BEFORE THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS

IN MEDICINE AND SURGERY

IN THE MATTER OF: **MICHAEL SHELL, D.O.** Holder of License No. **2921** For the practice of osteopathic medicine in the State of Arizona	**Case No.: DO-15-0289A** **CONSENT AGREEMENT AND ORDER FOR PROBATION**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Board of Osteopathic Examiners in Medicine and Surgery ("Board") and Michael Shell, D.O. ("Respondent"), the parties agree to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. Respondent admits to the findings of fact and conclusions of law contained in the Consent Agreement and Order.

5. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

7. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Board's website.

8. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

9. If the Board does not adopt this Consent Agreement, (1) Respondent will not assert as a defense that the Board's consideration of the Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense; and (2) the Board will not consider content of this Consent Agreement as an admission by Respondent.

REVIEWED AND ACCEPTED THIS 10 DAY OF December 2016.

Michael Shell, DO

Michael Shell, D.O.

JURISDICTIONAL STATEMENT

1. The Board is empowered, pursuant to A.R.S. § 32-1800, *et seq.* to regulate the licensing and practice of osteopathic medicine in the State of Arizona.

2. Respondent holds license No. 2921 issued by the Board to practice as an osteopathic physician.

FINDINGS OF FACT

1. The Board initiated case DO-15-0289A after receiving a notice of an action taken against Respondent's license in Colorado.

2. The Colorado Medical Board found the following:

a. That on or about December 4, 2006, through September 4, 2012, Respondent provided medical care in the form of pain management for patient B.B. At different times, Respondent treated B.B. with opioids, including ones containing oxycodone, morphine and hydrocodone.

b. During the course of treatment provided by Respondent for B.B., Respondent failed to adequately document his review of earlier physician pain management records for B.B. to ascertain prior treatments and responses with either interventions or medications, as well as possible signs of aberrant behavior.

c. During the course of treatment provided by Respondent for B.B., B.B. had several negative urine drug screens, suggestive of diversion and/or abuse, which should have generated more stringent monitoring by Respondent.

d. During the course of treatment provided by Respondent for B.B., and as a result of Respondent's monitoring efforts, Respondent received notice of B.B.'s use of marijuana during this time frame and of B.B.'s use of medications not prescribed by Respondent, which should have raised questions regarding compliance with medications and/or abuse or diversion of medications. Respondent continued to treat B.B. by prescribing multiple opioids while continuing monitoring efforts.

e. On or about September 4, 2012, B.B. died as a result of morphine and oxycodone intoxication. On autopsy, on the dorsal ankle and foot overlying the posterior tibial vein and left popliteal vein is a linear array of needle punctures indicating misuse/abuse of his medications.

f. Respondent's pain management medical care and the documentation of his medical care of B.B. were at times substandard.

g. On or about April 27, 2011 through December 27, 2012, Respondent provided medical care in the form of pain management for patient J.G. At different times and in different combinations, Respondent treated J.G.'s pain, anxiety and panic attacks with medications including, MS Contin, hydrocodone/acetaminophen, Ativan, carisoprodol, Roxicodone, Xanax, Neurontin BuSpar and Zanaflex.

h. During the course of treatment provided by Respondent for J.G., Respondent failed to adequately document his review of earlier physician pain management records for J.G. to ascertain prior treatments and responses with either interventions or medications, as well as possible signs of aberrant behavior.

i. During the course of treatment provided by Respondent for J.G., Respondent failed to adequately refer to the Physician Drug Monitoring Program ("PDMP") despite the use of chronic opioid therapy with the addition of other potentially addicting medications such as Ativan or soma. It appears that J.G. was obtaining prescriptions from other providers, which is not referenced by Respondent in his records.

j. During the course of treatment provided by Respondent for J.G., J.G. had several "red flags" associated with chronic opioid care, such as a result of a stolen prescription, that J.G.'s wife had used his medication, and requests for early refills, all of which can be suggestive of diversion and/or abuse.

k. On or about December 28, 2012, J.G. died as a result of an accidental overdose.

l. Respondent's pain management medical care and the documentation of his medical care of J.G. were at times substandard.

m. On or about July 29, 2008 through January 10, 2014, Respondent provided medical care in the form of pain management for patient D.O. During these years of treatment, Respondent treated D.O. at different times with opioids, including those

containing hydrocodone, fentanyl, Morphine, Dilaudid, and oxycodone. In addition, Respondent treated D.O.'s pain and anxiety with, methylprednisolone and Ambien.

n. During the course of treatment provided by Respondent for D.O., the medical records do not reflect Respondent's typical practice of obtaining an initial informed consent for chronic pain management and an opioid contract for new patients.

o. During the course of treatment provided by Respondent for D.O., Respondent did not recognize D.O.'s deceptive behavior in obtaining prescription medications from multiple providers by referring to the PDMP until March 2013.

p. During the course of treatment provided by Respondent for D.O., D.O. had several "red flags" associated with chronic opioid misuse, such as a report of stolen medications and reference in the PDMP which indicated that D.O. was being provided medications from three (3) different providers, which are suggestive of diversion and/or abuse.

q. Respondent's pain management medical care and the documentation of his medical care of D.O. were at times substandard.

r. On or about July 31, 2007 through January 15, 2014, Respondent provided medical care in the form of pain management for patient T.N. At different times, Respondent treated T.N.'s chronic pain with opioids containing morphine, hydrocodone and oxycodone.

s. During the course of treatment provided by Respondent for T.N. objective testing showed only degenerative changes with no ongoing pathology consistent with T.N.'s subjective complaints of low back pain.

t. During the course of treatment provided by Respondent for T.N., T.N. had several "red flags" associated with chronic opioid misuse, requests for and actually obtaining early refills and a notation that T.N. has presented the same prescriptions to multiple pharmacies on the same day, which are suggestive of diversion and/or abuse.

u. Respondent's pain management medical care and the documentation of his medical care of T.N. were at times substandard.

CONCLUSIONS OF LAW

1. Pursuant to A.R.S. § 32-1800, *et seq.* the Board has subject matter and personal jurisdiction in this matter.

2. The conduct and circumstances as described in the paragraphs above, constitute unprofessional conduct as defined in the following paragraphs of A.R.S. § 32-1854:

> (6) Engaging in the practice of medicine in a manner that harms or may harm a patient or that the Board determines falls below the community standard.
>
> (18) The denial of or disciplinary action against a license by any other state, territory, district or country, unless it can be shown that this occurred for reasons that did not relate to the person's ability to safely and skillfully practice osteopathic medicine or to any act of unprofessional conduct as provided in this section.
>
> (38) Any conduct or practice that endangers a patient's or the public's health or may reasonably be expected to do so.

ORDER

Pursuant to the authority vested in the Board, **IT IS HEREBY ORDERED** that Michael Shell, D.O, holder of osteopathic medical License number 2921, voluntarily agrees to the following:

1. Respondent shall comply with any and all terms of the Stipulation and Final Agency Order issued by the Colorado Medical Board on December 4, 2015.

2. Respondent shall not apply for or obtain a DEA registration in Arizona without receiving prior approval by the Board.

3. Respondent's Arizona license, no. 2921 is placed on PROBATION for a minimum period of three (3) years. Respondent shall petition the Board for termination of this Consent Agreement and Order.

4. Any modifications to Stipulation and Final Agency Order issued by the Colorado Medical Board on December 4, 2015, shall have no effect on this Consent Agreement and Order for Probation. In addition, Respondent must seek termination of this Consent Agreement and Order from the Board.

4. Any costs of compliance with this Order are to be borne by Respondent.

5. Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in the State of Arizona.

6. Respondent shall appear in person before the Board or Board staff for interviews upon request, upon reasonable notice.

7. Respondent shall notify the Board within ten (10) days, in writing, of any change in office or home addresses and telephone numbers.

8. Respondent's failure to comply with the requirements of this Order shall constitute an allegation of unprofessional conduct as defined at A.R.S. § 32-1854(25); proven violations may be grounds for further disciplinary action (e.g., suspension or revocation of license).

9. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effective.

ISSUED THIS 14th DAY OF December, 2016.
STATE OF ARIZONA
BOARD OF OSTEOPATHIC EXAMINERS
IN MEDICINE AND SURGERY

By: _____
Jenna Jones, Executive Director

Original filed this 14th day of December, 2016 with the:

Arizona Board of Osteopathic Examiners
In Medicine and Surgery
9535 East Doubletree Ranch Road
Scottsdale AZ 85258-5539

Copy of the foregoing sent via certified mail, return receipt requested this 14th day of December, 2016 to:

Scott King, Esq.
Broening Oberg Woods & Wilson
Address of record

Copy of the foregoing sent via regular mail this 14th day of December, 2016 to:

Michael Shell, D.O.
Address of Record

And

Jeanne Galvin, AAG
Office of the Attorney General SGD/LES
1275 West Washington
Phoenix AZ 85007