of the hearing had been granted. Moreover, had the Board requested a continuance because of an expert witness issue, it would have likely been granted[1]. The Board would have been supplied the names of experts and reports in advance of the new hearing date. A short continuance would have protected the Board's right to fair notice and due process in preparing to

[1] This Court has reviewed a number of administrative appeals including Medical Board appeals and has never seen a request for a continuance for the agency or board denied by a hearing officer.

cross-examine any such experts and protected Appellant's constitutional due process rights to present a vigorous defense of his professional license. Moreover, if Appellant had failed to comply with the new order a denial of a second continuance or exclusion of the expert's testimony would have been proper and not even an issue.

The Board's and the Attorney General's argument that the public would be unprotected during the 60 day continuance because Appellant would be allowed to continue to practice was without merit and disingenuous. The Board had the legal right to seek an emergency suspension prior to any hearing if the Board truly believed Appellant posed a danger to patients if he continued to practice. R.C. 4731.22(G) allows for a pre-hearing suspension if the Board believes the doctor's "continued practice presents a danger of immediate and serious harm to the public." The Board did not seek such an order. Finally, to this point, the hearing officer took five months to write the report, and Appellant practiced during this entire time.

The hearing officer also applied an incorrect legal standard in requesting Appellant to "demonstrate extraordinary circumstances exist that would justify delaying the hearing." The legal standard for granting a continuance is a balancing test and does not require a showing of "extraordinary circumstances." *Warren v. Warren*, 10th Dist. No. 10Ap-837, 2011-Ohio-3083, ¶¶8, 9. A more detailed review of the legal standard in the next section of this Order will further establish why the hearing officer abused his discretion in denying the continuance request.

III. <u>LEGAL STANDARD AND ANALYSIS</u>

A reviewing court should only reverse the denial of a continuance if the denial was an abuse of discretion. *Warren*, supra at ¶7. An abuse of discretion implies the denial of the continuance was "unreasonable, arbitrary, or unconscionable." Id.

Constitutional due process requirements are implicated in the suspension of a person's professional license. A fundamental requirement of due process is that the licensee has the "right to be heard, by testimony or otherwise, and to have the right of controverting, by proof, every material fact which bears on the question of the right in the matter involved." *Williams v. Dollison,* 62 Ohio St.2d 297 (1980). Due process includes the right to a reasonable continuance to secure expert testimony in order to present a meaningful defense. *Warren*, supra at ¶15.

In the *Warren* case, the trial court denied a motion made on the day of the hearing to continue the case so that Mrs. Warren could obtain an expert witness. The Tenth District Court of Appeals reversed the decision of the trial court as an abuse of discretion. The appellate court applied the following balancing test in reviewing cases were a continuance was denied:

> When reviewing a trial court's decision on a continuance, the appellate court must apply a balancing test, weighing the trial court's interest in controlling its own docket, including facilitating the efficient dispensation of justice, versus the potential prejudice to the moving party. *Burton v. Burton*, 132 Ohio App.3d 473, 476, 1999 Ohio 844, 725 N.E.2d 359. The trial court may consider several factors when determining whether to grant a continuance, including: (1) the length of the delay requested; (2) whether previous continuances have been granted; (3) the inconvenience to the parties, witnesses, attorneys, and the court; (4) whether the request is reasonable or purposeful and contrived to merely delay the proceedings; and (5) whether the movant contributed to the circumstances giving rise to the request. Id., citing *Unger; State v. Hines*, 3d Dist. No. 9- 05-13, 2005 Ohio 6696, ¶12.

Id. at ¶9.

The case at bar is similar to the *Warren* case. Application of the relevant factors to the instant case provide an even more compelling argument than was present in *Warren* that a continuance was warranted and denial of the same was an abuse of discretion. One, Appellant herein requested a short delay of 45 to 90 days, which was not unreasonable given the complexity of the case and the voluminous evidence and time necessitated to review the medical charts of 14 patients. The record in this case is thousands of pages long. Thus, a request for this period of time was reasonable especially in light of Appellant having to obtain new counsel.

Two, no previous continuances had been granted, which militated in favor of granting the request. Three, in addressing any inconvenience to the parties, the tribunal, and witnesses, the request was made three weeks before the hearing, not on the actual date of the hearing as occurred in *Warren*. The hearing officer could have rescheduled the hearing in advance and minimized any impact on any witnesses. Dates could have been chosen to accommodate the State's expert and any other witnesses. Thus, the impact would have been minimal, if any, on any of the individuals involved because of the <u>advance</u> notice of the request for the continuance.

Four, the request was reasonable and not contrived to merely delay the proceedings. Appellant's counsel withdrew from the case less than 32 days prior to the hearing. Absolutely no evidence exists that Appellant was at fault for the withdrawal. As noted above, having new counsel with less than 30 days to prepare for a complex hearing and to secure any expert the new counsel wanted was next to impossible. The request was reasonable under the circumstances of the prior counsel's unilateral withdrawal. The request was not contrived and not merely to seek delay.

Five, Appellant did not contribute to the circumstances giving rise to the request for a continuance. No evidence exists in the record that Appellant was at fault in the withdrawal of his counsel. One could speculate as to many reasons why counsel withdrew, but the reality is that no evidence exists that Appellant caused the withdrawal of his counsel. Moreover, the hearing officer allowed the withdrawal. The hearing officer could have certainly denied the request.

Additionally, as set forth in the factual recitation, the hearing officer's reasons for denying the continuance included an improper standard (a showing of "extraordinary circumstances") and failed to analyze the correct legal standards set forth in the *Warren* case and other due process cases. The additional reason for denying the continuance (Appellant would continue to practice and be a potential threat to patients) was disingenuous and illusory. As noted above, the allegations were then unproven, and Appellant had the right to continue to practice until the allegations were proven. The Board could also have sought a pre-hearing suspension of Appellant's license if it truly had legitimate concerns for the safety of the public if Appellant continued to practice while the case was continued. See R.C. 4731.22(G). The Appellant was permitted to continue to practice while the hearing examiner took 5 months to write a report[2].

Therefore, this Court concludes the hearing officer's denial of the continuance was arbitrary and unreasonable. Furthermore, the hearing officer's utilization of an improper legal test and failure to consider the proper legal standards establishes the denial order was contrary to law and prejudicial to Appellant. See *Boggs v. Ohio Real Estate Comm'n*, 186 Ohio App.3d 96, 2009-Ohio-6325, ¶12 (10th Dist.)("[i]n an

[2] The Report was 92 pages long and illustrates the complexity and voluminous nature of the case and further demonstrates why new counsel should have been granted more than 30 days to prepare.

administrative appeal under R.C. 119.12, the common pleas court must consider the entire record to determine whether reliable, probative, and substantial evidence supports the administrative agency's order and the order is in accordance with law"). Because the order was contrary to law, and for all of the reasons set forth herein, the Court **REVERSES** the order of the Board and **REMANDS** this case for a new hearing.

Pursuant to Civ. 58(B), the Clerk of Courts is hereby directed to serve upon all parties notice of and the date of this judgment. Costs to Appellee.

IT IS SO ORDERED.

Franklin County Court of Common Pleas

Date: 08-08-2013

Case Title: FRANKLIN D DEMINT -VS- OHIO STATE MEDICAL BOARD

Case Number: 13CV004850

Type: DECISION/ENTRY

It Is So Ordered.

/s/ Judge Mark Serrott

Court Disposition

Case Number: 13CV004850

Case Style: FRANKLIN D DEMINT -VS- OHIO STATE MEDICAL BOARD

Case Terminated: 18 - Other Terminations

Final Appealable Order: Yes

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

FRANKLIN D. DEMINT, D.O.,	:	
Appellant,	:	Case No. 13-CV-004850
vs.	:	Judge Mark A. Serrott
STATE MEDICAL BOARD OF OHIO,	:	
Appellee.	:	

JOURNAL ENTRY CONDITIONALLY STAYING THE APRIL 18, 2013 ORDER OF THE STATE MEDICAL BOARD

This case is before the Court upon the appeal, pursuant to R.C. 119.12, of the Entry of Order of the State Medical Board of Ohio issued April 10, 2013 (mailed April 18, 2013). The order indefinitely suspended Dr. Smith's certificate to practice medicine and surgery in Ohio for a minimum of 180 days, with interim monitoring and conditions for reinstatement imposed. Appellant has petitioned this Court for a limited stay that will require him to comply with all terms in the April 18, 2013 order of the Medical Board except that he may continue in the practice of medicine pending the duration of the appeal to this Court. The State does not oppose this motion. For good cause shown it is hereby:

ORDERED, ADJUDGED AND DECREED that the April 18, 2013 order of the Appellee, State Medical Board of Ohio is stayed as to the suspension of practice only, all other terms and conditions of the order shall remain in full force and effect. This conditional stay shall expire when this Court issues a final Judgment entry in the above captioned matter.

IT IS SO ORDERED.

_____ _____
Date **JUDGE SERROTT**

APPROVED BY:

/s/ James R. Kingsley
JAMES R. KINGSLEY (0010720)
Kingsley Law Office
157 West Main Street
Circleville, Ohio 43113
740-477-2546
740-477-2976 Facsimile

Counsel for Franklin D. Demint, D.O.

/s/ Kyle C. Wilcox
KYLE C. WILCOX (0063219)
Assistant Attorney General
Health & Human Services Section
30 East Broad Street, 26th Floor
Columbus, Ohio 43215-3400
614 466-8600
614-466-6090 Facsimile

Counsel for the State Medical Board

Franklin County Court of Common Pleas

Date: 05-09-2013

Case Title: FRANKLIN D DEMINT -VS- OHIO STATE MEDICAL BOARD

Case Number: 13CV004850

Type: AGREED ORDER

It Is So Ordered.

/s/ Judge Mark Serrott

Court Disposition

Case Number: 13CV004850

Case Style: FRANKLIN D DEMINT -VS- OHIO STATE MEDICAL BOARD

Motion Tie Off Information:

1. Motion CMS Document Id: 13CV0048502013-04-3099920000

   Document Title: 04-30-2013-MOTION TO STAY

   Disposition: MOTION GRANTED

IN THE COURT OF COMMON PLEAS FOR FRANKLIN COUNTY, OHIO

BEFORE THE STATE MEDICAL BOARD OF OHIO
ATTN: Case Control Officer

In the matter of:	:	Common Pleas No. _____
Franklin Donald Demint, D.O.	:	Medical Board No. 12-CRF-018

NOTICE OF APPEAL

Pursuant to RC §119.12, take notice that Franklin D. Demint hereby appeals the decision of the Medical Board mailed on 4/18/2013.

/s/ James R. Kingsley
James R. Kingsley (0010720)
Attorney for Franklin D. Demint
157 West Main Street
Circleville, Ohio 43113
Telephone: 740-477-2546
FAX: 740-477-2976
email: kingsleyjrlaw@yahoo.com

MEMORANDUM IN SUPPORT

The agency's order is not supported by reliable, probative and substantial evidence and is not in accordance with law.

Appellant's contemplated specific grounds for appeal include:

1. Was it error to deny the requested continuance of final hearing?
2. Was it error to reject the proffered testimony of Dr. Pryor?
3. Was it error to allow the testimony of Dr. Cicek because:
   - A. RC §2743.43 applied
   - B. She lacked foundational qualifications

C. She was impeached to the extent that her testimony was incredible.

4. Was the recommendation of the hearing officer too vague to be enforceable?

5. Could handwriting be a basis to suspend?

6. Could charting be a basis for suspension?

7. Can acting without prior records be a basis for suspension?

8. Can waiting for a confirmation test be a basis for suspension?

9. Does a doctor have to suspend treatment when an inconsistent test result is explained?

10. Is a doctor required to reduce the amount of medication to a patient until receipt of prior records and/or test results?

11. Is not written, not done a medical standard?

12. Must a doctor discharge a patient who admits to abusing illegal drugs?

13. May a doctor treat a patient for fibromyalgia and/or COPD in accordance with medical literature?

14. Was a 6 month suspension too harsh of a sanction in light of no harm and no complaints from patients, an erroneous belief there was a pill mill, compliance with standards set forth in the literature?

Respectfully submitted

/s/ James R. Kingsley
James R. Kingsley (0010720)
Attorney for Franklin D. Demint

CERTIFICATE OF SERVICE

The undersigned does hereby certify that he personally delivered to the State Medical Board a second original of the above Notice of Appeal on the 30th day of April, 2013 and by mailing a copy to Kyle C. Wilcox, Assistant Attorney General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215-3400 and by email to kyle.wilcox@ohioattorneygeneral.gov on this 29th day of April, 2013.

.

/s/ James R. Kingsley
James R. Kingsley (0010720)
Attorney for Franklin D. Demint

State Medical Board of Ohio

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

(614) 466-3934
med.ohio.gov

April 10, 2013

Franklin Donald Demint, D.O.
535 Jadwin Road
Kingston, OH 45644

RE: Case No. 12-CRF-018

Dear Dr. Demint:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of R. Gregory Porter, Esq., Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on April 10, 2013, including motions approving the Conclusions of the Hearing Examiner; modifying the Findings of Fact, and adopting an amended Order.

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

J. Craig Strafford

J. Craig Strafford, M.D., M.P.H.
Secretary For authorization Sallie J. Schott

JCS:jam
Enclosures

CERTIFIED MAIL NO. 91 7199 9991 7032 2854 9664
RETURN RECEIPT REQUESTED

Cc: James R. Kingsley, Esq.
CERTIFIED MAIL NO. 91 7199 9991 7032 2854 9671
RETURN RECEIPT REQUESTED

Mailed 4-18-13

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation R. Gregory Porter, Esq., State Medical Board Attorney Hearing Examiner; and excerpt of the Minutes of the State Medical Board, meeting in regular session on April 10, 2013, including motions approving and confirming the Conclusions of the Hearing Examiner; modifying the Findings of Fact and adopting an amended Order, constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter Franklin Donald Demint, D.O., Case No. 12-CRF-018, 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.

J. Craig Strafford

J. Craig Strafford, M.D., M.P.H.
Secretary Per authorization Sallie J. Debolt

(SEAL)

April 10, 2013
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*	
	*	CASE NO. 12-CRF-018
FRANKLIN DONALD DEMINT, D.O.	*	

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on April 10, 2013.

Upon the Report and Recommendation of R. Gregory Porter, Esq., 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 within, and upon the modification, 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.

RATIONALE FOR AMENDMENT: Finding of Fact 3 is amended to reflect the Board's determination that there was not adequate documentation for the diagnosis of fibromyalgia for Patient 1. The conditions of reinstatement are amended to require the completion of a course that should more specifically address the deficiencies in Dr. Demint's practice.

AMENDED FINDINGS OF FACT

3. The evidence is sufficient to support a finding that Dr. Demint practiced below the minimal standard of care by inappropriately prescribing narcotics to Patient 1 for treatment of diagnosed fibromyalgia.

It is hereby ORDERED that:

A. **SUSPENSION OF CERTIFICATE**: Commencing on the thirty-first day following the date on which this Order becomes effective, the certificate of Franklin Donald Demint, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than 180 days. During the thirty-day interim, Dr. Demint shall not undertake the care of any patient not already under his care.

B. **INTERIM MONITORING**: During the period that Dr. Demint's certificate to practice osteopathic medicine and surgery in Ohio is suspended, Dr. Demint shall comply with the following terms, conditions, and limitations:

1. **Obey the Law**: Dr. Demint shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

2. **Declarations of Compliance**: Dr. Demint shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the date his quarterly declaration would have been due pursuant to his March 2010 Step II Consent Agreement. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Demint shall appear in person for interviews before the Board or its designated representative. The first such appearance shall take place on or before the date his appearance would have been scheduled pursuant to his March 2010 Step II Consent Agreement. Subsequent personal appearances shall occur every three months thereafter, and/or as otherwise directed by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

4. **Absences from Ohio:** Dr. Demint shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have the discretion to grant a waiver of part or all of the probationary terms set forth in this Order for occasional periods of absence of fourteen days or less.

   In the event that Dr. Demint resides and/or is employed at a location that is within fifty miles of the geographic border of Ohio and any of its contiguous states, Dr. Demint may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Demint is able to otherwise maintain full compliance with all other terms, conditions and limitations set forth in this Order.

5. **Ban on Administering, Furnishing, or Possessing Controlled Substance; Log**: Dr. Demint shall not, without prior Board approval, administer, personally furnish, or possess (except as allowed under Paragraph B.6.a) any controlled substances as defined by state or federal law.

In the event that the Board agrees at a future date to modify this Order to allow Dr. Demint to administer or personally furnish controlled substances, Dr. Demint shall keep a log of all controlled substances prescribed, administered or personally furnished. Such log shall be submitted in the format approved by the Board and shall be submitted to the Board no later than the date upon which Dr. Demint's declarations of compliance quarterly declaration is due, or as otherwise directed by the Board. Further, Dr. Demint shall make his patient records with regard to such prescribing, administering, or personally furnishing available for review by an agent of the Board immediately upon request.

6. **Sobriety**

   a. **Abstention from Drugs**: Dr. Demint shall abstain completely from the personal use or personal possession of drugs, except those prescribed, dispensed or administered to him by another so authorized by law who has full knowledge of Dr. Demint's history of chemical dependency. Further, in the event that Dr. Demint is so prescribed, dispensed or administered any controlled substance, carisoprodol, or tramadol, Dr. Demint shall notify the Board in writing within seven days, providing the Board with the identity of the prescriber; the name of the drug Dr. Demint received; the medical purpose for which he received said drug; the date such drug was initially received; and the dosage, amount, number of refills, and directions for use. Further, within thirty days of the date said drug is so prescribed, dispensed, or administered to him, Dr. Demint shall provide the Board with either a copy of the written prescription or other written verification from the prescriber, including the dosage, amount, number of refills, and directions for use.

   b. **Abstention from Alcohol**: Dr. Demint shall abstain completely from the use of alcohol.

7. **Drug and Alcohol Screens/Drug Testing Facility and Collection Site**: Dr. Demint shall submit to random urine screenings for drugs and alcohol at least two times per month, or as otherwise directed by the Board. Dr. Demint shall ensure that all screening reports are forwarded directly to the Board on a quarterly basis. The drug testing panel utilized must be acceptable to the Secretary of the Board, and shall include Dr. Demint's drug(s) of choice.

   Dr. Demint shall abstain from the use of any substance and the consumption of poppy seeds or any other food or liquid that may produce a low level positive result in a toxicology screen. Dr. Demint shall be held to an understanding and knowledge that the consumption or use of such substances, including but not limited to substances such as mouthwash or hand cleaning gel, may cause a positive drug screen that may not be able

to be differentiated from intentional ingestion, and therefore such consumption or use is prohibited under this Order.

All such urine screenings for drugs and alcohol shall be conducted through a Board-approved drug testing facility and collection site pursuant to the global contract between said facility and the Board, that provides for the Board to maintain ultimate control over the urine screening process and to preserve the confidentiality of all positive screening results in accordance with Section 4731.22(F)(5), Ohio Revised Code, and the screening process shall require a daily call-in procedure. Further, in the event that the Board exercises its discretion, as provided in Paragraph B.8 below, to approve urine screenings to be conducted at an alternative drug testing facility and/or collection site or a supervising physician, such approval shall be expressly contingent upon the Board retaining ultimate control over the urine screening process in a manner that preserves the aforementioned confidentiality of all positive screening results.

Dr. Demint shall submit, at his expense and on the day selected, urine specimens for drug and/or alcohol analysis. All specimens submitted by Dr. Demint shall be negative, except for those substances prescribed, administered, or dispensed to him in conformance with the terms, conditions and limitations set forth in this Order. Refusal to submit such specimen, or failure to submit such specimen on the day he is selected or in such manner as the Board may request, shall constitute a violation of this Order.

Further, within thirty days of the effective date of this Order, Dr. Demint shall enter into the necessary financial and/or contractual arrangements with the Board-approved drug testing facility and/or collection site in order to facilitate the urine screening process in the manner required by this Order. Further, Dr. Demint shall promptly provide to the Board written documentation of completion of such arrangements, including a copy of any contract entered into between Dr. Demint and the Board-approved drug testing facility and/or collection site. Dr. Demint's failure to timely complete such arrangements, or failure to timely provide written documentation to the Board of completion of such arrangements, shall constitute a violation of this Order.

Dr. Demint shall ensure that the urine screening process performed through the Board-approved drug testing facility and/or collection site requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Demint and the Board-approved drug testing facility and collection site shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

Dr. Demint shall ensure that the Board-approved drug testing facility and/or collection site provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Order, and whether all urine screens have been negative.

In the event that the Board-approved drug testing facility and/or collection site becomes unable or unwilling to serve as required by this Order, Dr. Demint must immediately notify the Board in writing, and make arrangements acceptable to the Board pursuant to Paragraph B.8 below, as soon as practicable. Dr. Demint shall further ensure that the Board-approved drug testing facility and/or collection site also notifies the Board directly of its inability to continue to serve and the reasons therefore.

The Board expressly reserves the right to withdraw its approval of any drug testing facility and/or collection site in the event that the Secretary and Supervising Member of the Board determine that the drug testing facility and/or collection site has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

8. **Alternative Drug-testing Facility and/or Collection Site**: It is the intent of this Order that Dr. Demint shall submit his urine specimens to the Board-approved drug testing facility and collection site chosen by the Board. However, in the event that utilizing said Board-approved drug testing facility and/or collection site creates an extraordinary hardship upon Dr. Demint, as determined in the sole discretion of the Board, then subject to the following requirements, the Board may approve an alternate drug testing facility and/or collection site, or a supervising physician, to facilitate the urine screening process for Dr. Demint:

    a. Within thirty days of the date upon which Dr. Demint is notified of the Board's determination that utilizing the Board-approved drug testing facility and/or collection site constitutes an extraordinary hardship upon Dr. Demint, he shall submit to the Board in writing for its prior approval the identity of either an alternate drug testing facility and collection site, or the name of a proposed supervising physician, to whom Dr. Demint shall submit the required urine specimens. In approving a facility, entity, or an individual to serve in this capacity, the Board will give preference to a facility located near Dr. Demint's residence or employment location, or to a physician who practices in the same locale as Dr. Demint. Dr. Demint shall ensure that the urine screening process performed through the alternate drug testing facility and/or collection site, or through the supervising physician, requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Demint acknowledges that the alternate drug testing facility and collection site, or the supervising

physician, shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

b. Dr. Demint shall ensure that the alternate drug testing facility and/or collection site, or the supervising physician, provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Order, and whether all urine screens have been negative.

c. In the event that the designated alternate drug testing facility and/or collection site, or the supervising physician, becomes unable or unwilling to so serve, Dr. Demint must immediately notify the Board in writing. Dr. Demint shall further ensure that the previously designated alternate drug testing facility and collection site, or the supervising physician, also notifies the Board directly of the inability to continue to serve and the reasons therefore. Further, in order to ensure that there will be no interruption in his urine screening process, upon the previously approved alternate drug testing facility, collection site, or supervising physician becoming unable to serve, Dr. Demint shall immediately commence urine screening at the Board-approved drug testing facility and collection site chosen by the Board, until such time, if any, that the Board approves a subsequent alternate drug testing facility, collection site, or supervising physician, if requested by Dr. Demint.

d. The Board expressly reserves the right to disapprove any entity or facility proposed to serve as Dr. Demint's designated alternate drug testing facility and/or collection site, or any person proposed to serve as his supervising physician, or to withdraw approval of any entity, facility or person previously approved to so serve in the event that the Secretary and Supervising Member of the Board determine that any such entity, facility or person has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

e. In the event that the Board approved an alternate drug testing facility and/or collection site, or a supervising physician, pursuant to the March 2010 Step II Consent Agreement between Dr. Demint and the Board, the entity, facility or person previously approved by the Board to so serve pursuant to the March 2010 Step II Consent Agreement may, in the sole discretion of the Board, be approved to continue as Dr. Demint's designated alternate drug testing facility and collection site or as his supervising physician under this Order.

9. **Reports Regarding Drug and Alcohol Screens**: All screening reports required under this Order from the Board-approved drug testing facility and/or collection site, or from the alternate drug testing facility and/or collection site or supervising physician, must be received in the Board's offices no later than the due date for Dr. Demint's quarterly declaration. It is Dr. Demint's responsibility to ensure that reports are timely submitted.

10. **Additional Screening Without Prior Notice**: Upon the Board's request and without prior notice, Dr. Demint shall provide a specimen of his blood, breath, saliva, urine, and/or hair for screening for drugs and alcohol, for analysis of therapeutic levels of medications that may be prescribed for Dr. Demint, or for any other purpose, at Dr. Demint's expense. Dr. Demint's refusal to submit a specimen upon the request of the Board shall result in a minimum of one year of actual license suspension. Further, the collection of such specimens shall be witnessed by a representative of the Board, or another person acceptable to the Secretary and Supervising Member of the Board.

11. **Rehabilitation Program**: Dr. Demint shall maintain participation in an alcohol and drug rehabilitation program, such as A.A., N.A., C.A., or Caduceus, no less than twice per week with a minimum of ten per month. At least one of the abovementioned meetings shall be a Caduceus meeting. Substitution of any other specific program must receive prior Board approval.

    Dr. Demint shall submit acceptable documentary evidence of continuing compliance with this program, including submission to the Board of meeting attendance logs, which must be received in the Board's offices no later than the due date for Dr. Demint's quarterly declarations.

12. **Comply with the Terms of Aftercare Contract**: Dr. Demint shall maintain continued compliance with the terms of the aftercare contract entered into with a Board-approved treatment provider, provided that, where terms of the aftercare contract conflict with terms of this Order, the terms of this Order shall control.

13. **Releases**: Dr. Demint shall provide authorization, through appropriate written consent forms, for disclosure of evaluative reports, summaries, and records, of whatever nature, by any and all parties that provide treatment or evaluation for Dr. Demint's chemical dependency or related conditions, or for purposes of complying with this Order, whether such treatment or evaluation occurred before or after the effective date of this Order. To the extent permitted by law, the above-mentioned evaluative reports, summaries, and records are considered medical records for purposes of Section 149.43 of the Ohio Revised Code and are confidential pursuant to statute. Dr. Demint shall also provide the Board written consent permitting any treatment provider from whom he obtains treatment to notify the Board in the event he fails to agree to or comply with any

treatment contract or aftercare contract. Failure to provide such consent, or revocation of such consent, shall constitute a violation of this Order.

14. **Required Reporting of Change of Address**: Dr. Demint shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

C. **CONDITIONS FOR REINSTATEMENT OR RESTORATION**: The Board shall not consider reinstatement or restoration of Dr. Demint's certificate to practice medicine and surgery until all of the following conditions have been met:

1. **Application for Reinstatement or Restoration**: Dr. Demint shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.

2. **Compliance with Interim Conditions**: Dr. Demint shall have maintained compliance with all the terms and conditions set forth in Paragraph B of this Order.

3. **Controlled Substances Prescribing Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide acceptable documentation of successful completion of a course or courses dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

   In addition, at the time Dr. Demint submits the documentation of successful completion of the course(s) dealing with the prescribing of controlled substances, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

4. **Medical Records Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Demint submits the documentation of successful completion of the course(s) on maintaining adequate and appropriate medical records, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

5. **ACOFP Course**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide acceptable documentation of successful completion of the Annual ACOFP Intensive Update and Board Review in Osteopathic Medicine. This course shall be taken in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) during which it is completed.

   In addition, at the time Dr. Demint submits the documentation of successful completion of the ACOFP course, he shall also submit to the Board a written report describing the course, setting forth what he learned from the course, and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

6. **Additional Evidence of Fitness To Resume Practice**: In the event that Dr. Demint has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

D. **PROBATION**: Upon reinstatement or restoration, Dr. Demint's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:

1. **Terms, Conditions, and Limitations Continued from Suspension Period**: Dr. Demint shall continue to be subject to the terms, conditions, and limitations specified in Paragraph B of this Order.

2. **Practice Plan and Monitoring Physician**: Within 30 days of the effective date of Dr. Demint's reinstatement or restoration, or as otherwise determined by the Board, Dr. Demint shall submit to the Board and receive its approval for a plan of practice in Ohio. Dr. Demint shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

   At the time Dr. Demint submits his practice plan, he shall also submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in

the same locale as Dr. Demint and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Demint and his medical practice, and shall review Dr. Demint's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Demint and his medical practice, and on the review of Dr. Demint's patient charts. Dr. Demint shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Demint's declarations of compliance.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Demint shall immediately so notify the Board in writing. In addition, Dr. Demint shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Demint shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Demint's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Demint's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

E. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Demint's certificate will be fully restored.

F. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training, and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Demint shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including

but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments.

In the event that Dr. Demint provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.

These requirements shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Administration, through which he currently holds any professional license or certificate. Also, Dr. Demint shall provide a copy of this Order at the time of application to the proper licensing authority of any state or jurisdiction in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

3. **Required Reporting to Treatment Providers/Monitors**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to all persons and entities that provide chemical dependency/abuse treatment to or monitoring of Dr. Demint. This requirement shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

4. **Required Documentation of the Reporting Required by Paragraph F**: Dr. Demint shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (a) the return receipt of certified mail within 30 days of receiving that return receipt, (b) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (c) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (d) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

G. **VIOLATION OF THE TERMS OF THIS ORDER**: If Dr. Demint violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

H. **SUPERSEDE PREVIOUS CONSENT AGREEMENT**: Upon becoming effective, this Order shall supersede the terms and conditions set forth in the March 2010 Step II Consent Agreement between Dr. Demint and the Board.

EFFECTIVE DATE OF ORDER: This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

J. Craig Strafford

J. Craig Strafford, M.D., M.P.H.
Secretary Per authorization Sallie J. Debolt

(SEAL)

April 10, 2013
Date

STATE MEDICAL BOARD
OF OHIO

2013 FEB 14 PM 4:07

BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of	*	
		Case No. 12-CRF-018
Franklin Donald Demint, D.O.,	*	
		Hearing Examiner Porter
Respondent.	*	

ERRATA

The Report and Recommendation on this matter was filed on February 13, 2013. After the Report and Recommendation was filed, the Hearing Examiner learned that it contains an error.
Dr. Demint's written hearing request was received on April 9, 2012, and not February 16, 2012, as stated on the first page of the report.

R. Gregory Porter
Hearing Examiner

STATE MEDICAL BOARD
OF OHIO

2013 FEB 13 PM 2:43

BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of	*	
		Case No. 12-CRF-018
Franklin Donald Demint, D.O.,	*	
		Hearing Examiner Porter
Respondent.	*	

REPORT AND RECOMMENDATION

Basis for Hearing

By notice of opportunity for hearing dated March 14, 2012 ("Notice"), the State Medical Board of Ohio ("Board") notified Franklin Donald Demint, D.O., that it had proposed to take disciplinary action against his certificate to practice osteopathic medicine and surgery in Ohio. The Board based its proposed action on allegations concerning Dr. Demint's care and treatment of 14 patients.[1] The Board further alleged that Dr. Demint's conduct in treating those patients constituted the following:

- "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," as those clauses are used in Ohio Revised Code Section ("R.C.") 4731.22(B)(2);

- "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 R.C. 4731.22(B)(6);

- "Violation of the conditions of limitation placed by the board upon a certificate to practice," as that clause is used in R.C. 4731.22(B)(15); and/or

- "[V]iolating 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 R.C. 4731.22(B)(20), to wit: Ohio Administrative Code Rule ("Rule") 4731-21-02, Utilizing Prescription Drugs for the Treatment of Intractable Pain. Furthermore, pursuant to Rule 4731-21-05, a violation of Rule 4731-21-02 also constitutes violation of R.C. 4731.22(B)(2) and 4731.22(B)(6).

Accordingly, the Board advised Dr. Demint of his right to request a hearing, and received his written hearing request on February 16, 2012. (State's Exhibits ("St. Exs.") 20A, 20B)

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[1] All patients referenced herein were identified on a Confidential Patient Key. (State's Exhibit 15)

Appearances

Mike DeWine, Attorney General, and Kyle C. Wilcox and Melinda Ryans Snyder, Assistant Attorneys General, for the State of Ohio. James R. Kingsley, Esq., on behalf of Dr. Demint.

Hearing Dates: September 4 through 6, 2012

PROCEDURAL MATTERS

The hearing record was held open following the hearing to allow the parties an opportunity to present written closing arguments. The parties' closing arguments were received in a timely manner, were marked State's Exhibit 21 and Respondent's Exhibit L, and admitted to the record. The hearing record closed on October 29, 2012.

SUMMARY OF THE 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 Information

1. Franklin Donald Demint, D.O., obtained his osteopathic medical degree in 1990 from the Ohio University College of Osteopathic Medicine[2] in Athens, Ohio. From 1990 through 1991 he completed an internship at Metropolitan General Hospital in Pinellas Park, Florida, and from 1991 through 1992 he completed eight months of family practice residency at that same institution. Dr. Demint was certified by the American Osteopathic Board of Family Physicians and by the American Osteopathic Board of Neuromusculoskeletal Medicine. He is also a diplomate of the American Academy of Pain Management ("AAPM"). (Hearing Transcript ("Tr.") at 16-17, 55; Respondent's Exhibit "(Resp. Ex.") C)

2. Dr. Demint testified that he obtained certification from the American Board of Osteopathic Family Physicians because he was allowed to "grandfather" in. Dr. Demint testified that, in order to obtain board certification, he had had to practice for five years, complete a certain number of hours of continuing medical education ("CME"), then sit for an examination. Dr. Demint obtained his board certification around 1997, and the option to grandfather in ended shortly after that. (Tr. at 18-19)

3. Dr. Demint testified that he does not currently hold admitting privileges at any hospitals. Dr. Demint further testified that he last held privileges at Doctor's Hospital of Nelsonville in Nelsonville, Ohio, in 1997. Dr. Demint indicated that he does only outpatient practice and prefers to leave inpatient practice to hospitalists. (Tr. at 19-20)

[2] Dr. Demint testified that this school is now known as the Heritage College of Osteopathic Medicine. (Tr. at 19)

Dr. Demint's Pain Management Practice

4. Dr. Demint testified that he currently practices as a solo practitioner in Kingston, Ohio, and that his practice is called Kingston Family Medicine, LLC, which he had begun in 1998 or 1999. Dr. Demint further testified that his practice includes family medicine but that he also does a substantial amount of addiction medicine, including Suboxone therapy. Dr. Demint testified that between 80 to 90 percent of his current patients are Suboxone patients. Dr. Demint indicated that he had formerly specialized in pain management, but discontinued when House Bill 93 took effect in mid-2011. Dr. Demint testified that he currently has only ten pain patients out of a total population of about 200 patients. (Tr. at 14-16, 32-34, 284-286, 300-301, 619-620)

5. Dr. Demint testified that he had taken several hundred hours of CME in pain medicine, and had taken and passed a credentialing examination to become a diplomate of the AAPM. Dr. Demint further testified that he has taken pain management CMEs since 1992, but did not begin concentrating his practice in that area until 2002. (Tr. at 17, 21)

6. Pursuant to an August 2009 Step I Consent Agreement, Dr. Demint's certificate was suspended for at least 180 days based upon violations of R.C. 4731.22(B)(5), (10), (20), and (26). The Step I Consent Agreement was based upon Dr. Demint's dependence on and excessive and habitual use of marijuana, and his admission of having possessed and dispensed generic Tylenol #3 tablets to a family member under circumstances not constituting an emergency, without performing and documenting an examination and without maintaining patient records. Among other things, Dr. Demint was required to complete 28 days of inpatient treatment at a Board-approved treatment facility for his abuse of and/or dependency upon marijuana, his drug of choice, and to maintain sobriety and submit to interim monitoring requirements. Pursuant to a March 2010 Step II Consent Agreement, Dr. Demint's certificate was reinstated subject to various probationary requirements, including practice monitoring. Dr. Demint remains subject to the requirements of his Step II Consent Agreement. (St. Ex. 18; Tr. at 46-50)

7. Dr. Demint testified that, shortly before his license was suspended, he had entered into a contract with Adena Health Systems in Chillicothe, Ohio, to work in their pain management practice. Dr. Demint testified that he had sent letters to his patients informing them that he was leaving his practice and going to work for Adena. However, prior to starting his position at Adena, his license was suspended and his position with Adena fell through. (Tr. at 33-34)

8. Dr. Demint testified that, following the reinstatement of his certificate, and during the time period relevant to this hearing, which is from March 2010 through about April 2011, he had worked at three locations, two of which are relevant to this matter. One location was Lance Family Medicine ("Lance") in Jackson, Ohio. Dr. Demint testified that he had been the only physician at that location. Dr. Demint started working there in March 2010 and continued until June 2011. (Tr. at 21-23; St. Ex. 19 at 7)

   Dr. Demint further testified that, when his license was reinstated in March 2010, he did not want to reopen his practice because he had grown tired of the business side of medicine.

Dr. Demint testified that he had planned on finding full-time employment as a physician, which he had thought he had found at Lance. However, Dr. Demint testified that he had only been needed about two days per week. When it became obvious to Dr. Demint that practicing at Lance would not provide him sufficient income, he reopened his practice. Dr. Demint testified that his practice reopened in the same location as before; however, his old patients did not return and the practice grew very slowly. Dr. Demint testified that "a lot of pain patients * * * came in when [he] first opened up[,]" but that by 2011 his patient load had grown to only about 200 patients. (Tr. at 35-37)

Dr. Demint testified that he had worked Mondays and Fridays at Lance, and worked Tuesday, Wednesday, and Thursday, plus a half day on Saturday, at his Kingston practice. (Tr. at 24-27, 32-34)

9. Dr. Demint testified that he had seen approximately 20 to 30 patients per day at Lance. (Tr. at 25)

10. Dr. Demint testified that approximately 95 percent of the patients at Lance had been treated with controlled substances. Dr. Demint further testified that approximately 99 percent of his patients at his own practice had been treated with controlled substances. (Tr. at 25-28, 38-39)

11. Dr. Demint testified that Lance took insurance, and most of the patients he saw there had some form of insurance. (Tr. at 297)

12. Dr. Demint testified that his practice in Kingston was cash-only during the time period relevant to this hearing. Dr. Demint testified that he had tried accepting insurance from about 2003 to about 2007, but that the reimbursements he received from private insurance were at or below Medicare levels. Dr. Demint testified that that had been insufficient, so he returned to accepting cash only. (Tr. at 38-40)

13. Dr. Demint testified that he had charged his pain management patients $200 for an initial visit and $120 for follow-up visits. Dr. Demint testified that he gave all of his patients receipts with billing codes so that they could send them to their insurance companies for reimbursement. Dr. Demint further testified that his policy was for the patients to pay in advance of service: "[I]t got to the point where I took the cash first because, if you didn't do what they wanted [you] to [such as give them the medications they wanted], they wouldn't pay you on the way out, you know. So if I got the cash first, I knew I would be paid for my visit." (Tr. at 41-42)

14. Dr. Demint testified that he drew his patients primarily from the area around Kingston up to about a 50- or 60-mile radius. He testified that Kingston is located between Chillicothe and Circleville, Ohio, and he drew most of his patients from those communities. (Tr. at 44)

The State's Expert Witness – Wendy Cicek, M.D.

15. Wendy Cicek, M.D., obtained her medical degree in 1998 from the Case Western Reserve University School of Medicine ("CWRU") in Cleveland, Ohio. From 1998 through 1999, she completed her first year of family practice residency at the University of Wisconsin in

Madison, Wisconsin. From 1999 through 2001, she returned to Cleveland and completed a family practice residency at MetroHealth Medical Center, where she was Chief Resident during her final year. Dr. Cicek was licensed to practice medicine and surgery in Ohio in 2001. She also holds an inactive license in Wisconsin. She was certified by the American Board of Family Practice in 2001 and her certification remains current. (St. Ex. 17; Tr. at 317-319)

16. Dr. Cicek testified that she is not board-certified in pain management. (Tr. at 466)

17. Prior to embarking on a career as a physician, Dr. Cicek had been a registered nurse. Dr. Cicek had obtained her nursing degree in 1987 from the Huron Road Hospital School of Nursing in Cleveland. (St. Ex. 17)

18. Dr. Cicek recently changed employment in August 2012 and currently practices in the Clinical Decision Unit at Kaiser Permanente where she "assesses patients to determine if they need to be admitted to the hospital or they can be discharged after being sent over to the emergency room." Prior to that, from 2006 through July 2012, Dr. Cicek practiced family medicine at MetroHealth Medical Center-McCafferty Clinic ("McCafferty Clinic") in Cleveland. She also serves on a part-time basis as a Clinical Instructor in the Department of Family Medicine at CWRU. In addition, she has an academic appointment through 2014 as a Clinical Assistant Professor of Family Medicine at the Ohio University College of Osteopathic Medicine. She also assists third-year medical students rotating through family medicine clerkships. (St. Ex. 17; Tr. at 320-322)

19. Dr. Cicek is a member of several professional associations. Among these, she has been a member of the American Society of Addiction Medicine since 2008. (St. Ex. 17)

20. Dr. Cicek described her family practice experience with the McCafferty Clinic:

> I was a * * * family physician working with five other providers, physicians, and a nurse practitioner, providing primary care to adults, children, pregnant patients, in a mostly inner-city population, small amount of ring suburb patients, large uninsured population and Medicaid population.
>
> * * *
>
> * * * Averaged about 25 patients a day. * * * We were the safety net hospital in the area, the county hospital, so we saw anybody who came in.
>
> My patient population spanned from birth to my oldest patient[s] [were] in their 90s. The majority of my patients, I would say, were between the ages of 21 and 50, 55, with a wide range of medical problems.
>
> * * *

> We had patients with—a lot of patients with chronic back pain; patients with back injuries, herniated disks; we had a large amount of patients with fibromyalgia; patients with acute injuries where we used narcotics acutely.
>
> * * *
>
> We did have a handful of patients also with malignant situations that were, you know, being managed a little differently in terms of their pain management.

(Tr. at 322-324) Dr. Cicek added that about 30 to 40 percent of the patient population was treated for chronic pain, and many of them received opioids. (Tr. at 324)

21. Dr. Cicek testified that her training in the field of pain management consists of CME conferences and online training. Dr. Cicek also testified that she had utilized Suboxone while practicing at the McCafferty Clinic and had done some additional training in pain management for that. (Tr. at 329-330)

22. Dr. Cicek testified that, in connection with her review in this matter, the Board had provided her with copies of patient records along with the Board's intractable pain rules. (Tr. at 331) She further testified that she had referenced other materials as well:

> I referred to my facility's guidelines on prescribing narcotics for chronic pain. I referred to some guidelines that were available through the Federation of State Medical Boards. I referred to a couple of textbooks that I have at home. And then some of the different CME items I have received from—from the American Board of Family Physicians and information and written documents I have from my Suboxone training.

(Tr. at 332)

Dr. Demint's Pain Management Practice

"The Four A's"

23. During his testimony concerning individual patients, Dr. Demint made reference to a concept he referred to as the "four A's":

> The four A's is one of the ways you—you, you know, evaluate patients in pain and how well they're responding to treatment and stuff.
>
> The first A is analgesia. You know, you can ask anybody, "How's your pain doing?", versus using a numerical scale. I—I often use what we call a multidimensional scale where I don't just ask what's your pain at now, but I ask you, you know, what's the best it's been in—since I've last seen you, what's the worst it's been, or the average.

> The second A is activities. I ask about, you know, what—what can you do, what can't you do, things like that.
>
> Let's see. Analgesia, activities. Adverse effects. You know, are you having problems with the medication? Is it causing you constipation, sedation, any other problems?
>
> And then the—the last A is aberrant behavior. And that's the—you know, that's just looking at, you know, are they calling in for pill counts a lot? Or, you know, do they have—the drug screens.

(Tr. at 621-622; See, also, Tr. at 53, 57-59)

Dr. Demint also testified that he used a "brief pain inventory," which is a questionnaire that asks the patient to assign a numerical value of zero through ten to elements such as the severity of pain at its worst, at its least, and on average, and its effect on the patient's general activity, mood, walking ability, work, interpersonal relationships, sleep, and enjoyment of life. It also asks the patient to note on a diagram where the patient's pain is located. (Tr. at 623-624)

Dr. Demint testified that he believes that the SOAP notes, four A's, and the brief pain inventory together provide him sufficient information to diagnose and treat his patients. (Tr. at 624-625)

24. In support of his use of the four A's, Dr. Demint presented a medscape.org CME article dated March 15, 2012, that he had completed entitled *Treatment Initiation.* This article discusses the "four A's" of pain management. (Tr. at 670-674; Resp. Ex. G)

25. Dr. Cicek testified that "[t]he four A's are not a universally accepted assessment of pain." Dr. Cicek further testified that an assessment based on the four A's does not meet the minimal standard of care "as outlined by the State of Ohio in their document."[3] (Tr. at 511-512)

Dr. Demint – Prescribing In or Out of "The Box"

26. Another medscape.org CME article that Dr. Demint submitted is dated June 2008 and entitled *The Changing Paradigm of Pain Policy: Effects on Clinical Care,* authored by Kenneth L. Kirsh, Ph.D., and Steven D. Passik, Ph.D. This article describes the concept of prescribing "in and out of the box." Dr. Demint testified that "in the box" refers to practices that are commonly accepted and "out of the box" refers to practices that may be uncommon. The article also makes reference to opiate doses "in the moderate range (up to 180 mg morphine equivalent per day)" and indicates that "[d]aily doses above [that amount] involving patients with chronic noncancer pain have not been validated in clinical trials of significant size. National prescribing data suggest that 80% of patients are taking less than this dose in any case." Moreover, it states that individual patients frequently need higher doses and that such prescribing is legitimate; however, "it is important for a clinician to recognize that a "high dose" (as defined by being in the upper

[3] The Hearing Examiner presumed that Dr. Cicek was referring to the Board's intractable pain rules.

20% of doses nationally) might require better and more detailed documentation to protect the patient and the prescriber in such cases." It further indicates that prescribing in the upper 20% nationally would be "out of the box." (Tr. at 671-672; Resp. Ex. B)

27. Dr. Cicek testified that Medscape is an authoritative source that she uses in conjunction with other sources; however, she testified that she is unfamiliar with the Kirsch and Passik article and the concept of prescribing in or out of the "box." Dr. Cicek indicated that that terminology is not used in the facilities where she has worked. (Tr. at 515; Resp. Ex. B)

    In addition, Dr. Cicek disagreed that that a daily dose of morphine equivalent dose of 180 milligrams per day is a moderate dose. She further testified that "[t]here's actually data showing that above 150 milligrams of morphine equivalent a day, there's increased risk of death." Dr. Cicek further testified that patients who receive more than that dose should consult a specialist. (Tr. at 519-521)

State's Expert Witness' Definition of "Minimal Standard of Care"

28. Dr. Cicek defined the concept of "minimal standard of care" as follows:

    > [The minimal standard of care for a family physician] is being able to care for a patient with the minimal—the minimal amount of knowledge, expertise, and treatment that would differentiate one—one person as a family physician from someone without that particular knowledge. So someone who has the training and experience to provide a basic level of care to a patient.

    (Tr. at 333-334)

The Board's March 14, 2012 Notice of Opportunity for Hearing

29. On March 14, 2012, the Board issued a notice of opportunity for hearing to Dr. Demint alleging that he had practiced below the minimal standard of care in his treatment of 14 identified patients in a manner including, but not limited to, specific alleged conduct. (St. Ex. 20A) In the next section of the report, each patient and the allegations relevant to each patient will be described individually.

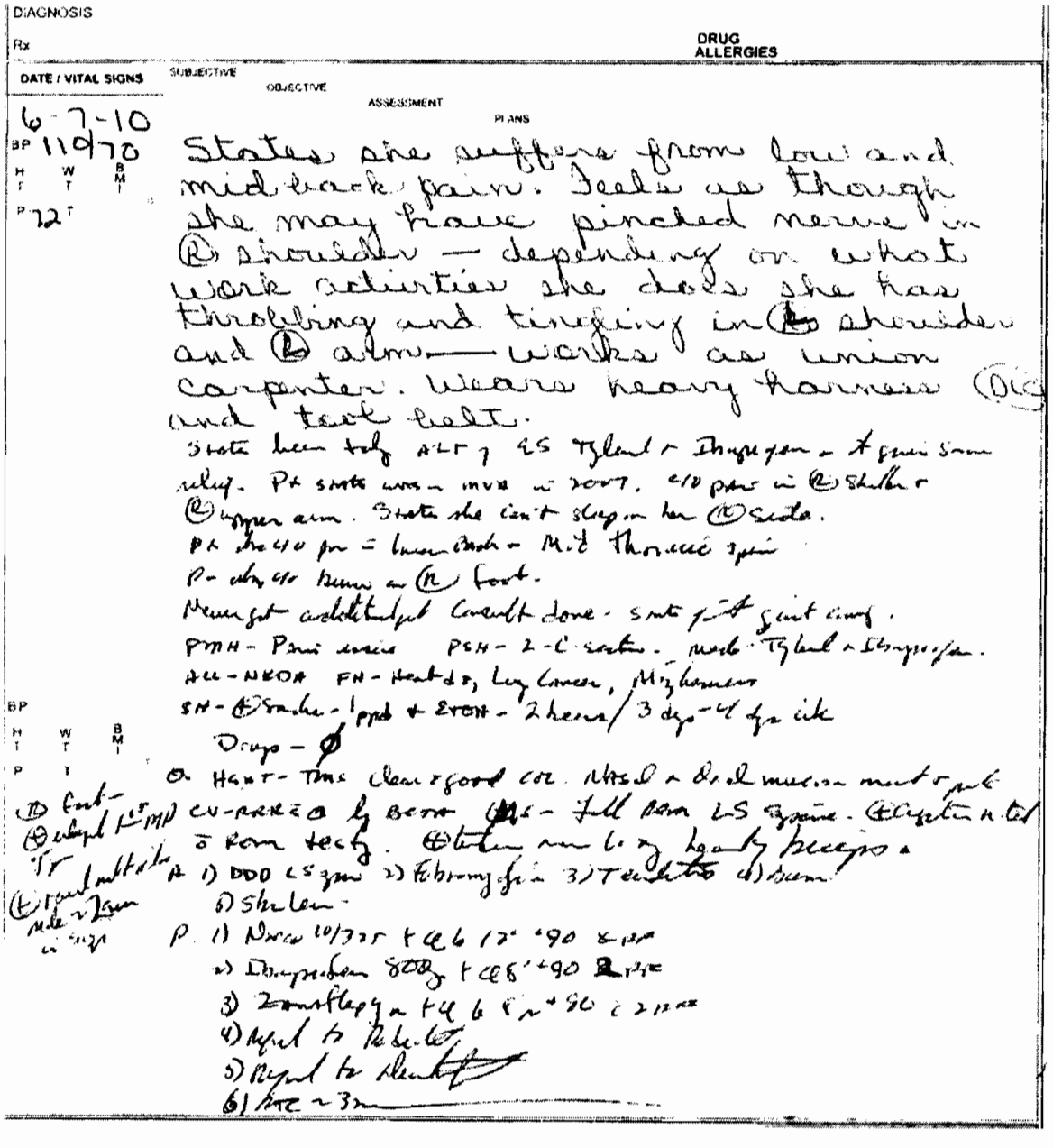
Patient 1

30. Patient 1, a female born in 1961, first saw Dr. Demint on June 7, 2010, at Lance. Previously, she had in the past been an established patient at that practice, and she had last visited Lance in March 2008. The medical record indicates that, on March 27, 2008, a former physician at the practice had referred Patient 1 to an addictionologist to "[e]valuate if pt is appropriate for pain mgt" due to her "misuse of pain meds."[4] According to a progress note dated March 28, 2008, and an undated note on the same page, Patient 1 was unable to see the addictionologist

[4] A January 2008 urine drug screen report indicates inconsistent positive results for alcohol and propoxyphene. (St. Ex. 1 at 11)

at that time because of her current job assignment. The undated note also states, "Will wait till current job is done (construction work)." The medical records do not reflect any more visits until she saw Dr. Demint in June 2010. (St. Ex. 1 at 26, 32, 34, 52)

Dr. Demint's initial visit note is reproduced below:


DIAGNOSIS
Rx
DRUG ALLERGIES
DATE / VITAL SIGNS
SUBJECTIVE
OBJECTIVE
ASSESSMENT
PLANS

6-7-10
BP 110/70
H T W T B M I
P 72 T

States she suffers from low and mid back pain. Feels as though she may have pinched nerve in (R) shoulder — depending on what work activities she does she has throbbing and tingling in (R) shoulder and (R) arm — works as union carpenter. Wears heavy harness (DC) and tool belt.
States been taking ALT q 2S Tylenol + Ibuprofen + Aspirin sometimes relief. Pt states was in MVA in 2007. c/o pain in (R) shoulder + (R) upper arm. States she can't sleep on her (R) side.
PA: c/o pain = lower back + Mid thoracic spine
P: c/o numbness in (R) foot.
Neurologic exam: Consult done - states pt's gait [illegible]
PMH - Pain issues PSH - 2-C sections. meds - Tylenol + Ibuprofen.
ALL - NKDA FH - Heart d's, Lung Cancer, Alzheimers
SH - (+) Smoker - 1 ppd + ETOH - 2 beers / 3 days - c/o fatigue ick
Drugs - Ø
BP
H T W T B M I
P T
O: HENT - TMs clear + good cone. Nasal + oral mucosa moist + pink
(D) foot - (+) tender 1st MP CV - RRR + Ø by Bruce (MS - full ROM LS spine. (+) tender + tight
Tr point notable (+) tender over L-5 by L-5 spinous process
ROM tests.
A 1) DDD LS spine 2) Fibromyalgia 3) Tendinitis 4) Burn
5) Shoulder
P. 1) Darvocet 100/325 + q 6 12 "90 x [illegible]
2) Ibuprofen 800 mg + q 8 "90 x [illegible]
3) Cyclobenzaprine + q 6 8 "90 x 2 [illegible]
4) Refer to Rheumatology
5) Refer to Neurology
6) RTC ~ 3 m

(St. Ex. 1 at 32) (Image cropped to remove patient-identifying information and save space, and edited to remove Dr. Demint's signature.)

31. Dr. Demint indicated in his initial visit note that Patient 1 "[n]ever got addictionologist consult done – [illegible] just quit [illegible]." He further documented that Patient 1 consumes two beers three to four days per week. (St. Ex. 1 at 32)

32. An in-house urine drug screen taken at Patient 1's initial visit indicates negative results for all substances tested. An OARRS report obtained that day indicates that she had last received a prescription for tramadol, a controlled substance, in July 2009. (St. Ex. 1 at 8, 18)

33. Dr. Demint diagnosed Patient 1 as suffering from (1) degenerative disk disease of the lumbar spine, (2) fibromyalgia,[5] (3) tendonitis, (4) bunion, and (5) skin lesion. (St. Ex. 1 at 32)

34. At Patient 1's initial visit on June 7, 2010, Dr. Demint prescribed Norco 10/325 #90 with 2 refills, with instructions to take one tablet every six to twelve hours; ibuprofen 800 mg #90 with 2 refills, with instructions to take one tablet every eight hours; and Zanaflex 4 mg #90 with 2 refills, with instructions to take one tablet every 6 to 8 hours. In addition, Dr. Demint referred Patient 1 to a dermatologist concerning her skin lesion to rule out melanoma, and to a podiatrist concerning a bunion on her right foot. (St. Ex. 1 at 2, 32, 48, 50)

35. Following her initial visit, Patient 1 continued to see Dr. Demint on a regular basis through March 14, 2011, the last visit documented in State's Exhibit 1. During this time Dr. Demint maintained Patient 1 on the same dose of Norco. (St. Ex. 1 at 2, 28-33)

36. Patient 1 submitted to and passed a pill count of Norco on March 30, 2011. (St. Ex. 1 at 11)

37. Dr. Demint documented no additional urine drug screens from Patient 1 other than the in-house screen performed at Patient 1's initial visit. (St. Ex. 1)

Allegation 2(a): Dr. Demint inappropriately prescribed narcotics to Patient 1 for treatment of diagnosed fibromyalgia

38. Dr. Cicek testified: "Fibromyalgia is a constellation of symptoms that is—has no appreciable objective test besides pressure points to make the diagnosis. Often it's a diagnosis of exclusion when people have a pain syndrome often complicated by a mood disorder, fatigue." Dr. Cicek further testified that narcotics are not appropriate for fibromyalgia "because there are classes of drugs that are appropriate and have been proven to actually improve function in fibromyalgia," including Lyrica, Cymbalta, and amitriptyline. (Tr. at 344-345)

39. Dr. Demint acknowledged that Patient 1 had had fibromyalgia, but that she had also suffered from other conditions as well. He further testified that he had prescribed Norco not just for her fibromyalgia, but as treatment for her pain overall. (Tr. at 697-698)

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[5] Dr. Demint described fibromyalgia as a neurological disease where the patient experiences widespread pain. (Tr. at 73-74)

40. The medical records indicate that Dr. Demint actually treated Patient 1 for several diagnoses, including degenerative disk disease of the lumbar spine, tendonitis, and fibromyalgia. (St. Ex. 1 at 32)

41. Dr. Demint testified that it may be appropriate to use an opioid to treat fibromyalgia and presented a collection of literature in support of his position. The first item is an excerpt from the *Handbook of Pain Management: A Clinical Companion to Wall and Melzack's Textbook of Pain,* published in 2003. Dr. Demint referenced a statement in that book that "Opioids are effective in most acute and chronic pain states. Although opioids are fairly commonly used in the treatment of fibromyalgia * * * there have been no controlled clinical trials." (Tr. at 654-655, 680-682; Resp. Ex. I at 102)

    The next document is a medscape.com article dated February 6, 2012, entitled *Pain Negatively Affects Cognition in Fibromyalgia.* Dr. Demint described the article:

    > [T]he gist of this article is that—that people with fibromyalgia, when given opioids, have improved cognition, which was even opposite of what they thought they were going to find. Because they figured you're on an opiate, it, you know, clouds your mind. That's not what they found.
    >
    > And, again, this makes sense in pain management in that, if they are truly just treating the pain, it won't affect. It just—you know, your pain is controlled, you're not high, you're not whatever. And if your pain is controlled, then you can think better because, I don't know about you, but when my back's hurting me, I don't think as well as I do when it's not, or any other pain.

    (Tr. at Tr. at 683)

    The last document is a medscape.com abstract from a 2011 article published in the American Journal of Health-System Pharmacy entitled *Pharmacotherapy of Fibromyalgia.* Dr. Demint testified that the article discusses the various medications that are prescribed for fibromyalgia, which includes opioids. (Tr. at 683-684; Resp. Ex. J)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

42. Dr. Cicek testified that Dr. Demint diagnosed Patient 1 with: 1) low back pain, 2) tendonitis, and 3) fibromyalgia. Dr. Cicek further testified that neither tendonitis nor fibromyalgia are diagnoses that are treated with narcotics. (Tr. at 337)

    Moreover, Dr. Cicek testified that she found that 30 milligrams of hydrocodone per day that Dr. Demint prescribed to Patient 1 at her first visit had been excessive. Dr. Cicek further testified that the physical examination documented by Dr. Demint at Patient 1's first visit does not support that dose of medication. (Tr. at 347-348)

Dr. Cicek testified that Norco 10/325 is stronger than traditional Vicodin, which has 5 mg of hydrocodone rather than the 10 mg of Norco. Dr. Cicek further testified that it is not clear from Dr. Demint's notes what diagnoses the Norco was intended to treat. (Tr. at 343-344)

43. Dr. Demint testified that his prescribing *was* supported by Patient 1's test findings. Dr. Demint referred to Patient 1's December 2006 MRI report indicating, among other things, that at L1-L2 "[t]here is mild wedging of the super endplate of L1 with a prominent Schmorl's node at this level. The study shows no evidence of prominent disc bulging, herniation, or canal stenosis." The report also referenced "mild disc bulging without focal herniation or canal stenosis" at L4-L5. Dr. Demint further referenced a September 22, 2010, MRI of Patient 1's humerus showing a "mildly displaced fracture of the proximal left humerus. There is some callus formation. Hence, findings may relate to a subacute fracture. Close clinical correlation and appropriate followup is suggested." That report also stated, "Oval abnormal osseous area along the posterior aspect of the humeral head/neck region. This my represent a fracture fragment versus osteophyte. Further evaluation with x-ray or CT scan of the left shoulder may be considered." Dr. Demint testified that those reports confirm the patient's report of pain in those areas. (Tr. at 690-691; St. Ex. 1 at 45, 55)

44. Dr. Demint testified that he had prescribed Norco to Patient 1 because she had taken it before and it provided relief, and she had already been taking over-the-counter NSAIDs and analgesics without sufficient relief. He further testified that she was a working carpenter and was physically active, and she needed stronger pain relief to keep her working. (Tr. at 76, 692)

    Dr. Demint testified that Norco is a combination of hydrocodone and acetaminophen. Dr. Demint testified that the morphine equivalent dose of her prescription was 30 mg per day if she took three tablets per day. The prescription allowed for a range of two per day to four per day, but 90 tablets were prescribed per month which was sufficient for three tablets per day over the course of 30 days. (Tr. at 75-76)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy

45. Dr. Cicek testified that the Board's intractable pain rules require physicians to develop individualized treatment plans for their intractable pain patients. Dr. Cicek further testified that she did not see such an individualized plan in Dr. Demint's medical record for Patient 1. (Tr. at 349-350)

46. Dr. Cicek testified concerning individualized treatment plans:

    > [A]n individualized treatment plan for a patient is assessing what their current level of function is, where their lack of ability to do what they need to do or want to do lies. Not just what their level or number of pain is, but how that's actually functioning their every—or, affecting their everyday life. What are

> they able to do? What are they not able to do that they need to do or want to do? And what are going to be the goals of pain treatment? The goals are never to make someone pain free. The goals are to make somebody functional.
>
> * * *
>
> And there needs to be some type of objective measure of that function. For example, the patient's not able to vacuum the house, or the patient's not able to take care of their own activities of daily living like showering, bathing. The goals of this patient's treatment are to maintain that middle level where they're able to provide their self-care, clean up around the house, back the car out of the driveway, et cetera. Some type of measurable goal.

(Tr. at 348-349)

The physician should then document whether the patient is meeting or not meeting the goals established. (Tr. at 350)

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics

47. Dr. Cicek noted that Dr. Demint obtained an in-office urine screen at Patient 1's first visit in June 2010 that yielded negative results for all substances tested. Dr. Cicek testified that the physician "can be somewhat comfortable with the fact that the—the tests are negative." However, Dr. Cicek further testified that if chronic narcotics are being prescribed by a family practitioner for non-cancer pain at a first visit, the standard of care is to send an in-house urine toxicology screen to a laboratory for confirmation:

> [F]amily physicians can have expertise in areas of things like pain management; however, we're not formally trained like a pain specialist would be. Therefore, we need to talk all appropriate precautions, making sure we're prescribing correct medications in a safe situation.

(Tr. at 341)

Finally, Dr. Cicek testified that "[t]here was no formal opioid risk tool or assessment of the patient's risk for prescribing opiates." (Tr. at 337)

Allegation 2(i): Medical charting was incomplete, often illegible and/or disorganized

48. Dr. Cicek testified that she used to engage in chart review at her previous position with the McCafferty Clinic. When asked what she looks for in a family physician's chart, Dr. Cicek replied:

> [A]n initial visit with a primary care provider, a family physician, typically reviews the patient's past medical history, past surgical history, family

> history, and social history. If they are coming in for a specific problem, the previous treatment of that problem and how the problem responded to that treatment. The current medications the patient's taking, their current allergies, and what their current complaints are.
>
> And, again, if we're talking about a situation where they're complaining of chronic pain, how that pain's limiting their function, their ability to proceed or, you know, live a productive life.
>
> And then a thorough physical exam. Often a review of systems if something's not addressed in what we call the HPI, the history of the present illness. A review of systems, a physical exam, and then an assessment and plan. And your assessment isn't simply a diagnosis; it's your thought process behind what leads you to that particular diagnosis.

(Tr. at 353-355)

Dr. Cicek testified that the same is true if the patient had previously been treated by a physician in the same practice: "If the patient is seeing me as a first visit for anything—diabetes, hypertension, pain management—my responsibility as the new provider is to review the things I just mentioned." (Tr. at 355) Dr. Cicek further testified regarding the standard of care:

> A. [by Dr. Cicek] You can't provide care to someone if you don't know what care has been provided or what their comorbidities are. That's just dangerous.
>
> Q. [by Mr. Wilcox] Okay. And it's not necessarily that you may not know, but you have to document that you know?
>
> A. Correct. Correct.
>
> Q. Otherwise, it wasn't done, correct?
>
> A. And it can be as simple as the statement, "Past medical history was reviewed and updated. Past surgical history was reviewed and updated." But then that has—that assumes that it's actually documented somewhere in the chart that's easy to find; on a problem list or on an initial paper that lists the patient's past history.

(Tr. at 355-356)

49. Dr. Cicek testified that she is familiar with the adage, "If it wasn't documented it wasn't done." Dr. Cicek further testified:

> As early as nursing school I learned that, if you don't write down what you're doing, what your assessment was, what you examined, or what you discussed, that it essentially wasn't done. The importance of documentation was—was

> essentially drilled into me as a nursing student, a medical student, and then as a physician.
>
> Because not only are we legally bound by that, but if someone else is providing care for that patient, it's very difficult if the information isn't written down to know either what was done, or what was evaluated, or what the person was thinking when they were putting together the plan of care.

(Tr. at 352-353)

50. Dr. Cicek testified that she had trouble reading some of Dr. Demint's notes. Dr. Cicek further testified that a physician's notes have to be readable to other physicians: "The charts need to be legible because, in the event the provider who's writing the notes is removed from care for whatever reason—injury, illness—the person covering needs to be able to read the notes and know what the treatment plan is." (Tr. at 342-343)

51. Dr. Cicek testified that she was unable "to decipher from his note where she was receiving treatment" prior to her first return visit with Dr. Demint in June 2010. (Tr. at 336-337)

52. Dr. Cicek further testified that Dr. Demint's documentation in Patient 1's chart fell below the minimal standard of care. (Tr. at 352)

Additional Information Concerning Patient 1

53. Dr. Cicek testified that Patient 1's drinking habits are concerning because she had previously identified as testing positive for alcohol on a drug screen, plus the fact that the in-office screen she submitted to during her June 2010 visit did not test for alcohol. (Tr. at 345-346)

54. Dr. Cicek testified that she found it to be concerning that Dr. Demint's only statement concerning Patient 1's previous referral to an addictionologist was the fact that it did not get done. She testified that there was no explanation of where the patient had been treated in the interim or what had happened. (Tr. at 346)

55. Dr. Cicek testified:

> The departure from the standard of care in this particular case was not further addressing the reason she was initially discharged from the practice, or at least providing some type of risk tool for providing narcotics to a patient who was previously discharged, nor sending a urine toxicology at the initial visit for a patient who had been previously discharged.

(Tr. at 337)

56. Dr. Demint acknowledged that Patient 1 had had an inconsistent urine screen prior to coming to him. However, Dr. Demint testified that he chose to see her as a patient because

she had made a good-faith effort to see an addictionologist to whom her prior physician had referred her, her OARRS was consistent, and he believed that, if he monitored her properly, it would be okay. Dr. Demint noted that he had had no problems with Patient 1 during the time he treated her. (Tr. at 691-692, 696)

57. Dr. Demint acknowledged that he had not referred Patient 1 to a specialist, but indicated that she had seen an orthopedic specialist on her own between her first and second visits. (Tr. at 693)

58. Dr. Demint testified that he had placed Patient 1 on a medication regimen that she had previously taken with good results. Dr. Demint further testified that his prescribing had been well within "the box," and that she had received a morphine equivalent dose of 30 milligrams. (Tr. at 694-695)

59. Dr. Demint opined that his medical documentation concerning Patient 1 had been sufficient. (Tr. at 698)

60. Dr. Demint testified that he stopped seeing Patient 1 in June 2011 as a result of the change in the pain management rules. (Tr. at 696)

Patient 2

61. Patient 2, a female born in 1965, first saw Dr. Demint on March 25, 2010. By that time she had been an established patient at Lance. The medical assistant documented Patient 2's complaints on March 25, 2010, as follows: "[Recheck.] States her back and thoracic area of back achy and painful. Having muscle spasms in back and legs. [Left] knee giving her a lot of pain. Oxycontin helping more c̄ pain than opana."[6] Dr. Demint documented:

> [Complained of left] knee swelling & achy all the time. States had synvisc injection help for a little while & then pain returned. Dr. Petty now gone from area. Never saw Dr. Freeman.[7] Neurontin → upset stomach. Lyrica → caused her to swell. Insurance wouldn't pay for Voltaren. PMH – HTN, Anxiety attacks, Depression, Allergy [continued on a different page]
>
> PSH – CTS release, Partial hysterectomy, ovarian cyst removal. 2 Bx Breast.
> SH – (+) Smoker 1 ppd X 30 yrs.

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[6] The symbol c̄ is a standard medical abbreviation for "with." Other common medical abbreviations used in this note are: PMH (past (or patient) medical history), HTN (hypertension), PSH (past (or patient) surgical history), CTS (carpal tunnel syndrome), Bx (biopsy), SH (social history), ETOH (alcohol), FH (family history), CAD (coronary artery disease), DM (diabetes mellitus), HEENT (head, eyes, ears, nose, throat), WNL (within normal limits), CV (cardiovascular), RRR (regular rate and rhythm), s̄ (without), MS (musculoskeletal), ROM (range of motion), LS (lumbosacral), CLBP (chronic low back pain), DDD (degenerative disc disease), and DJD (degenerative joint disease).

[7] According to a note dated October 28, 2009, an appointment had been scheduled for Patient 2 to see Dr. Petty for an orthopedic consult on November 10, 2009. Also, an appointment had been scheduled for Patient 2 to see Dr. Freeman for a pain management consult on November 24, 2009. (St. Ex. 2 at 54)

ETOH – seldom
Drugs – [none]
FH - CAD, Cancer – Ovarian, Skin melanoma, Prostate
DM

(St. Ex. 2 at 48, 50)

In the Objective portion of his progress note, Dr. Demint documented: "HEENT – WNL CV – RRR s̄ [illegible] [lungs] – BCTA MS – Full ROM LS spine –" (St. Ex. 2 at 48)

In his Assessment, Dr. Demint documented:

1) CLBP
2) DDD lumbar spine
3) DJD knee

(St. Ex. 2 at 48)

Finally, Dr. Demint noted in his Plan:

1) [Illegible – Explain?] need to be on long acting opioid eventually
2 short acting agents.
2) Morphine Sulfate ER 30 mg [one tablet twice per day] #60 [no] refill
3) Oxycodone IR 5 mg [one tablet every 4 to 6 hours as needed for breakthrough pain #90 [no] refill
4) Naproxen 500 mg [one tablet twice per day] #60
5) [Return to clinic] 1m

(St. Ex. 2 at 48)

62. Patient 2's next visit with Dr. Demint occurred about five months later on August 20, 2010. The progress note indicates that Patient 2 was returning to Lance after having been seen by another physician, with whom Patient 2 stated she was dissatisfied. Dr. Demint's assistant noted that Patient 2 was suffering from lumbar and thoracic pain, "[a]lso c̄ knee, arm and elbow pain." Dr. Demint documented: "Pt [complained of] pain [with or in] back, knee & arm. States [illegible] [illegible – got?] pain in low back & radiates [left] leg to foot." On physical examination, Dr. Demint made the following musculoskeletal findings: "↓ ROM [illegible – ll (left (or lower) leg)?] [illegible – plus?] LS spine." (St. Ex. 2 at 47)

In addition, Dr. Demint documented her current medications as: Opana 30 mg, one tablet twice per day; oxycodone 15 mg, one tablet four times per day; alprazolam 1 mg, one tablet three times per day; tizanidine 4 mg,[8] one tablet three times per day; along with verapamil, spironolactone, and Celexa. Dr. Demint documented that Patient 2 had advised that "Opana

[8] Tizanidine is the generic name for Zanaflex. (Tr. at 91)

does nothing" and that Celexa was not helping with her depression. She further stated that her pain was better controlled with OxyContin 10 mg.

Dr. Demint listed the same diagnoses previously identified in the March 2010 progress note. (St. Ex. 2 at 47)

Dr. Demint testified that his plan was for Patient 2 "was the medication" and for Patient 2 to return in one month. However, the progress note does not specify which medications were utilized: the medications that Dr. Demint previously prescribed or the medications that Patient 2 claimed to have been taking at that time. (St. Ex. 2 at 47; Tr. at 96) Fortunately, Dr. Demint kept a medication log elsewhere in the chart that indicates he prescribed the following medications: Oxycodone IR 5 mg #120, one tablet every 4 to 6 hours as needed for breakthrough pain; OxyContin 20 mg # 60, one tablet twice per day; tizanidine 4 mg #90, one tablet three times per day; plus fluoxetine, furosemide, and verapamil. (St. Ex. 2 at 3)

63. The following table identifies the medications and dosages prescribed by Dr. Demint to Patient 2:

Date of Script	Medication(s) Prescribed by Dr. Demint
3/25/10	morphine sulfate ER 30 mg #60 twice per day oxycodone IR 5 mg #90 three times per day Naprosyn 500 mg #60 twice per day [note Patient 2 still had refills for Xanax 1 mg #60, among other non-controlled meds]
8/20/10	OxyContin 20 mg #60 twice per day oxycodone IR 15 mg #120 every 4-6 hrs prn Xanax 1 mg #90 every 8-12 hours Verelan 120 mg[9] #30 x 2 refills twice per day verapamil 120 mg #30 x 2 refills[10] twice per day tizanidine 4 mg #90 x 2 refills three times per day fluoxetine 2 mg[11] #30 once per day furosemide 20 mg[12] #30 x 2 refills once per day

[9] Verelan is a brand name of verapamil, which is used to treat high blood pressure and control angina. (MedLine Plus, *Verapamil*, http://www.nlm.nih.gov/medlineplus/druginfo/ meds/a684030.html, accessed November 28, 2012)
[10] Note that verapamil and Verelan are the same medication. The medication log indicates that Patient 2 was instructed to take one tablet of Verelan in the morning and one at night. With respect to verapamil, the medication log first indicates QID (four times per day) which is scratched out, then QD (one per day) which is also scratched out, then BID (twice per day). However, Dr. Demint only prescribed 30 tablets of each medication, which is a sufficient quantity for Patient 2 to have taken one of each per day, totaling 240 mg of the medication per day. Dr. Demint's progress note for the August 20, 2010, visit does not explain why the medication was prescribed this way. Later, in October and November 2010, Dr. Demint discontinued the brand name prescription and prescribed only verapamil 120 mg #60, with instructions to take one tablet twice per day. (St. Ex. 2 at 3, 47)
[11] Fluoxetine is the generic name for Prozac, an antidepressant. (MedLine Plus, *Fluoxetine*, http://www.nlm.nih.gov/ medlineplus/druginfo/meds/a689006.html, accessed November 28, 2012)
[12] Furosemide is the generic name for Lasix, a diuretic used to treat water retention and high blood pressure. (MedLine Plus, *Furosemide*, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682858.html, accessed November 28, 2012)

Date of Script	Medication(s) Prescribed by Dr. Demint
9/13/10	OxyContin 20 mg #60 twice per day oxycodone IR 15 mg #120 every 4-6 hrs prn Xanax 1 mg #90 every 8-12 hours gabapentin 300 mg[13] #72 three times per day Effexor 25 mg[14] #72 three times per day
10/11/10	OxyContin 20 mg #60 twice per day oxycodone IR 15 mg #120 every 4-6 hrs prn Xanax 1 mg #90 every 8-12 hours verapamil 120 mg #60 x 2 refills twice per day gabapentin 300 mg #90 three times per day
11/15/10	OxyContin 20 mg #60 twice per day oxycodone IR 15 mg #120 every 4-6 hrs prn Xanax 1 mg #90 every 8-12 hours Claritin 10 mg #30 x 2 refills once per day tizanidine 4 mg #90 x 2 refills three times per day furosemide 20 mg #30 x 2 refills once per day gabapentin 300 mg #90 x 2 refills three times per day
12/10/10	OxyContin 20 mg #60 twice per day oxycodone IR 15 mg #120 every 4-6 hrs prn Xanax 1 mg #90 every 8-12 hours Z-Pak[15] as directed
1/10/11	oxycodone 30 mg #112[16] every 6 hrs prn Xanax 1 mg #84 every 8-12 hours verapamil 120 mg #60 x 2 refills
2/4/11	oxycodone 30 mg #112 every 6 hrs prn Xanax 1 mg #84 x 2 refills every 8-12 hours tizanidine 4 mg #90 x 2 refills three times per day gabapentin 300 mg #90 x 2 refills three times per day
2/28/11	oxycodone 30 mg #112 every 6 hrs prn furosemide 300 mg #30 x 2 refills three times per day
4/1/11	The progress note references the medication log, but there is no medication log for this date. A new medication log lists medications but no date and identifies no prescriptions issued. (St. Ex. 2 at2)

(St. Ex. 2 at 3)

64. The chart indicates that Patient 2 submitted to and passed a pill count on October 11, 2010. (St. Ex. 2 at 13)

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[13] Gabapentin is the generic name for Neurontin, an anticonvulsant that is also used to treat radicular pain. (Tr. at 427; MedLine Plus, *Gabapentin*, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a694007.html, accessed November 28, 2012)

[14] Effexor is a brand name for venlafaxine, an antidepressant. (MedLine Plus, *Venlafaxine*, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a694020.html, accessed November 28, 2012)

[15] Z-Pak was documented in the progress note only. (St. Ex. 2 at 41)

[16] Dr. Demint discontinued prescribing OxyContin. The progress note indicates that Patient 2 had complained about the cost of OxyContin versus oxycodone IR. (St. Ex. 2 at 3, 38)

65. No urine toxicology screens are documented during the time period that Dr. Demint treated Patient 2. (St. Ex. 2)

66. On May 3, 2010, Dr. Demint obtained an OARRS report on Patient 2. Subsequently, in March 2011, Dr. Demint obtained reports concerning Patient 2 from OARRS, KASPER, and the West Virginia Board of Pharmacy. (St. Ex. 2 at 15-20)

67. On June 28 and August 20, 2010, Patient 2 signed medical records releases directed to her former treatment provider. (St. Ex. 2 at 64, 139)

68. On October 11, 2010, Dr. Demint referred Patient 2 for a psychiatric consult based upon a diagnosis of depression. However, a Post-it note on the referral form says, "patient no longer has insurance or her job. Wants to wait on psychiatrist." (St. Ex. 2 at 61)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

69. Dr. Cicek stated that the amount of controlled substance medication prescribed to Patient 2 by Dr. Demint was not supported by the physical findings he documented in the chart. (Tr. at 360-362)

    Dr. Cicek testified that, at Patient 2's first visit with Dr. Demint, Dr. Demint addressed the patient's surgical, medical, social, and family history. However, she testified that documentation of the physical examination was simply that Patient 2 had full range of motion in her lumbosacral spine. Dr. Cicek further testified: "A musculoskeletal exam encompasses more than range of motion of the lumbosacral spine. It encompasses reflex testing, strength, sensation, range of motion, muscle asymmetry or atrophy" as well as the "patient's ability to walk, sit, stand." Dr. Cicek further testified that observing the patient's ability to get on and off the examination table can often be useful. (Tr. at 357-358)

70. Dr. Demint testified that MRIs from June and October 2009 confirm Patient 2's subjective complaints:

    - A June 16, 2009, report of a lumbar spine MRI stated the following impression: "Degenerative changes are seen in the facet joints." (St. Ex. 2 at 88)

    - An October 8, 2009, report of an MRI of Patient 2's left knee stated the following impressions: (1) Moderate Baker's cyst; (2) Mild osteoarthritis at the patellofemoral and medial compartments of the knee joint with associated chondromalacia as described elsewhere in the report, which references Grade II and Grade I chondromalacia; and (3) Mucoid degeneration at the posterior horn of the medial meniscus without evidence of discrete meniscal tear. (St. Ex. 2 at 91-92)

    (Tr. at 699-701)

71. Dr. Demint testified that his prescribing to Patient 2 had been within "the box," and that he had started her on a morphine equivalent dose of between 45 to 55 milligrams. However, assuming that the "morphine equivalent dose" concept applies to a *daily* dose, Dr. Demint's testimony does not agree with the medical records. For example, on March 25, 2010, Dr. Demint prescribed, among other things: morphine sulfate 30 mg to be taken twice per day, and oxycodone 15 mg with a supply sufficient to take three per day over the course of 30 days. That is 60 milligrams of morphine per day plus 45 milligrams of oxycodone per day. Assuming a one-to-one ratio between oxycodone and morphine, that is 105 milligrams morphine equivalent dose ("MED") per day at the first visit. (Tr. at 702-703; St. Ex. 2 at 3, 48, 50)

72. Dr. Demint testified that he had not tried Patient 2 on any non-medication therapies because she had already been taking OxyContin 10 mg and oxycodone 15 mg. However, Dr. Demint testified that he had discussed with Patient 2 going to physical therapy, and that he had documented that discussion in his April 1, 2011, progress note. (Tr. at 701-702; St. Ex. 2 at 33)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy

73. Dr. Cicek testified that she could not find any documentation of an individualized treatment plan for Patient 2 in her medical record, and that that is a violation of the Board's intractable pain rules. (Tr. at 360-362)

74. Dr. Demint disagreed with Dr. Cicek's opinion that he had failed to develop an individualized treatment plan for Patient 2. (Tr. at 714)

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics

75. Dr. Cicek testified that Dr. Demint failed to obtain a toxicology screen during the time he treated Patient 2. (Tr. at 360-362)

76. Dr. Demint acknowledged that he did not order a urine drug screen for Patient 2, but testified:

> I saw no reason to. Again, the—at that time, the law said "may" when you suspect aberrant behavior. This patient had no aberrant behavior. This patient had been consistent. Her pill counts was consistent. Her drug screens [from other physicians] were consistent. Her OARRS were consistent. Her [KASPER] and West Virginia was consistent.

(Tr. at 102)

77. Dr. Demint testified that he had obtained an OARRS report on Patient 2, as well as KASPER and West Virginia Board of Pharmacy reports. He also testified that he had

performed a pill count, which was consistent. In addition, Dr. Demint testified that he had obtained a urine drug screen on April 21, 2010; however, that screen had been ordered by another physician at Chillicothe Acute Care Clinic, not Dr. Demint. (Tr. at 703-704; St. Ex. 2 at 10)

Allegation 2(h): Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment

78. Dr. Cicek stated:

> There were multiple mentions of anxiety and depression and significant life/home stressors and Dr. Demint appropriately referred [Patient 2] to a psychiatrist in October 2010 after trying a few different antidepressants. The patient never followed through with this referral due to "problems with insurance."

(St. Ex. 16 at 2)

Allegation 2(i): Medical charting was incomplete, often illegible and/or disorganized

79. In her report, Dr. Cicek stated, in part:

> The documentation for [Patient 2] was often difficult to read and information is scant. Physical exams were not consistent with the subjective level of disability. The patient's severe anxiety and depression did not appear to have been well treated, as there were constant complaints of this through the record. Treating her anxiety and depression appropriately and utilizing the expertise of a psychiatrist would likely have aided in her pain management. The medication used to manage her chronic anxiety was not ideal. The amount of narcotic the patient received was not supported by her clinical findings (exam and tests). **This demonstrates a departure from the minimal standards of care that would be employed by similar practitioners.**

(St. Ex. 16 at 2) (Emphasis in original)

Additional Information

80. Dr. Demint noted that Dr. Cicek had stated in her report that his first visit with Patient 2 had taken place in August 2010 when, in fact, he first started treating Patient 2 on March 25, 2010. (Tr. at 704; St. Ex. 16 at 2)

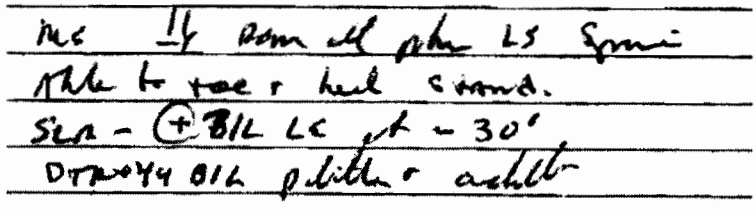
Patient 3

81. Patient 3, a male born in 1963, had previously been a patient of Dr. Demint's at his office in Kingston, Ohio, in the early 2000s. On December 29, 2010, Patient 3 returned to Dr. Demint at his re-opened Kingston practice and complained of constant pain in his lower back. Dr. Demint documented:

> States at night pain goes [left] gluteal/hip area. Pain level [illegible] 9/10. Use cane for stability. [Symptoms] "years" at least 7 yrs. Saw Southern Ohio Pain for years. Has been going to ER & taking lots of Tylenol & Ibuprofen. States went to ER at least 1/month. States x-rays were done in ER. States ER said his stomach was torn up from the otc meds he was taking.

(St. Ex. 3 at 19, 51) Dr. Demint further noted that Patient 3's urine drug screen had been positive for oxycodone and benzodiazepines.[17] Dr. Demint also documented that Patient 3 "denies arrest or legal problems [illegible] drugs or ETOH." (St. Ex. 3 at 51-52)

Dr. Demint documented the following physical examination findings:



(St. Ex. 3 at 51)

Dr. Demint diagnosed chronic lower back pain, and degenerative disc disease and spondylosis in the lumbosacral spine. (St. Ex. 3 at 51; Tr. at 107)

Dr. Demint prescribed oxycodone 15 mg #10, one tablet four times per day, gabapentin 300 mg #72, gradually increased to one table three times per day, and told Patient 3 to return in one month. (St. Ex. 2 at 15, 51)

82. An OARRS report obtained by Dr. Demint on December 29, 2010, indicates that Patient 3 had obtained tramadol, hydrocodone/APAP, and oxycodone/APAP[18] from several different

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[17] No prescription for a benzodiazepine was identified on the December 29, 2010 OARRS report or in the ER records for Patient 3's visits on December 19, 21, and 25, 2010. (St. Ex. 3 at 56-61)

[18] APAP is acetaminophen, the active ingredient in over-the-counter Tylenol. Hydrocodone/APAP is a generic equivalent of brand-name medications such as Vicodin and Norco; oxycodone/APAP is a generic equivalent of brand-name medications such as Percocet and Endocet. (MedLine Plus, *Acetaminophen*, http://www.nlm.nih.gov/medlineplus/druginfo/meds/ a681004.html, accessed November 30, 2012)

practitioners since September 2010, the last prescription having been tramadol issued on December 21, 2010. (St. Ex. 3 at 53)

In addition, the chart contains records of ER visits including a visit on December 18, 2010, for dental pain, when she received Vicodin and Pen Vee K. Two days later, on December 21, 2010, Patient 2 visited the ER for a complaint of dental pain and again received Vicodin and Pen Vee K. A few days later, on December 25, 2010, Patient 2 was seen at the ER for complaints of dental pain and diagnoses of dental abscess and odontalgia.[19]

83. At Patient 3's February 26, 2011, visit, Dr. Demint added a diagnosis of radicular symptoms. At that visit, he referred Patient 3 to physical therapy. (St. Ex. 3 at 47, 49)

84. The following table identifies the controlled substance medications prescribed by Dr. Demint to Patient 2, and the results of his urine drug-screens:

Date of Script	**Controlled Substance Medication(s) Prescribed by Dr. Demint**	**Date of Urine Sample**	**Positive Results for Urine Sample**	**Negative Results For Prescribed Medication(s)**
12/29/10	oxycodone 15 mg #120	12/29/10[20]	temazepam oxazepam hydromorphone[21] oxycodone oxymorphone[22]	hydrocodone
1/26/11	oxycodone 15 mg #120	n/a		
2/26/11	oxycodone 15 mg #150	n/a		
3/26/11	oxycodone 15 mg #150	3/26/11	buprenorphine[23]	oxycodone

(St. Ex. 3 at 15, 46-52)

[19] Odontalgia means toothache. (MedLine Plus Medical Dictionary, http://www.merriam-webster.com/medlineplus/odontalgia, accessed February 1, 2013)

[20] This tested for substances in Patient 3's urine *before* receiving any prescription from Dr. Demint. As previously noted, Patient 3 had received prescriptions for tramadol, hydrocodone/APAP, and oxycodone/APAP

[21] Hydromorphone is the generic name for Dilaudid. Hydromorphone is also detectable in urine as a metabolite of hydrocodone. (St. Ex. 3 at 13; MedLine Plus, *Hydromorphone Oral and Rectal*, http://www.nlm.nih.gov/medlineplus/druginfo/ meds/a682013.html, accessed November 30, 2012; National Center for Biotechnology Information/Mayo Clinic/Smith, H.S., *Opioid Metabolism*, July 2009, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2704133/, accessed November 30, 2012)

[22] Oxymorphone is the generic name for Opana. Oxymorphone is also detectable in urine as a metabolite of oxycodone. (St. Ex. 3 at 13; MedLine Plus, *Oxymorphone*, http://www.nlm.nih.gov/medlineplus/druginfo/ meds/a610022.html, accessed November 30, 2012; National Center for Biotechnology Information/Mayo Clinic/Smith, H.S., *Opioid Metabolism*, July 2009, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2704133/, accessed November 30, 2012)

[23] Buprenorphine is the generic name for Suboxone, a medication used to treat opioid dependence. (MedLine Plus, *Buprenorphine Sublingual*, http://www.nlm.nih.gov/medlineplus/druginfo/ meds/a610022.html, accessed November 30, 2012)

85. Patient 3's March 26, 2011, visit was his last visit with Dr. Demint. Following that, the chart includes a note dated March 30, 2010, that states: "Set pt. appt for April 6th @10:10 a.m. w/ Dr. Evans." (St. Ex. 3 at 46)

Allegation 2(b): Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records

86. Dr. Cicek testified that Dr. Demint made no notation on the initial visit form that he had reviewed Patient 3's prior medical records: "[T]ypically, when you receive old records on a patient, either a notation is made on the chart that the records have been received and reviewed, or a notation is made on the actual records * * * that they're received and reviewed. Because, again, if it's not written down, it's not done." Dr. Cicek testified that it is important that a physician review the prior records "[t]o know what their previous treatment had been and if there were any heightened concerns about opioid prescribing for a patient." (Tr. at 365-366)

87. Dr. Demint testified that he routinely goes through the prior treatment records of patients he sees for the first time. He further testified that he routinely reviews a patient's chart every time he looks at it. However, Dr. Demint testified that he does not always document his review. (Tr. at 99-101)

88. Dr. Demint testified that he diagnosed chronic low back pain, degenerative disk disease, spondylosis, and "lumbosacral spine," which is why he is sure that he had had Patient 3's prior medical records. Dr. Demint further testified that he had seen Patient 3 previously, in 2003, and identified an earlier progress note from May 10, 2003. (Tr. at 107; St. Ex. 3 at 115)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

89. Noting that Dr. Demint prescribed oxycodone 15 mg #120 at Patient 1's December 2010 visit, Dr. Cicek found that the amount of narcotics he prescribed was not supported by the history and physical examination findings. She noted that Patient 3 had normal reflexes and normal strength in his lower extremities, although his straight-leg raise was positive, which can be indicative of radicular pain. Dr. Cicek further testified that the patient had been receiving just regular-strength Vicodin and tramadol for his pain, and then Dr. Demint placed him "on high-dose oxycodone. So it was a drastic jump from what he had been receiving, according to his OARRS report." Moreover, Dr. Cicek testified that no reason was documented for the increase in medication from what Patient 3 had been receiving: "The assessment is only a statement of the diagnoses. There is not an assessment of his previous pain control in the assessment or, again, what his goals or objectives for the treatment were." (Tr. at 363-364)

90. When asked what nonnarcotic alternatives he had considered prior to prescribing oxycodone, Dr. Demint noted that his plan included (along with oxycodone) obtaining EMG and nerve conduction studies, and that he increased Patient 3's gabapentin and added a medication called Savella, "an SNRI antidepressant" used to treat neuropathic pain. When asked again if he had considered nonnarcotic alternatives *prior* to initiating

oxycodone, Dr. Demint did not answer directly, responding that the patient needed pain medication while Dr. Demint was working up the cause of his pain. (Tr. at 115-116)

Allegation 2(g): Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports; and

Allegation 2(h): Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment.

91. With respect to Patient 3's December 29, 2010, urine drug screen, Dr. Cicek testified that Patient 3 tested positive for benzodiazepines and oxycodone but not hydrocodone, even though hydrocodone had been prescribed to him recently. She further noted that, according to an OARRS report, Patient 3 had not filled a prescription for oxycodone since September 2010, three months earlier. Moreover, she noted that Patient 3 had not been prescribed any benzodiazepines. Therefore, Dr. Cicek testified that, even though the positive benzodiazepine results were marked "Consistent" on a confirmation report, the results were actually inconsistent because there is no record of Patient 3 having received a prescription for a benzodiazepine. (Tr. at 366-368)

    Additionally, with respect to a urine sample submitted by Patient 3 at his last visit on March 26, 2011, Dr. Cicek noted that the in-house test was positive for buprenorphine, which Dr. Demint did not prescribe, and negative for oxycodone, which Dr. Demint *did* prescribe. Dr. Demint documented in his progress note for that visit that Patient 3 denied using buprenorphine, and told Dr. Demint that he thought he had the flu and had been unable to keep anything down for two days. (Tr. at 368-370; St. Ex. 3 at 8, 46)

    Dr. Cicek testified that, under those circumstances, the standard of care would have required that Dr. Demint limit his prescribing to ten days' worth of medication and then bring Patient 3 back following laboratory confirmation of the in-house results. However, Dr. Cicek testified that the prescriptions Dr. Demint provided authorized the usual one-month supply of medication. (Tr. at 370-371)

92. Dr. Demint testified that he obtained OARRS, KASPER, and West Virginia Board of Pharmacy reports on Patient 3. Dr. Demint further testified that he obtained a second OARRS report in March 2011 that led to Patient 3's discharge from his practice. (Tr. at 709-710)

    Dr. Demint further testified that he performed a urine drug screen on Patient 3 that he had believed at the time to be consistent. Dr. Demint testified that, even though Patient 3 had tested positive for hydrocodone, and Dr. Demint had prescribed only oxycodone, he had reasoned that Patient 3 had been receiving medication from ERs and he may have had some hydrocodone left in his system. Dr. Demint further testified that a positive test with a

reasonable explanation is not a red flag. However, Dr. Demint testified that he later discharged Patient 3 for a second failed drug test. (Tr. at 710-711; St. Ex. 3 at 11)

93. On March 26, 2011, Dr. Demint obtained an in-house urine drug screen on Patient 3 that tested positive for buprenorphine. When asked why he had continued to prescribe oxycodone despite the positive test, Dr. Demint replied that he would not discontinue the patient's medication because it could have been a false positive. He further testified that he would first have to obtain laboratory confirmation of the positive result. (Tr. at 110-112)

    Dr. Demint acknowledged that there is no lab confirmation in State's Exhibit 3 for the March 26, 2011, urine drug screen but testified that the Board had subpoenaed the medical records shortly after Patient 3's March 26, 2011 appointment. He testified that he probably received the confirmation after the Board had subpoenaed Patient 3's record. (Tr. at 110-111)

Allegation 2(i): Medical charting was incomplete, often illegible and/or disorganized

94. At hearing, Dr. Cicek noted that the initial visit note for Patient 3 was more thorough than for the previous two patients. Nevertheless, Dr. Cicek testified that she found overall that Dr. Demint's chart for Patient 3 was below the minimal standard of care because of the illegibility of Dr. Demint's handwriting; she "had a lot of trouble reading the notes." (Tr. at 362-363)

Additional Information

95. Dr. Demint testified that he referred Patient 3 to physical therapy, and also referred him to a physical medicine and rehabilitation specialist for EMG studies. (Tr. at 710; St. Ex. 3 at 46)

96. Dr. Demint criticized Dr. Cicek for stating that he did not order physical therapy when, in fact, he did. Dr. Demint further disagreed with Dr. Cicek's opinions that he failed to appropriately document the patient's history, that his prescribing was not supported by the findings, and that he failed to properly document the actions taken in response to signs of patient drug abuse. Regarding the last point, Dr. Demint testified that he "discharged the patient after he failed a drug test and failed to respond to a pill count." (Tr. at 713-716)

Patient 4

97. Patient 4, a male born in 1960, first saw Dr. Demint on March 25, 2010, at Lance. At that time he was an established patient at that practice and had last been seen (by another physician) on February 19, 2010. (St. Ex. 4 at 31, 59-60)

    Dr. Demint's initial visit note states that Patient 4 had complained of "a lot of pain" in his back, right knee, and right shoulder, and that he had been out of medication. Dr. Demint documented that Patient 4 had advised that Percocet was not helping with his pain along with oxycodone IR. Dr. Demint noted that Patient 4 has a history of Hepatitis B, hiatal hernia, and suffers from

anxiety: "states grandchild died in his arms in 2008, has been upset since." Dr. Demint documented a physical examination finding that Patient 4 had decreased range of motion in all planes of the lumbosacral and thoracic spine. Dr. Demint diagnosed chronic back pain, degenerative disc disease in the thoracic and lumbosacral spine, anxiety, and hiatal hernia. (St. Ex. 4 at 59)

Dr. Demint documented as his plan to explain to Patient 4 the need to switch to an extended release opioid rather than take two short-acting opioids. Dr. Demint discontinued Percocet and prescribed morphine sulfate ER 30 mg #60 with instructions to take one tablet twice per day, continued oxycodone IR 30 mg #120 with instructions to take one tablet every six hours, continued Xanax 2 mg #75 with instructions to take one-half to one pill every eight hours as needed. Further, although not mentioned on the progress note, the medication log indicates that Dr. Demint also continued Patient 4's prescriptions for Zantac and Nexium and discontinued Veramyst Spray and Androgel. (St. Ex. 4 at 2, 59)

98. Medical records obtained from another practice, Chillicothe Acute Care Clinic, indicate that Patient 4 had been seen at that practice beginning in April 2010 by the same physician who had previously treated him at Lance. On April 21, 2010, Patient 4 received prescriptions including MS Contin, oxycodone IR, and alprazolam. In May and June 2010 he received prescriptions for OxyContin, oxycodone IR, and alprazolam, among other, non-controlled medications. As of June 2010, Patient 4 was receiving 200 milligrams of oxycodone per day: OxyContin 40 mg twice per day and oxycodone IR 30 mg every six hours, in addition to six milligrams of alprazolam per day. On July 21, 2010, Nucynta 100 mg #120, one tablet four times per day, was substituted for oxycodone IR. Patient 4 continued to receive OxyContin and alprazolam. (St. Ex. 4 at 91-106)

Subsequently, a note dated July 26, 2010, written by staff at Chillicothe Acute Care indicates that Patient 4 had been repeatedly calling the clinic complaining that "he wants his Percocets back" and that his disability coverage would not pay for them. The note further states that Patient 4 "proceeded to get rude and obnoxious" with the staff member. The note includes a description of an ensuing argument between the staff member and Patient 4:

> I told him, he still has not produced the records from Social Security where he told us he had been disabled some twenty years ago. We have records from 2006 and 2008, new MRI's etc., which show nothing. He stated he had a back injury; muscles were ripped from his spine. I told him, all of his tests we have [show] nothing, but a tear in his shoulder, that he never did anything about. He stated he did see a doctor in Portsmouth who wouldn't do the surgery, but was unable to produce the records. He said he did not want to contact SS, as they will get "nosey" and start snooping around. He came to this appointment and still did not have any records.

(St. Ex. 4 at 90) The note goes on to state that the treating physician decided that Patient 4 should be discharged "[d]ue to his misconduct and disagreeing with" the physician with respect to his care. (St. Ex. 4 at 90)

99. About one week later, on August 2, 2010, Patient 4 returned to Lance and saw Dr. Demint. Dr. Demint documented among other things that the patient advised that the other doctor had given him Nucynta breakthrough pain medication that he cannot obtain approval or preauthorization for. Dr. Demint prescribed oxycodone IR 15 mg #70 with instructions to take one tablet every six to eight hours as needed. (St. Ex. 4 at 2, 58)

100. Patient 4 next saw Dr. Demint on August 20, 2010. Dr. Demint prescribed essentially the same regimen that Patient 4 had received at the other practice in June: OxyContin 40 mg twice per day and oxycodone IR 30 mg every six hours, totaling 200 milligrams of oxycodone per day, plus Xanax 2 mg every eight hours, totaling six milligrams of alprazolam per day, in addition to other, non-controlled medications such as Nexium, Claritin, Advair, and Ventolin. (St. Ex. 4 at 2, 58)

101. Patient 4 continued to see Dr. Demint on a regular, monthly basis through April 2011, the last visit documented in State's Exhibit 4. Patient 4 received prescriptions for the same quantities of oxycodone and alprazolam each month. (St. Ex. 4 at 2, 40-58)

102. Dr. Demint obtained a urine sample for toxicology screening from Patient 4 in February 2011 that yielded results that were consistent with Dr. Demint's prescribing. (St. Ex. 4 at 9-11)

103. During the time that Dr. Demint treated Patient 4, Dr. Demint referred him to, or obtained for him various other medical or medically-related services including a urological consult in April 2010, a chest x-ray to rule out lung cancer and blood tests in August 2010, an MRI of the left shoulder in early September 2010, an MRI of the thoracic spine in late September 2010, a colonoscopy and a CT lung scan in October 2010, renewal of a five-year vehicle disability placard in January 2011, and physical therapy in April . (St. Ex. 4 at 111-117, 137, 139, 145-147, 161; St. Ex. 16 at 5)

104. The October 2010 CT lung scan was ordered in response to the radiologist's recommendation following the September 2010 thoracic spine MRI: "Indeterminate 3 mm T2 hyperintense nodular focus in the posterior left lung. Pulmonary nodule versus artifact. This is nonspecific for post inflammatory neoplastic etiology. Further evaluation with contrast enhanced CT of the chest is advised as a precautionary measure." (St. Ex. 4 at 53, 112, 161)

Dr. Demint documented the results of the CT lung scan in his November 15, 2010 progress note which appear to be positive for something; however, the Hearing Examiner is unable to read Dr. Demint's handwriting. (St. Ex. 4 at 51) Dr. Demint's note is reproduced below, enlarged from the original exhibit:

Tendon Reflex (L5-S1): _____

CT - (+) [illegible] LLL.

(St. Ex. 4 at 51)

Dr. Demint's plan might include a referral for something; however, again, the Hearing Examiner cannot read Dr. Demint's handwriting. It might also concern Dr. Demint's discontinuation of Patient 4's Proventil inhaler (see State's Exhibit 4 at 2). The possible referral is circled below:

PLAN

Y N Discuss pain and its etiology, prognosis and treatment options
Y N Patient was given instruction sheet on Back Pain
Y N Patient instructed on the risks and benefits of prescription medications and was advised to also read the pharmacy hand out sheet about their medication.
Y N The patient was advised to use heat/ice for pain management
RX prescribed: _____
Y N Physical Therapy at this time: __ US __ Alpha Stim __ Massage __ Manipulation __ ROM exercises __ Strengthening exercises __ Stretching exercises __ Balance exercising __ other: _____
Y N Testing: ___ X-rays : _____ ___ MRI: _____
___ EMG/NCT: _____ ___ Labs: ___ CBC w/diff ___ ESR ___ CRP ___ CMP ___ TSI
___ Urinalysis ___ HLA-B27 ___ Arthritis Profile ___ other: _____
Y N Discuss injections.

(St. Ex. 4 at 51)

Allegation 2(b): Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records

105. Dr. Cicek testified that if a new patient comes to a physician who has Hepatitis B or C, the physician needs to find out how the patient acquired that disease, whether the patient had a blood transfusion, obtained tattoos someplace other than a tattoo shop, or has a history of intravenous ("IV") drug use. Dr. Cicek noted that Dr. Demint obtained a liver function test in August 2010; however, she testified that Hepatitis B could not be ruled out based upon the results of that test. Dr. Cicek further testified that there is a specific test for hepatitis B and C. Moreover, if a patient informs a physician that he or she has hepatitis B and the physician does not have documentation of it, "the standard of care is to test for it." (Tr. at 372-373; St. Ex. 4 at 114)

Dr. Cicek testified that, if a patient has hepatitis B, that is a red flag and the physician needs to know how the patient was exposed to that disease "and confirm it wasn't through intravenous drugs." However, she testified that Dr. Demint only documented that Patient 4 had a history of hepatitis B; there was no statement concerning how that had been obtained, diagnosed, treated, or "addressed in terms of risk for prescribing narcotics." Moreover, Dr. Cicek testified that that omission does not reflect a thorough review of the patient's history. (Tr. at 374-375)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings;

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy; and

Allegation 2(h): Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment.

106. Dr. Cicek testified that the type and amount of medication that Dr. Demint prescribed to Patient 4 was not supported by the physical findings or documentation in the chart. Dr. Cicek further testified:

> [T]he patient has some subjective complaints; and we have a physical exam, again, consisting of decreased range of motion all planes of the lumbosacral and T spine, is the physical exam. So there's not a thorough physical exam of what exactly the patient's limitations are in relation to strength, gait, ability to navigate up and down from a chair, walk around the room. And there is no note in here of what the patient's pain's actually limiting him from doing.

(Tr. at 375-376)

Dr. Cicek testified that such documentation is part of formulating an individualized treatment plan for the patient, and is therefore required by the standard of care. Dr. Cicek further testified:

> The patient also mentions in the note that he has some stressors in his life of a grandchild dying in his arms and some underlying anxiety. In a situation like that, further exploration before giving large doses of narcotics would be indicated, as well, because of the effect of household stressors or an unstable household in someone who has a large amount of medication.

(Tr. at 376)

107. Dr. Cicek testified that she did not find documentation in Patient 4's chart that Dr. Demint had developed an individualized treatment plan for Patient 4. (Tr. at 376-377)

108. Noting that a number of the patients in this matter had severe limitations and/or multiple surgeries, Dr. Cicek was asked if Dr. Demint still had to document that he had discussed alternative treatments with the patients. Dr. Cicek replied:

> Yes. It's part of the initial visit, what treatments have been tried and been successful or failed. It's, again—Again, there's not data supporting long-term use of narcotics in chronic pain, so the goal is not to put someone on these medications and leave them on forever. The goal is, again, to put someone on the medication, get them to the most functional level that you can at the lowest possible dose of medication so they don't develop opioid hyperalgesia. And incorporating nonmedicinal approaches towards chronic pain is always indicated.

> You don't treat a broken leg just by giving a pain medication. You treat a broken leg by fixing it surgically, sending the patient to therapy, teaching them preventive strategies. You don't treat hypertension by just prescribing a medicine; you incorporate diet, lifestyle.

(Tr. at 378-379)

109. Referring to Patient 4's conduct documented by Chillicothe Acute Care, Dr. Cicek testified that it is a red flag when a patient repeatedly calls and becomes rude with office staff: "it doesn't mean the patient's a problem, but it means further exploration is indicated." Dr. Cicek further testified:

> I would review it with the patient because pain contracts almost always specifically state—well, they should state the expectations from the patient. And one of the expectations is that the patient behaves in an acceptable manner in the office. And calling people names on the phone isn't an acceptable manner.

(Tr. at 380)

110. Dr. Demint testified that, when he began working for Lance, there were a lot of things that the staff was not doing, and he had to work with the staff there to get them to do the things that he needed them to do. Dr. Demint further explained:

> I had to prioritize these patients, risk manage them, okay; what's the highest risk, what's the lowest risk. So, you know, when I'm—was going through these patients, the ones I was more getting first were the ones that were higher risk.
>
> Here's a man 50 years old with very few risk factors, I felt was a very low risk. He had been consistent. He had previous consistent tests he had previous consistent pill counts, had a consistent pill count with me, and has a consistent OARRS, KASPERs and West Virginia, at least once—let's see, how many—several of them—several of them at least down in here. Let me see how many. Four OARRS were done. All consistent. This man's risk was very low.
>
> We cannot be drug testing everybody every visit or the cost to the system will become so humongous, we won't be able to support it. We have to—What we do in pain management is we try to put risk to people; people at higher risk gets more surveillance, people with less risk gets less surveillance. You know, you try to make it make sense.

(Tr. at 135-137)

111. Dr. Demint testified that he had had objective evidence that supported Patient 4's claims of pain; namely MRIs showing spine abnormalities and disk herniation. Dr. Demint disagreed

with Dr. Cicek that those findings were minimal. Dr. Demint further testified that he had diagnosed Patient 4 with GERD and COPD, and that the GERD diagnosis is significant because that limits the patient's ability to tolerate NSAIDs. (Tr. at 716-717, 721-722)

112. Dr. Demint testified that he had assumed the care of Patient 4 at Lance, and first saw him on March 25, 2010. Dr. Demint testified that Patient 4 had indicated a history of hepatitis B, but that Dr. Demint later did a liver function test and found nothing. Dr. Demint speculated:

> He might have been saying that because Percocet's got acetaminophen in it; and if he knows about liver problems and if I say something about aceta- — about it, you know, that I could get off my medication with acetaminophen. Obviously, he wasn't happy being on these two shorter-acting medications, which is a good thing, because there's—really probably not a great idea to do it that way, but [some doctors do do it that way].

(Tr. at 123-124)

When asked if a patient lying to him about a condition would "cause him alarm, a red flag," Dr. Demint replied, "A little bit." (Tr. at 124)

113. Dr. Demint disagreed that the amount of oxycodone he prescribed to Patient 4—OxyContin 40 mg twice per day and oxycodone 30 mg every six hours—had been a large amount of medication. Dr. Demint testified that the morphine equivalent dose he prescribed had been either 140 or 220 milligrams per day, depending on whether oxycodone is calculated to have a one-to-one or three-to-two ratio with morphine. Dr. Demint stated that, either way, it was in the neighborhood "of 180 milligram in-the-box treatment. 180 milligram morphine equivalent a day is a moderate dose, not a large dose. So, no, I do not believe this man had an excessive dose." (Tr. at 130-131, 720-721)

Dr. Demint testified that Patient 4 had already been taking that level of medication, and that he had simply switched Patient 4 from short-acting medications to a long-acting medication supplemented by a short-acting medication for breakthrough pain. (Tr. at 131-132)

114. Dr. Demint disagreed that with Dr. Cicek's opinion that he had started Patient 4 on OxyContin 40 mg. He testified that Patient 4's prior physician had started him on that medication. An August 2, 2010, OARRS report confirms that statement, and that another physician started Patient 4 on OxyContin 40 mg twice per day on or around June 19, 2010. (Tr. at 721; St. Ex. 4 at 22)

115. Dr. Demint testified that he had referred Patient 4 to physical therapy and to various specialists, including a vascular surgeon and a gastroenterologist. (Tr. at 717-720)

116. Dr. Demint disagreed with Dr. Cicek's criticism that he should have started Patient 4 on an NSAID, because Patient 4 had a diagnosis of GERD and NSAIDs would not have been appropriate. (Tr. at 723-724)

Additional Information

117. Dr. Demint testified that there is no relationship between pain and radiological findings: "Some people can have horrible, horrible looking x-rays and MRIs and have no pain at all; and then other people have nothing, hardly nothing, and have significant pain." (Tr. at 133-134)

Patient 5

118. Dr. Demint assumed the care of Patient 5, a male born in 1959, at Lance on May 21, 2010. At that time, Patient 5 complained of a painful, swollen left knee that was "holding fluid," a painful, swollen right ankle, and back pain. Patient 5 stated that he works as a carpenter. (St. Ex. 5 at 23, 32)

    Patient 5 had last been seen at Lance by another physician on February 19, 2010. (St. Ex. 5 at 33)

    At Patient 5's first visit, Dr. Demint documented diagnoses of: (1) chronic pain in the knee and ankle, (2) status-post fracture of the knee and ankle, (3) hypertension, and (4) anxiety. (St. Ex. 5 at 32)

    At Patient 5's first visit, Dr. Demint noted that he would refill Patient 5's medication, and prescribed Norco 10/325 mg #150, two refills authorized, with instructions to take two tablets every six hours; Valium 10 mg #60, two refills authorized, with instructions to take on-half tablet in the morning, one-half tablet in the evening, and one tablet at bedtime; Motrin 600 mg #90, two refills authorized, with instructions to take one tablet every eight hours; and lisinopril 10 mg #30,[24] two refills authorized, with instructions to take one tablet per day. (St. Ex. 5 at 3, 32)

119. The next time Dr. Demint saw Patient 5 was September 3, 2010. At that visit, Dr. Demint noted the following findings for the musculoskeletal examination: "[Right] knee tender to palpation—very slight swelling noted." (St. Ex. 5 at 30)

120. Patient 5 continued to see Dr. Demint on a regular basis every three months through March 28, 2011, the last visit documented in State's Exhibit 5. During this time, Dr. Demint maintained Patient 5 on the same medication regimen as the first visit except for an increase in the dosage of lisinopril in December 2010. (St. Ex. 5 at 3, 26-30)

121. A urine drug sample submitted by Patient 5 on March 28, 2011, tested positive in-house for opiates and benzodiazepines, which was consistent with Dr. Demint's prescribing. (St. Ex. 5 at 12)

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[24] Lisinopril is used to treat hypertension. (MedLine Plus, *Lisinopril*, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a692051.html, accessed December 7, 2012)

Allegation 2(b): Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records; and

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics.

122. Dr. Cicek acknowledged that Dr. Demint assumed the care of Patient 5 from another provider. Dr. Cicek further testified that the initial visit note includes a history concerning Patient 5's past surgeries and a small social history concerning his alcohol use—the patient told Dr. Demint that he drinks a six-pack of beer per weekend. However, there is no review of what has been done in the past to address his pain, or what non-narcotic therapies were attempted. Dr. Cicek further testified that there is no review concerning the medications that Patient 5 had tried that have been either effective or ineffective. Moreover, Dr. Cicek testified that the musculoskeletal physical examination documented states only that Patient 5 had numerous scars from prior surgeries. Finally, Dr. Cicek testified that Dr. Demint did not obtain an OARRS report or urine toxicology screen at Patient 5's first visit with him; he had had a previous consistent screen in 2008, but Dr. Demint failed to note in the chart that he had reviewed that report. (Tr. at 381-384)

123. Dr. Demint testified that, analyzing Patient 5 based on the "four A's": Patient 5 had been on a maintenance dose of analgesic medications; the patient was able to continue working as a carpenter; Patient 5 complained of no adverse effects such as sedation or constipation; and displayed no aberrant behaviors. Dr. Demint testified that Patient 5's OARRS screens were all consistent, his pill counts were consistent, and his toxicology screens were consistent. (Tr. at 151-152)

    Dr. Demint later acknowledged that he did not obtain an OARRS report initially, although he had obtained KASPER and West Virginia Board of Pharmacy reports. Dr. Demint could not recall why but speculated that the OARRS system must have been having problems at the time and he neglected to go back and obtain one. (Tr. at 725-726)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

124. Dr. Cicek testified that Dr. Demint's prescribing of controlled substances to Patient 5 at Patient 5's first visit had been inappropriate because there was no documentation of any musculoskeletal examination at that visit. (Tr. at 384)

125. When asked if Dr. Demint's documentation of his physical examination of Patient 5 met the standard of care, Dr. Cicek replied:

    > [T]here's no indication of actually what the patient is or is not able to do functionally besides the fact that it does say he works as a steelworker.[25] But there's no documentation of his limits in his job. It's also not noted if he

[25] At his previous visit Patient 5 had told Dr. Demint that he "[w]orks many hours daily as a carpenter." (St. Ex. 5 at 32)

> actually is taking the medication every day or—because I believe it was prescribed as needed. So you would want to know how many times a day is he actually taking the medication, what is the medication allowing him to do, and what is he still not able to do.
>
> And on a physical exam, you would want to document, particularly for the knee, their gait, their ability to sit and stand, if they have crepitus in their joint, if they're tender along the joint line, where are they tender in the knee. And if there's any recent imaging to address further diagnostics, or if there was imaging done in the past referring to it.

(Tr. at 385-386)

126. Dr. Demint testified that he had objective information to support Patient 5's complaint of *left* knee pain, including evidence of a "*right* fib-tib fracture, hardware removed * * *. Also, there's [a left knee] MRI on Page 65 that shows the fracture line. It shows the fracture problem there." (Tr. at 724-725; Emphasis added; St. Ex. 5 at 52, 65)

127. Dr. Demint testified that he had not referred Patient 5 to any non-pharmacological treatment because he had already undergone orthopedic surgery and physical therapy. (Tr. at 725)

128. Dr. Demint believes that his documentation in his first progress note for Patient 5 meets the standard of care, considering that he had assumed the care of the patient and had all the patient's prior treatment records in the file. (Tr. at 146-147)

129. Dr. Demint testified that Patient 5 was not on a high dose of medication, and that his MED had been 50 milligrams. (Tr. at 729)

Allegation 2(h): Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment

130. Dr. Cicek further testified that, in light of Patient 5's statement that he drinks a six-pack of beer on weekends, "[t]he standard of care would require discussing the risks of prescribing benzodiazepines and narcotics to somebody who drinks and works in a physical job where they could potentially be injured if they're using these medications." (Tr. at 387)

131. Dr. Demint acknowledged that Patient 5 had reported drinking a six-pack of beer on weekends. He further testified, "I'm assuming he had been warned about that in the past and—and that—at the pharmacist about mixing those, but I didn't feel it was excessive." (Tr. at 727)

When asked about the patient's alcohol consumption of a six-pack of beer on weekends combined with taking Valium, he replied:

> There are potential side effects, but this patient's been on this same medication, again, since two-thousand- —at least 2006, he's been a patient since 2004. And certainly I—I've warned him when I took his—his drinking history, other doctors have warned him, the pharmacy's warned him about that, they usually put a little sticker on the—on the bottle that says, you know, don't drink and mix with these medications and stuff. He was fully aware of it. He's been on these medications, like I say, at least since 2006. Had no incidents at all.

(Tr. at 150-151)

Patient 6

132. Patient 6, a male born in 1976, first saw Dr. Demint on June 8, 2010, at Dr. Demint's practice in Kingston complaining of lower back and right knee pain. At Patient 6's first visit, Dr. Demint documented that Patient 6:

- had two knee surgeries and suffered from lower back pain for six years after falling out of a bucket truck.
- has a history of spondylolisthesis and spondylolysis.
- was previously treated with steroid shots in the back that were no help.
- had previously tried physical therapy that increased pain.
- did not want surgery.
- experienced increased pain with prolonged laying down, standing, and sitting.
- experienced decreased pain with heat, massage, and medication.
- cannot bend or twist (illegible).
- was currently taking oxycodone 10/325 mg, Paxil (illegible) 20 mg once per day, Xanax 1 mg three times per day, and Flexeril.
- has depression and anxiety attacks, is getting a divorce, feels overwhelmed at times, and is trying to obtain SSI disability.

(St. Ex. 6 at 34)

Dr. Demint performed a physical examination and diagnosed: (1) chronic lower back pain, (2) degenerative disk disease of the lumbar spine, (3) lumbar spondylolisthesis, (4) degenerative joint disease of the knee, and (5) depression and anxiety. (St. Ex. 6 at 34)

Dr. Demint prescribed oxycodone/APAP 10/325 mg #120, no refills, with instructions to take one tablet every six hours; Xanax 1 mg #90, no refills, with instructions to take one tablet three times per day; Flexeril 10 mg #90, two refills, with instructions to take one tablet three times per day; naproxen 500 mg #60, two refills, with instructions to take one tablet twice per day; and Paxil 20 mg #30, two refills, with instructions to take one tablet daily. (St. Ex. 6 at 44-45)

133. Patient 6 signed a medication agreement on June 2, 2010. (St. Ex. 6 at 20-21)

134. Patient 6 continued to see Dr. Demint on a regular basis through March 23, 2011, the last visit documented in State's Exhibit 6. During this time, Dr. Demint maintained Patient 6 on the same regimen of oxycodone/APAP, Xanax, and naproxen, but provided no further prescriptions for Flexeril, switched Patient 6 from Paxil to Cialis in October 2010, and added gabapentin in February 2011. (St. Ex. 6 at 27-28, 31, 41-45)

135. On March 23, 2011, Dr. Demint referred Patient 6 for physical therapy. (St. Ex. 6 at 27)

136. An OARRS report obtained by Dr. Demint on March 30, 2011, shows that Patient 6 was filling on a monthly basis the prescriptions issued by Dr. Demint for oxycodone/APAP. (St. Ex. 6 at 4)

137. A urine sample submitted by Patient 6 on October 16, 2010, and confirmed by a laboratory, tested positive for alprazolam, which is appropriate since he was receiving Xanax. However, it also tested positive for lorazepam,[26] which Dr. Demint did not prescribe, and negative for oxycodone, which Dr. Demint did prescribe. (St. Ex. 6 at 11-14)

    In his progress note for Patient 6's December 16, 2011 visit, Dr. Demint documented: "Discuss Ativan in system. Pt claims he doesn't know how it got there—may have taken mother's by accident. Let pt know not to have another dirty urine." (St. Ex. 6 at 32)

138. Subsequently, a urine sample submitted by Patient 6 on March 23, 2011, and tested in-house yielded a positive result for benzodiazepines, which was appropriate, but a negative result for oxycodone, which was inappropriate. (St. Ex. 6 at 10)

139. Following his August 4, 2010 visit, Patient 6 did not return to Dr. Demint's practice until October 16, 2010. In his October 16, 2010 progress note, Dr. Demint documented that Patient 6 had been in jail from the last visit until October 10, 2010, based on an OMVI from a "long time ago." Dr. Demint documented that Patient 6 told him that he had unpaid fines that violated his probation. (St. Ex. 6 at 32)

    Later, in his February 23, 2011 progress note, Dr. Demint documented that Patient 6 had been in jail for driving under a suspended license. (St. Ex. 6 at 29)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy

140. Dr. Cicek testified that Dr. Demint's initial visit note for Patient 6 was much more thorough than for some of the other patients in this matter. However, Dr. Cicek testified that Dr. Demint did not document goals for Patient 6's treatment or what the expectations of treatment were. Accordingly, Dr. Demint failed to document the development of an

[26] Lorazepam is a benzodiazepine that is sold under the brand name Ativan. (MedLine Plus, *Lorazepam*, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html, accessed December 7, 2012)

individualized treatment plan for Patient 6. Dr. Cicek further testified: "[E]very patient has an individualized treatment plan based on their past medical history, allergies, drug intolerances, family situations, social situations." Moreover, Dr. Cicek testified that documenting the development of an individualized treatment plan is not just a requirement of the Board's intractable pain rules; it is also required under the standard of care. (Tr. at 388-390)

141. Dr. Demint testified that he did not refer Patient 6 to a specialist prior to prescribing medication but that Patient 6 had undergone previous specialist treatment. (Tr. at 731)

142. Dr. Demint testified that he had ordered physical therapy for Patient 6. (Tr. at 731)

143. Dr. Demint testified that he had administered trigger-point injections to Patient 6. (Tr. at 731; St. Ex. 6 at 25)

144. Dr. Demint testified that he had kept Patient 6 on his then-current medications, oxycodone/APAP and alprazolam, and added naproxen, Flexeril and Paxil "[t]o try to get better control of the pain and not needing to up the opioid dose any." (Tr. at 731-732)

Allegation 2(g): Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports; and

Allegation 2(h): Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment.

145. Dr. Cicek testified that she had stated in her report that Dr. Demint had not addressed a positive lorazepam result on Patient 6's urine drug screen; however, she acknowledged that he did in fact document a discussion with the patient in the December 16, 2010 progress note. (Tr. at 392-393)

Nevertheless, the patient's excuse that he "may have taken [his] mother's by accident" is a red flag:

> [I]t would indicate the need for a further discussion of safety and medications –
>
> * * *
>
> – keeping the medications separate from someone else who has controlled drugs in the house. If you are having difficulty taking your own medications, using some type of pillbox or reminder system. A discussion of how you're going to avoid that type of event in the future.

(Tr. at 393)

Dr. Cicek testified that no such discussion was documented in the chart, however. (Tr. at 394)

146. With respect to the second inconsistent urine screen in March 2011, Dr. Cicek testified that she found no mention of the test or a confirmation report in the chart. (Tr. at 396-400)

Dr. Cicek further testified that, despite Patient 6's negative in-house result for oxycodone on March 23, 2011, Dr. Demint continued to prescribe the usual dose and quantity of oxycodone/APAP at that visit. Dr. Cicek further testified that the negative result meant that he had gone at least three or four days without taking any of that medication. Moreover, if the patient can go that long without the medication, Dr. Cicek questioned why Dr. Demint prescribed four tablets per day to him. (Tr. at 400-401)

147. Dr. Cicek stated in her report:

> Pain medication for this patient is not inappropriate but there are concerns. His urine toxicology was inappropriately negative for oxycodone, he had consistently high levels of pain but mentions fishing and camping as activities, and he is receiving no mental health care with the exception of daily benzodiazepines. It is not clear how the inappropriate toxicology tests were addressed. It was also not clear the patient was progressing toward any goals.

(St. Ex. 6 at 6-7)

148. Dr. Demint acknowledged that Patient 6's October 2010 urine drug screen report indicated a positive result for Ativan, which he did not prescribe, and a negative result for oxycodone, which he did prescribe. However, Dr. Demint testified that Patient 6 had been in jail for an old OMVI conviction. Dr. Demint testified that the OMVI was a red flag but that you do not necessarily stop seeing a patient based on one red flag. Rather, Dr. Demint testified that it "means you need to increase your surveillance." Dr. Demint testified that he warned Patient 6 to not let it happen again. (Tr. at 165-167)

Dr. Demint testified that he obtained his next urine drug screen on Patient 6 in March 2011. Dr. Demint noted that the in-house results were positive for benzodiazepines, which was appropriate, but negative for oxycodone, which was not appropriate. Dr. Demint further testified that Patient 6 submitted to a pill count in May 2011, which he failed. Dr. Demint testified that he discharged Patient 6 after the failed pill count. (Tr. at 171-172, 732-733)

149. Dr. Demint disagreed that, because Patient 6 had been able to camp and fish, he should have stopped or altered Patient 6's dose of medication, as Dr. Cicek stated in her report.[27] Dr. Demint testified that he would not stop or alter the dose because the patient had been having problems but was doing better with medication. (Tr. at 734-735)

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[27] This somewhat misstates Dr. Cicek's statement. She questioned how Patient 6 could camp and fish yet consistently report high levels of pain. (St. Ex. 16 at 6)

150. Dr. Demint testified that he had obtained reports concerning Patient 6 from OARRS, KASPER, and the West Virginia Board of Pharmacy. (Tr. at 732)

Allegation 2(i): Medical charting was incomplete, often illegible and/or disorganized

151. Dr. Cicek opined that Dr. Demint's medical records for Patient 6 fell below the minimal standard of care based upon the legibility of the records, and a lack of an individualized treatment plan with goals to assess the patient's response to treatment. (Tr. at 398)

Patient 7

152. On September 14, 2010, Patient 7, a male born in 1960, first visited Dr. Demint at his practice in Kingston. He complained of continuous pain in the neck, back, and legs that resulted from rolling a tractor 15 years earlier. He also complained of being stressed-out all of the time. Dr. Demint documented that Patient 7 had been taking Percocet and Xanax for "many, many years," but that, at that time, Patient 7 had been taking no medication. Dr. Demint noted that Patient 7 told advised that he had been out of meds since August 31, 2010, about two weeks prior to the visit. (St. Ex. 7 at 27-31)

    Dr. Demint documented that Patient 7 had been discharged from another practice because of a urine sample that tested negative for all prescribed medications, but that Patient 7 stated that he had been taking his medications. (St. Ex. 7 at 27)

    Dr. Demint diagnosed: (1) chronic lower back pain, (2) "CCP," and (3) anxiety. Dr. Demint's plan was for Patient 7 to obtain his old treatment records before his next visit. In addition, Dr. Demint prescribed Percocet and Xanax and added gabapentin and naproxen, and warned him not to take other people's medication. (St. Ex. 7 at 27)

    Finally, Dr. Demint prescribed oxycodone/APAP 10/325 mg #120 with instructions to take one tablet every six to eight hours as needed for pain, Xanax 0.5 mg #90 with instructions to take every eight hours as needed for anxiety, gabapentin 300 #72 to be gradually increased to one tablet three times per day, and naproxen 500 mg #60 with instructions to take one tablet twice per day. No refills were authorized. (St. Ex. 7 at 29)

153. Dr. Demint obtained an OARRS report at Patient 7's first visit. The report indicates that Patient 7 had last filled a prescription from another physician for pain medication on August 31, 2010, when he received a prescription for tramadol 50 mg #112, identified as being a 28-day supply. Prior to that, on August 3, 2010, Patient 7 filled prescriptions from yet another physician for Endocet 10/325 mg #112, tramadol 50 mg #112, and alprazolam 1 mg #84. All the prescriptions were for 28-day supplies. (St. Ex. 7 at 61)

154. A urine drug screen confirmation report for a urine sample submitted by Patient 7 on September 14, 2010, tested positive for oxycodone and oxymorphone and negative for benzodiazepines. (St. Ex. 7 at 9) However, Patient 7 had told Dr. Demint that he had been out of medication for about two weeks. The urine drug screen report states that oxycodone

and oxymorphone are detectable in urine for only one to four days following ingestion. (St. Ex. 7 at 10, 28)

155. Patient 7 next visited Dr. Demint on November 3, 2011, and saw him again on December 4, 2010, and January 8, 2011, the last visit documented in State's Exhibit 7. At each visit, Dr. Demint continued the same medications as prescribed at the first visit. (St. Ex. 7 at 21-25)

156. A note dated January 10, 2011, indicates that a pharmacist had contacted Dr. Demint and informed him of an irregularity concerning Patient 7. Dr. Demint noted that the pharmacist told him that Patient 7 had been prescribed oxycodone/APAP 10/325 mg but was mistakenly given a lower strength, 5/325 mg, instead. The pharmacist contacted Patient 7 and told him that if he brought those tablets back to the pharmacy they would replace them with the 10/325 mg tablets. However, Patient 7 was unable to produce the 5/325 mg pills and instead brought a bottle from another pharmacy with a torn label, then told the pharmacist that his girlfriend had stolen the pills. Patient 7 then told the pharmacist not to tell his doctor about it. Dr. Demint noted advising the pharmacist that he would address the problem. (St. Ex. 7 at 2-3)

    The chart includes a copy of a letter dated January 28, 2011, that Dr. Demint sent to Patient 7 advising him that he was being dismissed from Dr. Demint's practice. Dr. Demint cited to violations of two paragraphs in his "pain agreement." Dr. Demint told Patient 7 about Dr. Demint's conversation with the pharmacist, and further told him that he had checked an OARRS report and discovered that Patient 7 had been receiving pain medication from other providers. Finally, he advised Patient 7: "You will have to find a new doctor to treat your pain issues. Once you have established yourself with a new doctor sign a release form and we will forward your records on to them." (St. Ex. 7 at 20)

Allegation 2(b): Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records

157. Dr. Cicek testified that the fact that Patient 7 had been discharged from another physician's practice for an irregular urine screen is a red flag. Dr. Cicek testified that she would provide a records release to the prior physician and ask them over the telephone why the patient had been discharged. (Tr. at 402, 407)

158. Dr. Cicek testified that Patient 7 had been told to obtain his prior medical records in order to continue to receive treatment; however, Dr. Demint prescribed oxycodone to Patient 7 on November 3 and December 4, 2010, prior to receiving the records on December 17, 2010. Dr. Cicek testified that it is okay to "issue a short amount of medication * * * so the patient doesn't go into withdrawal and so you're actually treating the patient." Dr. Cicek further testified that most providers provide their patients with a records release or else fax it to the prior physician themselves. (Tr. at 405-408)

159. Dr. Demint agreed that Patient 7's dismissal from another practice for a failed urine screen had been a red flag. However, Dr. Demint testified that he obtained an OARRS report, performed an appropriate workup, and did his "due diligence." (Tr. at 173-175)

160. Dr. Demint testified that he only saw Patient 7 a few times before he discharged him after being contacted by a pharmacist. Dr. Demint further testified that he did not obtain the prior treatment records for Patient 7 until after he had been discharged. (Tr. at 176-177)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

161. Dr. Cicek testified that Dr. Demint's documentation of a musculoskeletal examination for Patient 7 at Patient 7's first visit consisted of two lines, one of which referenced the lumbar spine but which Dr. Cicek could not read, and the other which states, "5 out of 5 strength bilateral upper extremities." Dr. Cicek further testified, "So, essentially, there's no physical exam of the musculoskeletal system with the exception of upper extremities strength." Dr. Cicek criticized Dr. Demint for not providing sufficient documentation to support the amount of medication he prescribed to Patient 7 at the first visit. (Tr. at 403-404; St. Ex. 7 at 27)

162. Dr. Demint testified that, when a patient was injured due to trauma, he "usually" ascertains the cause of the trauma. In Patient 7's case, Dr. Demint testified that he had claimed that he had "rolled a tractor on himself" 15 years earlier. (Tr. at 735-736, 742; St. Ex. 7 at 27)

163. Dr. Demint testified that Patient 7 had had great difficulty obtaining his prior treatment records but that he finally produced an MRI report. Dr. Demint further testified that the MRI report confirms that Patient 7 suffered from a condition that could cause pain. (Tr. at 736-737) The report states, under "Impression":

> Minimal diffuse posterior spondylytic [sic] bar with associated minimal diffuse bulging disc, more prominent to the right at the level of C5-C6 with some moderate narrowing of the right C5-C6 neuroforamen and minimal narrowing of the left C5-C6 neuroforamen. No definite soft disc herniation posteriorly. There is also minimal narrowing of the canal at the level of C5-C6.

(St. Ex. 7 at 8)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy

164. Dr. Cicek testified that she did not find that Dr. Demint had documented an individualized treatment plan for Patient 7. (Tr. at 404-405)

165. Dr. Demint testified that he tried non-pharmacological treatment with Patient 7; namely, osteopathic manipulative therapy ("OMT") on November 3, 2010. Dr. Demint testified Patient 7 experienced good results and had some increased range of motion. (Tr. at 737; St. Ex. 7 at 22)

166. Dr. Demint testified that he had made some changes to the medication regimen that Patient 7 had been taking prior to seeing him. Dr. Demint testified that he continued oxycodone/APAP 10/325 mg but decreased his alprazolam 1 mg to 0.5 mg, and added naproxen and gabapentin. (Tr. at 738)

Additional Information

167. Dr. Cicek noted that Dr. Demint's chart for Patient 7, like his chart for Patient 6, contains more documentation than some of the other charts. (Tr. at 401)

Patient 8

168. Patient 8, a female born in 1959, first saw Dr. Demint on October 22, 2008, at Dr. Demint's practice in Kingston. At that time, she reported a medical history of having injured her back in 1993 while working as a home health aide when she was helping to turn a 400-pound patient. She suffered severe pain in her back and right leg. As a result, she underwent a partial discectomy in 1993. When she saw Dr. Demint, she indicated she was still suffering from severe pain in her lumbar region and right buttock with occasional pain in her right calf. (St. Ex. 8 at 143, 258)

    Patient 8 continued to see Dr. Demint through July 2009. (St. Ex. 8 at 232-261)

169. In August 2009, Patient 8 began seeing another physician at Chillicothe Acute Care Clinic. She continued see the other physician until July 2010 when the physician discharged her from that practice. (St. Ex. 8 at 168-232)

    With respect to Patient 8's discharge, office staff at Chillicothe Acute Care Clinic wrote the following note: "Dr. * * * has discharged this patient due to not taking Opana, nor can present them to our office – only had Percocet this last month – no phone call of same or call of pain or Opana not working. This was pt's last visit. She had failed 2 previous urine drug screens." On July 10, 2010, the physician provided Patient 8 with oxycodone/APAP 10/325 mg #70 with instructions for Patient 8 to wean herself from oxycodone over a four-week period. (St. Ex. 8 at 173, 187)

170. Patient 8 returned to Dr. Demint on July 21, 2010. At that time, Dr. Demint documented among other things that her previous physician had prescribed Opana which had caused her to throw up. Patient 8 claimed she "flushed" the medication and, when she saw the doctor again, she was discharged. She told Dr. Demint that she had previously been prescribed OxyContin but wanted off of it due to the expense of that medication and because BWC will not pay for it. (St. Ex. 8 at 142)

At Patient 8's initial return visit, Dr. Demint prescribed the following: oxycodone 30 mg #120 with instruction to take one tablet four times per day, oxycodone/APAP 10/325 mg #90 with instructions to take one tablet every four to six hours as needed for breakthrough pain, Lyrica 300 mg #60 with instructions to take one tablet twice per day, and Mobic 7.5 mg[28] #60 with instructions to take one tablet twice per day. Dr. Demint authorized two refills on the Lyrica and Mobic prescriptions. The total daily dose of oxycodone prescribed by Dr. Demint, if taken as directed, was 150 milligrams. (St. Ex. 8 at 146)

171. Patient 8 continued to see Dr. Demint on a regular basis through January 8, 2011, the last visit documented in State's Exhibit 8. He obtained one urine drug screen on Patient 8 in September 2010 which yielded consistent results. At that time, Dr. Demint noticed white powder in Patient 8's nose. He referred her for an addiction evaluation with a note that she was "snorting pain medication." (St. Ex. 8 at 3-5, 131-141)

Allegation 2(b): Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records; and

Allegation 2(g): Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports.

172. In her report, Dr. Cicek stated that "[n]o [prior] records appear to have been available at the time of the first visit, although they were requested." (St. Ex. 16 at 8)

173. With respect to "red flags" in Dr. Demint's treatment of Patient 8, Dr. Cicek noted that Dr. Demint's progress note for Patient 8's September 21, 2010 visit indicates he had a discussion with Patient 8 concerning an inconsistent urine screen with a previous provider. Dr. Cicek testified that Dr. Demint had her submit to a drug screen that was consistent with his prescribing. (Tr. at 414; St. Ex. 8 at 135)

    Dr. Cicek further testified that there was mention of Patient 8 having problems with her previous provider that were not investigated. (Tr. at 414-415)

174. Dr. Demint testified that he had originally seen Patient 8 in October 2008 at his own practice in Kingston prior to his Board suspension. He testified that, when he was suspended, Patient 8 had seen another physician in Chillicothe. She then returned to him in July 2010 when he reopened his practice. (Tr. at 182-184)

175. Dr. Demint agreed that Patient 8's discharge from the other practice had been a red flag, but testified that he had done "numerous screenings and stuff, what we do when we get red flags, and she was okay. There's all sorts of reasons to have a red flag besides addiction or diversion or misuse." (Tr. at 189-191)

[28] Dr. Cicek testified that Mobic is a nonsteroidal anti-inflammatory medication. (Tr. at 410)

176. Dr. Demint testified that he had obtained two urine drug screens on Patient 8. (Tr. at 746-747)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

177. Dr. Cicek testified that Patient 8's initial visit physical examination was essentially normal with the exception of decreased range of motion in all planes of her lumbar spine. Dr. Cicek further testified, "[T]here's no indication from that physical exam that she needs a drastic increase in medication." (Tr. at 415; St. Ex. 8 at 142)

178. Patient 8 had regularly received from her prior physician Endocet 10/325 mg #90 and OxyContin 40 mg #60, a total daily dose of 110 milligrams of oxycodone. However, at Patient 8's initial visit with Dr. Demint, he prescribed a total of 150 milligrams of oxycodone per day, an increase of 40 milligrams. (St. Ex. 8 at 146-147)

    Dr. Cicek characterized Dr. Demint's prescribing at Patient 8's initial visit as a "drastic increase in [the] dose of medication without justification of why that increase was being prescribed." (Tr. at 408-413)

179. Dr. Demint testified that Patient 8 had a history of two failed surgeries and had had bone harvested from her hip. (Tr. at 744)

180. Dr. Demint testified that Patient 8 had already tried surgery and physical therapy before she came to him. Dr. Demint acknowledged that the only referral he had made for Patient 8 had been to an addictionologist at the very end of her treatment. (Tr. at 744-745)

181. Dr. Demint testified that he had increased her dose of oxycodone when she first came to him, from 120 milligrams to 150 milligrams per day. However, he testified that that had still been "in the box." (Tr. at 745-746)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy

182. Dr. Cicek testified that Dr. Demint failed to document an individualized treatment plan for Patient 8. (Tr. at 413-414)

Allegation 2(i): Medical charting was incomplete, often illegible and/or disorganized

183. Dr. Cicek found overall that Dr. Demint's medical chart for Patient 8 fell below the minimal standard of care. (Tr. at 416)

Additional Information

184. Dr. Cicek noted that Dr. Demint had performed a urine drug screen at Patient 8's initial visit which was consistent with the medications she had been prescribed. (Tr. at 413)

185. Dr. Cicek noted that Dr. Demint had obtained an OARRS report the day before Patient 8 first came back to his office, which is a good thing to do. (Tr. at 409)

186. With regard to long-acting versus short-acting medications, Dr. Demint testified that it is advisable to keep chronic pain patients on long-acting medications as their treatment, and possibly use short-acting medication for breakthrough pain. The idea is to keep the patient's medication level as steady as possible. The short-acting breakthrough medication helps patients who experience pain between the time after one dose of long-acting medication begins to wear off and before the next dose of medication takes effect. Dr. Demint testified that maintaining chronic pain patients on short-acting medications only causes them to go through numerous "peaks and valleys" of pain relief. (Tr. at 748-749)

187. Dr. Demint testified that he had prescribed Xanax to Patient 8 because she was experiencing a lot of stressors in her life and had asked for something. Dr. Demint testified that he had prescribed Xanax at a very low dose, 0.25 milligrams. (Tr. at 193-195)

Patient 9

188. Patient 9, a male born in 1954, first saw Dr. Demint at his Kingston practice on July 17, 2010, for chronic pain in his back and neck. Patient 9 indicated that he had been injured in 1990 when, as a pedestrian, he was struck by a car. On Patient 9's history form, Dr. Demint noted that Patient 9 had "[t]oo many surgeries to mention" including two neck surgeries, a left leg amputation, and had a plate in his jaw. He suffered from, among other things, chronic obstructive pulmonary disease ("COPD"), emphysema, and congestive heart failure ("CHF"). His current medications included oxygen (2 liters), albuterol inhaler, Combivent inhaler, Advair, Remeron, gabapentin 600mg three times per day, OxyContin 40 mg twice per day, oxycodone/APAP 10/325 mg for breakthrough pain,[29] and Xanax 1 mg.[30] (St. Ex. 9 at 50-52)

    At Patient 9's first visit, Dr. Demint prescribed OxyContin 60 mg #60 with instructions to take one tablet twice per day, and oxycodone/APAP 10/325 mg #120 to take one tablet every four to six hours as needed for breakthrough pain. (St. Ex. 9 at 54)

189. Patient 9 continued to see Dr. Demint on a regular basis through March 29, 2011. During this time, Dr. Demint continued prescribing, among other things, OxyContin and

[29] The dosing frequency is illegible to the Hearing Examiner. (St. Ex. 9 at 51)
[30] No dosing frequency was documented. (St. Ex. 9 at 51)

oxycodone IR. In addition, at Patient 9's September 16, 2010 visit, he added Xanax 1 mg with instructions to take one tablet twice per day. (St. Ex. 9 at 32-49)

190. At Patient 9's final visit on March 29, 2011, Dr. Demint dismissed Patient 9 from his practice for having failed three urine drug tests. However, Dr. Demint provided Patient 9 with a prescription for, among other things, oxycodone 30 mg #74 with instructions to taper the dose to wean himself off the medication. (St. Ex. 9 at 30-32)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

191. Dr. Cicek noted that Patient 9 had a lot of chronic medical problems, and that Dr. Demint diagnosed chronic low back pain, chronic cervical pain, degenerative disc disease, COPD, and hypertension. Moreover, Dr. Demint documented that Patient 9 had had numerous surgeries including amputation of his left leg. Nevertheless, Dr. Cicek found that Dr. Demint's documentation did not support the medication he prescribed. She explained:

> On this patient for the physical exam there's decreased range of motion in [the] lumbar and cervical spine; reflexes two out of four, that's considered normal; five out of five strength is considered normal, bilateral upper extremity—I can't read the next word.
>
> So, again, we don't have a picture of the patient's function. Is the patient ambulating with a prosthesis? Is the patient wheelchair-bound? There's not an indication of—I can't read this physical exam and picture the patient.
>
> * * *
>
> If he's ambulating, if he's in a wheelchair, what his actual level of function is. Because if you look at his history, his function could be sitting in a reclining chair, but it could be going to the grocery store. So without having any kind of physical exam or indication of what his treatment objectives are, it's hard to even know what—well, you can't know what this patient's functional status is.
>
> * * *
>
> There is a lack of subjective data—or, objective data to support the medication he's receiving.

(Tr. at 420-421)

192. Dr. Demint testified that in the past Patient 9 was severely injured in a motorcycle accident, and had undergone a left leg amputation and two cervical spine fusions. Dr. Demint further testified that he also suffered from phantom pain from the amputation. (Tr. at 749-750)

Allegation 2(d): Dr. Demint inappropriately prescribed high doses of narcotics despite diagnoses of underlying Chronic Obstructive Pulmonary Disease

193. Dr. Cicek further criticized Dr. Demint for failing to document taking into account Patient 9's serious respiratory problems when prescribing large doses of opiate medications. Dr. Cicek testified that opiates have a side effect of respiratory depression. Dr. Cicek was apprised of Dr. Demint's testimony that Patient 9 had developed a tolerance to the opiate medication which reduced the risk of respiratory depression, and that he had performed breathing exams which showed that Patient 9 did not have depressed respiration. However, even if that had occurred,[31] Dr. Cicek testified that respiration rate is "just one part of the assessment of [patients'] respiratory function." Dr. Cicek stated: "[Y]ou could have * * * arterial blood gases. You could have a report from a pulmonologist that tells you what stage of COPD the patient's at; if they're a CO2 retainer or not. The different things you worry about in suppressing respirations in a patient." (Tr. at 421-424)

194. As stated above, on July 17, 2010, Dr. Demint provided Patient 9 with prescriptions for OxyContin 60 mg #60 to take one tablet twice per day, and oxycodone/APAP 10/325 mg #120 to take one tablet every four to six hours as needed for breakthrough pain. Assuming Patient 9 took the maximum dose over the course of thirty days, his daily dose of oxycodone would have been 160 milligrams. However, according to an OARRS report obtained by Dr. Demint at Patient 9's initial visit, during the three months prior to his first visit, from April through June 2010, Patient 9 had received only two prescriptions for hydrocodone/APAP 5/500 mg #30.[32] In fact, Patient 9 had not received any large doses of opiates since March 26, 2010, when he filled prescriptions for OxyContin 40 mg #28 and Endocet 10/325 mg #42 that were written for a 14-day supply. (St. Ex. 9 at 54-55)

    Dr. Cicek testified that going from small doses of opiates to the dose Dr. Demint prescribed at Patient 9's first visit "in a patient with COPD severe enough to require oxygen is very concerning." She further testified that it fell below the minimal standard of care. (Tr. at 424-425)

195. Dr. Cicek testified that she did not criticize Dr. Demint for treating a patient who had COPD with narcotics, per se. Dr. Cicek testified: "I want him to discuss with the patient the risks of high-dose opioids and respiratory depression with his underlying lung disease; that he's had that discussion, that this patient is a high-risk patient for receiving opioids because of his COPD, and what's going to be done to monitor that for the patient's safety." (Tr. at 541-542)

196. Dr. Demint testified that he had sought confirmation through medical literature that he was doing the right thing with respect to Patient 9. He referenced two Medscape.com articles, the first entitled *Opioids Underprescribed for Refractory COPD, per Small Study,* dated

[31] In Patient 9's chart, Dr. Demint regularly documented his temperature, blood pressure, and heart rate but documented his respiration rate only once; on March 15, 2011, his respiration rate was 16. (St. Ex. 9 at 32, 34-35, 40-41, 50)

[32] The total oxycodone content of each of those prescriptions was 150 milligrams, ten milligrams less than the daily dose prescribed by Dr. Demint.

April 28, 2012, and the second entitled *Opioids Underused in Advanced COPD,* dated September 14, 2009. Dr. Demint testified that those articles support his decision to treat this patient with opioids.[33] (Tr. at 677-679; Resp. Ex. I)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy

197. Dr. Cicek testified that Dr. Demint failed to develop or document developing an individualized treatment plan for Patient 9. (Tr. at 421)

198. Dr. Demint acknowledged that he did not refer Patient 9 to physical therapy, but testified that Patient 9 had already been through surgeries and physical therapy on multiple occasions. Dr. Demint further testified that Patient 9 suffered from COPD and appeared much older than he actually was, and Dr. Demint believes that Patient 9 would have had difficulty participating in physical therapy. (Tr. at 750-751)

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics;

Allegation 2(g): Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports; and

Allegation 2(h): Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment.

199. Dr. Cicek noted that, on his initial visit note, Dr. Demint documented that Patient 9 had been discharged from his prior physician's practice because he could not produce a urine sample. Patient 9 told Dr. Demint that that was because he was suffering from pneumonia at the time and had been dehydrated. However, Dr. Cicek testified it is standard practice that, "[w]hen a patient is unable to give a urine specimen, * * * they're given a glass of water or something to drink so they can give the specimen." (Tr. at 418)

200. Dr. Cicek testified that Patient 9 submitted to four urine drug screens while under the care of Dr. Demint. The first was done in September 2010, two months after Dr. Demint initiated care. The result was positive for oxycodone and oxymorphone, which is appropriate, but also positive for morphine, which Dr. Demint did not prescribe. Dr. Demint documented that Patient 9 told him that he had been using cough syrup containing codeine.[34] Dr. Cicek testified that it is good that Dr. Demint documented that;

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[33] Obviously, Dr. Demint could not have relied upon the first article, dated April 28, 2012, in his treatment decision because the article post-dates the time period relevant to this matter.
[34] Morphine is detectable in urine as a metabolite of codeine. (St. Ex. 9 at 20)

however, the medication contract forbade Patient 9 from obtaining narcotics from other people. (Tr. at 425-427; St. Ex. 9 at 19, 40)

Patient 9 next submitted a urine sample on January 15, 2011. The sample tested positive for oxycodone but negative for alprazolam and gabapentin, which was inconsistent with Dr. Demint's prescribing. In his progress note for February 2010, Dr. Demint documented that Patient 9 told him that he had stopped taking Xanax for one week the previous month. Dr. Cicek testified that this statement raises a question because abruptly stopping Xanax after having taken two milligrams per day for months put Patient 9 at risk for seizures. However, Dr. Cicek testified that the issue was not addressed. Dr. Cicek further testified: "If he was not needing them for a week, I think the discussion of decreasing the dose would be very appropriate here, and the discussion of the harm of abruptly stopping benzodiazepines, as well." However, Dr. Demint did note a discussion with the patient that, if he wants to wean off of Xanax, it has to be done gradually. Dr. Demint further noted that he would refill Patient 9's medications but would keep a close eye on him. (Tr. at 427-428; St. Ex. 9 at 17, 34-35, 53)

201. Also in his February 2010 progress note, Dr. Demint documented that Patient 9 expressed concern that his wife "was snorting her meds." Dr. Cicek testified that such information would require "a pretty serious discussion about keeping medications locked and in an appropriate place, because this is a family that's at very high risk for a negative outcome from potentially taking this patient's medications." (Tr. at 429; St. Ex. 9 at 34)

202. Dr. Demint testified that a prescription is not necessary to obtain cough syrup with codeine in Ohio; the patient simply has to go to a pharmacy and sign for it. Dr. Demint further testified that codeine ingestion can cause a positive result for morphine on a urine drug screen. (Tr. at 206)

203. Dr. Demint testified that he had performed urine drug screens on Patient 9. One, from January 2011, was confirmed to be negative for benzodiazepines even though Dr. Demint had been prescribing Xanax. Dr. Demint explained the result:

> Well, he—he had given me the explanation that he was trying to see if he could, you know, take himself off of it, but as most people who try to take themselves off this medication, he found he couldn't, either because of rebound anxiety—probably for rebound anxiety, you know. He thought he needed it and then he restarted it.

(Tr. at 752)

Dr. Demint testified that, when a second in-house screen tested positive for buprenorphine, he questioned Patient 9. Dr. Demint testified that Patient 9 gave him some story about eating a "funny piece of candy," then told him that some of his family members were on Suboxone. Dr. Demint further testified that, since he could not make a diagnosis based only on an in-house screen, he gave Patient 9 a two-week supply of medication and sent the urine sample to a lab for confirmation. When the positive buprenorphine result was

confirmed, he referred Patient 9 to an addictionologist and discharged him from the practice. (Tr. at 752-753; St. Ex. 9 at 30, 32)

204. Dr. Demint testified that Patient 9 had been taking Xanax for anxiety prior to seeing him. (Tr. at 754)

Patient 10

205. Patient 10, a male born in 1975, first visited Dr. Demint's Kingston office on September 16, 2010. At that time, he reported lower back pain since 2006. He claimed that a 2007 MRI showed a bulging disc at L4-L5. Patient 10 identified his current medications as oxycodone 15 mg four times per day, Percocet 5 mg three times per day, Claritin, an unnamed muscle relaxer, and gabapentin. Dr. Demint diagnosed chronic low back pain, degenerative disc disease of the lumbar spine by history, and an illegible reference to a dysfunction of the lumbar spine. Dr. Demint's plan included osteopathic manipulative therapy, obtaining a new MRI, and obtaining Patient 10's old medical records. Dr. Demint prescribed oxycodone/APAP 10/325 mg #120, one tablet every six to eight hours as needed for pain up to a maximum of four tablets per day; naproxen 500 mg #60, one tablet twice per day; and gabapentin 300 mg gradually increased to one tablet three times per day. (St. Ex. 10 at 37-39)

206. A November 9, 2010 MRI ordered by Dr. Demint provided the following impressions:

> 1. Right paracentral disk protrusion at L5-S1 extending into and severely effacing the right lateral recess with marked mass effect upon the right S1 nerve root within the right lateral recess. There is mild right neural foraminal narrowing as well.
> 2. Focal left paracentral disk protrusion at L4-5 without significant central canal stenosis or neural foraminal narrowing present.

(St. Ex. 10 at 11)

207. Patient 10 continued to see Dr. Demint on a regular basis through March 23, 2011, the last visit documented in State's Exhibit 10. During this time, Dr. Demint continued to prescribe naproxen and gabapentin to Patient 10. He added tramadol 50 mg #90 in January 2011. In addition, Dr. Demint increased the amount of oxycodone Patient 10 received to oxycodone 15 mg #120. (St. Ex. 10 at 27-36)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

208. Dr. Cicek testified:

> OARRS report was done * * *. Physical exam was normal at all visits, including reflexes and lower extremity strengths—strength. I believe there was not a straight-leg test that I could read documented as positive.

> So my assessment was that the patient's care—the patient had received large amounts of medication considering an essentially normal physical exam. The patient wasn't being treated, as one would expect with this type of pain, with nonsteroidal anti-inflammatories and gabapentin or Lyrica with small amounts of narcotic pain prescribed for exacerbations.

(Tr. at 431)

Dr. Cicek further testified that Patient 10 told Dr. Demint at the first visit that he was taking oxycodone and Percocet, but the chart includes reports from the West Virginia Board of Pharmacy, KASPER, and OARRS that were all negative for any narcotics except for those prescribed by Dr. Demint.[35] In addition, a urine drug test on a sample submitted by Patient 10 at his first visit was confirmed by a lab to be negative for all substances. Based on that information, Dr. Cicek testified that Patient 10 went from no medication to receiving 40 milligrams of oxycodone per day from Dr. Demint at his first visit. Moreover, Dr. Cicek testified that it had been below the minimal standard of care for Dr. Demint to prescribe that amount of medication to Patient 10 at his first visit. (Tr. at 431-433; St. Ex. 10 at 12-15, 17, 38)

209. Dr. Cicek testified that, if a patient reports that he is taking oxycodone and Percocet but other evidence indicates he is not, the standard of care requires that the physician address this issue with the patient. Dr. Cicek testified that a "miscommunication at the best and a lie at the worst is a huge red flag for writing of narcotics." (Tr. at 435-436)

210. Dr. Demint testified that he had ordered an MRI for Patient 10 that revealed "a protrusion that extends to and then severely effaces the right lateral recess with marked mass effect upon the right S1 nerve root within the right lateral recess. There is mild right foraminal narrowing as well." Dr. Demint testified that those findings substantiate Patient 10's pain complaint. (Tr. at 754-755; St. Ex. 10 at 10)

211. Dr. Demint testified that he had used non-pharmacological therapies in treating Patient 10. Dr. Demint testified that he had performed OMT on September 16, 2010, and referred him to physical therapy. (Tr. at 755-756; St. Ex. 10 at 30, 37)

212. Dr. Demint testified that he had started Patient 10 on 30 to 40 milligrams of oxycodone per day, which was a decrease from the 75 milligrams per day that he had been taking. Dr. Demint testified that his prescribing had been well within "the box." (Tr. at 756-757)

213. Dr. Demint acknowledged that he had believed Patient 10 at the initial visit when Patient 10 told him that he had been taking oxycodone 15 milligrams four time per day and Percocet 5/325 milligrams three times per day, among other things. However, Dr. Demint acknowledged that reports from KASPER, the West Virginia Board of Pharmacy, and OARRS do not show that Patient 10 had filled any prescriptions for controlled substances

[35] These reports were not obtained by Dr. Demint until January 2011. (St. Ex. 10 at 12-15)

prior to seeing Dr. Demint. Dr. Demint testified that he eventually received records from Columbus Southern Medical Center that indicated Patient 10 had been taking opioids. (Tr. at 221-224)

Dr. Demint added that he takes patients at their word "until proven otherwise." Dr. Demint testified that he believes, and was taught in medical school, that most patients tell the truth. Dr. Demint further testified: "I believe the vast majority are having legitimate pain. Do some lie to me? Yes. I mean, that's—but I'm going to tell you people lie to me about their cholesterol, and their diets, and everything else, too." (Tr. at 224)

214. Dr. Demint was asked whether he had had any evidence at Patient 10's initial visit that Patient 10 had been taking the medications he claimed to have been taking. Dr. Demint acknowledged that he had not known at that time what Patient 10 had been taking. (Tr. at 795-798; St. Ex. 10 at 12-15, 17, 38-39)

Dr. Demint was asked whether, in light of the evidence of the state pharmacy board reports and Patient 10's urine screen, whether Patient 10 had lied to him when he told him that he had been taking oxycodone. Dr. Demint replied that he may not necessarily have been lying. Dr. Demint testified that patients sometimes will report the medications they had been taking the last time that they were prescribed medication, even if they had not been taking them for a while. Dr. Demint further testified that the patient may not have actually been lying. (Tr. at 798-799)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy

215. When asked whether Dr. Demint had documented an individualized treatment plan for Patient 10, Dr. Cicek replied: "There are no goals for what they are attempting to achieve with his function, what he is not able to do that he wants to do, or what the goals for treating the pain to—what the improved functional goals are, which would be the individual treatment plan." (Tr. at 434-435)

Patient 11

216. Patient 11, a male born in 1974, first visited Dr. Demint at his Kingston practice on June 5, 2010, complaining of lower back, hip and leg pain. He stated that he was allergic to hydrocodone. Among other things, Patient 11 told Dr. Demint that he had been released by his previous physician.[36] Dr. Demint also noted that Patient 11 had been to Adena Pain Management which "wanted to do injections" but did not have any openings for two months. The next statement in the notes indicates that Patient 11 works from 4:30 a.m. to 4:30 p.m. and that he cannot miss any work. (St. Ex. 11 at 20-25)

[36] Patient 11's prior medical records, which appear to have been received by Dr. Demint on June 10, 2010, include a urine drug screen report for a urine sample Patient 11 submitted on March 11, 1010, that tested positive for cocaine metabolites and marijuana metabolites. (St. Ex. 11 at 30, 44-45)

At Patient 11, initial visit, Dr. Demint prescribed oxycodone/APAP 10/325 mg #90 to take one tablet three times per day, methocarbamol 500 mg #120 to take one tablet four times per day, naproxen 500 mg #60 to take one tablet twice per day, gabapentin 300 mg #72 to gradually increase to three times per day, and Effexor XR 75 mg #30 to take one tablet per day. (St. Ex. 11 at 22-23)

217. An OARRS report obtained by Dr. Demint on July 10, 2010, indicates that Patient 11 had for some time been prescribed the same dose of oxycodone/APAP prescribed by Dr. Demint at Patient 11's first visit. (St. Ex. 11 at 18)

218. Patient 11 saw Dr. Demint on four more occasions until October 9, 2010, the last visit documented in State's Exhibit 11. Dr. Demint maintained Patient 11 on the same level of oxycodone/APAP throughout his care until the October 2010 visit, when he prescribed 21 tablets with instructions for Patient 11 to wean himself from that medication. (St. Ex. 11 at 10-16)

219. A urine drug screen report dated September 15, 2010, concerning a sample Patient 11 submitted on September 9, 2010, indicates that Patient 11 tested positive for alprazolam, hydrocodone, and hydromorphone, which Dr. Demint had not prescribed.[37] It was also positive for carboxy THC. (St. Ex. 11 at 4)

Allegation 2(b): Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records

220. Dr. Cicek testified that, although Dr. Demint documented in his initial visit note that Patient 11 had been released from his prior physician's practice, he did not document any reason why that had happened. Dr. Cicek testified that Dr. Demint's failure to document exploring that issue constituted inadequate medical documentation. (Tr. at 437-439)

221. Dr. Demint testified that he had originally seen Patient 11 on June 5, 2010, and received his medical records on June 10, 2010. Dr. Demint further testified that the fax machine-imprinted date of May 31, 2010, on the fax cover sheet that Dr. Cicek referenced was erroneous. (Tr. at 765-767; St. Ex. 11 at 20, 30)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings

222. Dr. Cicek described the physical examination documented by Dr. Demint at Patient 11's initial visit on June 5, 2010:

> [T]his patient has on his physical exam pain with range of motion, tenderness LS spine with palpation, a straight—positive straight leg on the right, normal reflexes. I don't see strength on here. In his history, he complains of the low

[37] As indicated above, Patient 11 had told Dr. Demint that he is allergic to hydrocodone. (St. Ex. 11 at 4, 21)

> back pain raiding—radiating to his leg, and a couple of things that make it worse, like twisting and bending.
>
> So there is a small discussion of what he had done in the past and being referred for injections. I don't see any indication of previous medications tried and what worked and what didn't.

(Tr. at 439-440)

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics

223. Dr. Cicek testified that Dr. Demint did not obtain a urine sample for drug testing at Patient 11's initial visit. She further testified that the standard of care required Dr. Demint to obtain a urine screen, "[e]specially if he were discharged from another provider." (Tr. at 440)

Allegation 2(g): Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports

224. Patient 11's September 2010 urine drug screen tested positive for alprazolam, hydrocodone, hydromorphone, and THC. Dr. Cicek noted that, at Patient 11's next visit on October 9, 2010, Dr. Demint referred Patient 11 to an addictionologist and weaned him off of oxycodone, which she stated was "[a]bsolutely" appropriate. (Tr. at 440-442; St. Ex. 11 at 4)

    In fact, Dr. Cicek testified that she finds no fault with Dr. Demint's reaction when Patient 11 turned in a dirty urine sample. (Tr. at 442) The problem is, Dr. Demint should have avoided that situation at the outset:

    > Had the subjective, being discharged from a previous provider, been explored in more detail initially, giving the patient a small amount of medications while you have the chance to review the old records or get the old records or speak with the previous provider, this wouldn't have gone on for, what, five months, four months, before the patient was—ended up being discharged for illicit drug use.

    (Tr. at 442-443)

225. Dr. Demint acknowledged that Patient 11 had had a bad urine screen on May 6, 2010, while being treated by another provider, and tested positive for cocaine, marijuana, and Xanax. Dr. Demint testified that he did not have this information available at Patient 11's initial visit. However, he testified that, after obtaining this information later in June 2010, he increased his surveillance of the patient. (Tr. at 234-235)

226. Dr. Demint testified that Patient 11 never returned to his office after he referred him for an addiction evaluation. (Tr. at 243-244)

227. Dr. Demint reiterated that he does not deny treatment based upon marijuana use alone because he is aware of no drug interaction or lethality between THC and opioids. (Tr. at 768)

Patient 12

228. On April 5, 2010, at the Lance practice, Dr. Demint took over the care of Patient 12, a male born in 1949. At that time, Patient 12 complained of pain in his neck, back, feet, and left shoulder. He also complained of a cough. Dr. Demint documented among other things that Patient 12 did not drink alcohol or take drugs. He diagnosed chronic lower back pain and chronic cervical pain, degenerative disc disease of the lumbar and lumbosacral spine, anxiety, and acute bronchitis. (St. Ex. 12 at 41-42)

    At Patient 12's initial visit, Dr. Demint prescribed Norco 10/325 #180, one refill authorized, to take one tablet every four hours as needed; and Xanax 1 mg #60, one refill authorized, to take one tablet every six hours as needed. (St. Ex. 12 at 3)

229. At Patient 12's next visit, on May 21, 2010, Dr. Demint changed the bronchitis diagnosis to emphysema. (St. Ex. 12 at 41)

230. Patient 12 submitted a urine sample on October 1, 2010, that tested positive for marijuana. Dr. Demint stated in his progress note dated October 25, 2010, that Patient 12 had admitted smoking one to two joints per day, and that Dr. Demint had discussed Ohio marijuana laws with Patient 12. In a later progress note, dated March 21, 2011, Dr. Demint again discussed marijuana with Patient 12 and told him to stop smoking it. (St. Ex. 12 at 13, 15, 35, 39)

231. Patient 12 continued to see Dr. Demint on a regular basis through March 21, 2011, the last visit documented in State's Exhibit 12. During this time, Dr. Demint maintained Patient 12 on the same levels of Norco and Xanax and briefly added cyclobenzaprine 10 mg three times per day and an ipratropium inhaler. (St. Ex. 12 at 3, 33, 35-42)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings; and

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy.

232. Dr. Cicek testified as follows concerning Patient 12's first visit:

> [T]here's a brief review of the patient's past medical, surgical history. There is not any review of what modalities of pain management have been attempted

> in the past and if they worked. There's not a review of the patient's current level of function or the functional goals, and there's not an individualized treatment plan.

(Tr. at 444)

233. Dr. Demint testified that he had objective evidence to support Patient 12's pain complaints. Dr. Demint testified that Patient 12 "had fracture of hip, dislocated shoulder due to a four-wheeler accident which resulted in him having surgery, open reduction, internal fixation of the left hip and the left arm." (Tr. at 769)

    Dr. Demint further testified that imaging reports evidenced moderate degenerative changes in the cervical spine, along with evidence of old fractures to the left femur and hip joint. Moreover, Dr. Demint testified that there was evidence of herniated nucleus pulposus in the cervical spine and minimal bulging of two disk in the lumbar spine. (Tr. at 770-771)

234. Dr. Demint testified that he had prescribed a morphine equivalent dose of 60 milligrams to Patient 12, which he testified was only one-third of the 180 milligram "morphine equivalent of being in-the-box prescribing." (Tr. at 248)

235. Dr. Demint testified that his prescribing had been supported by the patient's history and examination findings. Dr. Demint further testified that he had not prescribed an excessive amount of medication to Patient 12. (Tr. at 774)

Allegation 2(d): Dr. Demint inappropriately prescribed high doses of narcotics despite diagnoses of underlying Chronic Obstructive Pulmonary Disease

236. Dr. Cicek stated that it had been below the minimal standard of care for Dr. Demint to prescribe "high doses of narcotics to someone with underlying COPD." (St. Ex. 16 at 11)

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics

237. The chart indicates that Dr. Demint began seeing Patient 12 on April 5, 2010, but did not obtain a urine drug screen until October 2010. (St. Ex. 12 at 13-15, 41-42)

Allegation 2(g): Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports

238. With respect to Patient 12's October 2010 urine screen that tested positive for THC, Dr. Cicek noted that Dr. Demint documented a discussion with Patient 12 in his October 25, 2010 progress note and that the patient admitted to using one or two "joints" per day. Dr. Cicek testified that, in Ohio, marijuana is an illegal drug that is not used medically, and that "using it would imply you're abusing it." She further testified that Patient 12 had signed a medication agreement wherein he agreed not to use illicit drugs. Dr. Cicek testified that the appropriate thing for Dr. Demint to have done pursuant to the intractable

pain rules would have been to refer Patient 12 for an addiction evaluation. Moreover, she testified that his failure to do so violated the standard of care. (Tr. at 445-447; St. Ex. 12 at 9-10, 13, 39)

239. Dr. Cicek testified that it is concerning that Patient 12 lied at the first visit saying that he did not use drugs when, in fact, he used marijuana daily. (Tr. at 449-450)

240. Dr. Demint acknowledged that Patient 12's marijuana use had violated his medication contract. However, Dr. Demint testified that Patient 12 had otherwise been compliant, and that Dr. Demint did not believe that Patient 12 had "a true addiction problem." Dr. Demint further testified that there are many other physicians who do not routinely discharge patients simply for smoking marijuana. (Tr. at 263-264)

Allegation 2(i): Medical charting was incomplete, often illegible and/or disorganized

241. Dr. Cicek testified that she found Dr. Demint's chart for Patient 12 to be poorly organized, hard to read, and difficult to determine Patient 12's physical findings without reviewing old records. (Tr. at 449)

Patient 13

242. On March 15, 2010, at the Lance practice, Dr. Demint assumed the care of Patient 13, a female born in 1957. At that time, she advised that an increase in pain medication that she had received at her previous visit was giving her pain relief. She also advised that she wakes up on occasion with the fingers on her right hand numb, and that the numbness lasts from ten minutes to an hour. She further advised that she had no insurance and could not afford any tests. Dr. Demint noted among other things that she had pain in her thoracic and lumbosacral spine and ankle; the note is difficult to read but it does not appear that he specified which ankle was painful or whether both ankles were painful. Dr. Demint diagnosed chronic low back pain, degenerative disk disease of the lumbosacral spine, and depression with anxiety. (St. Ex. 13 at 29, 42)

    On March 15, 2010, Dr. Demint prescribed oxycodone 30 mg #120 with instructions to take one tablet every six hours, no refills; clonazepam 0.5 mg # 90 with instructions to take one tablet three times per day, two refills authorized; and Zoloft 25 mg #30 with instructions to take one tablet each day, two refills authorized. These were all continuations of prescriptions previously issued to Patient 13 by her previous provider. (St. Ex. 12 at 3, 42)

243. Patient 13 continued seeing Dr. Demint on a regular basis through December 6, 2010, the last visit documented in State's Exhibit 13. He continued Patient 13 on the same level of oxycodone and clonazepam through November 5, 2010, and increased Patient 13's Zoloft prescription to 100 milligrams per day by July 2010. On December 6, 2010, Dr. Demint issued no prescriptions to Patient 13. (St. Ex. 13 at 3, 33-42)

244. Patient 13 submitted urine samples on three occasions during the time Dr. Demint treated her. Her first, submitted on October 4, 2010, tested positive for oxycodone, oxymorphone, and 7-aminoclonazepam, which is appropriate since she was being prescribed oxycodone and clonazepam, but it also tested positive for oxazepam, which Dr. Demint had not prescribed. The lab result was received by Dr. Demint's office on October 7, 2010. (St. Ex. 13 at 18)

    Patient 13's second urine sample, submitted on November 5, 2010, tested positive in-house for benzodiazepine, oxycodone, and cocaine. AIT Laboratories confirmed positive results for oxycodone and oxymorphone, and also confirmed a positive result for benzoylecgonine, a cocaine metabolite, at a level of 2018 ng/ml, well above the cutoff level of 30 ng/ml. In addition, the sample was confirmed negative for benzodiazepines, which, along with the positive cocaine result, was inappropriate. The lab report was received in Dr. Demint's office on November 17, 2010. (St. Ex. 13 at 14-16)

    Finally, Patient 13's third urine sample, submitted on December 6, 2010, tested positive in-house for cocaine and opiates; the results sheet indicates the sample was not tested for benzodiazepines or oxycodone. A lab report received by Dr. Demint's office on December 29, 2010, confirms a positive result for benzoylecgonine at a level of 864 ng/ml, along with positive results for oxycodone, oxymorphone, and 7-aminoclonazepam. A note on the lab report dated December 31, 2010, indicates that Patient 13 needs "[d]rug addiction evaluation & treatment." (St. Ex. 13 at 11-13)

245. On October 8, 2010, following her first inconsistent urine drug screen, Dr. Demint ordered that Patient 13 be called in for a "pill count, OARRS, and addiction evaluation." The chart indicates that Patient 13 was called on October 13, 2010, but told Dr. Demint's staff that her medication was stored in a locked box at her mother's house and that her mother was at work. The note further states that "[s]he was told to get meds as soon as possible or it would count as failed pill count. She was to take them to the pharmacy. She later called crying cause she could not get her pills as her mom was not home all day." The chart indicates that Patient 13 was subsequently called in for a pill count on October 27, 2010, and passed, with the note that she "has some extra" oxycodone. (St. Ex. 13 at 21, 23)

Allegation 2(b): Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records; and

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings.

246. Dr. Cicek testified that Dr. Demint's physical examination addressed Patient 13's range of motion in her lumbosacral spine but did not address her complaints concerning her hands, ankle, or thoracic spine. Dr. Cicek further testified: "Again, there is not any review here of the previous treatments from the patient's previous provider, what's been tried, what worked, what didn't work, tests that had been done and what they showed, and then what the goals for the patient's function were." Moreover, Dr. Cicek testified that the physical examination findings did not support the patient's claimed pain level. (Tr. at 451-452)

247. Dr. Demint testified that an MRI report concerning Patient 13's lumbar spine confirmed her pain complaint. Dr. Demint described the results:

> [A]n MRI of the lumbar spine * * * shows degenerative disk disease, disk protrusion, disk protrusion that abuts S1—the right S1 nerve root, annular tear with protrusion at S—that's at S1 nerve root. It talks about could elicit focal neuritis due to local inflammation. She also had mild bilateral neural foramen stenosis, right disk bulge, abuts to the L5 nerve root. Bulge at L4-L5. And then there's this [syringohydromelia] * * * of the distal conus measuring 2 millimeters.

(Tr. at 777)

248. Dr. Demint opined that he had performed an appropriate physical examination for a patient that had been established at the practice where he had assumed her care. (Tr. at 781-782)

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy;

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics;

Allegation 2(g): Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports; and

Allegation 2(h): Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment.

249. Dr. Cicek testified that Patient 13's inconsistent urine drug screen report and failure to come in for a pill count in October 2010 were red flags. Dr. Cicek further testified that, despite the red flags, Dr. Demint did not alter his prescribing to Patient 13. (Tr. at 453-454)

250. Dr. Cicek acknowledged that Dr. Demint referred Patient 13 for an addiction evaluation around December 6, 2010, and that that had been appropriate. A note on the copy of the referral form states that Patient 13 refused the referral and never returned to Dr. Demint's office. (Tr. at 454-456; St. Ex. 13 at 32)

251. Dr. Cicek noted that a previous provider had determined on February 2, 2009, that Patient 13 was positive for hepatitis C. She testified that that should have been documented on Dr. Demint's initial history, but was not. (Tr. at 456; St. Ex. 13 at 51)

252. Dr. Demint testified that Patient 13 suffered from some psychological issues and that he had documented her counseling with Catholic Social Services. Dr. Demint noted that she was suffering from depression and had a lot of issues with her family. Dr. Demint further testified that he had increased her Zoloft prescription when she first came to see him. (Tr. at 778-779)

253. Dr. Demint testified that he stopped Patient 13's medication and referred her to an addictionologist following repeated aberrant behavior, including failed urine screens. Dr. Demint testified that she never returned to his practice. (Tr. at 280-281, 779-781)

Patient 14

254. On March 15, 2010, Dr. Demint assumed the care of Patient 14 at Lance, who was a male born in 1971. Dr. Demint's progress note indicates that Patient 14 had undergone a laminectomy, decompression, and fusion on November 13, 2009, and was experiencing more back pain than he had prior to the surgery. Dr. Demint diagnosed a herniated disk at L5-S1. He continued the patient's medication from his previous visit and had Patient 14 continue with physical therapy. (St. Ex. 14 at 50)

    At the initial visit on March 15, 2010, Dr. Demint continued the medication and dosages that Patient 14 had been prescribed the previous month: MS Contin 30 mg #60 to take one tablet twice per day, Norco 10/325 mg #120 to take one tablet four times per day as needed for breakthrough pain, Valium 10 mg #90 to take one-half to one pill three times per day, and Soma 350 mg #120 to take one tablet four times per day as needed for spasms. (St. Ex. 14 at 2)

255. Patient 14 continued to see Dr. Demint on a regular basis through March 28, 2011, the last visit documented in State's Exhibit 14. During this time, Dr. Demint continued to prescribe the same medications and dosages with the following exceptions: in July 2010, Dr. Demint increased Patient 14's MS Contin prescription from 30 mg to 60 mg #60 with instructions to take one tablet twice per day, and added Effexor 25 mg #90 to take one tablet three times per day. (St. Ex. 14 at 2, 34-50)

256. A urine sample submitted by Patient 14 on October 4, 2010, tested appropriately for the medications he had been prescribed. (St. Ex. 14 at 10)

Allegation 2(c): The amount and/or type of narcotics prescribed was not supported by history, physical examination, and/or test findings; and

Allegation 2(e): Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, SSRIs, and/or physical therapy.

257. Dr. Cicek commented on Dr. Demint's documentation for his first visit with Patient 14:

> So, again, the initial visit doesn't—it reviews the surgery date and just pain worse since surgery. We don't have a past medical history, thorough past surgical history, a social history, or a family history here.
>
> The musculoskeletal exam on this patient documents the range of motion, but not strength, sensation, gait.
>
> And then the assessment is just a herniated disk status post-surgery and see med list, continue PT.
>
> So not thorough documentation for an initial visit. Not an individualized treatment plan. The only treatment plan is the medications and the PT. There's no statement of goals or what you're hoping to achieve with pain management.

(Tr. at 457-458)

Dr. Cicek further testified that it is important for a physician who assumes the care of a patient to review this information at the first visit "so you are not prescribing things that could possibly harm the patient. If you don't know their past medical history, for instance, someone with hepatitis C, you wouldn't want to give large doses of Tylenol. So you have to be aware of their comorbidities to treat the patient appropriately." (Tr. at 458)

Moreover, Dr. Cicek testified that just knowing that information is not enough; it must be documented. Dr. Cicek testified that "if it's not documented, it's not done." She added: "There's no way to know if those—the past history was addressed or reviewed because it doesn't say anywhere it was addressed or reviewed." She also stated that "you can't assume something when you're providing care. * * * We, as providers, don't assume something was done." (Tr. at 458-459)

258. Dr. Cicek further testified that the medications that Dr. Demint prescribed for Patient 14 were not supported by testing or the medical records:

> [W]e have the physical exam, which essentially doesn't give us a lot of idea of the patient's function. It does mention the patient is very—is having pain from stimuli that shouldn't cause pain. And the patient is prescribed MS Contin or morphine 60 milligrams twice a day;[38] in addition, hydrocodone, a total of 40 milligrams a day; Valium a total of 30 milligrams a day; and Soma, which is a muscle relaxer that metabolizes to a barbiturate, a total of at least—well, four pills a day of that, as well.

(Tr. at 460)

[38] Dr. Demint initially prescribed MS Contin *30 milligrams* twice per day. He increased the dose to 60 milligrams twice per day in July 2010. (St. Ex. 14 at 2)

259. Dr. Cicek testified that Patient 14 had "continually escalating doses of narcotics"[39] while being treated by Dr. Demint although they did not seem to improve Patient 14's pain or ability to function. She further testified that Dr. Demint failed to obtain a urine drug screen at the initiate of his care despite Patient 14's history of being dropped by a previous physician for a failed toxicology screen. Moreover, Dr. Cicek testified that Dr. Demint had failed to summarize a plan when he assumed the care of Patient 14, and documented nothing to measure Patient 14's improvement of function. (Tr. at 461-462)

260. Dr. Demint testified that Patient 14 came to him four months after having had a laminectomy, decompression, and fusion of his lumbar spine. Dr. Demint further testified that his surgeon was managing everything in Patient 14's his post-surgical recovery except for medication management. Dr. Demint testified that Patient 14 came to him taking MS Contin 30 mg twice per day, hydrocodone/APAP 10/325 four times per day as needed for breakthrough pain, Valium 10 mg, and Soma 325 mg as needed for spasm. (Tr. at 783-784)

261. Dr. Demint testified that he did not particularly like the combination of medication he prescribed to Patient 14, but that the patient had been taking those medications for some time and they were effective for him. Dr. Demint testified:

> [T]his patient is on a combination of medicine I don't particularly like to give. I don't like Soma very much, and as you know this is the only patient I have on Soma, but he had tried several other muscle relaxants and—and other adjuncts and could not tolerate them. So this was, you know, the exception that he use that drug.
>
> You know, I did use Effexor on him for his neuropathic pain. I had tried gabapentin, and that was the second or third time he had been tried on gabapentin, but he could not tolerate it due to the side effects.
>
> So, you know, sometimes you prescribe medicines you don't particularly like because the one you like just doesn't work or they can't tolerate them, you know. You know, that's—that's part of the practice of medicine.

(Tr. at 295-296)

262. Dr. Demint testified that he had utilized non-narcotic adjunctive medication in his treatment of Patient 14. He attempted gabapentin but Patient 14 could not tolerate it. He then placed Patient 14 on Effexor to treat his neuropathic pain. (Tr. at 784-785)

Allegation 2(f): Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics

263. Dr. Cicek testified that it was below the minimal standard of care for Dr. Demint to wait seven months prior to obtaining a urine drug screen on Patient 14. Dr. Cicek further

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[39] As stated above, Dr. Demint increased Patient 14's morphine dose only once, although it was doubled at that time from 60 milligrams per day to 120 milligrams per day. (St. Ex. 14 at 2)

testified that, for an individualized treatment plan, Dr. Demint should have noted when the urine drug screen would be repeated. (Tr. at 459-460)

264. Dr. Demint testified that he had had reports concerning Patient 14 from OARRS, KASPER, and West Virginia Board of Pharmacy. Dr. Demint further testified that he obtained urine screens from Patient 14 that were all consistent. (Tr. at 785-786)

Conclusions of Dr. Cicek

265. Dr. Cicek summarized her opinion concerning Dr. Demint's care and treatment of Patients 1 through 14:

> [I]n terms of the drug treatment of intractable pain guidelines from the Board, we're required to make an assessment of the impact of pain on a patient's physical and psychological functions, as well as reviewing previous diagnostic studies, previous utilized therapies, coexisting illnesses, and an appropriate physical exam, which in almost all the charts we reviewed was lacking.
>
> Medical diagnoses should be established when possible. Back pain is a symptom, it's a diagnosis—if you can't find a cause for it, more appropriate than back pain would be what's—the diagnosis of what's actually causing the back pain so you know how to treat it appropriately.
>
> The individual treatment plan shall be formulated and documented in the patient's medical record. Again, the individual treatment plans were essentially prescriptions. There is no mention of goals that are desirable for the patient in terms of function, mobility, what they're able to do. And there's not regular assessments of what the patients are and are not able to do that they should be able to do or want to do because of their pain.
>
> So, again, the subjective, it clearly states that some patients' intractable pain are at risk of developing increasing prescription drug consumption without improvement in functional status. Subjective reports by the patient should be supported by objective data. And that needs to be an ongoing assessment. And if the patient is continually needing elevations in their drugs, they should be referred to an appropriate specialist to further evaluate them, which was not done on a regular basis.
>
> The patients were consistently given large—a month's supply of medication at their first visit without having a urine toxicology done most of the time. Then when urine tox screens were inconsistent, patients should—the frequency of visits should have been increased so the patient was being seen more frequently or that was being addressed in some manner with the patient.

(Tr. at 462-464)

When asked about her comments in her written report concerning long-acting versus short-acting medications, Dr. Cicek testified:

> [T]he standard of care for treating intractable pain is that you put a patient—when you can determine their dosage, put them on a long-acting narcotic which gives them consistent pain control over a longer period of time, as opposed to frequent dosing of a short-acting medication, and they have a certain amount of medication for breakthrough pain.
>
> If a patient is on a long-acting narcotic and taking their breakthrough pain medication every four hours, then you need to assess why the long-acting narcotic isn't working and if it needs to be increased or changed. And, again, if you're continually escalating that dose and not seeing improvements in function, then it's the inappropriate therapy for the patient or you need to get a specialist's opinion.
>
> There were a couple of people on long-acting medications, but the majority had high dosages of short-acting medications. And when they were on long-acting medications, they often had large amounts of short-acting medications for breakthrough pain; 112, 120 of 5 or 10 milligram oxycodones in addition to their long-acting medication.

(Tr. at 464-465)

266. Dr. Cicek testified that she had not had "enough information in the notes to actually paint a picture" of the patients because there was insufficient information documented in the charts. (Tr. at 482-483)

267. Dr. Cicek testified that in six years of practice she discharged about 10 to 20 patients for violating their medication contract. When asked why so few, Dr. Cicek replied that she screens patients at their initial visits: "[I]f there is a patient who comes in who has a prior discharge from someone or an OARRS report that's not reflecting what they're telling me, I don't take them on as a chronic pain patient." (Tr. at 466-467)

268. Dr. Cicek testified that, if a patient who receives prescriptions for narcotics and benzodiazepines tells the physician that he or she drinks a couple beers at a time, the physician needs to address that with the patient and counsel the patient concerning the potentiating or addictive effects of combining alcohol with those medications. Dr. Cicek added that "people typically underreport their alcohol intake." Moreover, Dr. Cicek testified that that discussion needs to be documented in the patient's chart. (Tr. at 499-502)

269. Dr. Cicek testified that it is necessary for a physician to sign off on initial patient documentation coming in from another source, such as imaging reports or prior treatment records, that the physician has reviewed. When asked why, she replied: "The same reason we write a physical exam for a patient or we take a medical history; because it shows that we've reviewed the previous information and incorporated it into the current plan of care."

Moreover, Dr. Cicek testified that "[e]very practice institution I have trained at and worked in in Ohio and other states, it is standard of care to sign off on something you've received and reviewed." She further testified that, if it is not signed off on, it is possible that it was still reviewed but that that cannot be assumed. (Tr. at 505-511)

270. Dr. Cicek testified that medication contracts are the standard of care. Dr. Cicek testified that they should be entered into at the same time narcotic medication is initiated. Moreover, she testified that if care of the patient is transferred to a new provider then the contract should be reviewed and re-signed with the new provider to document that the contract was addressed. (Tr. at 523-524)

271. When asked if it is okay if a physician, upon being told by his patient that the patient smokes marijuana in violation of the medication contract, tells the patient to stop smoking marijuana but agrees to continue to prescribe controlled substances, Dr. Cicek replied, "I wouldn't prescribe that person narcotics if they admitted to smoking an illegal substance." When asked if the "millions of Americans" who have pain and smoke marijuana have to be refused care because they use an illegal drug, Dr. Cicek replied: "If they're using an illegal drug, then they need an addiction assessment prior to receiving chronic narcotics from a primary care provider. Again, that obligates you to getting a specialist's input." Finally, Dr. Cicek noted that medical marijuana is not legal in Ohio. (Tr. at 525-527)

272. With respect to the established patients that Dr. Demint took over at the Lance practice, Dr. Cicek testified that Dr. Demint had a responsibility to treat them like they were new patients. She noted that they were "brand new to him." (Tr. at 530-531)

273. Dr. Cicek was asked what a physician is supposed to document as the patient's individualized goals. Dr. Cicek testified:

> What the patient hopes to achieve by controlling their pain. Do they want to be able to work full time? Do they want to be able to go to the grocery store? Do they want to be able to care for their children? What activities in their life are they unable to do because of the pain and what would they like to achieve with control of their pain? How else are you going to objectively – [measure their progress?]

(Tr. at 538-539)

274. Dr. Cicek testified that writing "See Rx" does not constitute a sufficient treatment plan. Dr. Cicek testified that, patients should be treated with non-narcotic modalities first, and, when they are treated with narcotics, it is "a multimodal approach. So 'See Rx' as the plan is not an individualized treatment plan, and we—we know that because that's what the plan is for every chart that I reviewed, is 'See Rx.'" (Tr. at 540-541)

275. Dr. Cicek acknowledged that there is some lag in OARRS reports between what is reported and the most recent transactions. For example, and OARRS report might not have last week's prescriptions on it. (Tr. at 549)

Dr. Demint's Conclusions

276. Dr. Demint testified that he follows accepted methodology when he performs his initial evaluations of patients. Dr. Demint testified that he follows the SOAP form of recordkeeping,[40] whereby the patients' subjective complaints are documented, he documents objective findings during examinations, he assesses the patients' problems, documents diagnoses, and he documents plans. (Tr. at 620-621)

    Dr. Demint testified that he believes that the SOAP notes, four A's, and the brief pain inventory together provide him sufficient information to diagnose and treat his patients. (Tr. at 624-625)

277. Dr. Demint testified that there is no correlation between a patient's subjective sensation of pain and the results of imaging studies:

    > I have seen patients with the worst-looking x-rays and have no—or MRIs, not complain of any pain at all of any significance. And then I have others that had not had what was considered any significant abnormality and have almost debilitating pain. Again, as I said, fibromyalgia is one of the—one of those—-those conditions.

    (Tr. at 625)

278. Dr. Demint testified that he gives his patients individualized treatment, and that he tailors the treatment he gives to the individual needs of each patient. Dr. Demint further testified that his treatment of the patient evolves over time. Moreover, Dr. Demint testified:

    > Where we evolve during the times you see the patient, you know, I think that's one of the things that I think you can tell a pill mill from someone who's trying to do a good job. Pill mill doesn't give individual treatment. They give the same medications all the time, you know. They always give an opioid of choice, whichever opioid that is; they give a benzodiazepine of choice, usually Xanax; and then they give Soma. And everyone gets that. So that's not individualized.
>
> If you look at these patients, none of these patients have the same medications, because I not only use the opioids, but I use the adjunctive medications; the gabapentins, the Lyricas, the SNRIs such as Cymbalta and Effexor.

    (Tr. at 626-627)

[40] SOAP is a mnemonic for Subjective, Objective, Assessment, and Plan.

279. With respect to documenting his review of patients' prior medical records, Dr. Demint acknowledged that he does not always sign the old records. Dr. Demint further testified:

> I may not say, "Oh, reviewed records," but you can see that by my diagnoses or something that I had to have gotten that from the—the records.
>
> You know, that would have been something I wouldn't have gotten from the patient, and to me that proves I must have looked at the records. Otherwise, how would I have come up with that information?

(Tr. at 631-632)

Dr. Demint further testified that he believes that the standard of care requires only that his note references a prior treatment record. Moreover, Dr. Demint testified that he is unaware of any written requirement that he must sign prior treatment records. (Tr. at 632)

280. Dr. Demint testified that he disagreed with Dr. Cicek's opinion that a physician should start a new pain patient on the minimum dose of medication:

> Because the minimum dose may not provide enough pain relief for their situation, and so the patient's continuing to suffer from pain. And this is very troublesome when you have people in acute pain, and like I say, most of her discussion really applied more to acute pain than chronic pain. But if you don't get adequate control of acute pain, it can tend to become chronic pain and now we got a big bugaboo. I think that's part of the problem that got us where we are now, you know, and the whole opioid—is that if people would have treated a lot of these people's patient—pain effectively initially, they never would have been chronic pain patients.

(Tr. at 673-674)

281. Dr. Demint testified that, with respect to urine drug screens, the intractable pain rules state that if he becomes suspicious about a patient he *may* do a urine screen. He further testified that the rule requires that a patient be referred for addiction services should he or she refuse to consent to the screen. (Tr. at 632-633)

Dr. Demint further testified that the standard of care does not require action based simply on a *screen*, and that the physician must get *confirmation*. Dr. Demint testified that the in-office screens are too unreliable to serve as a basis for medical decisions, although a medical decision could sometimes be made on an initial screen that is totally negative. (Tr. at 634)

Dr. Demint believes that a physician should not alter a patient's medication regimen based on an inconsistent in-house urine screen. He further testified that physicians have faced lawsuits for such action when the laboratory report following an inconsistent in-house screen was confirmed to be okay. Therefore, Dr. Demint testified, he feels obligated to continue the patient's medication until he receives laboratory confirmation. (Tr. at 636)

282. Dr. Demint was questioned concerning Dr. Cicek's opinion that, faced with an inconsistent in-house urine screen result, a physician should only prescribe enough medication to last until the physician receives the laboratory confirmation. He testified that the typical one-month supply of medication that he prescribes is reasonable because delays in receiving the lab reports are not unusual. Dr. Demint further testified that he practices in an area where a lot of people are economically disadvantaged and that it would be a hardship for the patient to return in two weeks. (Tr. at 636-638)

Dr. Demint opined that the standard of care does not require any particular maximum period of time to prescribe medication pending lab confirmation of an inconsistent in-house urine drug screen result. (Tr. at 638-639) In support of his opinion, Dr. Demint presented a letter he received dated June 8, 2012, from AIT Laboratories. The letter states, in pertinent part:

> Immunoassay tests, whether they are a point of care device, such as an instant cup, or a dipstick test or even a laboratory initial screening test, are based on the principle that antibodies are able to recognize and bind to the drug of interest. These antibodies are designed to be highly selective, which means they preferentially bind to the drug of interest. In the absence of the drug, this binding does not eliminate the possibility of binding to other drugs that have similar chemical characteristics (i.e. similar chemical structure). This secondary binding is commonly called a "false positive" result. It is not possible to design an antibody that binds to a single drug exclusively. Additionally, given the vast number of drugs available on the market (illicit, prescription and over-the-counter) and the vast number of metabolites produced by the body, it is also not possible to evaluate all possible "false positives." As an example, the target drugs in the amphetamine immunoassay screening analysis in the laboratory are Amphetamine, Methamphetamine, and MDMA. Other amphetamine-like drugs, such as Ephedrine (Ephedra), Pseudoephedrine (Sudafed/Actifed), and Phentermine (Adipex), as well as the acid-reflux medication, Ranitidine (Zantac), and the antidepressant, Trazodone (Desyrel), can cross react (if present in a specific amount) and cause a positive result leading to a "false positive." As another example, the target drug in the cannabinoid immunoassay screening analysis is Carboxy THC, the main urinary metabolite of THC, the primary psychoactive ingredient in cannabis. The acid-reflex medication, Pantoprazole (Protonix), and the antiretroviral drug, Efavirenz (Sustiva), can cross react and cause a "false positive."
>
> While the POC screening testing is valuable, the possibility of the "false positive" result is the underlying reason that no medical decision be made on the POC screening result on its own. A confirmatory test, typically either gas chromatography with mass spectrometry (GC/MS) or liquid chromatography with tandem mass spectrometry (LC/MS/MS), is needed for unequivocal identification of the drug or metabolites present.

(Resp. Ex. H)

283. Dr. Demint further testified that his position is supported by a book entitled *The Massachusetts General Hospital Handbook of Pain Management, Third Edition* ("MGH Handbook"), edited by Jane C. Ballantyne, M.D.[41] Dr. Demint testified that Massachusetts General Hospital is the training facility for Harvard University College of Medicine and that Dr. Ballantyne is a highly respected pain specialist. Dr. Demint further testified that the MGH Handbook sets forth appropriate knowledge and the standards one needs to follow practicing pain management. (Tr. at 655-656, 663-664; Respondent's Substitute Exhibit ("Resp. Sub. Ex.") A)

With respect to urine drug screens, the MGH Handbook states, in pertinent part:

> Unfortunately, routine urine assays provide only qualitative results (i.e., the presence or absence of a representative from a specific drug class, e.g., opioid and benzodiazepine). This is simply a screening method, which needs to be followed by a second confirmatory test. The preliminary test result must be validated when the consequences of a false-positive result are crucial, such in the case of ongoing litigation.

(Tr. at 675-677; Resp. Sub. Ex. A at 520)

284. Dr. Demint testified that there is no rule that states that a physician cannot treat a pain patient who admits to smoking marijuana, even if that violates their medication contract. Dr. Demint testified that the physician must counsel the patient, but it is not necessary to discharge the patient even if the patient had previously lied about his or her use of illicit drugs. (Tr. at 644-646)

Dr. Demint further testified that he does not believe there is a requirement to refer a patient to an addictionologist simply because the patient admits using marijuana. Moreover, Dr. Demint testified that he does not believe that marijuana use per se constitutes drug abuse or addiction. (Tr. at 648-649)

285. When asked about a responsibility to counsel a patient who states that he drinks a six-pack of beer on weekends, Dr. Demint replied:

> Well, I usually, you know, patients [who are] totally new to me, you know, I—I probably mention something, but I may not particularly document it in the chart. But also I know he's going to get counseling at the pharmacy when he picks up his medications. Actually, the pharmacist often knows that—you know, the interactions and stuff better than we do.

(Tr. at 649-650)

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[41] The third edition was copyrighted in 2006. (Resp. Sub. Ex. A at iv)

286. Dr. Demint testified that medication contracts are not required by any government rule but are considered to be the standard of care. However, he testified that he is unaware of any standard concerning the contents of such contracts. Dr. Demint testified that he obtained the contract he uses from the American Academy of Pain Management and modified it to suit his practice. He further testified that they are available in textbooks and from other sources. (Tr. at 646-647)

287. Dr. Demint does not believe that his handwriting in his medical charts is illegible. Dr. Demint further testified that he has never had any complaints prior to Dr. Cicek that his charts are unreadable. Moreover, Dr. Demint testified that he has had pharmacy technicians and nurses comment to him how much better his handwriting is compared to other physicians. (Tr. at 650)

288. Dr. Demint presented a statistical compilation from AIT Laboratories that he says demonstrates that his patients' compliance rate is higher than that reported by AIT labs in general. (Tr. at 685-688; Resp. Ex. K)

289. Addressing the issue of new patients who have previously been discharged from other physicians' practices, Dr. Demint testified that he does not believe that there is any particular action that can be called "the standard of care" under such circumstances, nor does he believe that he must withhold treatment until he obtains a urine drug test. He further testified that a prior discharge does not automatically form a basis to deny treatment. He stated that each patient's situation must be looked at individually to determine whether to treat or deny treatment to that patient. (Tr. at 643-644)

290. Dr. Demint testified concerning the reasons why he is willing to take patients who were discharged from other physicians' practices:

> [T]he biggest reason for a misuse is not addiction like most people think, but the studies show that the biggest reason for misuse is undertreatment of pain and using drugs to treat their pain. And so I'm willing to give someone a chance to—to relieve their pain.
>
> You know, again, they have to go through a new contract with me, they know—I mean, after a while, when you kick out enough patients, the word gets around that, you know, Dr. Demint will kick you out. You know, will I give them a chance because I know I would do the proper screening, risk evaluation, and—and such.
>
> If you notice as we've gone through here, you know, not everybody got screened the same way. That's because I do a risk management, you know. That's how we're going to—you know, if I did—you know, if we did drug screens on every patient every day—every time they came in the office, if we did an OARRS every time they came to the office, did the pill count once a month, logistically, it would be impossible. We—you know, the logistics of it would be impossible. The cost of it would be such a burden on the system.
>
> * * *

> * * * The health care system couldn't afford it. You know, I mean, you've got to think about all those costs if you add up. You know, it's—so you have to do a risk stratification, you know. You know, the risk factors, you know.
>
> And according to those risk factors, you stratify them, and then you do your monitoring or surveillance per those risks. So those with higher risk get more monitoring, as you noticed for some of these patients, where I did maybe a drug screen again in—you know, on the next visit or the visit after, where others would go a long time. I mean, I think that's the whole purpose why that law said [you may].

(Tr. at 790-792)

291. Dr. Demint testified concerning Respondent's Exhibit E, a collection of continuing medical education certificates for "hundreds of hours" of courses he completed since 2006. Dr. Demint testified that he is required to take a certain number of hours to maintain his status of diplomate in the American Academy of Pain Management, and testified that he has completed "much more than is required." (Resp. Ex. E; Tr. at 615-617)

Dr. Cicek – Response to MGH Handbook

292. Dr. Cicek testified that she is not familiar with *Pain Medicine, a Comprehensive Review,* by Raj; or *The Massachusetts General Hospital Handbook of Pain Management*. She acknowledged that they may be authoritative sources but that she does not refer to them. Dr. Cicek testified that she mainly relies upon online resources. (Tr. at 475-476)

293. Dr. Cicek was asked whether she agrees with a statement in *The Massachusetts General Hospital Handbook of Pain Management* ("MGH Handbook"), in a chapter entitled Assessment of Pain, that states, in bold print, "**There is no objective measure of pain.**" Dr. Cicek indicated that she disagreed with that statement, stating that there are some objective measures of pain such as "[e]levated blood pressure, elevated pulse, facial expressions, [and] someone's ability to walk, sit, stand." (Resp. Sub. Ex. A at 58; Tr. at 479)

    Dr. Cicek was also asked whether she agrees with another statement from the MGH Handbook that says: "Reports of pain may not correlate with the degree of disability or findings on physical examination." Dr. Cicek indicated agreement but referenced an additional statement in the same paragraph that says: "The most important of these factors [to be considered in combination by a physician assessing pain] is the patient's report of pain, but other factors such as personality and culture, psychological status, the existence of secondary gain, and drug-seeking behavior should also be considered." (Resp. Sub. Ex. A at 58; Tr. at 480-481)

294. Dr. Cicek indicated agreement with the following statement in the MGH Handbook:

> Opioids are the core pharmacologic treatment of pain. They are the mainstay for treatment of both acute pain and cancer pain, and although controversy still exists over their use in chronic nonterminal pain (CNTP), they are increasingly used for this indication also. Opioids are the only pain medications that have no ceiling effect and are therefore the only systemic treatment that can be used to treat severe accelerating pain.

(Resp. Sub. Ex. A at 105; Tr. at 485-486)

295. A statement in the MGH Handbook states, with respect to medication contracts for pain patients receiving opioids: "[A]lthough there is limited scientific evidence to support success with contracts in the pain population, the practice seems to be widespread." (Resp. Sub. Ex. A at 521-523) Dr. Cicek testified that she disagrees with that statement:

> I think a contract states to the patient what they can expect from the provider and what the provider expects from them. It's—makes clear at the outset what the expectations are. If you're going to go to a job, you get a contract that states what the expectations of your performance are and what you can expect from your employer.

(Tr. at 498)

Additional Testimony of Dr. Demint

296. Dr. Demint testified that patients in chronic pain appear differently on examination from patients in acute pain, because the nervous system of chronic pain patients undergoes changes due to a process he called neuroplasticity. Dr. Demint further testified that the result of these changes is called neuropathic pain. Moreover, Dr. Demint testified that, unlike acute pain, neuropathic pain does not respond well to nonsteroidal anti-inflammatory drugs, but is better treated with gabapentin or a serotonin–norepinephrine reuptake inhibitor ("SNRI") such as Effexor or Cymbalta. (Tr. at 640-641)

    Dr. Demint testified that patients in chronic pain do not exhibit the same objective characteristics shown by patients in acute pain whose blood pressure and pulse can be elevated. Moreover, Dr. Demint testified that Dr. Cicek demonstrated "ignorance of pain management" by not differentiating between the presentations of acute pain and chronic pain. (Tr. at 642)

    Dr. Demint testified that a statement in Chapter 6 of the MGH Handbook, "Reports of pain may not correlate with the degree of disability or findings on physical examination," supports his testimony. (Tr. at 657; Resp. Sub. Ex. A at 58)

Testimony of Barry Bennett

297. Barry Bennett testified that he is the Executive Director of Pickaway Area Recovery Services ("PARS"), Fayette Recovery Center, and Washington Courthouse Women's Residential Program. Mr. Bennett testified that PARS is a substance abuse outpatient counseling center that is licensed by the Ohio Department of Alcohol and Drug Addiction Services. (Tr. at 544)

298. Mr. Bennett testified that he is familiar with Dr. Demint. Mr. Bennett testified that Dr. Demint has referred Suboxone patients to PARS who suffer from anxiety or depression. Mr. Bennett testified that PARS has staff who are qualified to treat such patients. He testified that many other physicians refer patients to PARS as well. However, Mr. Bennett testified that "Dr. Demint and Children's Hospital are the two that follow up the most with their clients." (Tr. at 545)

Testimony of Stephen G. Allen

299. Stephen G. Allen testified that he is a registered pharmacist in the State of Ohio and works at Allen's Medical Pharmacy in Chillicothe. Mr. Allen testified that he is familiar with Dr. Demint through Dr. Demint's prescriptions and that he has known Dr. Demint for about 20 years. Mr. Allen testified that Dr. Demint seems very concerned about the problem of drug diversion, and frequently calls his pharmacy asking questions about patients. Likewise, Mr. Allen testified that he has contacted Dr. Demint about suspect prescriptions and that Dr. Demint has always been cooperative in that regard. He further testified that Dr. Demint appears to be "very active in pursuing that things are being done legitimately." (Tr. at 570-572)

300. Mr. Allen testified that he is very familiar with the prevalence of drug abuse and diversion in his area and stated that it is a huge problem. Mr. Allen further testified:

> Even if—if you have a patient that maybe has a legitimate problem, I think even many times they are taking part of it, selling part of it.
>
> A lot of physicians have become very prudent in doing drug screens, and if they don't find any showing up in the urine test, then they're out. I am seeing physicians quicker to let people go than they used to be. But we have a long, long, long, long way to go.
>
> And it seems like when you solve one thing, something else pops up. You know, there used to be a time when marijuana was a problem. Now it seems like something very minor. But now we have kids—people growing up with meth and all their teeth are falling out. And you can almost tell some of the people that come in the store that—you can almost tell they're meth'd up, as we call them.
>
> It's a terrible industry. It's a terrible, terrible thing. And in my time left in this profession, I don't see it being totally solved, but I would like to see steps going that direction. I think we're—we're turning that direction.

(Tr. at 580-583)

301. Mr. Allen testified concerning OARRS that there is a lag time between prescriptions being issued and the prescriptions appearing on OARRS reports. He further testified that the information in OARRS is not perfect and that sometimes patients are misidentified. Also, when patients fail to pick up a prescription that has been filled, there is no way of reversing the information input into OARRS short of writing a letter. In addition, Mr. Allen testified that OARRS uses ZIP codes to search; "[i]f the patient would give me as little misleading information as their ZIP code and I search the wrong ZIP code, that will not come up." Finally, Mr. Allen testified, "OARRS is a wonderful thing, but it has a ways to go." (Tr. at 575-579)

Testimony of Phillip Prior, M.D.

302. Phillip Prior, M.D., testified that he is an addictionologist and that he practices at the Veterans Administration hospital in Chillicothe. Dr. Prior testified that he is board-certified in family medicine and in addiction medicine. Dr. Prior further testified that he has been an addictionologist for about ten years. (Tr. at 588, 595)

303. Dr. Prior testified that he is Dr. Demint's monitoring physician for purposes of Dr. Demint's consent agreement with the Board. As Dr. Demint's monitoring physician, Dr. Prior performs periodic reviews of Dr. Demint's patient records to ensure that he is practicing medicine in accordance with the minimal standard of care. Moreover, Dr. Prior provides a general assessment of the quality of Dr. Demint's recovery program. (Tr. at 588-589)

Dr. Prior testified that, in his capacity as Dr. Demint's monitoring physician, he has not had any problems with Dr. Demint's medical charts with respect to their legibility. Dr. Prior further testified:

- As part of the chart review process, Dr. Prior determines whether or not the care provided to the patient appeared to be appropriate.

- He has not been concerned that Dr. Demint's initial visit notes were so brief that he could not ascertain the purpose of the patient's visit. Dr. Prior further testified that he believes that Dr. Demint's initial visit notes are appropriate.

- Dr. Prior testified that an initial treatment plan "consists of a diagnosis and whatever therapeutic measures are going to be undertaken to deal with that diagnosis." Dr. Prior testified that he believes from his reviews of Dr. Demint's charts that Dr. Demint has an initial treatment plan for each patient.

- Dr. Prior does not believe that all of the information a physician needs to make a decision has to be in one particular place in the file. Dr. Prior testified, "the standard

of care would be for the information that you're seeking to be somewhere in the chart"

- Dr. Prior testified that the patient's report of pain does not always correlate with the patient's degree of disability or the examination findings.

(Tr. at 591-594)

FINDINGS OF FACT

1. On or about August 12, 2009, Franklin Donald Demint, D.O., entered into a Step I Consent Agreement with the Board in lieu of formal proceedings based upon violations of Sections 4731.22(B)(26), (5), (10), and (20), Ohio Revised Code. The Step I Consent Agreement was based upon Dr. Demint's dependence on and excessive and habitual use of marijuana, and his admission of having possessed and dispensed generic Tylenol #3 tablets to a family member under circumstances not constituting an emergency, without performing and documenting an examination and without maintaining patient records.

   Subsequently, on or about March 10, 2010, Dr. Demint entered into a Step II Consent Agreement with the Board, pursuant to which his Ohio certificate to practice osteopathic medicine and surgery was reinstated, subject to certain terms, conditions, and limitations.

   To date Dr. Demint remain subject to all terms, conditions and limitations of the Step II Consent Agreement, as modified by the Board, including Paragraph 1, which requires that you obey all federal, state, and local laws, and all rules governing the practice of osteopathic medicine in Ohio.

2. During the time period of March 2010 to in or about April 2011, Dr. Demint provided care in the routine course of his practice for Patients 1 through 14 as identified in a confidential Patient Key.

   In his treatment of Patients 1 through 14, Dr. Demint practiced below minimal standards of care, including, but not limited to, the following:

   a. See Finding of Fact 3, below.

   b. With respect to Patients 3 through 5, 7, 8, 11, and 13, Dr. Demint failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records.

      Dr. Cicek persuasively opined that physicians must review and document their review of patients' histories and prior medical records. The documentation can be as brief as "medical history reviewed and updated." She further testified that the importance of documentation and the adage that, if it is not documented, it was not done is common knowledge in the physician community. Dr. Demint's suggestion that one can tell

from his diagnoses that he had reviewed histories or records is unpersuasive—medical records should clearly and accurately reflect what the physician did, and the burden of including a short note to that effect is not too great.

c. With respect to Patients 1 through 5, and 7 through 14, the amount and/or type of narcotics prescribed by Dr. Demint was not supported by history, physical exam and/or test findings.

Dr. Cicek opined there was a lack of physical examination findings documented to support the level of narcotic prescribing for each of these patients. She noted that the musculoskeletal examinations were incomplete, and failed to include all of the necessary elements such as range of motion, reflex testing, strength, sensation, and muscle atrophy or asymmetry. Moreover, Dr. Demint failed to evaluate patients' ability to stand, walk, and sit. None of the patient records for Patients 1 through 5, and 7 through 14, include all, or even most, of those elements.

Dr. Demint noted that some of these patients had had radiological studies that supported their pain complaints. However, as Dr. Demint himself persuasively opined, there is no direct relationship between radiological findings and patients' subjective reports of pain—patients with terrible radiological studies can be pain free and patients in terrible pain can have normal radiological studies. As useful as radiological studies may be, it is the physician's responsibility to determine the patients' level of pain via examination, pain inventories, and histories. Accordingly, Dr. Cicek's opinion is deemed more credible.

d. With respect to Patients 9 and 12, Dr. Demint inappropriately prescribed high doses of narcotics despite diagnoses of underlying Chronic Obstructive Pulmonary Disease.

Dr. Cicek persuasively opined that Dr. Demint should have documented discussions with these patients concerning their increased risks of respiratory depression and his plans for monitoring them.

e. With respect to Patients 1, 2, 4, 6 through 10, and 12 through 14, Dr. Demint failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, selective serotonin reuptake inhibitors, and/or physical therapy.

Dr. Demint argued that he had not simply prescribed the same medications to every patient, and that he had utilized non-narcotic adjunctive medications such as gabapentin, antidepressants, and NSAIDs in his treatment of his patients. Moreover, the record indicates that Dr. Demint had referred some of his patients for mental health treatment and physical therapy. However, Dr. Cicek testified persuasively that no *plan* was documented for these patients. There was no documented attempt to determine how therapy would be used to assist the patients to achieve improvements in functioning, or monitoring to assess whether those goals were being met.

f. With respect to Patients 2, 5, 9, and 11 through 14, Dr. Demint failed to obtain toxicology screens prior to prescribing narcotics.

g. With respect to Patients 3, 6, 8, 9, 11, 12, and 13, Dr. Demint failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports.

h. With respect to Patients 3 through 6, 9, and 13, Dr. Demint failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment.

i. The evidence overwhelmingly supports a finding that, with respect to Patients 1 through 3, 6, 8, and 12, Dr. Demint's medical charting was incomplete, often illegible and/or disorganized.

Nevertheless, Dr. Demint established that he had provided his patients with actual medical care; this is not a "pill-mill" situation. Despite any shortcomings in his treatment of these patients, it is evident that Dr. Demint cares about his patients' well-being and he did not place his own needs, i.e. financial needs, ahead of the needs of his patients.

3. The evidence is insufficient to support a finding that Dr. Demint practiced below the minimal standard of care by inappropriately prescribing narcotics to Patient 1 for treatment of diagnosed fibromyalgia. First, Dr. Demint had also diagnosed Patient 1 as suffering from degenerative disk disease of the lumbar spine, and there is no evidence that narcotics would be inappropriate to treat that condition. Second, Dr. Demint presented medical literature in support of his position that narcotics are not per se inappropriate to treat fibromyalgia.

4. The evidence is insufficient to support a finding that Dr. Demint practiced below the minimal standard of care by failing to obtain a toxicology screen on Patient 1 prior to prescribing narcotic medication. Dr. Demint's medical record for Patient 1 establishes that he did obtain an in-house urine screen on Patient 1 at her initial visit.

5. The evidence is insufficient to support a finding that Dr. Demint practiced below the minimal standard of care by failing to appropriately evaluate, or document the appropriate evaluation of Patient 2's situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment. The evidence establishes that Dr. Demint appropriately referred Patient 2 to a psychiatrist in October 2010, although she did not follow through for lack of insurance coverage.

CONCLUSIONS OF LAW

1. The acts, conduct, and/or omissions of Franklin Donald Demint, D.O., as described in Findings of Fact 2 and 2.b through 2.i, 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 R.C. 4731.22(B)(2).

2. Dr. Demint's acts, conduct, and/or omissions as described in Findings of Fact 2 and 2.b through 2.i, 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 R.C. 4731.22(B)(6).

3. Dr. Demint's acts, conduct, and/or omissions as described in Findings of Fact 1, 2, and 2.b through 2.i, above, individually and/or collectively, constitute a "[v]iolation of the conditions of limitation placed by the board upon a certificate to practice," as that clause is used in R.C. 4731.22(B)(15), Ohio Revised Code. This is based solely on the violations of the Medical Practice Act set forth herein in Conclusions of Law 1, 2, and 4.

4. Dr. Demint's acts, conduct, and/or omissions as described in Findings of Fact 2 and 2.b through 2.i, 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 R.C. 4731.22(B)(20), to wit: Rule 4731-21-02, Utilizing Prescription Drugs for the Treatment of Intractable Pain. Furthermore, pursuant to Rule 4731-21-05, violation of Rule 4731-21-02 also constitutes violation of R.C. 4731.22(B)(2) and 4731.22(B)(6).

RATIONALE FOR THE PROPOSED ORDER

This matter concerns Dr. Demint's care and treatment of pain management patients. According to Dr. Demint, he is no longer practicing pain management. However, the evidence in this matter concerns problems with Dr. Demint's practice of medicine that could carry over into other fields of medicine.

The Proposed Order would suspend Dr. Demint's medical license for a minimum of 180 days following a 30-day period to wind down his practice. Prior to reinstatement, Dr. Demint must undergo an evaluation to ensure that he can practice appropriately. Following the evaluation, Dr. Demint would then have to comply with any remedial program recommended by the evaluators. In addition, Dr. Demint would be required to successfully complete a course on prescribing controlled substances as well as a course on medical recordkeeping. Following reinstatement, Dr. Demint's practice would be subject to monitoring by chart review in addition to other appropriate probationary conditions.

In addition, the Proposed Order supersedes and replaces Dr. Demint's March 2010 Step II Consent Agreement. During a February 12, 2013, teleconference with the Hearing Examiner and counsel for the parties, Dr. Demint, through counsel, agreed to waive objection to the inclusion of impairment-related requirements in the Proposed Order.[42] Accordingly, the Proposed Order carries forward the impairment-related monitoring requirements from Dr. Demint's March 2010 Step II Consent Agreement.

PROPOSED ORDER

It is hereby ORDERED that:

A. **SUSPENSION OF CERTIFICATE**: Commencing on the thirty-first day following the date on which this Order becomes effective, the certificate of Franklin Donald Demint, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than 180 days. During the thirty-day interim, Dr. Demint shall not undertake the care of any patient not already under his care.

B. **INTERIM MONITORING**: During the period that Dr. Demint's certificate to practice osteopathic medicine and surgery in Ohio is suspended, Dr. Demint shall comply with the following terms, conditions, and limitations:

1. **Obey the Law**: Dr. Demint shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

2. **Declarations of Compliance**: Dr. Demint shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the date his quarterly declaration would have been due pursuant to his March 2010 Step II Consent Agreement. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Demint shall appear in person for interviews before the Board or its designated representative. The first such appearance shall take place on or before the date his appearance would have been scheduled pursuant to his March 2010 Step II Consent Agreement. Subsequent personal appearances shall occur every three months thereafter, and/or as otherwise directed by the Board. If an appearance

[42] In *In re Eastway* (1994), 95 Ohio App.3d 516, 642 N.E.2d 1135, cert. denied, the Franklin County Court of Appeals held that the Board could not require psychiatric treatment as a condition of probation when it had not charged a physician with being mentally impaired. In such a situation, a Board order that includes such sanctions is not supported by reliable, probative, and substantial evidence and is not in accordance with the law. See also *Lawrence S. Krain, M.D. v. State Medical Board of Ohio* (Oct. 29, 1998), Franklin App. No. 97APE08-981, unreported. However, a respondent may waive his or her objection to a Board order that includes such sanctions.

is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

4. **Absences from Ohio:** Dr. Demint shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have the discretion to grant a waiver of part or all of the probationary terms set forth in this Order for occasional periods of absence of fourteen days or less.

   In the event that Dr. Demint resides and/or is employed at a location that is within fifty miles of the geographic border of Ohio and any of its contiguous states, Dr. Demint may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Demint is able to otherwise maintain full compliance with all other terms, conditions and limitations set forth in this Order.

5. **Ban on Administering, Furnishing, or Possessing Controlled Substance; Log**: Dr. Demint shall not, without prior Board approval, administer, personally furnish, or possess (except as allowed under Paragraph B.6.a) any controlled substances as defined by state or federal law.

   In the event that the Board agrees at a future date to modify this Order to allow Dr. Demint to administer or personally furnish controlled substances, Dr. Demint shall keep a log of all controlled substances prescribed, administered or personally furnished. Such log shall be submitted in the format approved by the Board and shall be submitted to the Board no later than the date upon which Dr. Demint's declarations of compliance quarterly declaration is due, or as otherwise directed by the Board. Further, Dr. Demint shall make his patient records with regard to such prescribing, administering, or personally furnishing available for review by an agent of the Board immediately upon request.

6. **Sobriety**

   a. **Abstention from Drugs**: Dr. Demint shall abstain completely from the personal use or personal possession of drugs, except those prescribed, dispensed or administered to him by another so authorized by law who has full knowledge of Dr. Demint's history of chemical dependency. Further, in the event that Dr. Demint is so prescribed, dispensed or administered any controlled substance, carisoprodol, or tramadol, Dr. Demint shall notify the Board in writing within seven days, providing the Board with the identity of the prescriber; the name of the drug Dr. Demint received; the medical purpose for which he received said drug; the date such drug was initially received; and the dosage, amount, number

of refills, and directions for use. Further, within thirty days of the date said drug is so prescribed, dispensed, or administered to him, Dr. Demint shall provide the Board with either a copy of the written prescription or other written verification from the prescriber, including the dosage, amount, number of refills, and directions for use.

b. **Abstention from Alcohol**: Dr. Demint shall abstain completely from the use of alcohol.

7. **Drug and Alcohol Screens/Drug Testing Facility and Collection Site**: Dr. Demint shall submit to random urine screenings for drugs and alcohol at least two times per month, or as otherwise directed by the Board. Dr. Demint shall ensure that all screening reports are forwarded directly to the Board on a quarterly basis. The drug testing panel utilized must be acceptable to the Secretary of the Board, and shall include Dr. Demint's drug(s) of choice.

Dr. Demint shall abstain from the use of any substance and the consumption of poppy seeds or any other food or liquid that may produce a low level positive result in a toxicology screen. Dr. Demint shall be held to an understanding and knowledge that the consumption or use of such substances, including but not limited to substances such as mouthwash or hand cleaning gel, may cause a positive drug screen that may not be able to be differentiated from intentional ingestion, and therefore such consumption or use is prohibited under this Order.

All such urine screenings for drugs and alcohol shall be conducted through a Board-approved drug testing facility and collection site pursuant to the global contract between said facility and the Board, that provides for the Board to maintain ultimate control over the urine screening process and to preserve the confidentiality of all positive screening results in accordance with Section 4731.22(F)(5), Ohio Revised Code, and the screening process shall require a daily call-in procedure. Further, in the event that the Board exercises its discretion, as provided in Paragraph B.8 below, to approve urine screenings to be conducted at an alternative drug testing facility and/or collection site or a supervising physician, such approval shall be expressly contingent upon the Board retaining ultimate control over the urine screening process in a manner that preserves the aforementioned confidentiality of all positive screening results.

Dr. Demint shall submit, at his expense and on the day selected, urine specimens for drug and/or alcohol analysis. All specimens submitted by Dr. Demint shall be negative, except for those substances prescribed, administered, or dispensed to him in conformance with the terms, conditions and limitations set forth in this Order. Refusal to submit such specimen, or failure to submit such specimen on the day he is selected or in such manner as the Board may request, shall constitute a violation of this Order.

Further, within thirty days of the effective date of this Order, Dr. Demint shall enter into the necessary financial and/or contractual arrangements with the Board-approved drug testing facility and/or collection site in order to facilitate the urine screening process in the manner required by this Order. Further, Dr. Demint shall promptly provide to the Board written documentation of completion of such arrangements, including a copy of any contract entered into between Dr. Demint and the Board-approved drug testing facility and/or collection site. Dr. Demint's failure to timely complete such arrangements, or failure to timely provide written documentation to the Board of completion of such arrangements, shall constitute a violation of this Order.

Dr. Demint shall ensure that the urine screening process performed through the Board-approved drug testing facility and/or collection site requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Demint and the Board-approved drug testing facility and collection site shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

Dr. Demint shall ensure that the Board-approved drug testing facility and/or collection site provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Order, and whether all urine screens have been negative.

In the event that the Board-approved drug testing facility and/or collection site becomes unable or unwilling to serve as required by this Order, Dr. Demint must immediately notify the Board in writing, and make arrangements acceptable to the Board pursuant to Paragraph B.8 below, as soon as practicable. Dr. Demint shall further ensure that the Board-approved drug testing facility and/or collection site also notifies the Board directly of its inability to continue to serve and the reasons therefore.

The Board expressly reserves the right to withdraw its approval of any drug testing facility and/or collection site in the event that the Secretary and Supervising Member of the Board determine that the drug testing facility and/or collection site has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

8. **Alternative Drug-testing Facility and/or Collection Site**: It is the intent of this Order that Dr. Demint shall submit his urine specimens to the Board-approved drug testing facility and collection site chosen by the Board. However, in the event that utilizing said Board-approved drug testing facility and/or collection site creates an extraordinary hardship upon Dr. Demint, as determined in the sole discretion of the Board, then subject to the following requirements, the Board may approve an alternate drug testing facility and/or collection site, or a supervising physician, to facilitate the urine screening process for Dr. Demint:

a. Within thirty days of the date upon which Dr. Demint is notified of the Board's determination that utilizing the Board-approved drug testing facility and/or collection site constitutes an extraordinary hardship upon Dr. Demint, he shall submit to the Board in writing for its prior approval the identity of either an alternate drug testing facility and collection site, or the name of a proposed supervising physician, to whom Dr. Demint shall submit the required urine specimens. In approving a facility, entity, or an individual to serve in this capacity, the Board will give preference to a facility located near Dr. Demint's residence or employment location, or to a physician who practices in the same locale as Dr. Demint. Dr. Demint shall ensure that the urine screening process performed through the alternate drug testing facility and/or collection site, or through the supervising physician, requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Demint acknowledges that the alternate drug testing facility and collection site, or the supervising physician, shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

b. Dr. Demint shall ensure that the alternate drug testing facility and/or collection site, or the supervising physician, provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Order, and whether all urine screens have been negative.

c. In the event that the designated alternate drug testing facility and/or collection site, or the supervising physician, becomes unable or unwilling to so serve, Dr. Demint must immediately notify the Board in writing. Dr. Demint shall further ensure that the previously designated alternate drug testing facility and collection site, or the supervising physician, also notifies the Board directly of the inability to continue to serve and the reasons therefore. Further, in order to ensure that there will be no interruption in his urine screening process, upon the previously approved alternate drug testing facility, collection site, or supervising physician becoming unable to serve, Dr. Demint shall immediately commence urine screening at the Board-approved drug testing facility and collection site chosen by the Board, until such time, if any, that the Board approves a subsequent alternate drug testing facility, collection site, or supervising physician, if requested by Dr. Demint.

d. The Board expressly reserves the right to disapprove any entity or facility proposed to serve as Dr. Demint's designated alternate drug testing facility and/or collection site, or any person proposed to serve as his supervising physician, or to withdraw approval of any entity, facility or person previously approved to so serve in the event that the Secretary and Supervising Member of the Board determine that any such entity, facility or person has demonstrated a

lack of cooperation in providing information to the Board or for any other reason.

e. In the event that the Board approved an alternate drug testing facility and/or collection site, or a supervising physician, pursuant to the March 2010 Step II Consent Agreement between Dr. Demint and the Board, the entity, facility or person previously approved by the Board to so serve pursuant to the March 2010 Step II Consent Agreement may, in the sole discretion of the Board, be approved to continue as Dr. Demint's designated alternate drug testing facility and collection site or as his supervising physician under this Order.

9. **Reports Regarding Drug and Alcohol Screens**: All screening reports required under this Order from the Board-approved drug testing facility and/or collection site, or from the alternate drug testing facility and/or collection site or supervising physician, must be received in the Board's offices no later than the due date for Dr. Demint's quarterly declaration. It is Dr. Demint's responsibility to ensure that reports are timely submitted.

10. **Additional Screening Without Prior Notice**: Upon the Board's request and without prior notice, Dr. Demint shall provide a specimen of his blood, breath, saliva, urine, and/or hair for screening for drugs and alcohol, for analysis of therapeutic levels of medications that may be prescribed for Dr. Demint, or for any other purpose, at Dr. Demint's expense. Dr. Demint's refusal to submit a specimen upon the request of the Board shall result in a minimum of one year of actual license suspension. Further, the collection of such specimens shall be witnessed by a representative of the Board, or another person acceptable to the Secretary and Supervising Member of the Board.

11. **Rehabilitation Program**: Dr. Demint shall maintain participation in an alcohol and drug rehabilitation program, such as A.A., N.A., C.A., or Caduceus, no less than twice per week with a minimum of ten per month. At least one of the abovementioned meetings shall be a Caduceus meeting. Substitution of any other specific program must receive prior Board approval.

    Dr. Demint shall submit acceptable documentary evidence of continuing compliance with this program, including submission to the Board of meeting attendance logs, which must be received in the Board's offices no later than the due date for Dr. Demint's quarterly declarations.

12. **Comply with the Terms of Aftercare Contract**: Dr. Demint shall maintain continued compliance with the terms of the aftercare contract entered into with a Board-approved treatment provider, provided that, where terms of the aftercare contract conflict with terms of this Order, the terms of this Order shall control.

13. **Releases**: Dr. Demint shall provide authorization, through appropriate written consent forms, for disclosure of evaluative reports, summaries, and records, of whatever nature, by any and all parties that provide treatment or evaluation for Dr.

Demint's chemical dependency or related conditions, or for purposes of complying with this Order, whether such treatment or evaluation occurred before or after the effective date of this Order. To the extent permitted by law, the above-mentioned evaluative reports, summaries, and records are considered medical records for purposes of Section 149.43 of the Ohio Revised Code and are confidential pursuant to statute. Dr. Demint shall also provide the Board written consent permitting any treatment provider from whom he obtains treatment to notify the Board in the event he fails to agree to or comply with any treatment contract or aftercare contract. Failure to provide such consent, or revocation of such consent, shall constitute a violation of this Order.

14. **Required Reporting of Change of Address**: Dr. Demint shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

C. **CONDITIONS FOR REINSTATEMENT OR RESTORATION**: The Board shall not consider reinstatement or restoration of Dr. Demint's certificate to practice medicine and surgery until all of the following conditions have been met:

1. **Application for Reinstatement or Restoration**: Dr. Demint shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.

2. **Compliance with Interim Conditions**: Dr. Demint shall have maintained compliance with all the terms and conditions set forth in Paragraph B of this Order.

3. **Post-Licensure Assessment Program**: Prior to submitting his application for reinstatement or restoration, Dr. Demint shall have undergone an assessment and completed the recommended educational activities, as developed for Dr. Demint by the Post-Licensure Assessment System [PLAS] sponsored by the Federation of State Medical Boards and the National Board of Medical Examiners. Dr. Demint's participation in the PLAS shall be at his own expense.

   a. Prior to the initial assessment by the PLAS, Dr. Demint shall furnish the PLAS copies of the Board's Order, including the Summary of the Evidence, Findings of Fact, and Conclusions of Law, and any other documentation from the hearing record that the Board may deem appropriate or helpful to that assessment.

   b. Should the PLAS request patient records maintained by Dr. Demint, Dr. Demint shall furnish copies of the patient records at issue in this matter along with any other patient records he submits. Dr. Demint shall further ensure that the PLAS maintains patient confidentiality in accordance with Section 4731.22(F)(5), Ohio Revised Code.

   c. Dr. Demint shall ensure that the written Assessment Report by the PLAS includes the following:

- A detailed plan of recommended practice limitations, if any;
- Any recommended education;
- Any recommended mentorship or preceptorship;
- Any reports upon which the recommendation is based, including reports of physical examination and psychological or other testing.

Moreover, Dr. Demint shall ensure that, within ten days of its completion, the written Assessment Report by the PLAS is submitted to the Board.

d. Any Learning Plan recommended by the PLAS shall have been developed subsequent to the issuance of a written Assessment Report, based on an assessment and evaluation of Dr. Demint by the PLAS. Dr. Demint shall successfully complete the educational activities as recommended in the Learning Plan, including any final assessment or evaluation.

e. At the time he submits his application for reinstatement or restoration, Dr. Demint shall submit to the Board satisfactory documentation from the PLAS indicating that he has successfully completed the recommended educational activities.

4. **Controlled Substances Prescribing Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide acceptable documentation of successful completion of a course or courses dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

   In addition, at the time Dr. Demint submits the documentation of successful completion of the course(s) dealing with the prescribing of controlled substances, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

5. **Medical Records Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision

shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Demint submits the documentation of successful completion of the course(s) on maintaining adequate and appropriate medical records, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

6. **Additional Evidence of Fitness To Resume Practice**: In the event that Dr. Demint has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

D. **PROBATION**: Upon reinstatement or restoration, Dr. Demint's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:

1. **Terms, Conditions, and Limitations Continued from Suspension Period**: Dr. Demint shall continue to be subject to the terms, conditions, and limitations specified in Paragraph B of this Order.

2. **Post-Licensure Assessment Program**: Dr. Demint shall practice in accordance with the Learning Plan developed by the PLAS, unless otherwise determined by the Board. Dr. Demint shall cause to be submitted to the Board quarterly declarations from the PLAS documenting Dr. Demint's continued compliance with the Learning Plan.

   Dr. Demint shall obtain the Board's prior approval for any deviation from the Learning Plan.

   If, in a manner not authorized by the Board, Dr. Demint fails to comply with the Learning Plan, Dr. Demint shall cease practicing medicine and surgery beginning the day following Dr. Demint's receiving notice from the Board of such violation and shall refrain from practicing until the PLAS provides written notification to the Board that Dr. Demint has reestablished compliance with the Learning Plan. Practice during the period of noncompliance shall be considered practicing medicine without a certificate, in violation of Section 4731.41, Ohio Revised Code.

3. **Practice Plan and Monitoring Physician**: Within 30 days of the effective date of Dr. Demint's reinstatement or restoration, or as otherwise determined by the Board, Dr. Demint shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Demint's activities will be directly supervised and overseen by a monitoring physician approved by the Board. The practice plan shall, as determined by the Board, reflect, but not be limited to, the

PLAS Learning Plan. Dr. Demint shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

At the time Dr. Demint submits his practice plan, he shall also submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Demint and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Demint and his medical practice, and shall review Dr. Demint's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Demint and his medical practice, and on the review of Dr. Demint's patient charts. Dr. Demint shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Demint's declarations of compliance.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Demint shall immediately so notify the Board in writing. In addition, Dr. Demint shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Demint shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Demint's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Demint's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

E. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Demint's certificate will be fully restored.

F. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to all employers or

entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training, and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Demint shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments.

In the event that Dr. Demint provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.

These requirements shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Administration, through which he currently holds any professional license or certificate. Also, Dr. Demint shall provide a copy of this Order at the time of application to the proper licensing authority of any state or jurisdiction in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

3. **Required Reporting to Treatment Providers/Monitors**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to all persons and entities that provide chemical dependency/abuse treatment to or monitoring of Dr. Demint. This requirement shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

4. **Required Documentation of the Reporting Required by Paragraph F**: Dr. Demint shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (a) the return receipt of certified mail within 30 days of receiving that return receipt, (b) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (c) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (d) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

G. **VIOLATION OF THE TERMS OF THIS ORDER**: If Dr. Demint violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

H. **SUPERSEDE PREVIOUS CONSENT AGREEMENT**: Upon becoming effective, this Order shall supersede the terms and conditions set forth in the March 2010 Step II Consent Agreement between Dr. Demint and the Board.

EFFECTIVE DATE OF ORDER: This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

R. Gregory Porter
Hearing Examiner

State Medical Board of Ohio

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EXCERPT FROM THE DRAFT MINUTES OF APRIL 10, 2013

REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDERS

Dr. Steinbergh announced that the Board would now consider the Reports and Recommendations appearing on its agenda.

Dr. Steinbergh 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: Ellyn M. Castro; Franklin Donald Demint, D.O.; Aida Esther Figueroa, M.D.; and Erica Lynne Forney, M.T.

A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Dr. Bechtel	- aye
	Dr. Mahajan	- aye
	Dr. Ramprasad	- aye
	Dr. Steinbergh	- aye
	Dr. Madia	- aye
	Dr. Talmage	- aye
	Ms. Elsass	- aye
	Mr. Kenney	- aye
	Mr. Gonidakis	- aye

Dr. Steinbergh 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
	Dr. Bechtel	- aye
	Dr. Mahajan	- aye
	Dr. Ramprasad	- aye
	Dr. Steinbergh	- aye
	Dr. Madia	- aye
	Dr. Talmage	- aye
	Ms. Elsass	- aye
	Mr. Kenney	- aye
	Mr. Gonidakis	- aye

Dr. Steinbergh 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 any disciplinary matters. In the matters before the Board today, Dr. Strafford served as Secretary, Dr. Bechtel served as Supervising Member, and Dr. Talmage served as Secretary and/or Acting Supervising Member.

Dr. Steinbergh 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.

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FRANKLIN DONALD DEMINT, D.O., Case No. 12-CRF-018

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Dr. Madia moved to approve and confirm Mr. Porter's Findings of Fact, Conclusions of Law, and Proposed Order in the matter of Franklin Donald Demint, D.O. Dr. Mahajan seconded the motion.

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Dr. Talmage exited the meeting during this discussion.

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Dr. Madia moved to amend Finding of Fact #3 to read as follows:

> The evidence is sufficient to support a finding that Dr. Demint practiced below the minimal standard of care by inappropriately prescribing narcotics to Patient 1 for treatment of diagnosed fibromyalgia.

Dr. Madia further moved to amend the Proposed Order to read as follows:

It is hereby ORDERED that:

A. **SUSPENSION OF CERTIFICATE**: Commencing on the thirty-first day following the date on which this Order becomes effective, the certificate of Franklin Donald Demint, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than 180 days. During the thirty-day interim, Dr. Demint shall not undertake the care of any patient not already under his care.

B. **INTERIM MONITORING**: During the period that Dr. Demint's certificate to practice osteopathic medicine and surgery in Ohio is suspended, Dr. Demint shall comply with the following terms, conditions, and limitations:

1. **Obey the Law**: Dr. Demint shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

2. **Declarations of Compliance**: Dr. Demint shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the date his quarterly declaration would have been due pursuant to his March 2010 Step II Consent Agreement. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Demint shall appear in person for interviews before the Board or its designated representative. The first such appearance shall take place on or before the date his appearance would have been scheduled pursuant to his March 2010 Step II Consent Agreement. Subsequent personal appearances shall occur every three months thereafter, and/or as otherwise directed by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

4. **Absences from Ohio:** Dr. Demint shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have the discretion to grant a waiver of part or all of the probationary terms set forth in this Order for occasional periods of absence of fourteen days or less.

   In the event that Dr. Demint resides and/or is employed at a location that is within fifty miles of the geographic border of Ohio and any of its contiguous states, Dr. Demint may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Demint is able to otherwise maintain full compliance with all other terms, conditions and limitations set forth in this Order.

5. **Ban on Administering, Furnishing, or Possessing Controlled Substance; Log**: Dr. Demint shall not, without prior Board approval, administer, personally furnish,

or possess (except as allowed under Paragraph B.6.a) any controlled substances as defined by state or federal law.

In the event that the Board agrees at a future date to modify this Order to allow Dr. Demint to administer or personally furnish controlled substances, Dr. Demint shall keep a log of all controlled substances prescribed, administered or personally furnished. Such log shall be submitted in the format approved by the Board and shall be submitted to the Board no later than the date upon which Dr. Demint's declarations of compliance quarterly declaration is due, or as otherwise directed by the Board. Further, Dr. Demint shall make his patient records with regard to such prescribing, administering, or personally furnishing available for review by an agent of the Board immediately upon request.

6. **Sobriety**

   a. **Abstention from Drugs**: Dr. Demint shall abstain completely from the personal use or personal possession of drugs, except those prescribed, dispensed or administered to him by another so authorized by law who has full knowledge of Dr. Demint's history of chemical dependency. Further, in the event that Dr. Demint is so prescribed, dispensed or administered any controlled substance, carisoprodol, or tramadol, Dr. Demint shall notify the Board in writing within seven days, providing the Board with the identity of the prescriber; the name of the drug Dr. Demint received; the medical purpose for which he received said drug; the date such drug was initially received; and the dosage, amount, number of refills, and directions for use. Further, within thirty days of the date said drug is so prescribed, dispensed, or administered to him, Dr. Demint shall provide the Board with either a copy of the written prescription or other written verification from the prescriber, including the dosage, amount, number of refills, and directions for use.

   b. **Abstention from Alcohol**: Dr. Demint shall abstain completely from the use of alcohol.

7. **Drug and Alcohol Screens/Drug Testing Facility and Collection Site**: Dr. Demint shall submit to random urine screenings for drugs and alcohol at least two times per month, or as otherwise directed by the Board. Dr. Demint shall ensure that all screening reports are forwarded directly to the Board on a quarterly basis. The drug testing panel utilized must be acceptable to the Secretary of the Board, and shall include Dr. Demint's drug(s) of choice.

   Dr. Demint shall abstain from the use of any substance and the consumption of poppy seeds or any other food or liquid that may produce a low level positive result

in a toxicology screen. Dr. Demint shall be held to an understanding and knowledge that the consumption or use of such substances, including but not limited to substances such as mouthwash or hand cleaning gel, may cause a positive drug screen that may not be able to be differentiated from intentional ingestion, and therefore such consumption or use is prohibited under this Order.

All such urine screenings for drugs and alcohol shall be conducted through a Board-approved drug testing facility and collection site pursuant to the global contract between said facility and the Board, that provides for the Board to maintain ultimate control over the urine screening process and to preserve the confidentiality of all positive screening results in accordance with Section 4731.22(F)(5), Ohio Revised Code, and the screening process shall require a daily call-in procedure. Further, in the event that the Board exercises its discretion, as provided in Paragraph B.8 below, to approve urine screenings to be conducted at an alternative drug testing facility and/or collection site or a supervising physician, such approval shall be expressly contingent upon the Board retaining ultimate control over the urine screening process in a manner that preserves the aforementioned confidentiality of all positive screening results.

Dr. Demint shall submit, at his expense and on the day selected, urine specimens for drug and/or alcohol analysis. All specimens submitted by Dr. Demint shall be negative, except for those substances prescribed, administered, or dispensed to him in conformance with the terms, conditions and limitations set forth in this Order. Refusal to submit such specimen, or failure to submit such specimen on the day he is selected or in such manner as the Board may request, shall constitute a violation of this Order.

Further, within thirty days of the effective date of this Order, Dr. Demint shall enter into the necessary financial and/or contractual arrangements with the Board-approved drug testing facility and/or collection site in order to facilitate the urine screening process in the manner required by this Order. Further, Dr. Demint shall promptly provide to the Board written documentation of completion of such arrangements, including a copy of any contract entered into between Dr. Demint and the Board-approved drug testing facility and/or collection site. Dr. Demint's failure to timely complete such arrangements, or failure to timely provide written documentation to the Board of completion of such arrangements, shall constitute a violation of this Order.

Dr. Demint shall ensure that the urine screening process performed through the Board-approved drug testing facility and/or collection site requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Demint

and the Board-approved drug testing facility and collection site shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

Dr. Demint shall ensure that the Board-approved drug testing facility and/or collection site provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Order, and whether all urine screens have been negative.

In the event that the Board-approved drug testing facility and/or collection site becomes unable or unwilling to serve as required by this Order, Dr. Demint must immediately notify the Board in writing, and make arrangements acceptable to the Board pursuant to Paragraph B.8 below, as soon as practicable. Dr. Demint shall further ensure that the Board-approved drug testing facility and/or collection site also notifies the Board directly of its inability to continue to serve and the reasons therefore.

The Board expressly reserves the right to withdraw its approval of any drug testing facility and/or collection site in the event that the Secretary and Supervising Member of the Board determine that the drug testing facility and/or collection site has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

8. **Alternative Drug-testing Facility and/or Collection Site**: It is the intent of this Order that Dr. Demint shall submit his urine specimens to the Board-approved drug testing facility and collection site chosen by the Board. However, in the event that utilizing said Board-approved drug testing facility and/or collection site creates an extraordinary hardship upon Dr. Demint, as determined in the sole discretion of the Board, then subject to the following requirements, the Board may approve an alternate drug testing facility and/or collection site, or a supervising physician, to facilitate the urine screening process for Dr. Demint:

   a. Within thirty days of the date upon which Dr. Demint is notified of the Board's determination that utilizing the Board-approved drug testing facility and/or collection site constitutes an extraordinary hardship upon Dr. Demint, he shall submit to the Board in writing for its prior approval the identity of either an alternate drug testing facility and collection site, or the name of a proposed supervising physician, to whom Dr. Demint shall submit the required urine specimens. In approving a facility, entity, or an individual to serve in this capacity, the Board will give preference to a facility located near Dr. Demint's residence or employment location, or to a physician who practices in the same locale as Dr. Demint. Dr. Demint shall ensure that the

urine screening process performed through the alternate drug testing facility and/or collection site, or through the supervising physician, requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Demint acknowledges that the alternate drug testing facility and collection site, or the supervising physician, shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

b. Dr. Demint shall ensure that the alternate drug testing facility and/or collection site, or the supervising physician, provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Order, and whether all urine screens have been negative.

c. In the event that the designated alternate drug testing facility and/or collection site, or the supervising physician, becomes unable or unwilling to so serve, Dr. Demint must immediately notify the Board in writing. Dr. Demint shall further ensure that the previously designated alternate drug testing facility and collection site, or the supervising physician, also notifies the Board directly of the inability to continue to serve and the reasons therefore. Further, in order to ensure that there will be no interruption in his urine screening process, upon the previously approved alternate drug testing facility, collection site, or supervising physician becoming unable to serve, Dr. Demint shall immediately commence urine screening at the Board-approved drug testing facility and collection site chosen by the Board, until such time, if any, that the Board approves a subsequent alternate drug testing facility, collection site, or supervising physician, if requested by Dr. Demint.

d. The Board expressly reserves the right to disapprove any entity or facility proposed to serve as Dr. Demint's designated alternate drug testing facility and/or collection site, or any person proposed to serve as his supervising physician, or to withdraw approval of any entity, facility or person previously approved to so serve in the event that the Secretary and Supervising Member of the Board determine that any such entity, facility or person has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

e. In the event that the Board approved an alternate drug testing facility and/or collection site, or a supervising physician, pursuant to the March 2010 Step II Consent Agreement between Dr. Demint and the Board, the entity, facility or person previously approved by the Board to so serve pursuant to the March

2010 Step II Consent Agreement may, in the sole discretion of the Board, be approved to continue as Dr. Demint's designated alternate drug testing facility and collection site or as his supervising physician under this Order.

9. **Reports Regarding Drug and Alcohol Screens**: All screening reports required under this Order from the Board-approved drug testing facility and/or collection site, or from the alternate drug testing facility and/or collection site or supervising physician, must be received in the Board's offices no later than the due date for Dr. Demint's quarterly declaration. It is Dr. Demint's responsibility to ensure that reports are timely submitted.

10. **Additional Screening Without Prior Notice**: Upon the Board's request and without prior notice, Dr. Demint shall provide a specimen of his blood, breath, saliva, urine, and/or hair for screening for drugs and alcohol, for analysis of therapeutic levels of medications that may be prescribed for Dr. Demint, or for any other purpose, at Dr. Demint's expense. Dr. Demint's refusal to submit a specimen upon the request of the Board shall result in a minimum of one year of actual license suspension. Further, the collection of such specimens shall be witnessed by a representative of the Board, or another person acceptable to the Secretary and Supervising Member of the Board.

11. **Rehabilitation Program**: Dr. Demint shall maintain participation in an alcohol and drug rehabilitation program, such as A.A., N.A., C.A., or Caduceus, no less than twice per week with a minimum of ten per month. At least one of the abovementioned meetings shall be a Caduceus meeting. Substitution of any other specific program must receive prior Board approval.

    Dr. Demint shall submit acceptable documentary evidence of continuing compliance with this program, including submission to the Board of meeting attendance logs, which must be received in the Board's offices no later than the due date for Dr. Demint's quarterly declarations.

12. **Comply with the Terms of Aftercare Contract**: Dr. Demint shall maintain continued compliance with the terms of the aftercare contract entered into with a Board-approved treatment provider, provided that, where terms of the aftercare contract conflict with terms of this Order, the terms of this Order shall control.

13. **Releases**: Dr. Demint shall provide authorization, through appropriate written consent forms, for disclosure of evaluative reports, summaries, and records, of whatever nature, by any and all parties that provide treatment or evaluation for Dr. Demint's chemical dependency or related conditions, or for purposes of complying with this Order, whether such treatment or evaluation occurred before or after the

effective date of this Order. To the extent permitted by law, the above-mentioned evaluative reports, summaries, and records are considered medical records for purposes of Section 149.43 of the Ohio Revised Code and are confidential pursuant to statute. Dr. Demint shall also provide the Board written consent permitting any treatment provider from whom he obtains treatment to notify the Board in the event he fails to agree to or comply with any treatment contract or aftercare contract. Failure to provide such consent, or revocation of such consent, shall constitute a violation of this Order.

14. **Required Reporting of Change of Address**: Dr. Demint shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

C. **CONDITIONS FOR REINSTATEMENT OR RESTORATION**: The Board shall not consider reinstatement or restoration of Dr. Demint's certificate to practice medicine and surgery until all of the following conditions have been met:

1. **Application for Reinstatement or Restoration**: Dr. Demint shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.

2. **Compliance with Interim Conditions**: Dr. Demint shall have maintained compliance with all the terms and conditions set forth in Paragraph B of this Order.

3. **Controlled Substances Prescribing Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide acceptable documentation of successful completion of a course or courses dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

   In addition, at the time Dr. Demint submits the documentation of successful completion of the course(s) dealing with the prescribing of controlled substances, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

4. **Medical Records Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint

shall provide acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Demint submits the documentation of successful completion of the course(s) on maintaining adequate and appropriate medical records, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

5. **ACOFP Course**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Demint shall provide acceptable documentation of successful completion of the Annual ACOFP Intensive Update and Board Review in Osteopathic Medicine. This course shall be taken in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) during which it is completed.

   In addition, at the time Dr. Demint submits the documentation of successful completion of the ACOFP course, he shall also submit to the Board a written report describing the course, setting forth what he learned from the course, and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

6. **Additional Evidence of Fitness To Resume Practice**: In the event that Dr. Demint has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

D. **PROBATION**: Upon reinstatement or restoration, Dr. Demint's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:

1. **Terms, Conditions, and Limitations Continued from Suspension Period**: Dr. Demint shall continue to be subject to the terms, conditions, and limitations specified in Paragraph B of this Order.

2. **Practice Plan and Monitoring Physician**: Within 30 days of the effective date of Dr. Demint's reinstatement or restoration, or as otherwise determined by the Board, Dr. Demint shall submit to the Board and receive its approval for a plan of practice in Ohio. Dr. Demint shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

   At the time Dr. Demint submits his practice plan, he shall also submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Demint and who is engaged in the same or similar practice specialty.

   The monitoring physician shall monitor Dr. Demint and his medical practice, and shall review Dr. Demint's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

   Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Demint and his medical practice, and on the review of Dr. Demint's patient charts. Dr. Demint shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Demint's declarations of compliance.

   In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Demint shall immediately so notify the Board in writing. In addition, Dr. Demint shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Demint shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

   The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Demint's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Demint's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

E. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Demint's certificate will be fully restored.

F. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training, and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Demint shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments.

   In the event that Dr. Demint provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.

   These requirements shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Administration, through which he currently holds any professional license or certificate. Also, Dr. Demint shall provide a copy of this Order at the time of application to the proper licensing authority of any state or jurisdiction in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

3. **Required Reporting to Treatment Providers/Monitors**: Within 30 days of the effective date of this Order, Dr. Demint shall provide a copy of this Order to all persons and entities that provide chemical dependency/abuse treatment to or monitoring of Dr. Demint. This requirement shall continue until Dr. Demint receives from the Board written notification of the successful completion of his probation.

4. **Required Documentation of the Reporting Required by Paragraph F**: Dr. Demint shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (a) the return receipt of certified mail within 30 days of receiving that return receipt, (b) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (c) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (d) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

G. **VIOLATION OF THE TERMS OF THIS ORDER**: If Dr. Demint violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

H. **SUPERSEDE PREVIOUS CONSENT AGREEMENT**: Upon becoming effective, this Order shall supersede the terms and conditions set forth in the March 2010 Step II Consent Agreement between Dr. Demint and the Board.

EFFECTIVE DATE OF ORDER: This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

Dr. Mahajan seconded the motion.

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A vote was taken on Dr. Madia's motion to amend:

ROLL CALL:	Dr. Strafford	- abstain
	Dr. Bechtel	- abstain
	Dr. Mahajan	- aye
	Dr. Ramprasad	- aye
	Dr. Steinbergh	- aye
	Dr. Madia	- aye
	Ms. Elsass	- aye
	Mr. Kenney	- aye
	Mr. Gonidakis	- aye

The motion to amend carried.

Dr. Ramprasad exited the meeting at this time.

Dr. Mahajan moved to approve and confirm Mr. Porter's Findings of Fact, Conclusions of Law, and Proposed Order, as amended, in the matter of Franklin Donald Demint, D.O. Dr. Madia seconded the motion. A vote was taken:

ROLL CALL:	Dr. Strafford	- abstain
	Dr. Bechtel	- abstain
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Madia	- aye
	Ms. Elsass	- aye
	Mr. Kenney	- aye
	Mr. Gonidakis	- 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

March 14, 2012

Case number: 12-CRF- 018

Franklin Donald Demint, D.O.
535 Jadwin Rd.
Kingston, OH 45644

Dear Doctor Demint:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) On or about August 12, 2009, you entered into a Step I Consent Agreement with the Board in lieu of formal proceedings based upon violations of Sections 4731.22(B)(26), (5), (10), and (20), Ohio Revised Code [Step I Consent Agreement]. Your Step I Consent Agreement was based upon your dependence on and excessive and habitual use of marijuana, and your admission of having possessed and dispensed generic Tylenol #3 tablets to a family member under circumstances not constituting an emergency, without performing and documenting an examination and without maintaining patient records.

Subsequently, on or about March 10, 2010, you entered into a Step II Consent Agreement with the Board [Step II Consent Agreement], pursuant to which your Ohio certificate to practice osteopathic medicine and surgery was reinstated, subject to certain terms, conditions, and limitations.

To date you remain subject to all terms, conditions and limitations of the Step II Consent Agreement, as modified by the Board, including Paragraph 1, which requires that you obey all federal, state, and local laws, and all rules governing the practice of osteopathic medicine in Ohio.

Mailed 3-15-12

(2) During the time period of in or about March 2010 to in or about April 2011, you provided care in the routine course of your practice for Patients 1 through 14 as identified in the attached Patient Key (Patient Key confidential and to be withheld from public disclosure).

In your treatment of Patients 1 – 14, you practiced below minimal standards of care, including, but not limited to, the following:

(a) In regards to Patient 1, you inappropriately prescribed narcotics for treatment of diagnosed fibromyalgia;

(b) In regards to Patients 3 – 5, 7 – 8, 11, and 13, you failed to obtain, appropriately review and/or properly document review of patient histories and/or prior medical records;

(c) In regards to Patients 1 – 5, and 7 – 14, the amount and/or type of narcotics prescribed was not supported by history, physical exam and/or test findings;

(d) In regards to Patients 9, and 12, you inappropriately prescribed high doses of narcotics despite diagnoses of underlying Chronic Obstructive Pulmonary Disease.

(e) In regards to Patients 1, 2, 4, 6 – 10, and 12 – 14, you failed to develop and/or properly document the development of an individualized treatment plan and/or goals for therapy including, but not limited to, counseling, mental health treatment, selective serotonin reuptake inhibitors [SSRI] and/or physical therapy;

(f) In regards to Patients 1, 2, 5, 9, and 11 – 14, you failed to obtain toxicology screens prior to prescribing narcotics;

(g) In regards to Patients 3, 6, 8, 9, 11, 12, and 13, you failed to appropriately act and/or properly document appropriate action when presented with signs of patient drug abuse and/or diversion, including early refills and/or multiple abnormal toxicology reports;

(h) In regards to Patients 2 – 6, 9, and 13, you failed to appropriately evaluate, or document the appropriate evaluation of the patient situation with respect to possible adverse drug effects, signs of any illegal drug and/or alcohol use or abuse, and assessment of quality of patient's home and/or work environment; and

(i) In regards to Patients 1 – 3, 6, 8, and 12, your medical charting was incomplete, often illegible and/or disorganized.

Your acts, conduct, and/or omissions as alleged in paragraph (2) 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.

Further, your acts, conduct, and/or omissions as alleged in paragraph (2) 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 as alleged in paragraphs (1) and (2) above, individually and/or collectively, constitute a "[v]iolation of the conditions of limitation placed by the board upon a certificate to practice," as that clause is used in Section 4731.22(B)(15), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (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 clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-21-02, Ohio Administrative Code, Utilizing Prescription Drugs for the Treatment of Intractable Pain. Furthermore, pursuant to Rule 4731-21-05, Ohio Administrative Code, violation of Rule 4731-21-02, Ohio Administrative Code, also constitutes violation of Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. 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 osteopathic 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,

J. Craig Strafford MD MPH

J. Craig Strafford, M.D., M.P.H.
Secretary

JCS/AMM/flb
Enclosures

CERTIFIED MAIL #91 7199 9991 7030 3383 7437
RETURN RECEIPT REQUESTED

cc: James R. Kingsley, Esq.
157 West Main Street
Circleville, OH 43113-1619

CERTIFIED MAIL #91 7199 9991 7030 3383 7420
RETURN RECEIPT REQUESTED

IN THE MATTER OF FRANKLIN DONALD DEMINT, D.O.

12-CRF-018

MARCH 14, 2012, NOTICE OF OPPORTUNITY FOR HEARING - PATIENT KEY

SEALED TO PROTECT PATIENT CONFIDENTIALITY AND MAINTAINED IN CASE RECORD FILE.

STEP II
CONSENT AGREEMENT
BETWEEN
FRANKLIN DONALD DEMINT, D.O.,
AND
THE STATE MEDICAL BOARD OF OHIO

This Consent Agreement is entered into by and between Franklin Donald DeMint, D.O., [Dr. DeMint], and the State Medical Board of Ohio [Board], a state agency charged with enforcing Chapter 4731., Ohio Revised Code.

Dr. DeMint enters into this Consent Agreement being fully informed of his rights under Chapter 119., Ohio Revised Code, including the right to representation by counsel and the right to a formal adjudicative hearing on the issues considered herein.

BASIS FOR ACTION

This Consent Agreement is entered into on the basis of the following stipulations, admissions and understandings:

A. The Board is empowered by Section 4731.22(B), Ohio Revised Code, to limit, revoke, suspend a certificate, refuse to register or reinstate an applicant, or reprimand or place on probation the holder of a certificate for violation of Section 4731.22(B)(26), Ohio Revised Code, "impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice;" Section 4731.22(B)(5), Ohio Revised Code, "[m]aking a false, fraudulent, deceptive, or misleading statement in the solicitation of or advertising for patients; in relation to the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or a limited branch of medicine; or in securing or attempting to secure any certificate to practice or certificate of registration issued by the board," Section 4731.22(B)(10), Ohio Revised Code, "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed;" and/or Section 4731.22(B)(20), Ohio Revised Code, "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."

B. The Board enters into this Consent Agreement in lieu of formal proceedings based upon the violation of Sections 4731.22(B)(26), and 4731.22(B)(5), Ohio Revised Code, and 4731.22(B)(10), Ohio Revised Code, to wit: Section 2925.11, Ohio Revised Code, Possession of Controlled Substances, and Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-08(A), Ohio Administrative Code,

Utilizing Controlled Substances for Self and Family Members, as set forth in the Step I Consent Agreement Between Franklin Donald DeMint, D.O., and the State Medical Board of Ohio [August 2009 Step I Consent Agreement], effective August 12, 2009, and Paragraphs E-G, below, and expressly reserves the right to institute formal proceedings based upon any other violations of Chapter 4731. of the Revised Code, whether occurring before or after the effective date of this Agreement. Such express reservation includes, but is not limited to, violations based on any methods used by Dr. DeMint to obtain controlled substances or drugs for self-use other than as particularly described herein, criminal acts other than as specifically referenced herein, acts involving patient care or otherwise involving others, and/or a plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, any criminal offense(s) other than those specifically described herein.

In addition, Dr. DeMint states that he understands that the Board will pursue by separate action any violations beyond the particular criminal acts set specifically forth in the August 2009 Step I Consent Agreement, including but not limited to, any matters related to drug use by others, any matters related to trafficking of drugs, and any matters related to aiding and abetting and/or complicity, even if such violations arise from the same common nucleus of operative facts. Dr. DeMint further states and acknowledges that he understands that subsequent Board actions may supersede this Consent Agreement and may result in further discipline, up to and including permanent revocation of his certificate to practice osteopathic medicine and surgery in Ohio or any other certificate issued by the Board in the future.

C. Dr. DeMint is seeking reinstatement of his certificate to practice osteopathic medicine and surgery, license number 34. 005493, which was indefinitely suspended, but not less than 180 days, pursuant to the August 2009 Step I Consent Agreement, a copy of which is attached hereto and incorporated herein.

D. Dr. DeMint states that he is not licensed to practice in any other state or jurisdiction,

E. Dr. DeMint admits that he was impaired in his ability to practice osteopathic medicine and surgery pursuant to the terms of his August 2009 Step I Consent Agreement. Dr. DeMint states, and the Board acknowledges receipt of information to support, that he successfully completed twenty-nine days of inpatient treatment at the Center for Chemical Addictions Treatment, a Board-approved treatment provider located in Cincinnati, Ohio, on September 11, 2009. Dr. DeMint further states, and the Board acknowledges receipt information to support, that he entered into an aftercare contract on November 11, 2009, with the Cornerstone of Recovery [Cornerstone], a Board-approved treatment provider located in Dublin, Ohio. Dr. DeMint further states, and the Board acknowledges receipt information to support, that he has remained compliant with his aftercare contract with Cornerstone. Further, Dr. DeMint attests

that no criminal charges have been brought against him related to the events described in the August 2009 Step I Consent Agreement.

F. Dr. DeMint states, and the Board acknowledges, that David Goldberg, D.O., of Greene Hall Chemical Dependency Services, Greene Memorial Hospital, a Board approved treatment provider in Dayton, Ohio, and Steven Clay, D.O., an osteopathic physician previously approved by the Board, have provided written reports indicating that Dr. DeMint's ability to practice has been assessed and that he has been found capable of practicing osteopathic medicine and surgery according to acceptable and prevailing standards of care, so long as certain treatment and monitoring requirements are in place.

G. Dr. DeMint states, and the Board acknowledges, that Dr. DeMint has fulfilled the conditions for reinstatement of his certificate to practice osteopathic medicine and surgery in the State of Ohio, as established in the above-referenced August 2009 Step I Consent Agreement.

AGREED CONDITIONS

Wherefore, in consideration of the foregoing and mutual promises hereinafter set forth, and in lieu of any formal proceedings at this time, the certificate of Dr. DeMint to practice osteopathic medicine and surgery in the State of Ohio shall be REINSTATED, and Dr. DeMint knowingly and voluntarily agrees with the Board to the following PROBATIONARY terms, conditions and limitations:

1. Dr. DeMint shall obey all federal, state, and local laws, and all rules governing the practice of osteopathic medicine in Ohio.

2. Dr. DeMint shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Consent Agreement. The first quarterly declaration must be received in the Board's offices on the date his quarterly declaration would have been due pursuant to his August, 2009 Step I Consent Agreement with the Board, or as otherwise requested by the Board. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. Dr. DeMint shall appear in person for an interview before the full Board or its designated representative. The first such appearance shall take place on the date his appearance would have been scheduled pursuant to his August 2009 Step I Consent Agreement with the Board. Subsequent personal appearances must occur every three months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

4. Dr. DeMint shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have the discretion to grant a waiver of part or all of the probationary terms set forth in this Consent Agreement for occasional periods of absence of fourteen days or less. In the event that Dr. DeMint resides and/or is employed at a location that is within fifty miles of the geographic border of Ohio and any of its contiguous states, Dr. DeMint may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. DeMint is able to otherwise maintain full compliance with all other terms, conditions and limitations set forth in this Consent Agreement.

5. In the event Dr. DeMint is found by the Secretary of the Board to have failed to comply with any provision of this Consent Agreement, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Consent Agreement.

MONITORING OF REHABILITATION AND TREATMENT

Drug Associated Restrictions

6. Dr. DeMint shall keep a log of all controlled substances prescribed. Such log shall be submitted, in the format approved by the Board, on the date upon which Dr. DeMint's quarterly declaration is due, or as otherwise directed by the Board. Further, Dr. DeMint shall make his patient records with regard to such prescribing available for review by an agent of the Board immediately upon request.

7. Dr. DeMint shall not, without prior Board approval, administer, personally furnish, or possess (except as allowed under Paragraph 8 below) any controlled substances as defined by state or federal law. In the event that the Board agrees at a future date to modify this Consent Agreement to allow Dr. DeMint to administer or personally furnish controlled substances, Dr. DeMint shall keep a log of all controlled substances prescribed, administered or personally furnished. Such log shall be submitted in the format approved by the Board and shall be submitted to the Board no later than the date upon which Dr. DeMint's quarterly declaration is due, or as otherwise directed by the Board. Further, Dr. DeMint shall make his patient records with regard to such prescribing, administering, or personally furnishing available for review by an agent of the Board immediately upon request.

Sobriety

8. Dr. DeMint shall abstain completely from the personal use or personal possession of drugs, except those prescribed, dispensed or administered to him by another so authorized by law who has full knowledge of Dr. DeMint's history of chemical dependency. Further, in the event that Dr. DeMint is so prescribed, dispensed or administered any controlled substance, carisoprodol, or tramadol, Dr. DeMint shall notify the Board in writing within seven days, providing the Board with the identity of the prescriber; the name of the drug Dr. DeMint received; the medical purpose for which he received said drug; the date such drug was initially received; and the dosage, amount, number of refills, and directions for use. Further, within thirty days of the date said drug is so prescribed, dispensed, or administered to him, Dr. DeMint shall provide the Board with either a copy of the written prescription or other written verification from the prescriber, including the dosage, amount, number of refills, and directions for use.

9. Dr. DeMint shall abstain completely from the use of alcohol.

Drug and Alcohol Screens/Drug Testing Facility and Collection Site

10. Dr. DeMint shall submit to random urine screenings for drugs and alcohol at least two times per month, or as otherwise directed by the Board. Dr. DeMint shall ensure that all screening reports are forwarded directly to the Board on a quarterly basis. The drug testing panel utilized must be acceptable to the Secretary of the Board, and shall include Dr. DeMint's drug(s) of choice.

    Dr. DeMint shall abstain from the use of any substance and the consumption of poppy seeds or any other food or liquid that may produce a low level positive result in a toxicology screen. Dr. DeMint acknowledges that he understands that the consumption or use of such substances, including but not limited to substances such as mouthwash or hand cleaning gel, may cause a positive drug screen that may not be able to be differentiated from intentional ingestion, and therefore such consumption or use is prohibited under this Consent Agreement.

    All such urine screenings for drugs and alcohol shall be conducted through a Board-approved drug testing facility and collection site pursuant to the global contract between said facility and the Board, that provides for the Board to maintain ultimate control over the urine screening process and to preserve the confidentiality of all positive screening results in accordance with Section 4731.22(F)(5), Ohio Revised Code, and the screening process shall require a daily call-in procedure. Further, in the event that the Board exercises its discretion, as provided in Paragraph 11 below, to approve urine screenings to be conducted at an alternative drug testing facility and/or collection site or a supervising physician, such approval shall be expressly contingent upon the Board retaining ultimate control over the urine screening process in a

manner that preserves the aforementioned confidentiality of all positive screening results.

Dr. DeMint shall submit, at his expense and on the day selected, urine specimens for drug and/or alcohol analysis. All specimens submitted by Dr. DeMint shall be negative, except for those substances prescribed, administered, or dispensed to him in conformance with the terms, conditions and limitations set forth in this Consent Agreement. Refusal to submit such specimen, or failure to submit such specimen on the day he is selected or in such manner as the Board may request, shall constitute a violation of this Consent Agreement.

Further, within thirty days of the effective date of this Consent Agreement, Dr. DeMint shall enter into the necessary financial and/or contractual arrangements with the Board-approved drug testing facility and/or collection site in order to facilitate the urine screening process in the manner required by this Consent Agreement. Further, Dr. DeMint shall promptly provide to the Board written documentation of completion of such arrangements, including a copy of any contract entered into between Dr. DeMint and the Board-approved drug testing facility and/or collection site. Dr. DeMint's failure to timely complete such arrangements, or failure to timely provide written documentation to the Board of completion of such arrangements, shall constitute a violation of this Consent Agreement. However, Dr. DeMint and the Board further agree that in the event Dr. DeMint previously entered into the aforementioned financial and contractual agreements pursuant to the requirements of a prior consent agreement with the Board under which Dr. DeMint is currently participating in an ongoing urine screening process, then this requirement shall be waived under the instant consent agreement.

Dr. DeMint shall ensure that the urine screening process performed through the Board-approved drug testing facility and/or collection site requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. DeMint and the Board-approved drug testing facility and collection site shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

Dr. DeMint shall ensure that the Board-approved drug testing facility and/or collection site provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Consent Agreement, and whether all urine screens have been negative.

In the event that the Board-approved drug testing facility and/or collection site becomes unable or unwilling to serve as required by this Consent Agreement, Dr. DeMint must immediately notify the Board in writing, and make arrangements acceptable to the Board pursuant to Paragraph 11 below, as soon as practicable. Dr.

DeMint shall further ensure that the Board-approved drug testing facility and/or collection site also notifies the Board directly of its inability to continue to serve and the reasons therefore.

Dr. DeMint acknowledges that the Board expressly reserves the right to withdraw its approval of any drug testing facility and/or collection site in the event that the Secretary and Supervising Member of the Board determine that the drug testing facility and/or collection site has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

11. Dr. DeMint and the Board agree that it is the intent of this Consent Agreement that Dr. DeMint shall submit his urine specimens to the Board-approved drug testing facility and collection site chosen by the Board. However, in the event that utilizing said Board-approved drug testing facility and/or collection site creates an extraordinary hardship upon Dr. DeMint, as determined in the sole discretion of the Board, then subject to the following requirements, the Board may approve an alternate drug testing facility and/or collection site, or a supervising physician, to facilitate the urine screening process for Dr. DeMint:

    a. Within thirty days of the date upon which Dr. DeMint is notified of the Board's determination that utilizing the Board-approved drug testing facility and/or collection site constitutes an extraordinary hardship upon Dr. DeMint, he shall submit to the Board in writing for its prior approval the identity of either an alternate drug testing facility and collection site, or the name of a proposed supervising physician, to whom Dr. DeMint shall submit the required urine specimens. In approving a facility, entity, or an individual to serve in this capacity, the Board will give preference to a facility located near Dr. DeMint's residence or employment location, or to a physician who practices in the same locale as Dr. DeMint. Dr. DeMint shall ensure that the urine screening process performed through the alternate drug testing facility and/or collection site, or through the supervising physician, requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. DeMint acknowledges that the alternate drug testing facility and collection site, or the supervising physician, shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

    b. Dr. DeMint shall ensure that the alternate drug testing facility and/or collection site, or the supervising physician, provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Consent Agreement, and whether all urine screens have been negative.

c. In the event that the designated alternate drug testing facility and/or collection site, or the supervising physician, becomes unable or unwilling to so serve, Dr. DeMint must immediately notify the Board in writing. Dr. DeMint shall further ensure that the previously designated alternate drug testing facility and collection site, or the supervising physician, also notifies the Board directly of the inability to continue to serve and the reasons therefore. Further, in order to ensure that there will be no interruption in his urine screening process, upon the previously approved alternate drug testing facility, collection site, or supervising physician becoming unable to serve, Dr. DeMint shall immediately commence urine screening at the Board-approved drug testing facility and collection site chosen by the Board, until such time, if any, that the Board approves a subsequent alternate drug testing facility, collection site, or supervising physician, if requested by Dr. DeMint.

d. The Board expressly reserves the right to disapprove any entity or facility proposed to serve as Dr. DeMint's designated alternate drug testing facility and/or collection site, or any person proposed to serve as his supervising physician, or to withdraw approval of any entity, facility or person previously approved to so serve in the event that the Secretary and Supervising Member of the Board determine that any such entity, facility or person has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

e. In the event that the Board approved an alternate drug testing facility and/or collection site, or a supervising physician, pursuant to the August 2009 Step I Consent Agreement between Dr. DeMint and the Board, Dr. DeMint and the Board agree that the entity, facility or person previously approved by the Board to so serve pursuant to the August 2009 Step I Consent Agreement is hereby approved to continue as Dr. DeMint's designated alternate drug testing facility and collection site or as his supervising physician under this Consent Agreement.

12. All screening reports required under this Consent Agreement from the Board-approved drug testing facility and/or collection site, or from the alternate drug testing facility and/or collection site or supervising physician, must be received in the Board's offices no later than the due date for Dr. DeMint's quarterly declaration. It is Dr. DeMint's responsibility to ensure that reports are timely submitted.

13. The Board retains the right to require, and Dr. DeMint agrees to submit, blood, urine, breath, saliva and/or hair specimens for screening for drugs and alcohol, for analysis of therapeutic levels of medications that may be prescribed for Dr. DeMint, or for any other purpose, at Dr. DeMint's expense upon the Board's request and without prior notice. Dr. DeMint's refusal to submit a specimen upon request of the Board shall result in a minimum of one year of actual license suspension. Further, the collection

of such specimens shall be witnessed by a representative of the Board, or another person acceptable to the Secretary or Supervising Member of the Board.

Monitoring Physician

14. Before engaging in any medical practice, Dr. DeMint shall submit to the Board in writing the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. DeMint and who is engaged in the same or similar practice specialty.

    The monitoring physician shall monitor Dr. DeMint and his medical practice, and shall review Dr. DeMint's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

    Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. DeMint and his medical practice, and on the review of Dr. DeMint's patient charts. Dr. DeMint shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. DeMint's quarterly declaration.

    In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. DeMint must immediately so notify the Board in writing. In addition, Dr. DeMint shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. DeMint shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

    The Board expressly reserves the right to disapprove any person proposed to serve as Dr. DeMint's designated monitoring physician, or to withdraw approval of any person previously approved to serve as Dr. DeMint's designated monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

Rehabilitation Program

15. Dr. DeMint shall maintain participation in an alcohol and drug rehabilitation program, such as A.A., N.A., C.A., or Caduceus, no less than four times per week. At least one

of the abovementioned meetings shall be a Caduceus meeting. Substitution of any other specific program must receive prior Board approval.

Dr. DeMint shall submit acceptable documentary evidence of continuing compliance with this program, including submission to the Board of meeting attendance logs, which must be received in the Board's offices no later than the due date for Dr. DeMint's quarterly declarations.

Aftercare

16. Dr. DeMint shall contact an appropriate impaired physicians committee, approved by the Board, to arrange for assistance in recovery or aftercare.

17. Dr. DeMint shall maintain continued compliance with the terms of the aftercare contract entered into with a Board-approved treatment provider, provided that, where terms of the aftercare contract conflict with terms of this Consent Agreement, the terms of this Consent Agreement shall control.

Releases

18. Dr. DeMint shall provide authorization, through appropriate written consent forms, for disclosure of evaluative reports, summaries, and records, of whatever nature, by any and all parties that provide treatment or evaluation for Dr. DeMint's chemical dependency or related conditions, or for purposes of complying with this Consent Agreement, whether such treatment or evaluation occurred before or after the effective date of this Consent Agreement. To the extent permitted by law, the above-mentioned evaluative reports, summaries, and records are considered medical records for purposes of Section 149.43 of the Ohio Revised Code and are confidential pursuant to statute. Dr. DeMint further agrees to provide the Board written consent permitting any treatment provider from whom he obtains treatment to notify the Board in the event he fails to agree to or comply with any treatment contract or aftercare contract. Failure to provide such consent, or revocation of such consent, shall constitute a violation of this Consent Agreement.

Required Reporting by Licensee

19. Within thirty days of the effective date of this Consent Agreement, Dr. DeMint shall provide a copy of this Consent Agreement to all employers or entities with which he is under contract to provide health care services (including but not limited to third party payors) or is receiving training, and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. DeMint shall promptly provide a copy of this Consent Agreement to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. In the

event that Dr. DeMint provides any health care services or health care direction or medical oversight to any emergency medical services organization or emergency medical services provider, within thirty days of the effective date of this Consent Agreement Dr. DeMint shall provide a copy of this Consent Agreement to the Ohio Department of Public Safety, Division of Emergency Medical Services. Further, Dr. DeMint shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.

20. Within thirty days of the effective date of this Consent Agreement, Dr. DeMint shall provide a copy of this Consent Agreement to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Dr. DeMint further agrees to provide a copy of this Consent Agreement at time of application to the proper licensing authority of any state in which he applies for any professional license or for reinstatement of any professional license. Further, Dr. DeMint shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.

21. Dr. DeMint shall promptly provide a copy of this Consent Agreement to all persons and entities that provide Dr. DeMint chemical dependency treatment or monitoring. Further, Dr. DeMint shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature

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22. Dr. DeMint shall notify the Board in writing of any change of principal practice address or residence address within thirty days of such change.

FAILURE TO COMPLY

If, in the discretion of the Secretary and Supervising Member of the Board, Dr. DeMint appears to have violated or breached any term or condition of this Consent Agreement, the Board reserves the right to institute formal disciplinary proceedings for any and all possible violations or breaches, including, but not limited to, alleged violations of the laws of Ohio occurring before the effective date of this Consent Agreement.

If the Secretary and Supervising Member of the Board determine that there is clear and convincing evidence that Dr. DeMint has violated any term, condition or limitation of this Consent Agreement, Dr. DeMint agrees that the violation, as alleged, also constitutes clear and convincing evidence that his continued practice presents a danger of immediate and serious harm to the public for purposes of initiating a summary suspension pursuant to Section 4731.22(G), Ohio Revised Code.

DURATION/MODIFICATION OF TERMS

Dr. DeMint shall not request termination of this Consent Agreement for a minimum of five years. In addition, Dr. DeMint shall not request modification to the probationary terms, limitations, and conditions contained herein for at least one year, except that Dr. DeMint may make such request with the mutual approval and joint recommendation of the Secretary and Supervising Member. Otherwise, the above-described terms, limitations and conditions may be amended or terminated in writing at any time upon the agreement of both parties.

In the event that the Board initiates future formal proceedings against Dr. DeMint, including but not limited to issuance of a Notice of Opportunity for Hearing, this Consent Agreement shall continue in full force and effect until such time that it is superseded by ratification by the Board of a subsequent Consent Agreement or issuance by the Board of a final Board Order.

In the event that any term, limitation, or condition contained in this Consent Agreement is determined to be invalid by a court of competent jurisdiction, Dr. DeMint and the Board agree

that all other terms, limitations, and conditions contained in this Consent Agreement shall be unaffected.

ACKNOWLEDGMENTS/LIABILITY RELEASE

Dr. DeMint acknowledges that he has had an opportunity to ask questions concerning the terms of this Consent Agreement and that all questions asked have been answered in a satisfactory manner.

Any action initiated by the Board based on alleged violations of this Consent Agreement shall comply with the Administrative Procedure Act, Chapter 119., Ohio Revised Code.

Dr. DeMint hereby releases the Board, its members, employees, agents, officers and representatives jointly and severally from any and all liability arising from the within matter.

This Consent Agreement shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code. Further, this information may be reported to appropriate organizations, data banks and governmental bodies. Dr. DeMint acknowledges that his social security number will be used if this information is so reported and agrees to provide his social security number to the Board for such purposes.

EFFECTIVE DATE

It is expressly understood that this Consent Agreement is subject to ratification by the Board prior to signature by the Secretary and Supervising Member and shall become effective upon the last date of signature below.

Franklin Donald DeMint, D.O.
FRANKLIN DONALD DEMINT, D.O.

2/24/2010
DATE

Lance A. Talmage, MD/BAJ by authorization
LANCE A. TALMAGE, M.D.
Secretary

March 10, 2010
DATE

James R. Kingsley
JAMES R. KINGSLEY, ESQ.
Attorney for FRANKLIN DONALD DEMINT, D.O.

3.3.05
DATE

Raymond J. Albert/BAJ by authorization
RAYMOND J. ALBERT
Supervising Member

March 10, 2010
DATE

David P. Katko

DAVID P. KATKO
Enforcement Attorney

03/08/10

DATE

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A. The Board is empowered by Section 4731.22(B), Ohio Revised Code, to limit, revoke, suspend a certificate, refuse to register or reinstate an applicant, or reprimand or place on probation the holder of a certificate for violation of Section 4731.22(B)(26), Ohio Revised Code, "impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice;" Section 4731.22(B)(5), Ohio Revised Code, "[m]aking a false, fraudulent, deceptive, or misleading statement in the solicitation of or advertising for patients; in relation to the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or a limited branch of medicine; or in securing or attempting to secure any certificate to practice or certificate of registration issued by the board;" Section 4731.22(B)(10), Ohio Revised Code, "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed;" and/or Section 4731.22(B)(20), Ohio Revised Code, "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."

B. The Board enters into this Consent Agreement in lieu of formal proceedings based upon the violation of Sections 4731.22(B)(26), and 4731.22(B)(5), Ohio Revised Code, and 4731.22(B)(10), Ohio Revised Code, to wit: Section 2925.11, Ohio Revised Code, Possession of Controlled Substances, and Section 4731.212(B)(20), Ohio Revised Code, to wit: Rule 4731-11-08, Ohio Administrative Code, Utilizing Controlled Substances for Self and Family Members, as set forth in Paragraph E below, and expressly reserves the

right to institute formal proceedings based upon any other violations of Chapter 4731. of the Revised Code, whether occurring before or after the effective date of this Agreement. Such express reservation includes, but is not limited to, violations based on any methods used by Dr. DeMint to obtain controlled substances or drugs for self-use other than as particularly described herein, criminal acts other than as specifically referenced herein, acts involving patient care or otherwise involving others, and/or a plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, any criminal offense(s) other than those specifically described herein.

In addition, Dr. DeMint states that he understands that the Board will pursue by separate action any violations beyond the particular criminal acts set specifically forth in Paragraph E, below, including but not limited to, any matters related to drug use by others, any matters related to trafficking of drugs, and any matters related to aiding and abetting and/or complicity, even if such violations arise from the same common nucleus of operative facts as outlined within this Consent Agreement. Dr. DeMint further states and acknowledges that he understands that subsequent Board actions may supersede this Consent Agreement and may result in further discipline, up to and including permanent revocation of his certificate to practice osteopathic medicine and surgery in Ohio or any other certificate issued by the Board in the future.

C. Dr. DeMint is licensed to practice osteopathic medicine and surgery in the State of Ohio, License number 34. 005493.

D. Dr. DeMint states that he is not licensed to practice in any other state or jurisdiction.

E. Dr. DeMint admits that marijuana is his drug of choice; that he began smoking marijuana in or about 1974 and that he smoked marijuana on a routine basis from 1974 to 1982; that he smoked marijuana only intermittently from 1982 to 1997 because he was in the military and medical school; and that from 1997 to the present he has smoked one to two joints on a daily basis every evening after work and that he last smoked marijuana on August 2, 2009. Dr. DeMint also admits that he is currently impaired in his ability to practice osteopathic medicine according to acceptable and prevailing standards of care, as defined in Section 4731.22(B)(26), Ohio Revised Code, due to his dependence on marijuana and based on his excessive and habitual use of marijuana. Dr. DeMint expressly denies that that he ever smoked marijuana while on call or that he ever saw patients while under the influence of marijuana. Dr. DeMint further expressly denies that he ever cultivated marijuana, sold marijuana to others, or traded any medical services or prescriptions to others in exchange for marijuana.

Dr. DeMint also admits that he possessed a bulk amount of generic Tylenol #3 tablets that was not in conformance with Board rules and statutes, and that he dispensed controlled substances to a family member, as that term is defined in Rule 4731-11-08, Ohio Administrative Code, under circumstances that did not constitute an emergency,

and failed to perform and document a proper physical examination prior to dispensing and/or prescribing said medication.

Dr. DeMint admits that on or about August 5, 2009, local law enforcement executed a search warrant at his residence, which revealed the presence of marijuana and Tylenol #3 as described above. Dr. DeMint specifically states that he is not aware of any formal criminal charges being pending against him at this time related to his possession of those two substances, but acknowledges that such charges may be forthcoming.

Dr. DeMint further admits that although he was engaged in the habitual daily use of marijuana from 1997 to the present, he falsely answered "no" to the question on his biennial license renewals during that time period that asked whether he was dependent upon any chemical substance.

Dr. DeMint asserts that he is in the process of researching Board-approved treatment facilities, and anticipates entering inpatient treatment in the immediate future.

AGREED CONDITIONS

Wherefore, in consideration of the foregoing and mutual promises hereinafter set forth, and in lieu of any formal proceedings at this time, Dr. DeMint knowingly and voluntarily agrees with the Board to the following terms, conditions and limitations:

SUSPENSION OF CERTIFICATE

1. The certificate of Dr. DeMint to practice osteopathic medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than 180 days.

Obey all Laws

2. Dr. DeMint shall obey all federal, state, and local laws.

Sobriety

3. Dr. DeMint shall abstain completely from the personal use or personal possession of drugs, except those prescribed, dispensed or administered to him by another so authorized by law who has full knowledge of Dr. DeMint's history of chemical dependency. Further, in the event that Dr. DeMint is so prescribed, dispensed or administered any controlled substance, carisoprodol, or tramadol, Dr. DeMint shall notify the Board in writing within seven days, providing the Board with the identity of the prescriber; the name of the drug Dr. DeMint received; the medical purpose for which he received said drug; the date such drug was initially received; and the dosage, amount, number of refills, and directions for use. Further, within thirty days of the date said drug

is so prescribed, dispensed, or administered to him, Dr. DeMint shall provide the Board with either a copy of the written prescription or other written verification from the prescriber, including the dosage, amount, number of refills, and directions for use.

4. Dr. DeMint shall abstain completely from the use of alcohol.

Absences from Ohio

5. Dr. DeMint shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have the discretion to grant a waiver of part or all of the monitoring terms set forth in this Consent Agreement for occasional periods of absence of fourteen days or less. In the event that Dr. DeMint resides and/or is employed at a location that is within fifty miles of the geographic border of Ohio and any of its contiguous states, Dr. DeMint may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. DeMint is able to otherwise maintain full compliance with all other terms, conditions and limitations set forth in this Consent Agreement.

Releases; Quarterly Declarations and Appearances

6. Dr. DeMint shall provide authorization, through appropriate written consent forms, for disclosure of evaluative reports, summaries, and records, of whatever nature, by any and all parties that provide treatment or evaluation for Dr. DeMint's chemical dependency or related conditions, or for purposes of complying with this Consent Agreement, whether such treatment or evaluation occurred before or after the effective date of this Consent Agreement. To the extent permitted by law, the above-mentioned evaluative reports, summaries, and records are considered medical records for purposes of Section 149.43 of the Ohio Revised Code and are confidential pursuant to statute. Dr. DeMint further agrees to provide the Board written consent permitting any treatment provider from whom he obtains treatment to notify the Board in the event he fails to agree to or comply with any treatment contract or aftercare contract. Failure to provide such consent, or revocation of such consent, shall constitute a violation of this Consent Agreement.

7. Dr. DeMint shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Consent Agreement. The first quarterly declaration must be received in the Board's offices on the first day of the third month following the month in which this Consent Agreement becomes effective, or as otherwise requested by the

Board. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

8. Dr. DeMint shall appear in person for an interview before the full Board or its designated representative during the third month following the effective date of this Consent Agreement. Subsequent personal appearances must occur every three months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

Drug & Alcohol Screens; Drug Testing Facility and Collection Site

9. Dr. DeMint shall submit to random urine screenings for drugs and alcohol at least four times per month, or as otherwise directed by the Board. Dr. DeMint shall ensure that all screening reports are forwarded directly to the Board on a quarterly basis. The drug testing panel utilized must be acceptable to the Secretary of the Board, and shall include Dr. DeMint's drug(s) of choice.

   Dr. DeMint shall abstain from the use of any substance and the consumption of poppy seeds or any other food or liquid that may produce a low level positive result in a toxicology screen. Dr. DeMint acknowledges that he understands that the consumption or use of such substances, including but not limited to substances such as mouthwash or hand cleaning gel, may cause a positive drug screen that may not be able to be differentiated from intentional ingestion, and therefore such consumption or use is prohibited under this Consent Agreement.

   All such urine screenings for drugs and alcohol shall be conducted through a Board-approved drug testing facility and collection site pursuant to the global contract between said facility and the Board, that provides for the Board to maintain ultimate control over the urine screening process and to preserve the confidentiality of all positive screening results in accordance with Section 4731.22(F)(5), Ohio Revised Code, and the screening process shall require a daily call-in procedure. Further, in the event that the Board exercises its discretion, as provided in Paragraph 10 below, to approve urine screenings to be conducted at an alternative drug testing facility and/or collection site or a supervising physician, such approval shall be expressly contingent upon the Board retaining ultimate control over the urine screening process in a manner that preserves the aforementioned confidentiality of all positive screening results.

   Dr. DeMint shall submit, at his expense and on the day selected, urine specimens for drug and/or alcohol analysis. All specimens submitted by Dr. DeMint shall be negative, except for those substances prescribed, administered, or dispensed to him in conformance with the terms, conditions and limitations set forth in this Consent Agreement. Refusal to submit such specimen, or failure to submit such specimen on the

day he is selected or in such manner as the Board may request, shall constitute a violation of this Consent Agreement.

Further, within thirty days of the effective date of this Consent Agreement, Dr. DeMint shall enter into the necessary financial and/or contractual arrangements with the Board-approved drug testing facility and/or collection site in order to facilitate the urine screening process in the manner required by this Consent Agreement. Further, Dr. DeMint shall promptly provide to the Board written documentation of completion of such arrangements, including a copy of any contract entered into between Dr. DeMint and the Board-approved drug testing facility and/or collection site. Dr. DeMint's failure to timely complete such arrangements, or failure to timely provide written documentation to the Board of completion of such arrangements, shall constitute a violation of this Consent Agreement.

Dr. DeMint shall ensure that the urine screening process performed through the Board-approved drug testing facility and/or collection site requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. DeMint and the Board-approved drug testing facility and collection site shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

Dr. DeMint shall ensure that the Board-approved drug testing facility and/or collection site provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Consent Agreement, and whether all urine screens have been negative.

In the event that the Board-approved drug testing facility and/or collection site becomes unable or unwilling to serve as required by this Consent Agreement, Dr. DeMint must immediately notify the Board in writing, and make arrangements acceptable to the Board, pursuant to Paragraph 10 below, as soon as practicable. Dr. DeMint shall further ensure that the Board-approved drug testing facility and/or collection site also notifies the Board directly of its inability to continue to serve and the reasons therefore.

Dr. DeMint acknowledges that the Board expressly reserves the right to withdraw its approval of any drug testing facility and/or collection site in the event that the Secretary and Supervising Member of the Board determine that the drug testing facility and/or collection site has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

10. Dr. DeMint and the Board agree that it is the intent of this Consent Agreement that Dr. DeMint shall submit his urine specimens to the Board-approved drug testing facility and collection site chosen by the Board. However, in the event that utilizing said Board-approved drug testing facility and/or collection site creates an extraordinary hardship

upon Dr. DeMint, as determined in the sole discretion of the Board, then subject to the following requirements, the Board may approve an alternate drug testing facility and/or collection site, or a supervising physician, to facilitate the urine screening process for Dr. DeMint:

a. Within thirty days of the date upon which Dr. DeMint is notified of the Board's determination that utilizing the Board-approved drug testing facility and/or collection site constitutes an extraordinary hardship upon Dr. DeMint, he shall submit to the Board in writing for its prior approval the identity of either an alternate drug testing facility and collection site, or the name of a proposed supervising physician, to whom Dr. DeMint shall submit the required urine specimens. In approving a facility, entity, or an individual to serve in this capacity, the Board will give preference to a facility located near Dr. DeMint's residence or employment location, or to a physician who practices in the same locale as Dr. DeMint. Dr. DeMint shall ensure that the urine screening process performed through the alternate drug testing facility and/or collection site, or through the supervising physician, requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. DeMint acknowledges that the alternate drug testing facility and collection site, or the supervising physician, shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

b. Dr. DeMint shall ensure that the alternate drug testing facility and/or collection site, or the supervising physician, provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Consent Agreement, and whether all urine screens have been negative.

c. In the event that the designated alternate drug testing facility and/or collection site, or the supervising physician, becomes unable or unwilling to so serve, Dr. DeMint must immediately notify the Board in writing. Dr. DeMint shall further ensure that the previously designated alternate drug testing facility and collection site, or the supervising physician, also notifies the Board directly of the inability to continue to serve and the reasons therefore. Further, in order to ensure that there will be no interruption in his urine screening process, upon the previously approved alternate drug testing facility, collection site, or supervising physician becoming unable to serve, Dr. DeMint shall immediately commence urine screening at the Board-approved drug testing facility and collection site chosen by the Board, until such time, if any, that the Board approves a subsequent alternate drug testing facility, collection site, or supervising physician, if requested by Dr. DeMint.

d. The Board expressly reserves the right to disapprove any entity or facility proposed to serve as Dr. DeMint's designated alternate drug testing facility and/or collection site, or any person proposed to serve as his supervising physician, or to withdraw approval of any entity, facility or person previously approved to so serve in the event that the Secretary and Supervising Member of the Board determine that any such entity, facility or person has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

11. All screening reports required under this Consent Agreement from the Board-approved drug testing facility and/or collection site, or from the alternate drug testing facility and/or collection site or supervising physician, must be received in the Board's offices no later than the due date for Dr. DeMint's quarterly declaration. It is Dr. DeMint's responsibility to ensure that reports are timely submitted.

12. The Board retains the right to require, and Dr. DeMint agrees to submit, blood, urine, breath, saliva and/or hair specimens for screening for drugs and alcohol, for analysis of therapeutic levels of medications that may be prescribed for Dr. DeMint, or for any other purpose, at Dr. DeMint's expense upon the Board's request and without prior notice. Dr. DeMint's refusal to submit a specimen upon request of the Board shall result in a minimum of one year of actual license suspension. Further, the collection of such specimens shall be witnessed by a representative of the Board, or another person acceptable to the Secretary or Supervising Member of the Board.

Rehabilitation Program

13. Within thirty days of the effective date of this Consent Agreement, Dr. DeMint shall undertake and maintain participation in an alcohol and drug rehabilitation program, such as A.A., N.A., C.A., or Caduceus, no less than three times per week. Substitution of any other specific program must receive prior Board approval.

    Dr. DeMint shall submit acceptable documentary evidence of continuing compliance with this program, including submission to the Board of meeting attendance logs, which must be received in the Board's offices no later than the due date for Dr. DeMint's quarterly declarations.

14. Immediately upon completion of any required treatment for chemical dependency, Dr. DeMint shall enter into an aftercare contract with a Board-approved treatment provider and shall maintain continued compliance with the terms of said aftercare contract, provided that, where the terms of the aftercare contract conflict with the terms of this Consent Agreement, the terms of this Consent Agreement shall control.

CONDITIONS FOR REINSTATEMENT

15. The Board shall not consider reinstatement or restoration of Dr. DeMint's certificate to practice osteopathic medicine and surgery until all of the following conditions are met:

    a. Dr. DeMint shall submit an application for reinstatement or restoration, as appropriate, accompanied by appropriate fees, if any.

    b. Dr. DeMint shall demonstrate to the satisfaction of the Board that he can resume practice in compliance with acceptable and prevailing standards of care under the provisions of his certificate. Such demonstration shall include but shall not be limited to the following:

        i. Certification from a treatment provider approved under Section 4731.25 of the Revised Code that Dr. DeMint has successfully completed any required inpatient treatment, including at least twenty-eight days of inpatient or residential treatment for chemical abuse/dependence, as set forth in Rules 4731-16-02 and 4731-16-08, Ohio Administrative Code, completed consecutively.

        ii. Evidence of continuing full compliance with, or successful completion of, a post-discharge aftercare contract with a treatment provider approved under Section 4731.25 of the Revised Code. Such evidence shall include, but not be limited to, a copy of the signed aftercare contract. The aftercare contract must comply with rule 4731-16-10 of the Administrative Code.

        iii. Evidence of continuing full compliance with this Consent Agreement.

        iv. Two written reports indicating that Dr. DeMint's ability to practice has been assessed and that he has been found capable of practicing according to acceptable and prevailing standards of care. The reports shall be made by physicians knowledgeable in the area of addictionology and who are either affiliated with a current Board-approved treatment provider or otherwise have been approved in advance by the Board to provide an assessment of Dr. DeMint. Further, the two aforementioned physicians shall not be affiliated with the same treatment provider or medical group practice. Prior to the assessments, Dr. DeMint shall provide the evaluators with copies of patient records from any evaluations and/or treatment that he has received, and a copy of this Consent Agreement. The reports from the evaluators shall include any recommendations for treatment, monitoring, or supervision of Dr. DeMint, and any conditions, restrictions, or limitations that should be

imposed on Dr. DeMint's practice. The reports shall also describe the basis for the evaluator's determinations.

All reports required pursuant to this paragraph shall be based upon examinations occurring within the three months immediately preceding any application for reinstatement. Further, at the discretion of the Secretary and Supervising Member of the Board, the Board may request an updated assessment and report if the Secretary and Supervising Member determine that such updated assessment and report is warranted for any reason.

c. Dr. DeMint shall enter into a written consent agreement including probationary terms, conditions and limitations as determined by the Board within 180 days of the date upon which all the above-specified conditions for reinstatement or restoration have been completed or, if the Board and Dr. DeMint are unable to agree on the terms of a written Consent Agreement, then Dr. DeMint further agrees to abide by any terms, conditions and limitations imposed by Board Order after a hearing conducted pursuant to Chapter 119. of the Ohio Revised Code. The Board shall provide notice to Dr. DeMint that said hearing has been scheduled, advising Dr. DeMint of his hearing rights, and stating the date, time, and location of the hearing at which the Board will present its evidence, after which the Board will make a determination of the matter by Board Order.

Further, upon reinstatement of Dr. DeMint's certificate to practice osteopathic medicine and surgery in this state, the Board shall require continued monitoring which shall include, but not be limited to, compliance with the written consent agreement entered into before reinstatement or with conditions imposed by Board Order after a hearing conducted pursuant to Chapter 119. of the Revised Code. Moreover, upon termination of the consent agreement or Board Order, Dr. DeMint shall submit to the Board for at least two years annual progress reports made under penalty of Board disciplinary action or criminal prosecution stating whether Dr. DeMint has maintained sobriety.

16. In the event that Dr. DeMint has not been engaged in the active practice of osteopathic medicine and surgery for a period in excess of two years prior to application for reinstatement, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of Dr. DeMint's fitness to resume practice.

REQUIRED REPORTING BY LICENSEE

17. Within thirty days of the effective date of this Consent Agreement, Dr. DeMint shall provide a copy of this Consent Agreement to all employers or entities with which he is under contract to provide health care services (including but not limited to third party payors) or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. DeMint shall promptly provide a copy of this

Consent Agreement to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. In the event that Dr. DeMint provides any health care services or health care direction or medical oversight to any emergency medical services organization or emergency medical services provider, within thirty days of the effective date of this Consent Agreement Dr. DeMint shall provide a copy of this Consent Agreement to the Ohio Department of Public Safety, Division of Emergency Medical Services. Further, Dr. DeMint shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.

18. Within thirty days of the effective date of this Consent Agreement, Dr. DeMint shall provide a copy of this Consent Agreement to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Dr. DeMint further agrees to provide a copy of this Consent Agreement at time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement of any professional license. Further, Dr. DeMint shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.

19. Dr. DeMint shall promptly provide a copy of this Consent Agreement to all persons and entities that provide Dr. DeMint chemical dependency treatment or monitoring. Further, Dr. DeMint shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated

report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.

20. Dr. DeMint shall notify the Board in writing of any change of principal practice address or residence address within thirty days of such change.

DURATION/MODIFICATION OF TERMS

The above-described terms, conditions and limitations may be amended or terminated in writing at any time upon the agreement of both parties. In the event that the Board initiates future formal proceedings against Dr. DeMint, including but not limited to issuance of a Notice of Opportunity for Hearing, this Consent Agreement shall continue in full force and effect until such time that it is superseded by ratification by the Board of a subsequent Consent Agreement or issuance by the Board of a final Board Order.

FAILURE TO COMPLY

If, in the discretion of the Secretary and Supervising Member of the Board, Dr. DeMint appears to have violated or breached any term or condition of this Consent Agreement, the Board reserves the right to institute formal disciplinary proceedings for any and all possible violations or breaches, including but not limited to, alleged violations of the laws of Ohio occurring before the effective date of this Consent Agreement.

ACKNOWLEDGMENTS/LIABILITY RELEASE

Dr. DeMint acknowledges that he has had an opportunity to ask questions concerning the terms of this Consent Agreement and that all questions asked have been answered in a satisfactory manner.

Any action initiated by the Board based on alleged violations of this Consent Agreement shall comply with the Administrative Procedure Act, Chapter 119., Ohio Revised Code.

Dr. DeMint hereby releases the Board, its members, employees, agents, officers and representatives jointly and severally from any and all liability arising from the within matter.

This Consent Agreement shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code. Further, this information may be reported to appropriate organizations, data banks and governmental bodies. Dr. DeMint acknowledges that his social security number will be used if this information is so reported and agrees to provide his social security number to the Board for such purposes.

EFFECTIVE DATE

It is expressly understood that this Consent Agreement is subject to ratification by the Board prior to signature by the Secretary and Supervising Member and shall become effective upon the last date of signature below.

FRANKLIN DONALD DEMINT, D.O.

8/11/09
DATE

LANCE A. TALMAGE, M.D.
Secretary

8-12-09
DATE

JAMES R. KINGSLEY
ATTORNEY FOR FRANKLIN DONALD DEMINT

8/11/09
DATE

RAYMOND J. ALBERT
Supervising Member

8/12/09
DATE

DAVID P. KATKO
Enforcement Attorney

08/12/09
DATE