DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 2012-09473
LICENSE NO.: ME0097540

JAMES M. HARDIMAN, M.D.,

Respondent.

/______________________________/

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) on August 4, 2017, in Miami, Florida, for the purpose of considering Respondent’s offer to voluntarily relinquish his license to practice medicine in the State of Florida. (Attached hereto as Exhibit A.) Said written offer of relinquishment specifically provides that Respondent agrees never again to apply for licensure as a physician in the State of Florida.

Upon consideration of the written offer of voluntary relinquishment, the charges, and the other documents of record, and being otherwise fully advised in the premises,

IT IS HEREBY ORDERED that Respondent’s Voluntary Relinquishment of his license to practice medicine in the State of Florida is hereby ACCEPTED, and shall constitute discipline upon Respondent’s license.
This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 23rd day of August, 2017.

BOARD OF MEDICINE

Claudia Kemp, J.D., Executive Director
For Magdalena Averhoff, M.D., Chair

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to JAMES M. HARDIMAN, M.D., 5606 Hawklake Road, Lithia, Florida 33547; to Allen R. Grossman, Esquire, Grossman, Furlow & Bayo, LLC, 2022-2 Raymond Diehl Road, Tallahassee, Florida 32308; by email to Allison Dudley, Associate General Counsel, Department of Health, at Allison.Dudley@flhealth.gov; and by email to Edward A. Tellechea, Chief Assistant Attorney General, at Ed.Tellechea@myfloridalegal.com this 25th day of August, 2017.

Deputy Agency Clerk
DEPARTMENT OF HEALTH, Petitioner,

v. 

JAMES M. HARDIMAN, M.D., Respondent.

DOH Case No. 2012-09473

VOLUNTARY RELINQUISHMENT OF LICENSE

Respondent JAMES M. HARDIMAN, M.D., license No. ME 97540, hereby voluntarily relinquishes Respondent’s license to practice medicine in the State of Florida and states as follows:

1. Respondent’s purpose in executing this Voluntary Relinquishment is to avoid further administrative action with respect to this cause. Respondent understands that acceptance by the Board of Medicine (hereinafter the Board)/Department of Health (hereinafter Department) of this Voluntary Relinquishment shall be construed as disciplinary action against Respondent’s license pursuant to Section 456.072(1)(f), Florida Statutes. As with any disciplinary action, this relinquishment will be reported to the National Practitioner Data Bank as disciplinary action. Licensing authorities in other states may impose discipline in their jurisdiction based on discipline taken in Florida.

2. Respondent agrees to never reapply for licensure as a physician in the State of Florida.

3. Respondent agrees to voluntarily cease practicing medicine immediately upon executing this Voluntary Relinquishment. Respondent further agrees to refrain from the
practice of medicine until such time as this Voluntary Relinquishment is presented to the Board and the Board issues a written final order in this matter.

4. In Order to expedite consideration and resolution of this action by the Board in a public meeting, Respondent, being fully advised of the consequences of so doing, hereby waives the statutory privilege of confidentiality of Section 456.073(10), Florida Statutes, regarding the complaint, the investigative report of the Department of Health, and all other information obtained pursuant to the Department's investigation in the above-styled action. By signing this waiver, Respondent understands that the record and complaint become public record and remain public record and that information is immediately accessible to the public. Respondent understands that this waiver of confidentiality is a permanent, non-revocable waiver.

5. In order to expedite consideration and resolution of this action by the Board in a public meeting, Respondent, being fully advised of the consequences of so doing hereby waives a determination of probable cause, by the Probable Cause Panel, or the Department when appropriate, pursuant to Section 456.073(4), Florida Statutes.

6. Upon the Board's acceptance of this Voluntary Relinquishment, Respondent agrees to waive all rights to seek judicial review of, or to otherwise challenge or contest the validity of, this Voluntary Relinquishment and of the Final Order of the Board incorporating this Voluntary Relinquishment.

7. Petitioner and Respondent hereby agree that upon the Board's acceptance of this Voluntary Relinquishment, each party shall bear its own attorney's fees and costs related to the prosecution or defense of this matter.
8. Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent in connection with the Board's consideration of this Voluntary Relinquishment. Respondent agrees that consideration of this Voluntary Relinquishment and other related materials by the Board shall not prejudice or preclude the Board, or any of its members, from further participation, consideration, or resolution of these proceedings if the terms of this Voluntary Relinquishment are not accepted by the Board.

DATED this 12th day of June, 2017.

STATE OF Florida
COUNTY OF Hillsborough

Before me, personally appeared James Hardiman, whose identity is known to me or who produced FL DL Exp. 2/19/2021 (type of identification) and who, under oath, acknowledges that his signature appears above.

Sworn to and subscribed before me this 12th day of June, 2017.

NOTARY PUBLIC

My Commission Expires: 3/9/19
STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

Petitioner,

v. Case No. 2012-09473

JAMES M. HARDIMAN, M.D.

Respondent.

ADMINISTRATIVE COMPLAINT

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

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

2. At all times material to this Complaint, Respondent was a licensed medical doctor within the state of Florida, having been issued license number ME 97540.

3. Respondent's address of record is 5606 Hawklake Rd., Lithia, Florida 33547.
FACTS SPECIFIC TO PATIENT E.P.

4. From on or about November 2, 2009, through on or about September 4, 2012, ("the treatment period") Respondent treated Patient E.P. for the back and leg pain with a lumbar spinal stenosis.

5. Respondent prescribed large quantities of Oxycodone APAP\(^1\), Percocet\(^2\), Oxycodone\(^3\), and Fentanyl\(^4\) to Patient E.P. during the treatment period.

6. Respondent failed to obtain, or alternatively, did not create or keep adequate documentation of obtaining an updated history on Patient E.P. during the treatment period.

7. Respondent failed to obtain, or alternatively, did not create or keep adequate documentation of obtaining an adequate periodic physical examination, including evaluations of Patient E.P.'s complaints and symptoms during the treatment period.

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

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

\(^3\) Oxycodone is commonly prescribed to treat pain. According to Section 893.03(2), Florida Statutes, oxycodone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of oxycodone may lead to severe psychological or physical dependence.

\(^4\) Fentanyl (brand names Sublimaze, Duragesic (patches), Actiq (lozenges), opioid, Schedule II, often is not included in routine drug screens). Fentanyl is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, fentanyl is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States. Abuse of fentanyl may lead to severe psychological or physical dependence.
8. Respondent did not adequately acknowledge, or did not document acknowledging, whether Patient E.P. developed a tolerance to the medications prescribed during the treatment period.

9. Respondent failed to order subsequent referrals, or failed to document referring, Patient E.P. for additional consultations and/or treatments.

10. Respondent failed to follow up on the findings or failed to document findings and/or results of Patient E.P.'s diagnostic studies, labs, referrals and procedures.

11. Respondent did not adequately justify, or did not document adequate justification for, the quantities and combinations of controlled substances prescribed to Patient E.P. during the treatment period.

12. The quantities and/or combinations of controlled substances prescribed by Respondent to Patient E.P. during the treatment period were excessive and/or inappropriate.

13. Respondent did not create or did not keep accurate, complete and legible medical records for the treatment of Patient E.P. during the treatment period.
14. Respondent failed to develop an appropriate and adequate treatment plan for Patient E.P., or alternatively, did not create or keep adequate documentation of developing the appropriate and adequate treatment plan.

15. Respondent showed a pattern of overprescribing and inappropriate prescribing to Patient E.P. overtime, with apparent deletion of prescriptions and medical records.

FACTS SPECIFIC TO PATIENT D.R.

16. From on or about October 28, 2011, through on or about May 22, 2012, ("the treatment period") Respondent treated Patient D.R., a seventeen year-old girl.

17. On multiple occasions, Respondent prescribed large quantities of Adderall\(^5\) to Patient D.R. during the treatment period.

18. Respondent failed to obtain, or alternatively, did not create or keep adequate documentation of obtaining an updated history on Patient D.R. during the treatment period.

\(^5\) Adderall (brand name for amphetamine, stimulant, Schedule II) Adderall is the brand name for a drug that contains amphetamine, commonly prescribed to treat attention deficit disorder. According to Section 893.03(2), Florida Statutes, amphetamine is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States. Abuse of amphetamine may lead to severe psychological or physical dependence.
19. Respondent failed to obtain, or alternatively, did not create or keep adequate documentation of obtaining an adequate periodic physical examination, including Patient D.R.'s complaints and symptoms during the treatment period.

20. Respondent did not adequately acknowledge, or did not document acknowledging, whether Patient D.R. developed a tolerance to the medications prescribed during the treatment period.

21. Respondent failed to order subsequent referrals, or failed to document referring, Patient D.R. for additional consultations and/or treatments.

22. Respondent failed to follow up on the findings or failed to document findings and/or results of Patient D.R.'s diagnostic studies, labs, referrals and procedures.

23. Respondent did not adequately justify, or did not document adequate justification for, the quantities of controlled substance prescribed to Patient D.R. during the treatment period.

24. The quantities of controlled substance prescribed by Respondent to Patient D.R. during the treatment period were excessive and/or inappropriate.
25. Respondent did not create or did not keep accurate, complete
and legible medical records for the treatment of Patient D.R. during the
treatment period.

26. Respondent failed to develop an appropriate and adequate
treatment plan for Patient D.R., or alternatively, did not create or keep
adequate documentation of developing the appropriate and adequate
treatment plan.

27. Respondent showed a pattern of increased overprescribing and
inappropriate prescribing to Patient D.R. overtime, with apparent deletion of
Patient D.R.'s prescriptions and medical records.

FACTS SPECIFIC TO PATIENT G.P.

28. From in or about 2009, through on or about December 30, 2012,
("the treatment period") Respondent treated Patient G.P. for a chronic
lumbar disc disease.

29. Respondent prescribed large quantities of Lortab/APAP\(^6\),
Demerol\(^7\), and Oxycodone APAP to Patient G.P. during the treatment period.

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\(^6\) Hydrocodone/APAP (brand names Vicodin, Lortab, Lorcet, opioid, Schedule III)
Hydrocodone/APAP contains hydrocodone and acetaminophen, or Tylenol and is prescribed to treat pain. According to Section 893.03(3), Florida Statutes, hydrocodone, in the dosages found in hydrocodone/APAP is a Schedule III controlled substance that has a potential for abuse less than the substances in Schedules I and II and has a currently accepted medical use in treatment in the United States. Abuse of the substance may lead to moderate or low physical dependence or high psychological dependence.

\(^7\) Meperidine (brand name Demerol, opioid, Schedule II) Meperidine, commonly known by the brand name Demerol, is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, meperidine is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States. Abuse of meperidine may lead to severe psychological or physical dependence.
30. On or about October 19, 2011, Respondent documented Patient G.P.’s prescriptions, including Lortab/APAP 10/500 mg 3120.

29. On or about April 26, 2012, Respondent documented Patient G.P.’s prescriptions for Lortab 5/500 mg #120 and Demerol 50 mg #60.

31. On or about July 20, 2011, Respondent began prescribing oxycodone APAP 10/325 #120 to Patient G.P.

32. Respondent failed to obtain, or alternatively, did not create or keep adequate documentation of obtaining an updated history on Patient G.P. during the treatment period.

33. Respondent failed to obtain, or alternatively, did not create or keep adequate documentation of obtaining an adequate periodic physical examination, including Patient G.P.’s complaints and symptoms during the treatment period.

34. Respondent did not adequately acknowledge, or did not document acknowledging, whether Patient G.P. developed a tolerance to the medications prescribed during the treatment period.

35. Respondent failed to order subsequent referrals, or failed to document referring, Patient G.P. for additional consultations and/or treatments.
36. Respondent failed to follow up on the findings or failed to document findings and/or results of Patient G.P.'s diagnostic studies, labs, referrals and procedures.

37. Respondent did not adequately justify, or did not document adequate justification for, the quantities of controlled substances prescribed to Patient D.P. during the treatment period.

38. The quantities of controlled substances prescribed by Respondent to Patient G.P. during the treatment period were excessive and/or inappropriate.

39. Respondent did not create or did not keep accurate, complete and legible medical records for the treatment of Patient G.P. during the treatment period.

40. Respondent failed to develop an appropriate and adequate treatment plan for Patient D.R., or alternatively, did not create or keep adequate documentation of developing the appropriate and adequate treatment plan.

41. Respondent showed a pattern of increased overprescribing and inappropriate prescribing to Patient D.R. overtime, with apparent deletion of Patient D.R.’s prescriptions and medical records.
FACTS SPECIFIC TO PATIENT S.R.

42. From in or about 2008, through on or about June 8, 2012, ("the treatment period") Respondent treated Patient S.R.

43. On multiple occasions, Respondent prescribed large quantities of Adderall and Oxycodone to Patient S.R.

44. On or about September 13, 2011, Respondent prescribed oxycodone 15 mg #100 and Adderall 30 mg #30 to Patient S.R. On that same day Respondent issued a duplicate prescription for oxycodone 15 mg #100 to Patient S.R., with no documentation that one prescription had been cancelled.

45. Respondent failed to obtain, or alternatively, did not create or keep adequate documentation of obtaining an updated history on Patient S.R. during the treatment period.

46. Respondent failed to obtain, or alternatively, did not create or keep adequate documentation of obtaining an adequate periodic physical examination, including Patient S.R.'s complaints and symptoms during the treatment period.
47. Respondent did not adequately acknowledge, or did not document acknowledging, whether Patient S.R. developed a tolerance to the medications prescribed during the treatment period.

48. Respondent failed to order subsequent referrals, or failed to document referring, Patient S.R. for additional consultations and/or treatments.

49. Respondent failed to follow up on the findings or failed to document findings and/or results of Patient S.R.'s diagnostic studies, labs, referrals and procedures.

50. Respondent did not adequately justify, or did not document adequate justification for, the quantities of controlled substance(s) prescribed to Patient S.R. during the treatment period.

51. The quantities of controlled substance(s) prescribed by Respondent to Patient S.R. during the treatment period were excessive and/or inappropriate.

52. Respondent did not create or did not keep accurate, complete and legible medical records for the treatment of Patient S.R. during the treatment period.
53. Respondent failed to develop an appropriate and adequate treatment plan for Patient S.R., or alternatively, did not create or keep adequate documentation of developing the appropriate and adequate treatment plan.

54. Respondent showed a pattern of increased overprescribing and inappropriate prescribing to Patient S.R. overtime, with apparent deletion of Patient S.R.'s prescriptions and medical records.

Section 458.331(1)(t)1., Florida Statutes

55. Section 458.331(1)(t)1., Florida Statutes (2011-2012), subjects a licensee to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes. Section 456.50(1)(g), Florida Statutes (2011-2012), states medical malpractice means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. Section 766.102, Florida Statutes (2011-2012), provides that the prevailing standard of care for a given healthcare provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.
56. At all times material to this complaint, the prevailing standard of care dictated that a physician treating a patient, such as Patient E.P., D.R., G.P., and/or S.R.:

(a) obtain an appropriate and complete medical history during the treatment period;

(b) perform a complete and comprehensive physical examination during the treatment period;

(c) provide an adequate diagnosis for the patient's pain generators during the treatment period;

(d) prescribe the appropriate amounts and/or combinations of drugs to determine whether the patient developed a tolerance to existing medications;

(e) adequately justify the quantities and/or combinations of controlled substances prescribed to the patient during the treatment period;

(f) obtain an updated history before each instance of providing treatment for the patient;
(g) refer the patient for additional consultations and/or treatments in order to minimize the use of controlled substances by the patient during the treatment period;

(h) perform diagnostic testing to evaluate the patient’s subjective complaints;

(i) create and implement a proper treatment plan for the patient, and/or

(j) determine the patient's pain intensity during the treatment period.

**Count I - Patient E.P.**

**Violation of Section 458.331(1)(t)1.**

57. Petitioner re-alleges and incorporates by reference paragraphs one (1) through fifteen (15) and fifty five (55) through fifty six (56) as if fully set forth herein.

58. Respondent fell below the prevailing standard of care in his treatment of Patient E.P. in one or more of the following ways:

(a) by failing to obtain a complete and updated history on Patient E.P. during the treatment period;
(b) by failing to perform an adequate periodic physical examination, including Patient E.P.'s complaints and symptoms during the treatment period;

(c) by failing to adequately acknowledge whether Patient E.P. developed a tolerance to the medications prescribed during the treatment period;

(d) by failing to order Patient E.P.'s subsequent referrals for additional consultations and/or treatments;

(e) by failing to follow up on the findings and/or results of Patient E.P.'s diagnostic studies, labs, referrals and procedures ordered by Respondent;

(f) by failing to adequately justify the quantities and combinations of controlled substances prescribed to Patient E.P. during the treatment period;

(g) by prescribing excessive and/or inappropriate quantities and/or combinations of controlled substances to Patient E.P. during the treatment period;

(h) by failing to develop an appropriate and adequate treatment plan for Patient E.P.; and/or
59. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2011-2012).

Count II — Patient D.R.
Violation of Section 458.331(1)(t)1.

60. Petitioner re-alleges and incorporates by reference paragraphs one (1) through three (3), sixteen (16) through twenty seven (27), and fifty five (55) through fifty six (56) as if fully set forth herein.

61. Respondent fell below the prevailing standard of care in his treatment of Patient D.R. In one or more of the following ways:

(a) by failing to obtain an updated history on Patient D.R. during the treatment period;

(b) by failing to obtain an adequate periodic physical examination, including Patient D.R.'s complaints and symptoms during the treatment period.;

(c) by failing to adequately acknowledge whether Patient D.R. developed a tolerance to the medications prescribed during the treatment period;

(d) by failing to order Patient D.R.'s subsequent referrals for additional consultations and/or treatments;
(e) by failing to follow up on the findings and/or results of Patient D.R.'s diagnostic studies, labs, referrals and procedures;

(f) by failing to adequately justify the quantities of controlled substances prescribed to Patient D.R. during the treatment period;

(g) by prescribing excessive and/or inappropriate quantities and/or combinations of controlled substances to Patient D.R. during the treatment period;

(h) by failing to develop an appropriate and adequate treatment plan for Patient D.R.;

62. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2009-2012).

Count III — Patient G.P.
Violation of Section 458.331(1)(t)1.

63. Petitioner re-alleges and incorporates by reference paragraphs one (1) through three (3), twenty eight (28) through forty one (41), and fifty five (55) through fifty six (56) as if fully set forth herein.

64. Respondent fell below the prevailing standard of care in his treatment of Patient G.P. in one or more of the following ways:
(a) by failing to obtain an updated history on Patient G.P. during the treatment period;

(b) by failing to obtain an adequate periodic physical examination, including Patient G.P.'s complaints and symptoms during the treatment period;

(c) by failing to adequately acknowledge whether Patient G.P. developed a tolerance to the medications prescribed during the treatment period;

(d) by failing to order Patient G.P.'s subsequent referrals for additional consultations and/or treatments;

(e) by failing to follow up on the findings and/or results of Patient G.P.’s diagnostic studies, labs, referrals and procedures;

(f) by failing to adequately justify the quantities of controlled substances prescribed to Patient G.P. during the treatment period;

(g) by prescribing excessive and/or inappropriate quantities and/or combinations of controlled substances to Patient G.P. during the treatment period;
by failing to develop an appropriate and adequate treatment plan for Patient G.P.;

65. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2009-2012).

Count IV – Patient S.R.
Violation of Section 458.331(1)(t)1.

66. Petitioner re-alleges and incorporates by reference paragraphs one (1) through three (3), forty two (42) through fifty six (56) as if fully set forth herein.

67. Respondent fell below the prevailing standard of care in his treatment of Patient S.R. in one or more of the following ways:

(a) by failing to obtain an updated history on Patient S.R. during the treatment period;

(b) by failing to obtain an adequate periodic physical examination, including Patient S.R.'s complaints and symptoms during the treatment period;

(c) by failing to adequately acknowledge whether Patient S.R. developed a tolerance to the medications prescribed during the treatment period;
(d) by failing to order Patient S.R.'s subsequent referrals for additional consultations and/or treatments;

(e) by failing to follow up on the findings and/or results of Patient S.R.'s diagnostic studies, labs, referrals and procedures;

(f) by failing to adequately justify the quantities of controlled substances prescribed to Patient S.R. during the treatment period;

(g) by prescribing excessive and/or inappropriate quantities and/or combinations of controlled substances to Patient S.R. during the treatment period;

(h) by failing to develop an appropriate and adequate treatment plan for Patient S.R.;

68. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2009-2012).

Section 458.331(1)(q), Florida Statutes

69. Section 458.331(1)(q), Florida Statutes (2011-2012), subjects a licensee to discipline for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other
than in the course of the physician's professional practice. For the purposes of the paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his or her intent.

**Count V – Patient E.P.**

**Violation of Section 458.331(1)(q)**

70. Petitioner realleges and incorporates paragraphs one (1) through fifteen (15) and paragraph sixty nine (69) as if fully set forth herein.

71. Respondent prescribed controlled substances to Patient E.P. inappropriately or in excessive or inappropriate quantities during the treatment period.

72. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2011-2012).

**Count VI – Patient D.R.**

**Violation of Section 458.331(1)(q)**

73. Petitioner realleges and incorporates paragraphs one (1) through three (3), sixteen (16) through twenty seven (27) and paragraph sixty nine (69) as if fully set forth herein.
74. Respondent prescribed controlled substances to Patient D.R. inappropriately or in excessive or inappropriate quantities during the treatment period.

75. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2011-2012).

Count VII – Patient G.P.
Violation of Section 458.331(1)(q)

76. Petitioner realleges and incorporates paragraphs one (1) through three (3), twenty eight (28) through forty one (41) and paragraph sixty nine (69) as if fully set forth herein.

77. Respondent prescribed controlled substances to Patient G.P. inappropriately or in excessive or inappropriate quantities during the treatment period.

78. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2011-2012).

Count VIII – Patient S.R.
Violation of Section 458.331(1)(q)

79. Petitioner realleges and incorporates paragraphs one (1) through three (3), forty two (42) through fifty four (54) and paragraph sixty nine (69) as if fully set forth herein.
80. Respondent prescribed controlled substances to Patient S.R. inappropriately or in excessive or inappropriate quantities during the treatment period.

81. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2011-2012).

Section 458.331(1)(m), Florida Statutes

82. Section 458.331(1)(m), Florida Statutes (2011-2012), subjects a licensee to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultation and hospitalizations.

83. Section 458.331(1)(nn), Florida Statutes (2011-2012), subjects a licensee to discipline for violation of any provision of Chapter 458 or Chapter 456, or any rules adopted pursuant thereto.
84. Rule 64B8-9.003, Florida Administrative Code (2014), is an administrative rule adopted pursuant to Chapter 458, Florida Statutes.

85. Rule 64B8-9.003, Florida Administrative Code (2009-2012), provides in pertinent part:

(2) A licensed physician shall maintain patient medical records in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.

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

Count IX — Patient E.P.
Violation of Section 458.331(1)(m)

86. Petitioner re-alleges and incorporates by reference paragraphs one (1) through fifteen (15), eighty (80) through eighty five (85) as if fully set forth herein.

87. In the alternative to the allegations in paragraph 58, Respondent failed to create, keep, and/or maintain records that justify the course of treatment of Patient E.P. by failing to:
(a) create or keep adequate documentation of obtaining an updated history on Patient E.P. during the treatment period;

(b) create or keep adequate documentation of obtaining an adequate periodic physical examination, including Patient E.P.'s complaints and symptoms during the treatment period;

(c) create, keep, and/or maintain medical records acknowledging, whether Patient E.P. developed a tolerance to the medications prescribed during the treatment period;

(d) document referring Patient E.P. for additional consultations and/or treatments;

(e) document findings and/or results of Patient E.P.'s diagnostic studies, labs, referrals and procedures ordered by Respondent;

(f) document adequate justification for, the quantities and combinations of controlled substances prescribed to Patient E.P. during the treatment period;
(g) create, keep, and/or maintain medical records evidencing that Respondent performed diagnostic testing to evaluate Patient E.P.'s subjective complaints;

(h) create or keep adequate documentation of developing the appropriate and adequate treatment plan for Patient E.P.;

and/or

(l) create, keep, and/or maintain accurate, complete and/or legible medical records for the treatment of Patient E.P.

88. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2011-2012), and/or Respondent violated Section 458.331(1)(nn), Florida Statutes (2011-2012) through a violation of Rule 64B8-9.003, Florida Administrative Code (2011-2012).

**Count X – Patient D.R.**

**Violation of Section 458.331(1)(m)**

89. Petitioner realleges and incorporates paragraphs one (1) through three (3), sixteen (16) through twenty seven (27) and paragraph eighty (80) through eighty five (85) as if fully set forth herein.

90. In the alternative to the allegations in paragraph 61, Respondent failed to create, keep, and/or maintain records that justify the course of treatment of Patient D.R. by failing to:
(a) create or keep adequate documentation of obtaining an updated history on Patient D.R. during the treatment period;

(b) create or keep adequate documentation of obtaining an adequate periodic physical examination, including Patient D.R.'s complaints and symptoms during the treatment period;

(c) create, keep, and/or maintain medical records acknowledging, whether Patient D.R. developed a tolerance to the medications prescribed during the treatment period;

(d) document referring Patient D.R. for additional consultations and/or treatments;

(e) document findings and/or results of Patient D.R.'s diagnostic studies, labs, referrals and procedures ordered by Respondent;

(f) document adequate justification for, the quantities and combinations of controlled substance prescribed to Patient D.R. during the treatment period;
(g) create, keep, and/or maintain medical records evidencing that Respondent performed diagnostic testing to evaluate Patient D.R.'s subjective complaints;

(h) create or keep adequate documentation of developing the appropriate and adequate treatment plan for Patient D.R.; and/or

(i) create, keep, and/or maintain accurate, complete and/or legible medical records for the treatment of Patient D.R.

91. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2011-2012), and/or Respondent violated Section 458.331(1)(nn), Florida Statutes (2011-2012) through a violation of Rule 64B8-9.003, Florida Administrative Code (2011-2012).

Count XI — Patient G.P.
Violation of Section 458.331(1)(m)

92. Petitioner re-alleges and Incorporates by reference paragraphs one (1) through three (3), twenty eight (28) through forty one (41) and paragraph eighty (80) through eighty five (85) as if fully set forth herein.

93. In the alternative to the allegations in paragraph 64, Respondent failed to create, keep, and/or maintain records that justify the course of treatment of Patient G.P. by failing to:
(a) create or keep adequate documentation of obtaining an updated history on Patient G.P. during the treatment period;

(b) create or keep adequate documentation of obtaining an adequate periodic physical examination, including Patient G.P.'s complaints and symptoms during the treatment period;

(c) create, keep, and/or maintain medical records acknowledging, whether Patient G.P. developed a tolerance to the medications prescribed during the treatment period;

(d) document referring Patient G.P. for additional consultations and/or treatments;

(e) document findings and/or results of Patient G.P.'s diagnostic studies, labs, referrals and procedures ordered by Respondent;

(f) document adequate justification for, the quantities and combinations of controlled substance prescribed to Patient G.P. during the treatment period;
(g) create, keep, and/or maintain medical records evidencing that Respondent performed diagnostic testing to evaluate Patient G.P.'s subjective complaints;

(h) create or keep adequate documentation of developing the appropriate and adequate treatment plan for Patient G.P.; and/or

(i) create, keep, and/or maintain accurate, complete and/or legible medical records for the treatment of Patient G.P.

94. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2011-2012), and/or Respondent violated Section 458.331(1)(nn), Florida Statutes (2011-2012) through a violation of Rule 64B8-9.003, Florida Administrative Code (2011-2012).

**Count XII — Patient S.R.**

**Violation of Section 458.331(1)(m)**

95. Petitioner re-alleges and incorporates by reference paragraphs one (1) through three (3), forty two (42) through fifty four (54) and paragraph eighty (80) through eighty five (85) as if fully set forth herein.

96. In the alternative to the allegations in paragraph 67, Respondent failed to create, keep, and/or maintain records that justify the course of treatment of Patient S.R. by failing to:
(a) create or keep adequate documentation of obtaining an updated history on Patient S.R. during the treatment period;

(b) create or keep adequate documentation of obtaining an adequate periodic physical examination, including Patient S.R.'s complaints and symptoms during the treatment period;

(c) create, keep, and/or maintain medical records acknowledging, whether Patient S.R. developed a tolerance to the medications prescribed during the treatment period;

(d) document referring Patient S.R. for additional consultations and/or treatments;

(e) document findings and/or results of Patient S.R.'s diagnostic studies, labs, referrals and procedures ordered by Respondent;

(f) document adequate justification for, the quantities and combinations of controlled substance prescribed to Patient S.R. during the treatment period;
(g) create, keep, and/or maintain medical records evidencing that Respondent performed diagnostic testing to evaluate Patient S.R.’s subjective complaints;

(h) create or keep adequate documentation of developing the appropriate and adequate treatment plan for Patient S.R.; and/or

(i) create, keep, and/or maintain accurate, complete and/or legible medical records for the treatment of Patient S.R.

97. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2011-2012), and/or Respondent violated Section 458.331(1)(nn), Florida Statutes (2011-2012) through a violation of Rule 64B8-9.003, Florida Administrative Code (2011-2012).

WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent’s license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.
SIGNED this 16 day of May, 2017.

Celeste Philip, M.D., M.P.H.
Surgeon General and Secretary

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