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DEPARTMENT OF JUSTICE
Drug Enforcement Administration

[Docket No. 16-25]
Garrett Howard Smith, M.D.
Decision and Order

On June 13, 2016, the Deputy Assistant Administrator, of the then Office of Diversion Control, issued an Order to Show Cause to Garrett Howard Smith, M.D. (hereinafter, Respondent), of Southfield, Michigan. ALJ Ex. 1, at 1. The Show Cause Order proposed the revocation of Respondent's Certificate of Registration, the denial of any pending applications to renew or modify his registration, and the denial of any applications for any other registration, on the ground that his "registration is inconsistent with the public interest." *Id*. (citing 21 U.S.C. §§ 824(a)(4) & 823(f)).

With respect to the Agency's jurisdiction, the Show Cause Order alleged that Respondent is registered as a practitioner in schedules II through V, pursuant to Certificate of Registration No. FS2592005, at the registered address of 29193 Northwestern Highway, Suite 571, Southfield, Michigan. *Id*. The Order also alleged that Respondent's "registration expires by its terms on February 28, 2017." *Id*.

As to the substantive grounds for the proceeding, the Show Cause Order alleged that Respondent "failed to comply with Federal and state laws relating to the prescribing of controlled substances by issuing purported 'prescriptions' outside the usual course of professional practice or for other than a legitimate medical purpose." *Id*. at 2 (citing 21 U.S.C. § 841(a), 21 CFR 1306.04, Mich. Comp. Laws §§ 333.7333(1), (3), & (4), 333.7405(1)(a)). The Show Cause Order then alleged that in three instances, Respondent unlawfully prescribed

controlled substances to two undercover investigators (hereinafter, BCI 1 and BCI 2) for Blue Cross/Blue Shield of Michigan. *Id*. at 2-3.

As to the first such instance, the Show Cause Order alleged that on February 19, 2015, Respondent prescribed to BCI 1, 65 dosage units of Norco 7.5/325 mg (hydrocodone), a schedule II controlled substance, as well as 60 Xanax .5 mg (alprazolam) and 30 Soma 350 mg (carisoprodol), the latter two drugs being schedule IV controlled substances. *Id*. at 2. The Show Cause Order also alleged that each of the prescriptions did not include information required under 21 CFR 1306.05(a) and (f), as they did not contain the patient's address. *Id*.

As to the second instance, the Show Cause Order alleged that on March 19, 2015, BCI 1 returned to Respondent's office "for a follow-up visit" and that Respondent again provided him with prescriptions for 65 dosage units of Norco 7.5/325 mg, 60 Xanax .5 mg, and 30 Soma 350 mg. *Id.* at 2-3. The Order again alleged that each of the prescriptions did not include information required under 21 CFR 1306.05(a) and (f), as they did not contain the patient's address. *Id*. at 3.

As to the third instance, the Show Cause Order alleged that on March 19, 2015, BCI 2 "presented for an office visit at" Respondent's office and "asked for refills of . . . prescriptions for Norco and Soma previously issued by another physician at the clinic . . . on February 20, 2015." *Id*. at 3. The Order alleged that Respondent issued BCI 2 prescriptions for 60 Norco 5/325 mg and 60 Soma 350 mg. *Id.* The Order again alleged that each prescription did not include information required under 21 CFR 1306.05(a) and (f), as they did not contain the patient's address.[1] *Id*.

[1] The Show Cause Order also made detailed factual allegations as to various acts performed by Respondent and the office staff as well as the statements made by Respondent and the Investigators at each of the visits. ALJ Ex. 1, at 2-3.

The Show Cause Order notified Respondent of his right to request a hearing on the allegations or to submit a written statement of position while waiving his right to a hearing, the procedure for electing either option, and the consequence of failing to elect either option. *Id*. at 3-4. The Show Cause Order also notified Respondent of his right to submit a corrective action plan pursuant to 21 U.S.C. § 824(c)(2)(C). *Id*. at 1, 4.

On July 13, 2016, Respondent, through his counsel, requested a hearing on the allegations. ALJ Ex. 2. The matter was placed on the docket of the Office of Administrative Law Judges and assigned to Chief Administrative Law Judge John J. Mulrooney, II (hereinafter, CALJ), who conducted pre-hearing procedures. ALJ Ex. 3. Following pre-hearing procedures, the CALJ conducted an evidentiary hearing on November 29-30, 2016 in Detroit, Michigan, after which both parties submitted briefs containing their proposed findings of fact and conclusions of law. Recommended Decision, at 2. Moreover, while the matter was pending the issuance of the Recommended Decision, the Government notified the CALJ that, on December 16, 2016, the Director of the Michigan Department of Licensing and Regulatory Affairs Bureau of Professional Licensing temporarily suspended his medical license thus rendering him without authority to handle controlled substances in the State of Michigan. *Id*. at 86.

On February 8, 2017, the CALJ issued his Recommended Decision. Therein, the CALJ found proved the allegations that all of the prescriptions issued to both undercover investigators "were issued outside of the usual course of professional practice, for no legitimate medical purpose, and outside the professional standards of a Michigan controlled substance prescriber." *Id*. at 80 (Feb. 19, 2015 prescriptions issued to BCI 1); *see also id*. at 82 (Mar. 19, 2015 prescriptions issued to BCI 1); *id*. at 84 (Mar. 19, 2015 prescriptions issued to BCI 2). The

CALJ further noted that "the record evidence of the three undercover visits under Factors 2 and 4 militates powerfully in favor of the revocation sanction sought by the Government." *Id*. at 85.

The CALJ also found proved the allegations that Respondent failed to include the patient's addresses on each of the eight prescriptions he issued to the two undercover investigators. *Id.* The CALJ further found that Respondent's failure to include the addresses violated 21 CFR 1306.05(a) and (f) and that these violations "weigh in some support of a sanction under Public Interest Factor 4." *Id*. at 85-86.

Finally, the CALJ found that "the parties have stipulated that the Respondent's Michigan medical license is currently suspended." *Id*. at 90. The CALJ rejected Respondent's claim that his lack of state authority could not be "properly considered against him in this matter because the allegation was not included in the" Show Cause Order. *Id*. at 86. The CALJ explained that notwithstanding the lack of notice in the Show Cause Order or the pleadings, "the Respondent here was put on notice of this essentially legal issue, and has had an opportunity to respond to the allegation that he lacks state authority." *Id*. at 88. The CALJ also rejected Respondent's contention that the Director of the Department of Licensing and Regulatory Affairs "is not 'a competent state authority'" within the meaning of 21 U.S.C. § 824(a)(3) because he "'does not have the ability to suspend, revoke, or otherwise discipline a license without a full vote of the Disciplinary Subcommittee,'" noting that Respondent "concede[d] that the Director does have authority to summarily suspend" and that, under agency precedent, the issue is whether he is currently authorized under state law to dispense controlled substances. *Id*. at 89. The CALJ thus found that because "Respondent does not presently possess the requisite authority to maintain his DEA registration, Agency precedent "compels the revocation of" his registration. *Id*. at 90.

The CALJ also addressed whether Respondent's prescribing of controlled substances supported a sanction. Noting that "the Government has met its *prima facie* burden of proving that the requirements for revocation or suspension . . . are satisfied," the CALJ found that Respondent did not "offer[] an unequivocal acceptance of responsibility," that he "offered excuses for his conduct that smacked more of contrivance than contrition, and lacked any present indication of remedial steps beyond not desiring to practice pain medicine in the future." *Id*. at 91. While noting that "the actual tally of transgressions on the present record is by no means overwhelming," and that "had this record presented a registrant who signaled at least some indication that he had committed serious errors in judgment, a persuasive argument could be made for a sanction short of revocation," the CALJ explained that this "was not the case here." *Id.* at 92.

The CALJ then concluded that "the issue of [specific] deterrence favors revocation of the Respondent's [registration] because he still remains committed to the concept that he acted within the bounds of his responsibilities as a registrant." *Id*. The CALJ subsequently observed that:

> [i]t was clear in the undercover recordings that this Respondent was not engaging in a thorough physical examination or asking probing, sincere questions regarding symptoms present in the two undercover investigators that would warrant pain medicine; he was merely exchanging a few pleasantries and going through some meaningless motions prior to doling out the medications that he knew he was giving-and the patients knew they were getting-from the moment they walked into the office. Specific deterrence is best served by revocation here.

Id. at 92-93.

With respect to the Agency's interest in general deterrence, the CALJ concluded that "[t]o impose a sanction short of revocation on these facts would send a message to the regulated community that the plausible deniability that comes from walking into a practice as a *locum*

tenens with no preparation can act as a shield to insulate a practitioner from consequences for failing to execute the responsibilities of a DEA registration in deterring diversion. . . . [A] sanction that falls short of revocation here . . . would communicate to the regulated community that there is no meaningful consequence to handing out powerful medications based on little more than small talk." *Id*. at 93.

The CALJ also concluded that Respondent's misconduct "does not present a picture of a lack of due care borne of a harried physician keeping up with the demands of practice, or an isolated blunder that has its genesis in lack of training; but rather, . . . measured, calculated decisions to issue powerful controlled substances backed up by little more than incomplete charts, vague answers, and casual banter and made in the face of talk of trading drugs and the street value of the medications." *Id*. Continuing, the CALJ explained that "[f]or a DEA registrant, the answer to a deficit of records and questionable patient responses cannot be to prescribe anyway and sort matters out at some future date." *Id*. at 93-94. The CALJ thus concluded that Respondent's misconduct "was sufficiently egregious to merit the sanction of revocation." *Id*. The CALJ recommended that Respondent's registration be revoked and that any pending application for renewal be denied. *Id.*

Neither party filed exceptions to the CALJ's Recommended Decision. Thereafter, the CALJ forwarded the record to my Office for Final Agency Action.

Having considered the record in its entirety, I adopt the CALJ's factual findings including his credibility determinations, his conclusions of law, and his recommendation that I revoke Respondent's registration and deny any pending application to renew his registration. I make the following factual findings.

FINDINGS OF FACT

Respondent is a medical doctor licensed by the Michigan Board of Medicine. While on December 13, 2016, the Board summarily suspended Respondent's medical license, on February 16, 2017 (eight days after the CALJ issued his Recommended Decision and well before the record was forward to my Office), the Board's Disciplinary Subcommittee and the Board entered into a Consent Order and Stipulation with Respondent.[2] Under the Consent Order, the Board found "that the allegations of fact contained in the complaint are true and that Respondent has violated section 16221(a) of the Public Health code." *Id*. at 2.

As a consequence, the Board placed Respondent on probation for a period of two years from the effective date of the Order. *Id*. As one of the terms of the Consent Order, Respondent agreed that he "shall not obtain, possess, prescribe, dispense or administer any drug designated as a controlled substance under the Public Health Code or its counterpart in federal law except in a hospital or other institutional setting." *Id*. In addition to imposing a variety of additional probationary terms, the Board fined Respondent $7,500. *Id.* at 5. The parties, however, also agreed to the dissolution of the summary suspension. *Id*. at 1.

Respondent also previously held DEA Certificate of Registration No. FS2592005, pursuant to which he was authorized to dispense controlled substances in schedules II through V, at the registered address of 29193 Northwestern Hwy., Suite 571, Southfield, Michigan. R.D. 3 (Stipulation of Fact No. 1). The expiration date of this registration was February 28, 2017. *Id*. According to the registration records of this Agency, of which I also take official notice, Respondent did not submit a renewal application until March 16, 2017, after the expiration date

[2] I take official notice of the Consent Order and Stipulation entered by Respondent with the Board on February 16, 2017. *See* 5 U.S.C. § 556(e). The parties are entitled to refute the findings based on the Consent Order and Stipulation by filing a properly supported motion for reconsideration within 10 business days of the issuance of this decision. It is further noted that while the CALJ's order directing the parties to "provide timely updates to this tribunal regarding any developments" pertaining to the status of Respondent's state license lapsed upon issuance of the Recommended Decision, ALJ Ex. 29, it is perplexing that neither party notified this Office that the summary suspension had been dissolved on February 16, 2017.

of his registration. I therefore find that Respondent's renewal application was untimely and that his registration expired on February 28, 2017. *See* 21 CFR 1301.36(i). I further find, however, that Respondent's March 16, 2017 application remains pending before the Agency.[3] *See Paul Volkman*, 73 FR 30641, 30644 (2008), *pet. for rev. denied*, *Volkman v. DEA*, 567 F.3d 215, 225 (6th Cir. 2009).

The Investigation of Respondent

This investigation arose out of the investigation of another physician (Dr. Vora), who, the Chief of Police of Gladwin, Michigan suspected was issuing prescriptions that lacked a legitimate medical purpose. Tr. 37. Because the physicians in the town knew local police officers[4] and the officers could not "do any undercover work," an officer with the Gladwin Police Department contacted James Howell, an investigator for Michigan Blue Cross/Blue Shield (hereinafter, BC) who the Chief had met at a state drug diversion conference, as they had "the tools to do" undercover work. *Id*. at 21. Mr. Howell (hereinafter, BCI 1[5]) agreed to assist the Gladwin Police by performing undercover visits to Dr. V's clinic; Jill Kraczon, a second BC Investigator (hereinafter, BCI 2[6]) also made several visits to the clinic.

BCI 1's Visits

[3] The parties are also entitled to refute the findings with respect to Respondent's registration status and application by filing a properly supported motion for reconsideration within 10 business days of the issuance of this decision.

[4] According to the Chief of the Gladwin Police Department, the Department has four full-time officers and six part-time officers. Tr. 21.

[5] Mr. Howell (BCI 1) had previously been employed by the Lincoln Park, Michigan Police Department for twenty-three years, where he did "all type[s] of police work including uniform patrol, detective work, undercover work, [and] violent crime investigations," retiring with the rank of lieutenant. Tr. 58. He testified that he had "attended a basic drug diversion school" which "was put on by the National Association of Drug Diversion Investigators," as well as "over 40 hours of training in other drug diversion seminars." *Id*. at 58-59.

[6] Ms. Kraczon (BCI 2) testified that prior to working for BC she had been a police officer with the Lansing Police Department for 16 years and that she had done undercover work for the last three years of her employment with the Department which included "over prescribing doctor cases." Tr. 190. She also testified that she had professional training with the National Association of Drug Diversion Investigators, as well as in-house training with Blue Cross, and had "done over 100 undercovers at Blue Cross." *Id*.

Using the name of James Howard, on November 10, 2014, BCI 1 made his first visit to the clinic. There, he completed an authorization for the release of his records from one Dr. Lindsay, a "Controlled Substances Management Agreement," a Medical History Form (on which he did not check any of the symptoms but did list Xanax as a medication he was currently taking), as well as other forms including one on which he noted that the reason for his visit was "refills." GX 10, at 14, 16-17, 19-20.

At this visit, BCI I saw Dr. Vora. GX 10, at 5-6. Dr. Vora created a visit note which documented BCI 1's chief complaints as including anxiety, back pain, and back stiffness; the note also listed vital signs, a history, a review of systems and various physical examination findings. *Id*. at 5. However, the physical exam section contained no findings as to the Investigator's back. *Id*. Nor were there any findings as to the Investigator's psychiatric condition.

As the treatment plan, Dr. Vora simply noted "Follow Up" and "After 1 month(s)." *Id*. at 5-6. Although the progress note for this visit does not list any prescriptions, the patient file includes copies of prescriptions issued by Dr. Vora to BCI 1for 60 Norco 7.5 mg and 60 Xanax 0.5 mg which are dated "11-10-14." *Id*. at 21. BCI 1's patient file also includes a copy of a report from the Michigan Automated Prescription System dated "10/20/2014." *Id*. at 23. It shows that James Howard had obtained alprazolam from four different providers, including one in Marquette, one in Detroit, and two with different addresses in Flint; the report also shows that one of the providers from Flint had also prescribed amphetamines to Howard. *Id*.

On December 15, 2014, BCI 1 again saw Dr. Vora, who noted that the former's "[p]roblem [l]ist" included both back pain and anxiety (both with an onset date of "12/15/2014"), as well as generalized anxiety disorder and lumbar paraspinal muscle spasm. *Id*. at 3. In the

Review of Systems section of the visit note, Dr. Vora made negative findings[7] except for with respect to "lower back pain" and "endocrinology anxiety." *Id.*

In the physical examination section, Dr. Vora documented findings of "lumbar spine point tenderness," "TTP L/S spine, pain with flexion/extension[,] Negative SLR [straight leg raise], No weakness with Toe/Heel walk b/l)." *Id*. at 4. Dr. Vora listed diagnoses of generalized anxiety disorder and lumbar paraspinal muscle spasm. *Id*. His treatment plan included an X-Ray of the Investigator's lumbar spine, a recommendation to BCI 1to ice his back for 20 minutes two to three times per day, and four prescriptions, including for 60 Norco 7.5/325 mg, 60 Xanax .5 mg, and two non-controlled drugs. *Id*.

On January 12, 2015, BCI 1 again saw Dr. Vora. *Id*. at 1. In the Review of Systems section of the visit note, Dr. Vora indicated the existence of musculoskeletal joint pain, muscle pain, lower back pain, back pain, and endocrinology anxiety. *Id.* However, in contrast to the previous visit note, there are no physical exam findings related to the Investigator's back pain. *Id*. at 1-2. Nor are there any findings related to BCI 1's anxiety. *Id*. Although the Treatment Plan section of the visit lists Zithromax Z-Pak as having been prescribed at this visit, it does not list any controlled substances as having been prescribed on this date. *Id*. at 2. Nonetheless, both Norco and Xanax are listed in the visit note under the "Reconciled Medications" and the patient file includes two prescriptions that were copied onto the same page: one for 66 Xanax (pill strength unclear) and one for 66 Norco 7.5/325 mg.[8] *Id*. at 10.

On February 19, 2015, BCI 1 returned to the clinic where he finally saw Respondent. After checking in and waiting for two hours, BCI 1was required to provide a urine sample for

[7] These negative findings included "Psychiatry depression." GX 10, at 3.

[8] While only the full date of the Norco prescription is clear, the year of the Xanax prescription is listed as "15," and both prescriptions were written on Dr. Vora's prescription forms. GX 10, at 10. Respondent was the only other physician seen by the Investigator at this clinic in 2015.

drug testing after which he was taken to an exam room where a medical assistant took his blood pressure and told him to wait for Respondent. Tr. 66, 69.

Respondent entered the exam room and after he and BCI 1 exchanged pleasantries, Respondent asked: "what brings you here? What hurts you?" to which BCI 1replied that he had come back for refills" and had "been seeing Dr. Vora here." GX 3, at 5. Respondent then asked BCI 1what he was "getting the medication for?" *Id*. BCI 1stated: "I take Norco for my back and I take Xanax on the weekends," prompting Respondent to ask: "Okay so you have back pain and some anxiety?" *Id*. BCI 1 replied, "I guess." *Id*.

Respondent asked BCI 1when his other doctor was "going to be here," to which the latter stated that he didn't know. *Id*. at 5-6. Respondent then asked BCI 1why he needed a Z-Pak (Zithromax) and if he had had an infection?; BCI 1answered that he "didn't get one," prompting Respondent to ask: "You didn't take it-any? Because it says." *Id*. at 6. BCI 1answered that while he "saw some paperwork for that," he "didn't get it," stated that he was ''cool," and denied that he was sick. *Id.*

BCI 1then asked Respondent if he was taking over for Dr. Vora. *Id*. Respondent replied that he did not know, that it was his "first time" at the clinic and "in this area ever," that he was from East Lansing," and that the Gladwin area was very rural and a lot different. *Id*. at 6-7.

After determining the Investigator's age (44), Respondent asked BCI 1how long he had had back pain; the latter answered: "probably ten years. Mostly just stiff." *Id*. at 7. Respondent then asked BCI 1if he got "any muscle spasms with the pain?" *Id*. BCI 1replied: "I don't know. It[] gets like tight. . . so I don't know. I don't know - I don't know what the word is for that. Stiff." *Id.*

After a discussion about Respondent's being left-handed, Respondent asked the Investigator: "[d]o you ever have to walk with a limp because your pain gets so bad?" *Id*. at 8. BCI 1 replied that "I strut a little bit. Does that count?" and added that "I got a little flavor to my stroll." *Id*. Respondent then asked BCI 1if he had ever fallen, BCI 1answered in the affirmative, whether he "had any loss of muscle strength?" to which BCI 1stated that he was "just getting older" and was not "a young buck," followed by his asking Respondent "are you a back doctor?" *Id*. Respondent answered that he "actually [does] procedures" and "reads MRI" and "CT scans." *Id*. at 8-9.

Respondent then asked BCI 1to stand up, turn around, and "point to one spot in your back that hurts the most?" *Id.* BCI 1pointed to the small of his lower back, about two inches above his tail bone, Tr. 164-65, and stated: "[m]ostly just stiff. Right there." GX 3, at 9. *Id*.

BCI 1 testified that when this occurred he was wearing outdoor winter clothing which he did not take off.[9] Tr. 73. BCI 1 also testified that Respondent did not palpate the area of his back that he pointed to, and that neither he nor Respondent lifted up the clothing that he was wearing. *Id*. at 175.

Respondent asked if the pain "shot anywhere" or "is it just localized?" GX 3, at 9. BCI 1 stated that "[i]t's localized." *Id.* Respondent then had BCI 1hold out his arms, and as Respondent held the top of BCI 1's arms, Tr. 166-67, he had BCI 1push up and then push down. GX 3, at 9. Notably, as he performed these tests, Respondent did not ask BCI 1 if either one caused pain and BCI 1 did not complain that either test caused pain. *Id.*; *see also* GX 3, Video 5, at 14:48:06-12. Thereafter, Respondent told BCI 1to have a seat and asked if he smoked or used marijuana; BCI 1answered "[n]ope" to both questions. GX 3, at 9.

[9] While the video reflects the presence of an item of clothing which BCI 1 brought with him and which he was not wearing during his visit with Respondent, BCI 1 testified that "normally," he wears multiple layers and that "[d]uring the exam, I had a hooded sweatshirt and some type of coat [or vest] over it." Tr. 174.

Next, Respondent asked BCI 1if he was a social drinker. *Id*. BCI 1 answered in the affirmative and added: "That's why I take the Xanax. Because when I do that it keeps me from drinking too much moonshine on the weekends." *Id*. BCI 1then asked Respondent if he "like[d] moonshine"; Respondent answered in the negative and added that he "heard its very strong." *Id*. BCI 1agreed and said: "But, y[ou] know, if I take those Xanax[,] I'm cool with it." *Id*.

Respondent asked BCI 1what he did on the weekends "[a]round here?" BCI 1replied: "Yeah. I go – I leave. I go to East Lansing with you and kick it at the club. Nah. There's not a lot going on. I like outdoors stuff myself." *Id*. at 9-10. Respondent and BCI 1then discussed a variety of topics including hunting, whether Respondent would be coming to the clinic on a "steady" basis, where else Respondent worked, where BCI 1had lived, and the traffic in the Washington, D.C. area, where Respondent had done his residency. *Id*. at 10-12.

Respondent told BCI 1that he was going to prescribe an "additional medication for [his] muscle spasm[,] Soma, " prompting the latter to say "[p]erfect." *Id*. at 12. Respondent then asked BCI 1if he had high blood pressure or diabetes; the latter answered "No" to both questions. *Id*.

After a lengthy discussion of the recent Super Bowl, the conversation turned to whether Respondent had any other offices and worked for himself. *Id*. at 12-14. Respondent answered that he worked in East Lansing and that he was "on a contract" and "share[d] in the profits," after which he turned to discussing the hassle of getting insurance companies to pay for medication. *Id*. at 14. While BCI 1said that he had not "had that problem" but had "heard about it," Respondent replied that "[i]ts crazy" and "[t]hose guys are making bank." *Id*.

Continuing, Respondent added that "I'd imagine these scripts right here that you are going to get would be like 6 or 7 hundred dollars. You know the pharmaceutical company are

[sic] making bank." *Id*. BCI 1commented: "Big cheese involved in that, ain[']t there?" *Id.* Respondent answered: "Right," prompting BCI 1to state: "Wonder why that is. They're worth a lot of money on the street." *Id*. Respondent then explained: "That's the whole point. They're pure. You know there is nothing cut down about them. So when you're selling them – its like you know – the person buying – legit." *Id.*

BCI 1replied "Right[,] Yeah," and Respondent added: "Its not cut or anything like that. That's one reason." *Id*. at 15. BCI 1then noted: "Well, it's a little safer to do it that way. You know what I mean," prompting Respondent to say "Right." *Id.*

BCI 1then told Respondent that "[a] couple of time I ran out of pills" and had to "trade with my neighbor." *Id*. Respondent remarked: "You did? Was it an equal trade?" to which BCI 1answered: "Yeah. It was –like I just asked Dr. Vora for a couple extra . . . . And then I just gave them back to old boy." *Id.* Respondent stated "okay," and BCI 1stated: "So we're cool. He wrote it for 66. I said I don't think they will fill that[.] [H]e said oh yeah they'll fill it for me. They did. Do they fill odd numbers like that? They did for me." *Id*.

Respondent replied: "Yeah. I mean they can fill it. He probably should have maybe said 65," prompting BCI 1 to say "Oh." *Id.* Laughing, Respondent stated: "66 you know, 65, 70, you know, something like that. But 66 what's that about?" *Id*. BCI 1then stated: "Yeah. Because I can't be paying – buying them on the street. You know what I mean?" *Id.* Respondent stated "Right" and BCI 1stated: "that's why I got good – this insurance I got is the whip. . . . I got Blue Cross. I figure I'd use it." *Id*. Respondent replied: "Right. They'll pay for it," and BCI 1stated that he would use the insurance "while I can." *Id*.

Respondent stated "okay" and added: "So what I did is I re-wrote your Xanax, your Norco and your – and Soma." *Id*. BCI 1replied: "Sweet. Thanks doctor," after which

Respondent and BCI 1discussed the timing of his next appointment ("in a month") and the visit ended. *Id*. at 15-16.

In the progress note for this visit, Respondent wrote in the "subjective" section that BCI 1 had "DDD [degenerative disc disease] for approximately 10 years. Pt does have associated muscle spasm." GX 10, at 31. Respondent also noted physical exam findings which included: "Slight limp that favors RLE [Right Lower Extremity]," "Moderate point tenderness to low back that is localized," "Good muscle tone, "5/5 Muscle Strength," "CN IV – XII intact," and "Oriented x 3." *Id*. Respondent noted diagnoses of "DDD," "Etoh" or Ethyl Alcohol," and "Anxiety." *Id.*

The visit note lists three prescriptions: 1) 65 dosage units of Norco (hydrocodone and acetaminophen) 7.5/325 mg; 2) 60 dosage units of Xanax 0.5 mg; and 3) 30 dosage units of Soma (carisoprodol) 350 mg. *Id.* The Investigator's patient file contains copies of each of these prescriptions. *Id*. at 29-30. Respondent did not include BCI 1's address on the prescriptions. *See id*; *see also* GX 4, at 1-3.

The patient file also includes the lab report for the urine sample provided by BCI 1 at this visit. *Id*. at 24-25. While the urine sample was not received by the lab until February 23, 2015 and the test results were not certified until the next day, BCI 1was negative for every drug listed on the result form, including alprazolam and hydrocodone, which had been prescribed to him by Dr. Vora at the previous visit. *Id*. at 24-25; 10.

On March 19, 2015, BCI 1 returned to the clinic and again saw Respondent. Tr. 81. After completing various forms and providing another urine sample, BCI 1was taken to an exam room. *Id*. at 84.

Upon Respondent's entering the room, he and BCI 1greeted each other, engaged in a short discussion of the NCAA basketball tournament, after which, Respondent asked: "So how has everything been going with your pain?" GX 5, at 3-4. BCI 1 replied: "Great. Yup everything is cool." *Id*. at 4. Respondent said "Ok[,] alright," and BCI 1stated: "I just pretty much need refills. I am easy. You got a special on old people today it looks like. Problem is I am one of them." *Id*.

Respondent directed BCI 1to "just walk back and forth for me" and told him to "just point to where it hurts in your back." *Id.* BCI 1stated that "I just got stiffness pretty much like right down there," and pointed to a spot about two inches above his tailbone in the middle of his back. Tr. 181. Respondent then asked: "Does it go to your leg or anything?" and BCI 1 replied: "No just like . . . you know." GX 5, at 4.

Respondent had BCI 1hold out his arms and had BCI 1 push up and down. *Id.* Here again, Respondent did not ask BCI 1 if either test caused pain and BCI 1 did not complain that either test caused pain. *Id.* Instead, upon completion of this test, Respondent asked: "so how would you rate your pain on a scale of 1-10 today?" *Id*. BCI 1 replied: "I am good today. I am good today." *Id*.

Respondent then told BCI 1that he was "going to just refill [his] prescriptions" to which BCI 1 replied: "Ok that is perfect. Straight. I am good then." *Id*. Respondent stated: "Yeah you are good." *Id*. BCI 1thanked Respondent and said he would see him in a month, and after Respondent determined that BCI 1 had provided a urine sample, the visit ended. *Id*.

Respondent wrote in the subjective section of the visit note that BCI 1 had "DDD For approximately 10 yrs" and that "Pt has associated muscle spasm [with] lbp" or lower back pain. *Id*. at 32. In the note's physical exam section, Respondent documented findings which included

"[w]alks [with] a slight limp that Favors RLE," "Moderate point tenderness to low back that is localized," "CN [illegible] – XII intact," "5/5 Muscle Strength," "good muscle tone," "2+ pulses throughout," "2/2 reflexes Full ROM." *Id.*

As for his diagnoses, Respondent noted: "DDD- Lumbar," "Etoh," "Anxiety," and "Muscle Spasm." *Id.* Respondent also documented the issuance of prescriptions for 65 dosage units of Norco 7.5/325 mg, 60 Xanax 0.5 mg, and 30 Soma 350 mg. *Id.* While the patient file includes copies of only the Xanax and Soma prescriptions, *see generally* GX 10, the Government submitted a separate exhibit which contains a copy of all three prescriptions issued by Respondent at this visit including the Norco prescription. *See* GX 6, at 1-3. Respondent also failed to include BCI 1's address on these prescriptions. *See id.*

BCI 2's Visit to the Clinic

Using the name Noelle Garcia, the second BC Investigator also made several visits to Dr. Vora's clinic. At her first visit (January 21, 2015), BCI 2 completed various forms including a medical history form on which she did not check any symptoms or conditions but listed Norco, Ambien and Xanax as medications she was currently taking. GX 11, at 10. Her file also includes a Michigan Automated Prescription System report (dated "1/12/2015"), which shows that Noelle Garcia, whose residence was reported as being in Grand Rapids, had last obtained controlled substance prescriptions eight months earlier on May 13, 2014 from a Nurse Practitioner in Flint. *Id.* at 15. The report also showed that the prescriptions were for 60 hydrocodone/apap 5/325 mg, 60 alprazolam .25 mg, and 30 zolpidem 5 mg. *Id.*

At the visit, BCI 2 saw Dr. Vora, who documented in the visit note that she:

> [p]resents with complaints of chronic back pain, anxiety and inability to sleep through a night. States has been taking Norco, Ambien and Xanax for years. States that her back pain fluctuates and today rates pain 0/10. States has tried physical therapy and states it helped temporarily and would like referral to

> physical therapy again, has not seen PT in over three years. Denies seeking therapy for anxiety but would like referral to physical therapy again, has not seen PT in over three years. Denies seeking therapy for anxiety but would like referral to speak so something, stating that anxiety stems from "struggling for change."

GX 11, at 1. The visit note further lists BCI 2's problems as "anxiety," "Chronic lumbar pain," "Sleep – wake disorder," "GAD (generalized anxiety disorder)," "Chronic pain," and "Sleep disorder," and states that BCI 2 "needs refills on Norco[,] Ambien and Xanax." *Id.*

In the visit note, Dr. Vora documented negative findings for every item, including lower back pain. *Id.* Dr. Vora also documented a variety of physical exam findings and made diagnoses of generalized anxiety disorder, chronic pain and sleep disorder. While Dr. Vora prescribed only a seven-day supply of Motrin 800 mg (a non-controlled substance), he made the following additional notes in the "Treatment Plan" section of the visit note.

First, with respect to BCI 2's "[h]istory of chronic lumbar pain," he documented:

> States in the past was prescribed Norco for pain by a provider in Flint. Has not been prescribed medication in over four months and has been "'borrowing from a friend." Referral to Pain Clinic for treatment of chronic pain. Referral to physical therapy. 7 days of 800 mg Motrin prescribed.

Id. at 2. Second, with respect to BCI 2's anxiety, Dr. Vora documented: "States that in the past was prescribed Xanax by a provider in Flint MI[.] Has not had filled prescription in over four months. States has been borrowing from a friend. Referral to MidMichigan Mental Health for evaluation and recommendation of treatment." *Id*.

Two days later, BCI 2 was seen by the Pain Clinic (which shared the building or adjoined Dr. Vora's clinic) and completed additional forms including a Pain Clinic History Questionnaire and a Narcotic Agreement. *Id.* at 23-24 (Pain Hx form); *id*. at 26 (Narcotic Agreement). On this form, BCI 2 indicated that her "pain problem" was an old injury and that on a "0 to 10 pain scale," her pain was presently a "0" but was "[u]sually a "4" and ranged from "0-4." *Id*. She

noted that her pain was decreased by medication and that her current medications, which she listed as Norco 5/325 mg, Ambien 5 mg and Xanax .25 mg were "very good." *Id*. at 23. She also circled numerous medications that she had tried, indicated that she had previously had physical therapy, and that she had not seen "any neurologist, neurosurgeon, orthopedic surgeons or any other pain physicians." *Id*. While she admitted to using alcohol, she denied marijuana use. *Id*. at 24. Notably, BCI 2 did not indicate on the form the location of her pain, how long she had suffered it, nor any activity which increased it. *See id.* at 23.

According to the visit note, BCI 2 was seen by Dr. R., who documented that she complained of "[p]ain in the lumbar spine." *Id*. at 16. Dr. R. noted that BCI 2 "fell off a horse 10 years ago and since then has had pain in her right lumbar area"; she also noted that "PT didn't help" and that "she has not been considered for spinal interventions or seen by a surgeon." *Id*. Dr. R. conducted a review of various symptoms, documenting under "[m]usculoskeletal" that BCI 2 had "[n]o joint pain, redness or swelling" but had "[l]umbar back pain." *Id.*

Dr. R. also documented that she performed a physical exam. In her findings as to the "musculoskeletal" portion, Dr. R. noted "tenderness in lumbar spine, no pain on ROM [range of motion] of lumbar spine, pinprick intact b/l lower extremities, 4/5 strength b/l lower extremities, [D]TR 2+ lower extremities." *Id*. Dr. R. made a diagnosis of "[l]umbar facet pain." *Id*. As for her plan, Dr. R. listed "[o]btain updated MRI of lumbar spine," "consider LMBB," and issued prescriptions for 60 Norco 5/325 mg, 30 Ambien 5 mg with four refills, and 60 Xanax 0.25 mg, also with four refills. *Id*. *See also id*. at 28 (copies of each prescription).

On February 20, 2015, BCI 2 returned to the Pain Clinic and again saw Dr. R. In the visit note, Dr. R. documented that "[p]atient is having good pain control on Norco. Did not get MRI." *Id*. at 18; *see also id*. at 29. Under review of systems, Dr. R. documented that "[a]ll 14

systems within normal limits." *Id*. at 18. Dr. R.'s physical exam findings included "tenderness in lumbar spine, pinprick intact, some pain on ROM of spine[,] 5/5 strength in upper and lower extremities." *Id.* Dr. R noted the same diagnosis as before of lumbar facet pain. *Id*. Her plan included having BCI 2 get an MRI of her lumbar spine, "try[ing] [S]oma this month instead of Norco," and "consider spinal interventions." *Id*.

BCI 2's patient file contains copies of two prescriptions issued this date: one for 120 du of Soma 350 mg, the other for five du of Norco 5/325. *Id*. at 30. The file also includes a signed order by Dr. R. for an MRI of BCI 2's lumbar spine; the form lists the date and time of the appointment as "3/5" at "10:30 AM." *Id*. at 31.

BCI 2's patient file also includes a lab report which shows that BCI 2 provided a urine sample at her February 20, 2015 visit. *Id.* at 32. According to the report, the specimen was received by the lab on February 26, 2015 and the results, which were negative for all drugs including those prescribed to her at the previous visit (Norco (hydrocodone) and Xanax (alprazolam)). *Id*. The report further indicates that BCI 2's sample failed validity tests and lists a urine creatinine level (27 mg/dl) below the reference range (37 – 300 mg/dl). *Id*. at 32-33.

On March 19, 2015, BCI 2 returned to the clinic and saw Respondent. Tr. 191-92. After providing a urine sample, BCI 2 was taken to an exam room, and after a short wait, Respondent entered the room. *Id*. at 194. Respondent and BCI 2 exchanged pleasantries, after which Respondent asked: "so tell me what's going on?" GX 7, at 2. BCI 2 stated that she was "just here for refills," prompting Respondent to state: "Ok. Alright and how are you feeling?" *Id*. BCI 2 replied: "I feel great today. It's awesome outside." *Id*. Respondent noted that he had "[g]one outside pretty early this morning" and that "it was like barely light out," prompting BCI 2 to state that "[t]hat's too early to start work." *Id*.

Respondent then asked BCI 2: "[t]ell me how you, you been doing?" *Id.* BCI 2 answered: "actually I have been doing really good I have no complaints." *Id.* Respondent replied: "Ok well that's what I like to hear. You know, you know that's a good thing." *Id.* BCI 2 then noted that there were "a lot of chairs in this room" and this "makes it look like an intervention," prompting Respondent to comment: "Right, Right. One of those, you know surprise interventions. Families about to show up." *Id.* In response, BCI 2 stated that she "was about to see, like a camera man and relatives. Why are you here for pain pills?" *Id.* at 3.

Respondent then asked: "what's going on. Now where is it hurting you the most?" *Id.* BCI 2 replied: "Right, lower right but umm. No we are good[.] I don't want to bug you. Right, lower right." *Id.* Next, Respondent asked BCI 2 to "stand up for" him and "[p]oint to right where it is real quick." *Id.* BCI 2 stood up, pointed to her right lower hip area about three inches from her spine, Tr. 285,[10] and said "[u]mm right here." GX 7, at 3.

Respondent acknowledged the location to which BCI 2 had pointed and asked "does it shoot to like your hip or like your leg?" *Id.* BCI 2 responded: "Ummm. No it just stays there. But umm like right now I have like nothing. I feel good. I have good days and bad." *Id.* Respondent then had BCI 2 hold out her arms, placed his hands on her arms, Tr. 213, and directed her to press up and press down, *id.*, after which he asked: "[d]oes it ever cause you to limp?" GX 7, at 3; *see also* Tr. 213. BCI 2 answered "[n]o." GX 7, at 3.

Respondent had BCI 2 "[w]alk towards the wall and back," after which he asked if she was "a smoker." *Id.* BCI 2 said "no" and asked if she "look[ed] like one," prompting Respondent to say: "No, you look . . . That's one of those medical questions. Just in case." *Id.* BCI 2 then asked if she "ha[d] more refills than I am supposed too?" *Id.* Respondent answered: "No. . . . [N]ot at all" and asked "And how long have you had the pain? And how old are you

[10] BCI 2 also described this area as her "lower right back." Tr. 213.

now?" *Id*. After BCI 2 said she was "41," Respondent told her she could "sit down" and asked: "How long have you had the lower back pain." *Id*. BCI 2 replied: "Uh god for over 10 years," and Respondent asked: "how did it start?" and "[w]as it [an] injury?" *Id*. BCI 2 answered that she "fell off of a horse," and Respondent said "ok." *Id*.

BCI 2 then said: "And umm. Actually everything was fine though and I wasn't sure but I had the MRI but there was . . . there is nothing wrong, nothing broken, X-rays and all that stuff." *Id*. at 4. Respondent asked her when she had last had an MRI, and BCI 2 answered that she was "actually going today at 2 p.m." *Id*. Respondent then asked: "MRI of what? Your spine?" and BCI 2 replied: "Yep yep, cause doctor [R.] wanted me to get one and umm. So it's actually today at 2." *Id*.

Respondent asked BCI 2 "do you get 'muscle spasms?"; BCI 2 said "nope." *Id*. Respondent then asked: "And when does it hurt the most?" *Id*. BCI 2 answered: "Sometimes on occasion like when my alarm clock goes off in the morning and I am totally dead asleep and I'll twist to shut off my alarm . . . That's when it kind of screws it up." *Id*. Respondent said "ok,' and BCI 2 added: " But I haven't had that happen in a very long time like literally I have been really doing well." *Id*.

Respondent asked if she had "lost any flexibility or anything like that?" *Id*. BCI 2 answered that she did not "think so." *Id*.

Respondent then asked BCI 2 if she had any allergies. *Id*. BCI 2 answered: "Nope. She [Dr. R.] put me on Soma," prompting Respondent to comment that he saw that and Dr. R. "put you on quite a bit." *Id*. Respondent then told BCI 2 that "I will give you some Norco and I'll give you some Soma but I will only give you Soma for like twice a day." *Id*. BCI 2 said "ok," and Respondent repeated "[t]wice a day but I will give you some Norcos," and asked BCI 2 if

she "ha[d] any questions." *Id*. After Respondent confirmed that BCI 2 had given a urine sample the visit ended. *Id*. at 4-5. Consistent with Respondent's statement, the evidence shows that Respondent issued to BCI 2 prescriptions for 60 Norco (hydrocodone/apap) 5/325 mg. and 60 Soma (carisoprodol) 350 mg. GX 8, at 1-2. Respondent did not include BCI 2's address on either prescription. *See id.*

In the subjective section of the visit note, Respondent wrote; "LBP x 10 yrs [secondary] to falling off a horse." GX 11, at 35. As for his physical exam findings, he documented: "[p]oint tenderness to [right] lower back, shoots to left hip," "Full ROM," "slight limp," "5/5 Muscle strength," "Good Muscle tone," "CN II –XII intact," "2+ pulses throughout," "oriented x 3," and "2/2 reflexes." *Id.* As for his diagnoses, he listed "LBP x 10 yrs," "spasm," "Ø Smoking," and "Abnormal Gait periodically." *Id.*

The Government's Expert's Testimony

The Government called Carl W. Christensen, M.D. and Ph.D., as an Expert witness in pain management and the standard of care applicable in Michigan to general practitioners treating patients who complain of pain. Tr. 350-51. Following *voir dire*, the CALJ accepted Dr. Christensen as an expert in these areas and the CALJ ultimately found his testimony generally credible. R.D. at 40-41.

Dr. Christensen holds a Bachelor of Arts in Biology from Wayne State University (W.S.U.), which he obtained in 1977, as well as both a Doctor of Medicine and Doctor of Biochemistry from the W.S.U. School of Medicine, which he obtained in 1979 and 1985, respectively. GX 12, at 1-2. While much of his initial professional experience was in the specialty of obstetrics and gynecology, in 2002, Dr. Christensen began working with another physician who specialized in treating pregnant heroin addicts and became Board Certified in

Addiction Medicine; he also testified that he has been practicing chronic pain medicine "since." Tr. 350; *see also* GX 12, at 9. His professional experience includes serving as Director of Addiction Medicine Services, Detroit Medical Center, and as Medical Director of both the Dawn Farm Treatment Center in Ypsilanti, Michigan, and Spera Detox Center in Ann Arbor, Michigan. GX 12, at 5. He is a member and Distinguished Fellow of the American Society of Addiction Medicine, a member and former President of the Michigan Society of Addiction Medicine, and a member of the American Academy of Pain Management. *Id*. at 7. Dr. Christensen holds a current Michigan Medical License and Michigan Controlled Substance License, as well as a current DEA registration and DATA-Waiver Identification Number for treating patient with buprenorphine. *Id*. at 8. Dr. Christensen is also "one of two speakers employed by the Michigan State Medical Society to teach safe opioid practices . . . to local medical societies." Tr. 354; *see also id.* at 361-62 (discussing Risk Evaluation Mitigation Strategy lectures, in which he discusses the "safe prescribing of all opioids, including the new CDC . . . FDA guidelines").

Dr. Christensen testified that his practice primarily involves treating patients who are already taking controlled substances and who have been referred to him because the medication is no longer effective, the patient's physician suspects the patient is misusing or abusing the medication, or the patient needs to be prepared for surgery. *Id*. at 353. He also testified that he "do[es] pain medication management" and that he "manage[s] pain medications and associated medications, such as sedatives, muscle relaxers, and any medication that may interfere with pain management." *Id*. at 355.

On *voir dire*, Dr. Christensen acknowledged that he is not board certified in pain management because he does not do interventional pain management and that he does not believe he is eligible to sit for that board's examination. *Id*. at 357-58. However, he testified

that he does take patients without referrals who are addicted to pain medication, and that "probably over half" of his patients are patients who are being treated solely for pain. *Id*. at 360-61.

Also, on cross-examination, Dr. Christensen acknowledged that he had previously testified in court in two pain-related cases for the government. *Id*. at 484-85. He testified that since 2012, he has reviewed "between 10 and 20" cases total for the government, and that in approximately two-thirds of these matters, he rendered an opinion that supported the government allegations.[11] *Id*. at 485-86. He also testified that he has reviewed one case on behalf of a physician accused of improper prescribing and rendered an opinion that "was positive for the physician" and that case "was dismissed." *Id*. at 486.

Dr. Christensen's Testimony on the Standard of Care

Dr. Christensen testified that as a general matter, the standard of care requires that a patient present a complaint, after which "the first thing [a] physician should do is take a history," *id*. at 489, which is "relevant to [the] complaint." *Id*. at 365. The physician should then do "a physical examination that deals with that complaint." *Id*.; *see also id*. at 489. After the exam, the physician may need to do lab work and diagnostic tests "depending upon . . . the specific complaint . . . . [a]nd then make a diagnosis and offer a plan of treatment." *Id*. at 365; *see also id*. . at 489-90. Dr. Christensen acknowledged, however, that a physician may not be able to do diagnostic and lab tests at the initial visit but that these tests can be ordered. *Id*. at 367-68. He also testified that while a treatment plan should be offered, the plan may need to wait until the diagnosis is confirmed through testing. *Id*. at 490.

[11] Dr. Christensen also testified as to his hourly rate for both reviewing cases and testifying in court, as well as various functions he performs for Blue Cross/Blue Shield which include serving on the Medicare Drug Utilization Review Committee. Tr. 487-88.

In taking the history of a pain patient, Dr. Christensen testified that he uses and teaches medical students to use a mnemonic called "OLD CARTS." *Id*. at 373-74. He further testified that the steps set forth by this mnemonic constitute the standard of care in Michigan. *Id*. at 374. Dr. Christensen explained the questions pertinent to each letter as follows: O, the onset of the pain (when it began); L, the location of the pain; D, the duration of the pain; C, the character of pain (*i.e.*, whether it is dull, squeezing, burning, or shooting); A, factors that aggravate the pain; R, factors that relieve the pain; T, timing or what brings the pain on; S, the severity of the pain. *Id*. at 373-74. He further explained that as part of this process, the standard of care requires the assessment of the patient's functional or activity level with the pain. *Id.*at 374.

With respect to a chronic pain patient, who would be a patient "who has had pain for more than four to six months," Dr. Christensen would be concerned about the patient's psychiatric history as anxiety or depression "can dramatically affect [a patient's] pain level." *Id*. at 368. Dr. Christensen would also want to know if a patient has a substance abuse problem and "do an addiction evaluation to find out if there was also a co-occurring or a primary substance abuse problem." *Id*. Dr. Christensen further explained that he "would want to know what surgeries [the patient] had in the past and what procedures had been done." *Id.*

Dr. Christensen explained that once a physician makes a diagnosis of chronic pain and determines the patient's underlying condition, a treatment plan is offered to the patient. *Id*. at 369. He testified that on a return visit, the physician would focus on the patient's chief complaint, a review of systems, and the history of the patient's present illness, the latter involving asking the patient "how the pain's affecting you?" "how strong the pain is?" "does it radiate?" and "what makes it worse and what make it better?" *Id*. at 370. Dr. Christensen testified that the physician "would then be involved primarily in medical decision-making, which

means . . . look[ing] at the level of risk that the patient has," and that "in chronic pain management[,] . . . using a controlled substance [is] consider[ed] to be moderate risk." *Id*. The physician would also "look at the amount of information that [the physician] need[s] or the information that [the physician] ha[s]" and "the number of problems that the patient has" and formulate a treatment plan.[12] *Id*.

Asked on cross-examination whether his OLD CARTS + "sets the minimum standard of care," Dr. Christensen testified that "[t]his applies to [the] history of present illness, which depending upon the level of the visit requires a certain number of elements depending on the visit." *Id*. at 506. He further agreed that OLD CARTS "is a helpful mnemonic" that helps a physician "remember the types of things to ask that meet that standard." *Id*.

The Government also asked Dr. Christensen whether the standard of care is different when "a physician is acting as a *locum tenens* physician or is in a group practice?" *Id*. at 375. Dr. Christensen testified that "the standard of care is the same whether somebody is in a solo practice, a group practice, a hospital practice, or *locum tenens*. You're held to the same standards of care in the practice of medicine, and the underlying ethical principles are still the same." *Id*.

Turning to BCI I's first visit with Respondent (February 19, 2015), Dr. Christensen testified that the former's statement that "I just came back for refills" raised a red flag that he

[12] With respect to how a physician should evaluate whether to continue prescribing controlled substances after a patient's initial visit, Dr. Christensen testified as to the use of what he called "the five As" to assess the patient. *Id.* at 370. Dr. Christensen explained that these involve: 1) assessing the level of "analgesia" or pain level; 2) asking the patient about his/her activity or "functional level"; 3) asking "about adverse effects, which for opioids typically consist of . . . constipation, sweating, [and] swelling"; 4) looking for aberrant behavior such as use of illicit drugs or the failure to use prescribed drugs by conducting drug screens and obtaining MAPS reports to look for doctor shopping; and 5) looking at how the drugs "affect" the patient and how the patient appears and behaves during the visit. *Id*. at 370-72. Dr. Christensen testified that findings as to the five As should be documented every time. *Id*. at 373.

Yet on cross-examination, Dr. Christensen answered "no" when asked:"[t]here's no absolute standard of care requirement to go through these five As, right?" Tr. 506.

was just seeking medication "and has no other complaint." *Id*. at 376. As for BCI I's statement that "I take Norco for my back, and I take Xanax on the weekends," Dr. Christensen testified that this raised a red flag that the patient was either misusing or diverting controlled substances. *Id*. at 377. Dr. Christensen also noted that the statement "I take Xanax on the weekends . . . does not appear to be someone who's complaining about an anxiety diagnosis who's being prescribed Xanax for a documented anxiety disorder." *Id*. at 379. Dr. Christensen further found concerning the statement "I take Norco for my back," because while "back pain is one possible explanation," BCI 1 did not specifically complain of back pain, and while BCI 1 may have meant that, it may also "be a sign of somebody who is self-medicating." *Id*. at 379-80.

With respect to BCI 1's seeking Xanax, Dr. Christensen testified that "a reasonable practitioner . . . would want to know" if there had been a diagnosis of anxiety disorder, who "made the diagnosis," and what treatments had been tried. *Id*. at 381. With respect to BCI 1's seeking Norco, Dr. Christensen explained that he would "want to know the same thing," including what the diagnosis was, what medications had been tried, "and who made the diagnosis." *Id*.

Dr. Christensen also testified that the combination of drugs that BCI 1 claimed to be taking, *i.e.*, Norco and Xanax, was also a concern because "[t]hey are both controlled substances" and are "synergistic," in that "[t]hey are much more euphoric when taken together." *Id.* Dr. Christensen explained that this combination of controlled substances would cause concern as to the "underlying diagnosis" in that the "primary diagnosis is chemical dependence rather than a combination of moderate to severe back pain and a documented anxiety disorder." *Id*. at 382; *see also id*. at 406 (testimony of Dr. Christensen: "[F]rom this visit, it would appear that the diagnosis of back pain and anxiety is in doubt. There's a strong possibility of another

diagnosis, which would be chemical dependency, and that would mean that you would not be prescribing these medications. And, again, I would recommend referral to a substance abuse specialist.").

Next, Dr. Christensen testified that BCI I's statement that his back was "[m]ostly just stiff" is "not an indication for prescribing Norco" (hydrocodone). *Id*. at 383. As for the physical exam Respondent performed, Dr. Christensen testified that BCI 1 stated that his pain did not shoot anywhere and was localized, which means it "is more likely to be joint or musculoskeletal pain." *Id.* at 386. Dr. Christensen then explained that the tests Respondent performed in which he held BCI 1's arms and had him push up and push down "is a test for the cervical and upper thoracic nerves essentially in the neck." *Id.* Dr. Christensen noted, however, that BCI 1 complained of lower back pain and that this test was not appropriate for evaluating lower back pain. *Id.*; *see also id.* at 390.

Asked what the standard of care required of Respondent after he had BCI 1 point to where his pain was, Dr Christensen acknowledged that this was "a return visit for this patient." *Id*. at 386. Dr. Christensen explained, however, that "if a physical examination were to be done as part of the . . . visit, then you would want to check for tenderness and spasm in that area," and that this would be done either by "push[ing] on the patient's back or hav[ing] the patient push on their [sic] back and tell you if it hurts." *Id*. at 386-87. Dr. Christensen subsequently testified that a reasonable practitioner would put his hands on the patient's back and feel for tenderness and for a muscle spasm. *Id*. at 387. As for whether a physician could properly check for tenderness or spasm if the patient is wearing clothing, Dr. Christensen testified that "[i]t would be difficult" but "you could check for tenderness if you pushed hard enough." *Id*. Dr.

Christensen testified, however, that he did not "believe that you could test for spasm" if the patient was wearing clothing. *Id*.; *see also id*. at 389.

As for the scope of an appropriate physical exam for evaluating lower back pain, Dr. Christensen testified that "at a minimum" a reasonable practitioner "would check for flexion and extension," *id*. at 391, which involves seeing "[h]ow far [a patient] can bend over before [he/she] has[s] moderate to severe pain" and "how far can they lean back." *Id*. at 390.[13]

Dr. Christensen again testified that on a return visit, a physical exam is not required and the physician can rely on the history and the medical decision-making. *Id*. at 391. Asked by the CALJ if he would have expected to see "these tests . . . documented in the initial exam" or would have "just looked for the diagnosis," Dr. Christensen answered that "if this was a return visit for the patient and I was seeing the patient for the first time, I would hopefully find these things in the initial examination and the reasons for the diagnosis in the initial examination." *Id*. at 392. On further questioning as to whether, under such circumstances, he would be looking in the chart for documentation of various tests to support a diagnosis before he prescribed controlled substances, Dr. Christensen answered: "If the diagnosis is in question, if the initial evaluation did not document this, I would want to confirm the diagnosis before I prescribed controlled substances." *Id*. at 393.

As for BCI 1's statement that his back was "mostly just stiff," Dr. Christensen acknowledged that there could be "multiple reasons for it" such as "joint disease," "deconditioning," "central pain syndrome," or an "underlying medical condition." *Id*. at 389. Dr. Christensen nonetheless testified that he would "[n]ot automatically" equate stiffness with a

[13] Dr. Christensen identified other tests including "checking for side to side motion," doing a straight leg raise test if the patient complains of radiation, checking muscle strength in the lower extremities by having the patient push in and push out, checking the lower extremities for edema, checking the reflexes in the lower extremities, and if there is a neurological complaint of numbness or pain, "check[ing] for touch and sensation and pain in the bottom or the top . . . of the feet." Tr. 390.

complaint of pain and that to connect the two, the patient would also have to complain of pain. *Id*. at 389-90.

Addressing BCI 1's statement that he took Xanax "[b]ecause when I do that it keeps me from drinking too much moonshine on the weekends," Dr. Christensen noted that drinking and taking Xanax is "a potentially lethal combination. And if you add [h]ydrocodone, it's even more dangerous." *Id*. at 394. He explained that "[t]he combination of alcohol and benzodiazepines, [such as] Xanax, increases [the] chance of respiratory depression," and that when you "throw in an opiate . . . like [h]ydrocodone," the combination is "even more dangerous." *Id*. Continuing, Dr. Christensen testified that "[i]f somebody told me they were drinking on the weekends and there was a prescription for Xanax, [he] would be very concerned." *Id*. He added that drinking is "a contraindication to" Xanax, and because "the ethical principle here is do no harm[,] [he] would not prescribe . . . Xanax." *Id.* at 395.

Asked by the CALJ if this was his personal standard or the standard of care in Michigan, Dr. Christensen explained that because the FDA warning label strongly recommends against the use of alcohol when taking this medication, if the physician believes the patient is "going to continue drinking," "the standard of care is not to prescribe the medication." *Id*. at 396. Dr. Christensen then testified that "with that statement" (presumably BCI 1's statement), a reasonable general practitioner would refer the patient to an addiction specialist or counselor and not prescribe the medication. *Id*. at 396-397.

Dr. Christensen also found concerning Respondent's prescribing of Soma (carisoprodol) to BCI 1. *Id*. at 397. Dr. Christensen explained that carisoprodol "is now a controlled substance based on its abuse potential" and that with respect to BCI 1, "you've got somebody who admits to alcohol use, who is prescribed Xanax, and now you're adding a third sedation which also

increased the risk of accidents and overdose and death." *Id*. at 397-98. Dr. Christensen then testified that the combination of hydrocodone, Xanax, and Soma "is commonly known as the holy trinity," which is "a very euphoric combination, and [is] dangerous because you're mixing two sedatives together" as well as hydrocodone, which creates "the additive effect on respiratory depression." *Id*. at 398-99.

With respect to Respondent's statement that he was prescribing carisoprodol for BCI I's muscle spasms, GX 3, at 12, Dr. Christensen testified that he "didn't see any diagnosis of muscle spasms" and that a physician would diagnose a patient as suffering from spasms by palpating the patient's back. Tr. 399. According to Dr. Christensen, Respondent did not do this. *Id*.

Turning to the colloquy between Respondent and BCI 1 regarding the value of the drugs on the street, *see* GX 3, at 14-15, Dr. Christensen opined that this raised a concern because BCI 1 "did not initially raise it but was engaging in a discussion of diversion" and yet Respondent was "prescribing him controlled substances." *Id*. at 400-01. Dr. Christensen further testified that in response to this conversation, a physician acting in accordance with the Michigan standard of care would need to "make sure that there was an opioid agreement" with the patient and "to reinforce the opioid agreement and to monitor" the patient "or correct use" by doing urine drug screening. *Id*. at 402.

Next, the Government asked Dr. Christensen whether concerns were raised by the colloquy during which BCI 1 stated that "a couple of times" he had "r[un] out of pills" and had to "trade" with his neighbor, Respondent asked if it was "an equal trade," and BCI I added that he had asked Dr. Vora "for a couple [of] extra" pills" and that Dr. Vora had given him a couple of extra pills which he had given back to his neighbor. Tr. 402-03; GX 3, at 15. Dr. Christensen testified that the patient "is admitting to diversion" and that a physician must explain to the

patient that this is illegal and that the patient "ha[d] signed an opioid agreement" and that "according to the . . . agreement . . . if this occurs [the patient] will not be able to receive controlled substances." *Id*. at 403. Dr. Christensen further testified that, "at a minimum," a reasonable practitioner would explain that the opioid agreement prohibits trading and selling pills, "and that if it were to happen, [the physician] would not be able to prescribe him medications anymore." *Id*. at 405. He also testified that based on the transcript, the standard of care would require referral to an addiction specialist. *Id*. at 406.

Turning to BCI 1's patient file, Dr. Christensen testified that the November 10, 2014 medical history form was largely "blank, including [the section pertinent to] muscle, joint and bone." *Id*. at 410. Dr. Christensen testified that "[i]f you are getting a history and this isn't complete, you have to verify it independently" and that a physician "would be responsible for confirming the portion of the history and exam that dealt with your treatment plan, especially if it included controlled medications." *Id*. at 410-11. Dr. Christensen then testified that he "would look at the remainder of the file, which would be Dr. [Vora's] initial electronic medical record." *Id*. Dr. Christensen noted, however, that this record was also missing information, and that a reasonable practitioner would have to "[o]btain the information" and the missing history "if you are going to prescribe controlled substances." *Id*. at 411-12. With respect to the form which asked various questions about BCI 1's family history and which were not answered, GX 10, at 19, Dr. Christensen testified that the standard of care required obtaining this information because "[i]f you are treating the patient for back pain and . . . ruling out substances abuse" by the patient, "a family history of psychiatric or substance use disorders is important." Tr. 413; *see also id.* at 551 (testimony of Dr. Christensen agreeing that a physician "would want to look

through the . . . medical record to see if . . . a proper history [was] conducted and . . . fill in the gaps from what the patient failed to report on [his] questionnaire").[14]

As found above, BCI 1's file also contained a MAPS report. GX 10, at 23. Dr. Christensen found it notable that the report showed that BCI 1 had gotten four different prescriptions for Xanax and one prescription for amphetamines and that some of the providers, those whose offices were in Detroit and Marquette, were "400 miles apart." *Id*. at 413-14. Dr. Christensen testified that the "high geographic distance between providers" and the "multiple providers" are "signs of doctor shopping" and "diversion or misuse." *Id*. at 414.

Turning to Respondent's progress note for the visit, Dr. Christensen noted that while it documented a complaint of "associated muscle spasm," BCI 1 had "complained of stiffness," which "is a symptom." *Id*. at 415. Dr. Christensen testified that "spasm is a physical finding" which "would need to be corroborated later on in the examination" by "palpation," but according to the testimony of BCI 1, Respondent never touched him and thus could not possibly have diagnosed BCI 1 as having a muscle spasm. *Id*. at 415-16.

As for the other exam findings in this visit note, Dr. Christensen testified that he "didn't see documentation of [a] complaint of point tenderness." *Id*. at 417. Dr. Christensen acknowledged that he had no "way of knowing whether [BCI 1] had a limp that you couldn't see on the video" and that "[h]is muscle tone in the upper extremities may have been excellent." *Id*.

[14] As for the history listed by Dr. Vora at the December 15, 2014 visit, which included both a social history and diet history, Dr. Christensen testified that there was "no mention . . . of [the] presence or absence . . . of drug or alcohol use." Tr. 552. While Dr. Christensen acknowledged that BCI 1's self-report of alcohol use and Respondent's questioning BCI 1 as to whether he used marijuana rendered the history complete, Dr. Christensen expressed skepticism as to whether either Dr. Vora at the December 15, 2015 visit or Ms. S.A. (the person listed on the EMR as having reviewed BCI 1's Social History and Consumption/Diet) at the January 12, 2015 visit had actually done so. *Id*. at 553. When asked if "it would be fair to assume that there were two separate people who looked at the patient's history," he replied: "I believe it indicated that two different log-ons checked off that box" and "I don't know that it indicates they ever reviewed the history with the patient." *Id*.

As for the notation that "CN IV-XII intact," Dr. Christensen testified that video did not show that Respondent did the various cranial nerve tests as documented in the note. *Id*. at 417-19.

After noting Respondent's diagnoses of degenerative disc disease, positive ETOH, and anxiety, and the three prescriptions (Norco 7.5/325, SOMA 350, and Xanax .5), Dr. Christensen then opined that based on his review of the video, the transcript and the medical file, Respondent's prescription for Norco was inappropriate as "[t]here was no documentation of moderate to moderately severe pain." *Id*. at 419-20. There was also the "concern[] about another underlying diagnosis," *i.e.*, substance abuse, "that would have mandated either a referral or not writing the prescription." *Id*. at 420.

Dr. Christensen opined that the Xanax prescription was "not appropriate" because the drug is "contraindicated in somebody who is actively drinking." *Id*. Dr. Christensen also noted that he "did not see any documentation of an anxiety diagnosis." *Id.*

Dr. Christensen also opined that the Soma prescription was "not appropriate." *Id*. He explained that this drug is "indicated for short-term treatment of muscle spasms," but that "there is no documentation of this" condition. *Id*. Dr. Christensen further explained that Soma was "contraindicated with this patient's history." *Id*. He then opined that each of the three prescriptions Respondent issued at BCI 1's first visit was not issued for a legitimate medical purpose and in the usual course of professional practice. *Id*. at 425-26.

Turning to BCI 1's second visit (Mar. 19, 2015), Dr. Christensen noted that when Respondent asked BCI 1 about his pain, the latter responded that "everything is cool," and that "there's no pain level." *Id*. at 428. He also noted that BCI 1 complained only of stiffness, that BCI 1denied having pain that radiated down his leg, and that when Respondent asked BCI 1 to rate his pain level on a 1-10 scale, BCI 1 replied that he was "good today." *Id*. at 428-29. Dr.

Christensen opined that BCI 1's response when asked to rate his pain on the numeric scale was "a non-responsive . . . and . . . an evasive answer, which can be signs of drug-seeking behavior." *Id.* at 431.

Dr. Christensen opined that this "was a negative evaluation for moderate to moderately severe pain." *Id*. at 429. Dr. Christensen also testified that a reasonable practitioner "would have asked [BCI 1] about [his] functional level . . . . He would have asked about side effects. . . . And he would have . . . inquired about any aberrant behaviors." *Id*. He further testified that whether BCI 1's second visit was evaluated either on the basis of "face-to-face time," which was under two minutes, or "by complexity," this was not an adequate evaluation. *Id.* at 431. While Dr. Christensen noted that at a return visit, only two of the three components of a history, physical, and medical decisionmaking must be performed, he opined that if the adequacy of the evaluations was based on its "complexity," there was not "enough of an examination . . . to allow the medical decision-making." *Id*.

As noted above, the subjective section of the visit note repeats nearly verbatim the subjective notes written in the February 19 visit note in that it states: "44 y/o WM c DDD For approximately 10 yrs. Pt has associate muscle spasm c LBP." GX 10, at 32; *see also* Tr. 432. Dr. Christensen testified that the subjective section of the visit note "appears to be a repeat of the history from the previous examination." Tr. 432. Dr. Christensen noted, however, that while it is allowable to repeat the history from a previous examination, "there's no additional information from the visit that occurred" and nothing occurred at this visit to substantiate what was written in the subjective section of the note. *Id*. at 432-33.

Dr. Christensen further testified that neither the video nor the transcript provide evidence that Respondent performed the tests necessary to make several of the findings he documented in

the note's physical exam section. Dr. Christensen specifically identified the findings of "moderate point tenderness to low back," "cranial nerves 2 through 12 intact," "2+ pulses throughout,"[15] and "2/2 reflexes" as not supported by tests. *Id* at 433-35. Dr. Christensen also testified that with the exception of the diagnosis of Etoh, which was based on BCI 1's admission that he used alcohol, there was no documentation of findings to support the diagnoses of degenerative disc disease in the lumbar area, anxiety, and muscle spasm. *Id*. at 447; *see also* GX 10, at 32.

Noting the prescriptions for Norco and Xanax that were issued by Dr. Vora at BCI 1's January 12, 2015 visit, the Government asked Dr. Christensen whether the results of the urine drug screen administered on February 19, 2015, which were negative for these drugs, were aberrational. Tr. 439-441. Dr. Christensen noted, however, that the prescriptions were for a one-month supply and the drug screen was administered five weeks after the prescriptions were issued. Dr. Christensen testified that while it is possible the drugs should still show up in the urine screen even if BCI 1 has stopped taking the drugs one week earlier, "[t]here's no definite answer that I can give" because these results may have been caused by "run[ning] out of medications, which is legitimate." *Id*. at 440-41. Dr. Christensen testified that the standard of care required repeating the drug screen and doing so "at a time when the patient is taking the medications to see what happens" as well to consult with the patient. *Id*. at 441-42. Although Respondent repeated the drug screen at the second visit, he did not address the results with BCI 1. *See* GX 10, at 34. While Dr. Christensen further testified that the standard of care required

[15] With respect to this notation, Dr. Christensen testified that the notation "that the pulses are normal throughout . . . implies the upper and lower extremities." Tr. 434. He then explained that to make this finding, "[y]ou check typically for the radial pulse in both wrists and either the posterior tibia, which is behind your ankle, or the dorsalis pedis pulse, which is in the front of, the top of your foot." *Id*. at 435.

that Respondent document how he addressed the test result, there is no such documentation in the March 19 visit note. Tr. 443-444; *see also* GX 10, at 32.

With respect to each of the three prescriptions (65 Norco 7.5/325 mg, 60 Xanax 0.5 mg, and 30 Soma 350 mg) issued by Respondent to BCI 1 at this visit, Dr. Christensen opined that the prescriptions lacked a legitimate medical purpose. Tr. 448.

Dr. Christensen also testified about BCI 2's March 19, 2015 visit with Respondent. As found above, after an exchange of pleasantries, BCI 2 stated that she was "[j]ust here for refills" and answered his question "how are you feeling," stating: "I feel great today." Tr. 449. When further asked by Respondent to "tell me how you have been doing," BCI 2 replied: "actually, I've been doing really good. I have no complaints." *Id.*

With respect to this exchange, Dr. Christensen testified that BCI 2's statement that she had "no complaints . . . by itself does not mean anything." *Id.* at 450. Continuing, Dr. Christensen explained that "there's no identification yet if she's been taking the medication and if the medication is the reason . . . for how she feels. And, again, [BCI 2] states, 'I'm just here for refills.'" *Id.*

Dr. Christensen testified that a practitioner acting under the standard of care would follow up this exchange by "ask[ing] if [the patient has] been taking the medications, . . . then ask[ing] about pain level, activity level, side effects, and mak[ing] inquiries about are they [sic] having any problem with aberrant behavior, are they [sic] running out early." *Id.* Dr. Christensen then testified that none of this was done. *Id.*

Addressing the portion of the colloquy in which Respondent asked BCI 2 "where is it hurting the most" and BCI 2 replied "[r]ight, lower right but . . . no, we are good," Dr. Christensen testified that while BCI 2 "identifie[d] a location . . . again, there's no direct

answer." *Id.* at 450-51. As for the physical exam Respondent performed (after BCI 2 pointed to her lower back near her right hip) which involved having BCI 2 hold out her arms and press up and down as he held them, Dr. Christensen again testified that this "tests for upper extremity strength and integrity of the nerves in the neck and upper thoracic areas, which is the upper back" and would have no value in evaluating a rear right hip issue. *Id.*

As found above, after BCI 2 denied that she got muscle spasms, Respondent asked "when does it hurt most," and BCI 2 replied that "sometimes," when she was asleep, she would "twist to shut [her] alarm off" and "screw[] it up," but this had not "happen[ed] in a very long time" and she had "been really doing well." GX 7, at 4. Regarding this exchange, Dr. Christensen testified that "[t]here's no documentation of a moderate or higher pain level other than being stiff in the morning when you wake up. There's no discussion of whether or not this is due to her pain medications." Tr. 454. Dr. Christensen then opined that a reasonable practitioner would ask a patient who said she was not having any pain if she was taking her pain medications and then evaluate based on the answer. *Id.* at 455. Dr. Christensen noted that there was no indication in the transcript that Respondent asked this question. *Id.*

Dr. Christensen further noted that nothing was checked on the medical history form filled in by BCI 2 with respect to any symptoms of muscle, joint or bone pain even though she presented with "potential complaints of back pain" and that this should have prompted a discussion between Respondent and her. *Id.* at 456. Dr. Christensen further testified that a reasonable "practitioner is responsible for obtaining the history, so . . . he or she would need to ask the patients the questions directly" and fill in the blanks. *Id.* at 457.

As for the drugs (Norco, Ambien, and Xanax) which BCI 2 listed on the medical history form as her current medications, *see* GX 11, at 10, Dr. Christensen again observed "that Norco

and Xanax is a potentially dangerous combination and a patient who is prescribed these or taking these, I'm concerned about another underlying diagnosis," that being dependence. Tr. 457-58. Dr. Christensen further explained that while Ambien "is not technically a benzodiazepine . . . it is very similar and its side effects" and risks are similar to those of benzodiazepines. *Id.* at 457. Dr. Christensen testified that this drug combination raises concern as to why it "is being prescribed or taken" and a practitioner would "need to confirm that there was a legitimate medical diagnosis for it and not another underlying diagnosis, such as dependence." *Id*. at 458.

Turning to the family history form (GX 11, at 12) on which BCI 2 noted that the reason for her visit was "Refills – Norco, Ambien[,] Xanax," Dr. Christensen testified that this explanation is not one that he would typically expect a patient to provide at a first visit, *id*. at 462-63, and that "[a] practitioner would need to be concerned that someone was drug seeking" and visiting the doctor "simply to get the medications," especially given the combination of drugs. *Id*. at 458. Moreover, even after the CALJ questioned whether the concern would exist if it was not the patient's first visit to the practice, but was the first visit with the doctor, Dr. Christensen explained that "[i]f you are going to prescribe a controlled substance, the practitioner needs to confirm the diagnosis." *Id*. at 460.

As for the Pain Clinic History Questionnaire completed by BCI 2, Dr. Christensen noted that there was no "description circled for the pain," and nothing was "circled for what" increased the pain" and for how the pain made her feel. *Id*. at 461; *see also* GX 11, at 23. He observed that while her "pain level is listed as 0 to 4," there was no notation as to whether this was with medication or without medication. *Id*. at 461. He also noted that the location of the pain was not circled. *Id*. Dr. Christensen further observed that various sections of the form, including BCI 2's work history, domestic situation, and family history were left blank. *Id*. at 462.

Turning to the next page of the form, Dr. Christensen noted that while BCI 2 had indicated that she used alcohol, there was no discussion as to "how much [she was] drinking," because depending upon "the amount and the frequency, it will put [the patient] at risk of increased side effects and risks from the combination of medications they're currently taking." *Id.* Dr. Christensen further noted that the standard of care requires a physician to obtain this information. *Id*. at 462.

Addressing the note Respondent wrote for this visit, Dr. Christensen took issue with the adequacy of the subjective section, observing that it contained no notations about BCI 2's "pain level, [her] medications, any side effects, [and] any problems with medications." *Id*. at 464; *see also* GX 11, at 35. As for the physical exam findings documented by Respondent, Dr. Christensen identified multiple findings which the video and transcript show did not occur. Tr. 464-65.

With respect to his finding of point tenderness to BCI 2's right lower back, Dr. Christensen noted that "the investigator said she was good and she was great and there was no problem." *Id*. at 464. He also reiterated his earlier testimony that point tenderness would be evaluated by palpating the patient and asking if it hurt or not; Dr. Christensen testified that he did not see that this occurred at this visit. *Id*. at 464-65. As for Respondent finding that BCI 2's pain "shoots to left hip," consistent with the evidence, Dr. Christensen testified that he did not "believe that she complained about any radiation to the hip." *Id*. at 465; *see also* GX 7, at 1-5. With respect to Respondent's finding of "Full RoM," Dr. Christensen testified that while "she did abduct and adduct her upper extremities . . . [t]here was no other testing of range of motion that I saw either in the upper or lower extremities." *Id.* Finally, while Respondent also made findings of "CN II – XII intact," "2+ pulses throughout," and "2/2 reflexes," he did not see

evidence that Respondent performed the tests used to make these findings. *Id*. at 465-66; *see also* GX 11, at 35.

Dr. Christensen reiterated his earlier testimony that on a repeat visit, the standard of care does not require a physical examination. Tr. 366. However, he further testified that a physical exam for a complaint of back pain would involve "check[ing] for spasm in the lower back by palpation," checking both flexion and extension of the lower back, "check[ing] the gait," and "check[ing] the strength and reflexes in the lower extremities." *Id*. As for the items listed as Respondent's impression, Dr. Christensen acknowledged that while there was documentation of lower back pain based on BCI 2's statement that she fell off a horse 10 years ago as well as that she was a non-smoker, there was no documentation to support the diagnosis of spasm or an abnormal gait periodically. *Id*. at 467.

Dr. Christensen further observed that BCI 2's March 19, 2015 drug test produced several aberrational results. These included that she tested positive for THC and tested negative for Ambien and Xanax which had been prescribed with four refills at BCI 2's January 23, 2015 visit. *Id.* at 471; *see also* GX 11, at 37-38. He also testified that BCI 2 should have tested positive for Soma as this was prescribed to her at the February 20, 2015 visit. *Id*. at 471-72. Dr. Christensen acknowledged, however, that the March 19, 2015 test results were not available to Respondent on that date. *Id*. at 472.

Dr. Christensen then opined that the Norco and Soma prescriptions issued to BCI 2 on March 19, 2015 were not issued for a legitimate medical purpose. *Id*. at 473. Dr. Christensen further noted that because BCI 2's Xanax prescription had four refills, with Respondent's prescribing to her, she had current prescriptions for Norco, Xanax, Soma and Ambien, and that

this "combination of sedatives" increases the patient's risk level and is "a highly addictive . . . and . . . dangerous combination." *Id*. at 474.

On cross-examination, Dr. Christensen admitted that on the morning of his testimony, he had prescribed methadone to one of his pain management patients electronically and without either speaking with or seeing the patient. Tr. 475-76, 478. Dr. Christensen testified, however, that this patient has severe lumbar stenosis, that he has been on the same drug for eight years, that he sees the patient every 60 days, and that in between visits, the patient provides a urine drug screen two weeks before his prescription is reissued and a MAPS report is run on the day his prescription is due for renewal. *Id*. at 479. Dr. Christensen then explained that it is okay to simply issue a "refill"[16] if a "patient is stable," the drug screens and MAPS reports are confirmatory, there is no evidence of aberrant behavior, and the patient is "not experiencing undue adverse side effects." *Id*.

Dr. Christensen subsequently acknowledged that performing two of the three items (of history, physical examination, and medical decisionmaking) is not strictly required to prescribe controlled substances each month under the standard of care and that determining the past diagnosis and whether "the patient is well managed on the medication . . . are two of the requirements" of the standard of care. *Id*. at 481. He also acknowledged that Respondent's encounters with both undercovers were follow-up visits and that Respondent was not obligated to do all three things that are done at an initial visit but that he needed to verify that another physician had done these things. *Id*. at 490-91. Dr. Christensen explained, however, that whether it is okay to trust another physician's diagnosis "would depend on what the record[s] showed" and that he "would want to see evidence of a pertinent examination" by the other

[16] While called a refill, this was actually a new prescription.

physician if he was to "prescrib[e] a controlled substance for a history of back pain." *Id*. at 492; *see also id*. at 529-30.

After Dr. Christensen reiterated that a physician "need[s] to make sure that it [the prescription] is for a legitimate medical purpose," Respondent's counsel asked him "[w]here is that standard that you've said is the standard of care enumerated?" *Id*. at 493. Dr. Christensen then asked to "see the MCL," apparently referring to the Michigan Compiled Laws setting forth the "good faith" standard for prescribing controlled substances and testified:

> So it says that the prescribing is done . . . in the regular course of professional treatment by an individual who is under treatment by the practitioner for a condition other than the individual's physical or psychological dependence upon an addiction to a controlled substance.
>
> So I need to confirm, I believe the standard of care is you need to confirm that this is not an addictive disorder when you are seeing this combination of controlled substances being prescribed.

Id. at 493-94.

Then asked "where it is enumerated that the standard requires you to not trust the diagnosis of an initial physician when you're conducting a follow-up visit," Dr. Christensen answered that the Michigan pain guidelines "state that an examination shall be performed" and that when he "reviewed Dr. Vora's records, I did not see any musculoskeletal examination except for noting edema." *Id*. at 494.

Dr. Christensen acknowledged that there was a plus mark next to both lower back pain and endocrinology anxiety in the review of systems section of the note created by Dr. Vora for BCI 1's December 15, 2014 visit. *Id*. at 495 (discussing GX 10, at 3-4). He acknowledged that Dr. Vora's note contained various physical exam findings pertinent to BCI's 1 back, including that he had "lumbar spine point tenderness" and another notation indicated "tenderness to palpation," thus indicating that Dr. Vora had palpated the spine and found it tender. *Id*. at 497,

530-31. Dr. Christensen also acknowledged that Dr. Vora's note documented "Pain with Flexion/Extension," thus indicating that BCI 1 "was asked to flex and extend [his] back"; he also testified that other notations indicated that Dr. Vora did other tests including a straight leg raise test, a toe heel walk, and that he palpated and did range of motion testing on various parts of BCI 1's spine. *Id*. at 497-500, 530. Dr. Christensen then conceded that if all of these tests were done, this would be an appropriate physical examination of a patient complaining of lower back pain on a "follow-up visit."[17] *Id*. at 500, 530-31.

While Dr. Christensen testified that a finding of lumbar spine tenderness would "assist with a determination of back pain," he added that back pain is a symptom even though it has its own billing code and that it is not a real diagnosis which would involve determining the cause of the pain. *Id*. at 500-01. He acknowledged that in some cases back pain could be caused by neuropathy and that there may be no physical manifestation of an injury such as on radiology exams (MRI or X-rays) or other physical findings. *Id*. at 501.

Dr. Christensen also acknowledged that a patient's complaint of pain is an important indicator of whether he/she has pain and that this "should be taken as part of the history." *Id.* at 502. However, asked hypothetically whether a physician should believe a patient when a patient complains of high level of pain (nine out of 10) which cannot be verified by imaging or a physical exam, he answered that this "depends on the rest of the history and examination." *Id*. Dr. Christensen then agreed that the existence or non-existence of aberrant behavior would be a factor in whether a physician should believe such a patient. *Id*. at 503.

Turning to the undercover visits, Respondent's counsel questioned Dr. Christensen regarding Respondent's engaging in the various steps set forth by the OLD CARTS mnemonic.

[17] Notably, Dr. Vora's note for BCI 1's November visit contains no physical examination findings pertinent to BCI 1's back. *See* GX 10, at 5-6. However, Dr. Christensen was not asked whether these findings reflect the performance of an appropriate physical examination for an initial visit.

Dr. Christensen acknowledged that Respondent asked both BCIs to identify the location of their pain (the L in OLDCARTS) at their initial visits with him. *Id*. at 506-07. As for the onset of the pain, Dr. Christensen disagreed with the suggestion of Respondent's counsel that Respondent's question ("So how long have you had low back pain?") and BCI 1's answer ("Probably 10 years. Mostly just stiff."), was an indication of the onset of BCI's pain, explaining that this exchange simply addressed the pain's duration; however, Dr. Christensen acknowledged that onset and duration are only different if the pain had gone away and returned. *Id*. at 508-09, 511. Asked if BCI 1's statement about back stiffness "could also mean there is some pain," Dr. Christensen replied: "it could mean there is almost anything associated with it." *Id*. at 510.

Turning to the character of the pain (the C in OLD CARTS), while Dr. Christensen acknowledged that Respondent's question ("Is the pain shooting or localized") was designed to question whether one type of pain existed, he did "not necessarily" agree that Respondent satisfied this element, explaining that if BCI 1 had "complained of only shooting pain, then it would." *Id*. at 511-12. However, Dr. Christensen acknowledged that BCI 1 had stated that the pain was localized. *Id.*

As for the aggravating or associated factors (the A in OLD CARTS), Respondent's counsel asked Dr. Christensen if he saw "an indication in this visit that the patient made a statement about what makes [his] pain worse?" *Id*. Dr. Christensen testified that he would need "to go back over the," at which point, Respondent's counsel interrupted and stated: "No need to go back over it." *Id.*

Then asked if the questions embodied in the OLD CARTS mnemonic are "enumerated in the Michigan guidelines . . . for the use of controlled substance for the treatment of pain," Dr. Christensen initially testified to his belief that "if you go through the entire document," those

questions "are in there." *Id*. at 513. However, asked if he believed "all of the [OLD CARTS] elements are met in the Michigan guidelines," Dr. Christensen answered: "No, I believe they refer to the four As actually." *Id*. Dr. Christensen then disagreed with Respondent's counsel that "OLD CARTS isn't in the Michigan standard," explaining that he "believe[s] [that the] history of present illness is, which is what we're referring to" and that some of the elements are in the standard. *Id*.

Turning to BCI 1's statement at his first visit with Respondent ("I take Norco for my back and Xanax on the weekends"), Dr. Christensen adhered to his earlier testimony that the combination of Norco and Xanax was concerning, as was his statement that he took Xanax on the weekends. *Id*. at 513-14. While Dr. Christensen acknowledged that the statement "can be interpreted that Norco is for back pain," he noted that BCI 1's statement "doesn't specify that" and that additional questions to "confirm that" were necessary. *Id*. at 514. While Dr. Christensen acknowledged that Respondent did engage in further questioning when he asked BCI 1 "so you have back pain and some anxiety," he disagreed with the suggestion of Respondent's counsel that BCI 1's answer of "I guess" was confirmation that the latter had pain, characterizing the answer as "evasive" and subject to "many" possible interpretations. *Id*. at 515.

As for BCI 1's statement that he took Xanax because it kept him "from drinking too much moonshine on the weekends," GX 3, at 9, Dr. Christensen acknowledged that Dr. Vora's January 12, 2015 visit note (GX 10, at 2) lists anxiety as a diagnosis. Tr. 516. Dr. Christensen also acknowledged that it is "okay to trust medical documentation of a physician if . . . the elements of a diagnosis are met." *Id*. Dr. Christensen disagreed with the suggestion that BCI 1's earlier statement that "I take Xanax on the weekends" could "refer to the patient having increased periods of anxiety because of whatever he does on the weekend," explaining that he

did not know and would need to do "appropriate questioning" to reach this conclusion. *Id.* at 517. Dr. Christensen also testified that while the medical record lists a diagnosis of anxiety, he was "not agreeing with any diagnosis of anxiety." *Id.*

Asked whether it is "ever appropriate to simply cut . . . off" a person who has been "on Xanax for a long period of time," Dr. Christensen testified that it does not depend on the time the patient has been on the drug, but rather, "[i]t depends on the situation." *Id.* at 518. Continuing, Dr. Christensen testified that "[i]f somebody is mixing Xanax with another medication that is lethal, the patient should be referred immediately, but the medication, the prescription should not be continued." *Id.* Then asked if a physician "might want to consider cutting that patient off" where "the harm of taking . . . Xanax and the other substance is greater than the potential harm for withdrawal from Xanax," Dr. Christensen answered "[y]es" and added that "if somebody's taking Xanax on the weekend, there is no physical dependence to Xanax." *Id.*

Referring to BCI 1's statement that a couple of times he had run out of pills and traded with his neighbor, Dr. Christensen did not agree that this statement "indicate[d] that the patient was consistently using the Xanax in a manner that he actually ran out of his pills prior to the end of the prescription," noting that BCI 1 did not "specify which medication he's talking about." *Id.* at 520. While Dr. Christensen acknowledged that a patient going through alcohol withdrawal could suffer delirium tremens and be treated with benzodiazepines such as Xanax, he disagreed that BCI 1's statement that "I take Xanax because it keeps me from drinking too much moonshine" was a reference to his using Xanax to address "withdrawal from alcoholism [sic]." *Id.* at 521-22.

Still later on cross-examination, Dr. Christensen testified with respect to BCI 1's acknowledgment of having traded pills, that a patient's admission of diversion is "not an

automatic reason to discharge" the patient and that "you have to review the opioid agreement, let [the patient] know that this will not be tolerated, and monitor [the patient] more closely." *Id*. at 547. Dr. Christensen acknowledged that conducting urine drugs screens would be one of the things to do to monitor the patient more closely but that various guidelines including the Michigan guidelines do not require monthly drug screens. *Id*. at 547-48.

On further questioning as to the significance of BCI 1's statement about running out and trading pills, Respondent's counsel asked Dr. Christensen if this conduct could be explained by pseudo-addiction, which Respondent's counsel explained involved a patient engaging in aberrant behaviors because of under-treatment of this condition and not necessarily because of abuse or addiction. *Id*. at 549. While Dr. Christensen testified that pseudo-addiction occurs "[i]n very rare cases" and "[p]rimarily in cancer patients," and that "[i]t's possible" this could happen "[i]f a patient had uncontrolled pain," when asked whether this could explain BCI 1's statement about trading narcotics with a neighbor, he answered: "None of which I have seen." *Id*. at 549-51.

Turning to the physical exam Respondent performed on BCI 1, Dr. Christensen testified that the arm adduction and abduction tests do "not determine pain" but "determine normal function" in the upper spine and neck areas. *Id*. at 524. While Dr. Christensen acknowledged that a patient "may have more difficulty exerting resistance if they have increased pain," he further explained that "[t]he primary reason for doing that is to assess for damage, whether there's stenosis there." *Id.* at 524-25. He testified that this test is not used to determine "a lack of function due to pain," explaining that "[y]ou can have somebody who has give-away pain who can't tolerate the test at all. But when you perform what [Respondent] did, you're primarily assessing whether . . . there's [an] injury to the spinal nerves and spinal cord at that area." *Id*. at 525.

After recounting Dr. Christensen's testimony that the straight leg raise test is used to diagnose pain in the lower back, Respondent's counsel asked him if he was "saying that you can't use a test like that to determine back pain in the upper extremities." *Id.* After clarifying that Respondent's counsel was referring to the straight leg test, Dr. Christensen explained that "the straight leg test pulls on the sciatic nerve, which comes out of the bottom of the spinal cord." *Id.* Respondent's counsel then asked: "Isn't it possible that pushing down on the arms could be a test for referred pain from the lower back to the upper spine?" *Id.* at 525-26. Dr. Christensen answered that there is a test (the Waddell Test) which involves "push[ing] on various parts of the body, and if the patient complains of pain all over . . . it's felt to be psychosomatic pain." *Id.*

Dr. Christensen also rejected the suggestion of Respondent's counsel that the abduction test on BCI 1's arms would have shown an inconsistency with his complaint of only lower back pain if BCI 1 had given up resisting and complained of pain. *Id.* at 526-27. As he explained, Respondent did not ask BCI 1 if the test "was painful." *Id.* at 527. Nor did BCI 1 complain that the test was painful. GX 3, at 9. Dr. Christensen further rejected the suggestion of Respondent's counsel that that this test could be a sign of malingering by BCI 1. Tr. 527.

Respondent's counsel asked Dr. Christensen what the standard of care requires for a physical exam of a patient who complains of localized lower back pain. *Id.* at 528. Dr. Christensen testified that he "would check for tenderness," "for spasm actually next to the spine," and "test for range of motion." *Id.* When Respondent's counsel asked if a physical exam is needed on a follow-up visit if the first exam was sufficient, Dr. Christensen testified that "[i]f you are doing a physical exam as part of your office visit , then that [sic] would be the elements that I would do for low back pain." *Id.* at 529.

Respondent's counsel then revisited his earlier questioning regarding the physical examination documented by Dr. Vora in his December 15, 2014 visit note, with Dr. Christensen again acknowledging that the note documented that the various elements of an appropriate physical exam had been performed. *Id*. at 530-31. Dr. Christensen acknowledged that a second physician can reasonably rely on a medical record created by another physician who did a full and complete physical exam, provided that "a diagnosis is confirmed" and there is no indication that the first physician has not "been truthful in his medical documentation." *Id*. at 531-32. While Dr. Christensen testified that when he "see[s] a[n] electronic medical record like this that shows a complete visit, I'm always suspicious," he added that "that's not a standard of care issue." *Id*. at 533. Subsequently, he agreed that "if a physical exam was noted in the record, you wouldn't need to reconfirm the diagnosis." *Id*. at 534.

Dr. Christensen acknowledged that based on his review of the case, he did not know whether Respondent actually saw the urinalysis results. *Id.* However, he acknowledged that Respondent could not have seen BCI 2's March 19 test results and that her previous test result (Feb. 19, 2015) was below the level of detection. *Id*. at 534-36.

Dr. Christensen also acknowledged that the documentation by Dr. R. of her January 23, 2015 examination of BCI 2 reflected an "appropriate" musculoskeletal examination in that it involved identifying if there were spasms, checking for tenderness, and testing the range of motion of the lumbar spine. *Id*. at 537-38.

Dr. Christensen agreed that Dr. R.'s decision to order an MRI was a reasonable step to confirm her diagnosis of lower back pain and that patients "occasionally" do not get their MRI done before their next visit. *Id*. at 539-40. Dr. Christensen then acknowledged that it was reasonable for Respondent "to trust" the medical records created by Dr. R. for BCI 2's January

23 and February 20 visits. *Id*. at 540. He agreed that Dr. R. had issued to BCI 2 prescriptions for Norco, carisoprodol, and Xanax at these visits. *Id*. at 540-41. He acknowledged that there is no specific standard as to how often a physician should run a MAPS report and that this "depends on the patient." *Id*. at 541-42. Dr. Christensen also testified that the MAPS report in BCI 2's file, which showed that she had last obtained Xanax from a Nurse Practitioner eight months earlier, was actually obtained prior to Dr. R.'s issuance of the prescriptions on January 23, 2015. *Id.* at 544.

While Respondent's counsel then suggested that based on the MAPS report and Dr. R.'s February 20 note, Respondent "would have no indication that [BCI 2] had an outstanding prescription for Xanax at [the] time" of her March 19 visit with him, Dr. Christensen testified that Respondent would know without running another MAPS report if "the prescriptions were in the chart" or if "he asked the patient." *Id*. at 545. Dr. Christensen added that he "saw no indication that [Respondent] asked her what medications she was taking." *Id*. at 545. And on questioning by the CALJ, Dr. Christensen testified that Dr. R.'s January 23, 2015 visit note (GX 11, at 16) documented that the Xanax prescription she wrote that date provided four refills and that Respondent "would know that [BCI 2] was also taking Xanax." *Id*. at 546.

Asked by Respondent's counsel whether, based on "a review of her history and her MAPS report," BCI 2 "appeared to be a doctor shopper," Dr. Christensen testified: "she [did] not appear to have legitimate pain complaints and [was] seeking Norco and Xanax and Ambien." *Id*. at 555. Respondent's counsel then asked whether "it was reasonable for [Respondent] to prescribe [to her] based on her MAPS report and her prior history?" *Id.* While Dr. Christensen acknowledged that the MAPS report did not show that BCI 2 was engaged in doctor shopping

and that this was not a red flag, he then explained: "[e]xcept that she presented requesting refills and there was no sign that she was getting medication." *Id*. at 556.

Observing that in the note for BCI 2's January 21, 2015 visit, Dr. Vora had written that his treatment plan included a referral for a mental health evaluation (GX11, at 14), Respondent's counsel asked Dr. Christensen if "a referral like that would be for the purpose of treating potential addiction?" *Id*. at 558. Dr. Christensen testified "[n]ot necessarily, no," and after reading the contents of the note, added: "It doesn't say whether it's for addiction or anxiety." *Id.* at 558-59. While Dr. Christensen acknowledged that "[i]t's possible" that the referral was made because BCI 2 was engaged in "drug-seeking behavior," this was "[n]ot necessarily" the case. *Id*.

Dr. Christensen agreed that both Norco 5 mg and 7.5 mg are indicated for moderate to severe pain, and that on a pain scale, moderate pain is pain above 4. *Id*. at 559-60. Asked if the pain level which BCI 2 noted on her pain history questionnaire as the usual level of her pain ("4" on a 0 to 10 scale) should not be considered as "moderate pain," Dr. Christensen initially said "yes" but agreed that there is no universal agreement as to that standard. *Id*. at 561. He then acknowledged that it would be okay to prescribe Norco to someone complaining of pain at a level of 4, but that would be the minimum level for prescribing the drug. *Id*.

Noting that BCI 2's pain history questionnaire indicated that her present pain was at the "0" level and that her pain was decreased by "medication," Dr. Christensen disagreed that it would "be fair to assume" that Norco was the reason for her experiencing "0 pain." *Id*. at 562. He testified that this was "not necessarily" the case, noting that "when she said everything is

great, we don't know that that's because of her pain medication."[18] *Id.* Dr. Christensen acknowledged that "[i]t's possible" that BCI 2's statement to Respondent that "I'm good today" was "an indication that she's being well managed on her pain . . . with medication." *Id.* at 563-64. Dr. Christensen disagreed, however, with the suggestion of Respondent's counsel that it was "not unreasonable for [Respondent] to conclude that that statement means my current regime is appropriate." *Id.* at 564. As he further testified: "For a physician not to bother asking someone how much medication they're taking? Reasonable? . . . I'm sorry, sir, but I don't think it's reasonable for an interviewer to completely ignore asking, are you taking your medication? How much medication are you taking? It's missing." *Id.*

As for BCI 2's response ("Uh, just here for refills") to Respondent's question ("so tell me what's going on?"), GX 7, at 2, Dr. Christensen acknowledged that BCI 2's answer could potentially be "an indication that she is taking her medication and needs refills."[19] Tr. 566. Apparently interpreting the question as asking whether BCI 2 was taking the medications as prescribed, Dr. Christensen disagreed that this was a reasonable conclusion. *Id.* at 566-67. As he explained: "How much? . . . I will stand by my statement [that] it's inappropriate for a physician to ignore asking whether or not someone's taking their medication as prescribed, especially if there's been a change in the pain level." *Id.* at 567. In response to a similar question by Respondent's counsel, Dr. Christensen testified that "I believe that's insufficient information to assume they're [sic] taking the medication according to the prescribed schedule." *Id.*

[18] Dr. Christensen correctly observed that BCI 2's pain history questionnaire was not dated. Tr. 563. While Dr. Christensen testified that the document was used by Dr. R., he did not know if it was completed before BCI 2's first or second visit with Dr. R. *Id.*

[19] Respondent's counsel's question simply asked: "Is that to you an indication that she is taking her medication and needs refills of those medications?" Tr. 566. He did not ask if BCI 2's statement was an indication that she was taking her medication as prescribed. *Id.*

Asked how often a physical exam is required of a patient the same age as BCI 2 (41) who complains of back pain and was receiving Norco and "the more dangerous things have been ruled out," Dr. Christensen testified that DEA regulations require a visit "every 90 days for a schedule II medication" such as Norco.[20] *Id.* at 568. Dr. Christensen then testified that under DEA regulations, Respondent was not even required to conduct a visit with BCI 2 if she had previously received a prescription for Norco. *Id*. However, when then asked whether requiring the visit was "[o]ver and above what [he] believe[s] is required [by] the standard of care in Michigan," Dr. Christensen testified that "my interpretation of this patient is apparently different than [Respondent's], so I can't confirm your question." *Id*. at 569.

Asked by the CALJ if there is "a different standard that prevails in Michigan than the one that's in the DEA regulations in regards to the requirement of a visit," Dr. Christensen testified that he believed "the DEA prescriber manual . . . does give the 90-day interval as a requirement but also recommends that the visit be more frequent." *Id.* Then asked by the CALJ if Michigan's standard requires more frequent visits than every 90 days, Dr. Christensen testified: "I don't believe we have a standard." *Id*.

Respondent's counsel then asked if it would have been "okay for [Respondent] to prescribe controlled substances for a patient such as [BCI 2], assuming all the information you know about her, and not see her for 90 days?" *Id*. at 569-70. After clarifying that Respondent's counsel was referring to the information available at BCI 2's visit with Respondent, Dr.

[20] DEA's regulation does not, however, specify how often a patient who is being prescribed schedule II controlled substances must return for an office visit. *See* 21 CFR 1306.12. Rather, the regulation allows an individual practitioner to "issue multiple prescriptions authorizing the patient to receive up to a 90-day supply of a Schedule II" drug provided various conditions are met. *Id*. § 1306.12(b)(1). Indeed, the regulation states that "[n]othing in [it] shall be construed as mandating or encouraging individual practitioners to issue multiple prescriptions or to see their patients only once every 90 days when prescribing Schedule II controlled substances. Rather, individual practitioners must determine on their own, based on sound medical judgment, and in accordance with established medical standards, whether it is appropriate to issue multiple prescriptions and how often to see their patients when doing so." *Id*. § 1306.12(b)(2).

Christensen testified: "at that time, if you schedule a 90-day return visit and her urine drug screen came up negative for prescribed medications, you would need – I believe it would be appropriate to intervene." *Id.* at 570. Dr. Christensen testified that this would involve having her come back "about a week later" and doing a pill count. *Id.* Dr. Christensen then agreed that Respondent did not have the results of the March 19 drug test available to him[21] "[a]t the time of the visit." *Id.*

On cross-examination, Respondent's counsel also questioned Dr. Christensen regarding his direct testimony questioning Respondent's notation in the visit note that "[p]ain shoots to left hip." *Id.* at 571 (GX 11, at 35). As Dr. Christensen testified, the Investigator testified that when asked by Respondent "to point to where it is real quick," (GX 7, at 3), she pointed to her lower right hip area and not her left hip. Tr. 285; *see also id.* at 572.

Respondent's counsel then asked: "this statement here, shoots to left hip, if somebody's complaining of back pain, but when they're asked where it hurts and it manifests itself on the hip side, would that appear to you that the pain is shooting from one area to another area?" *Id.* at 572. Dr. Christensen testified: "If they complained of pain in both areas." *Id.* Then asked if "that would be consistent with shooting pain," Dr. Christensen testified: "If they said it was shooting. You could have pain in two separate locations. The shooting pain typically refers to nerve irritation or injury." *Id.* However, as found above, BCI 2 did not complain of shooting pain but said "it just stays there." GX 7, at 3.

On re-direct, Dr. Christensen testified that Respondent's prescribing of 60 Norco and 60 Soma to BCI 2 was a departure from Dr. R.'s treatment plan which she instituted at the February visit, and that while there was some discussion as to why Respondent reduced the Soma

[21] However, the results of the February 20 drug test, which was negative for all drugs including those that had previously been prescribed to her, would have been available on the date of BCI 2's visit, although Respondent claimed that he still did not have access to the results.

prescription, there was "no discussion" as to why he increased the Norco prescription. *Id*. at 576. Dr. Christensen explained that the standard of care in Michigan includes "the principle of informed consent" and that this "require[s] [that] if you're making a major change in a controlled substance, . . . to discuss it, [and] why you're recommending it." *Id*. at 577. Dr. Christensen testified that he found no evidence in the video that there was any discussion as to why Respondent increased the Norco. *Id*. He also testified that it appeared that Respondent was "ignoring the planned taper by Dr. [R.]" and that Respondent was trading an "increase" in the Norco prescription for a "decrease" in the Soma. *Id.*

While on re-cross, Dr. Christensen agreed that Respondent's decreasing of the Soma prescription was reasonable and this drug has an analgesic effect "in short-term treatment," he testified that increasing BCI 2's Norco prescription "to maintain the analgesic effect" was not "a rational therapeutic choice." *Id*. at 580. Then asked if he would rather have BCI 2 "on Norco only and not Soma or Soma only and not Norco," Dr. Christensen answered "[n]either." *Id*. at 580-81.

Respondent's Case

Respondent testified on his own behalf and called two other witnesses. The first of these was Dr. Carla Scott, a physician who is the medical director for the Wayne County Juvenile Detention Facility. Tr. 592. Dr. Scott, who did residencies in both internal medicine and pediatrics and is board certified in pediatrics, testified that her duties involve overseeing the facility's Health Services Department, including its Mental Health Department, and that the facility has a psychiatrist, two psychologists, three social workers, and two contractor physicians. *Id*. at 593-94. Dr. Scott also testified that she had "worked as a professor for a year at Baylor." *Id*. at 593.

Dr. Scott testified that when she first moved back to Detroit she had worked at an outpatient public health clinic for "[a]bout nine or 10 months, " *id*. at 595, but had left because she did not like the way the clinic practiced medicine, as "[t]hey really expected physicians to just pass out drugs" as "they got paid per capita" and "the more patients you saw, the faster you saw them, the more money the clinic made." *Id*. at 596. She explained that "they felt like I spent too much time with the patients" and because the clinic "push[ed] the doctors to . . . just keep the patients coming in . . . we had a lot of patients there who were just drug-seeking." *Id*. at 596-97. She testified that she was "threatened several times" and "had to have people removed from the clinic because" she was not "going to write the scripts." *Id.* at 597. Dr. Scott also testified that she "clearly . . . learned something" about identifying drug-seeking behavior, but acknowledged that "I can't say that I was an expert." *Id*.

Dr. Scott testified that she went to medical school with Respondent and that they "were pretty good friends" until their residencies led them to go their "separate ways." *Id*. at 598. Dr. Scott testified that she did not "hear from [Respondent] for like 25 years," at which point Respondent called and asked her to supervise him pursuant to an order of the Michigan Medical Board.[22] *Id*. As Dr. Scott did not have any available positions, Respondent worked at the detention center as a volunteer. *Id.* According to Dr. Scott, the letter she received from the Board after she agreed to supervise Respondent "was really vague" as to what this entailed, so Dr. Scott asked him where else he was working and asked to see some of his patient charts. *Id*. at 599.

[22] Respondent had been accepted for a fellowship at Johns Hopkins but was required to have a permanent license and list the license number on the application. Tr. 628. According to Respondent, he then had only a temporary educational license so he listed his roommate's license number. *Id*. While Respondent did receive a permanent license, he was sanctioned for falsifying his application. *Id*. at 628-30; *see also id*. at 601-02. Respondent testified that he "made a severe error in judgment" and that he "was dishonest on [his] application to Johns Hopkins." *Id*. at 628.

Respondent told Dr. Scott "that he had opened up his own private pain clinic," which sent Dr. Scott's "antennas up . . . because [she] ha[s] an issue about narcotics." *Id*. Dr. Scott asked to see these files and also went over to see his pain clinic. *Id.* Dr. Scott testified that she reviewed Respondent's charts and that after she fired one of the detention center's physicians, she hired Respondent as a part-time contractor. *Id*. at 603. Dr. Scott testified that her supervision began around April 2014 and lasted for one year, after which she wrote a letter to the Board. *Id*. at 604-05. She testified that she reviewed about 10 of his pain clinic charts, and that all of these charts were for patients who were receiving controlled substances. *Id*. at 605.

While Dr. Scott also reviewed hundreds of charts maintained by Respondent in the course of his employment at the detention center, she acknowledged that "not a lot of these" involve patients on controlled substances as "we give out little to no narcotics at the . . . detention facility." *Id*. at 606. She subsequently testified that controlled substances for pain were "probably less than five percent," and "might even be less than two percent" of the drugs that are prescribed at the detention facility. *Id*. at 607. While Dr. Scott testified that "we have a lot of kids on" controlled substances for psychiatric conditions, those prescriptions are "always done by the psychiatrist" unless the "psychiatrist is absent" and "they're always reviewed." *Id.*

Dr. Scott testified that she "did not have any problems with the" the 10 charts she reviewed from Respondent's private pain clinic. *Id*. at 610. She did, however, "talk to him about . . . making sure that he . . . sent people to physical therapy, and he already was." *Id*. Dr. Scott also testified that Respondent showed her that "they had to bring in films" and "different things"; Dr. Scott did not, however, clarify what these "different things" involved. *Id*.

Asked what she was looking for in reviewing Respondent's charts, Dr. Scott testified:

> . . . just that as a physician that someone gave him a good reason why they needed narcotics and that he had a plan in place on how to get them off narcotics, that there were

> . . . other modalities offered to people, that you talked to them about other things that they could do for pain control, that you made sure that, because . . . pain is nebulous. It's very difficult. I mean, you can tell me you're in pain, but . . . how do I know that you really are?
>
> So you, as a physician, you're going to have to try to figure out how, you know, this person's saying they're in pain . . . so what are the best steps in terms of getting them out of pain. . . .and what kind, what other kinds of things can you do besides give them pills. And that's what I wanted to see.

Id. at 610-11. Dr. Scott also testified that she never had an issue with Respondent's charting of his treatment of patients at the detention facility. *Id.* at 611. However, Dr. Scott offered no testimony to even establish that Respondent treated any of the detention facility's patients with narcotics.[23] *Id*.

Next, Respondent called Ms. Tyanna Clemmons. *Id*. at 613. Ms. Clemmons testified that she is a Certified Nursing Assistant and that she worked as Respondent's office manager at a clinic he owned in Flint, Michigan from March through July 2016. *Id*. at 616-17.

Ms. Clemmons testified that her duties involved "scheduling patients, collecting documentation for patients," and managing the patient files. *Id*. at 617-18. Asked what type of documentation she would see in the patient files, she testified that "all of our patients had to have imaging studies." *Id*. at 618. She also testified that "[w]e had the patients sign their consent forms," that she "would contact [the patient's] previous doctor to receive their documentation," and that Respondent "always reviewed" these records "to see . . . what was exactly going on with the patient." *Id*. at 619.

Ms. Clemmons testified that the patients would undergo monthly urinalysis testing, that Respondent reviewed each drug test result, and that there was one patient, who tested positive for cocaine and was discharged by Respondent. *Id*. at 619-20. Asked how she knew that

[23] Dr. Scott also testified that Respondent had an "excellent" work ethic at the detention facility, that she "would like for him to continue to be an employee," and that he is "providing a valuable service to the community." *Id*. at 611-12. None of this testimony is relevant in the public interest determination. *See Gregory Owens,* 74 FR 36751, 36756-57 (2009).

Respondent reviewed the drug test results, Ms. Clemmons testified: "Because I specifically gave them to [Respondent]. He would have them inside of his file . . . [and] he always reviewed his files before his examination." *Id*. at 620.

Ms. Clemmons testified that Respondent would see "about 10" patients a day and that he would spend "[r]oughly about 30 minutes" with the patients, although the amount of time per visit varied and was "[s]ometimes maybe 15 minutes, sometime maybe 45 minutes." *Id*. at 621. She also testified that a MAPS report would be obtained for every visit by a patient and that "every time" the report indicated that a patient was engaged in doctor shopping, the patient would be discharged. *Id*. at 622-23. Finally, she testified that patients were given referrals for "outpatient therapy, chiropractors and . . . home care services." *Id.*

Finally, Respondent testified on his own behalf. *Id*. at 624-700. Respondent testified that he received his undergraduate degree from the University of Michigan and his medical degree from Wayne State University. *Id*. at 624. Following medical school, Respondent did both an internship and a residency in radiology at Howard University Hospital. *Id*. at 625. He also did a fellowship in interventional radiology at the Detroit Medical Center and in neuroradiology at the University of Arizona. *Id*. Respondent testified that his neuroradiology fellowship involved interpreting MRIs of the brain, face, neck and spine and that he was "taught to evaluate pain pumps, kyphoplasty, vertebroplasty, nerve blocks, facet blocks, blood patches, [and] SI joint injections." *Id.* at 625. As for his fellowship in interventional radiology, Respondent testified that "you get taught in pain management as far as facet blocks, epidural injections, nerve blocks, [and] pain pump evaluations." *Id*. at 627. He also testified that while he is board eligible, he is not board certified. *Id*.

Subsequently, Respondent testified that prescribing narcotics was "[p]art of the training in each of [his] fellowships . . . because that's pain management." *Id*. at 647. Respondent also testified that he has had significant training in pain management. *Id*. at 648. He further testified that he has "a few months" of experience doing office-based pain management. *Id*. at 652.

Respondent testified that notwithstanding the earlier sanctions that were imposed on his medical licenses, all of his licenses are now "free and clear" with "no restrictions." *Id*. at 631. Describing his work at the juvenile detention facility, Respondent testified that it involved doing physicals and minor procedures and "not that much" prescribing of narcotics. *Id*. Continuing, Respondent offered vague testimony that "the anti-psychotics, stuff like that, I would say it's 10 to 20 percent because . . . the psychiatrists might not be there." *Id*. Respondent did not, however, identify what specific "anti-psychotics" he prescribed, and thus, there is no evidence as to whether this prescribing involved any drugs that are controlled substances.

Moving on to the allegations of the Show Cause Order, Respondent testified that in January 2015, he started doing *locum tenens* work for a company called Michigan Healthcare. *Id*. at 633. Respondent did one or two shifts at Michigan Healthcare before taking on *locum tenens* work at Dr. Vora's office.[24] *Id*. at 634.

Respondent testified that he understood his work at Dr. Vora's office would involve "just see[ing] patients and that I'd be doing procedures since I have been fellowship trained." *Id*. at 635. He testified that he was not informed that he would specifically be seeing pain management patients. *Id*. Rather, he explained: "The setup that it was supposed to be was that I'd go to Dr. Vora, Dr. Vora would set up [the] patient, and then I would see patients, because it was done through, at least the patient list was done through Dr. Vora's officer manager and the office

[24] Respondent testified that he became aware of the position at Dr. Vora's office through Michigan Healthcare. Tr. 635.

manager at Michigan Healthcare." *Id*. Respondent testified that he worked "two or three" days total at Dr. Vora's practice. *Id*.

Respondent testified that his first day at Dr. Vora's practice was February 19, 2015, the day he saw BCI 1. *Id.* at 636. Respondent testified that "[p]rior to showing up" on that morning, he had no communication with either Dr. Vora or his staff other than a conversation he had "on the way to Gladwin" (the location of the office), when "all [he] was told was that he was going to have some patients and . . . see patients." *Id*. at 636-37. He testified that he had "zero" opportunity to review the patient charts prior to arriving at the office and did not know how many patients he would see until he arrived and was provided with "a patient list" of 25 patients by the office manager. *Id*. at 637-38.

Respondent denied that he had access to the urine drug screen, stating that he did not "have access through the EMR" (the electronic medical records), because "something was going on with [the office's] computer system." *Id*. at 638-39. Respondent testified: "What Dr. Vora, his staff would do would give me these printouts of the charts and I would, you know, request." Continuing, Respondent testified: "I had at the very least to have the MAPS, but I said I also need the urinalysis in order to see what's going on with the patients and to . . . have what I would

think is a complete access to the medical records."[25] *Id.* Respondent further testified that he did not know if anyone could access the urine drug screen reports.[26] *Id*. at 639.

Asked whether he had "any discussions with Dr. Vora prior to walking in for [his] first patient," Respondent initially testified: "[z]ero . . . [o]ther than that he introduced himself to me." *Id*. However, when then asked by his counsel if Dr. Vora said "anything about his prior treatment of the patients or a care plan," Respondent testified:

> Oh, yeah. He said that all the patients that I was receiving he had seen, he had established a patient management plan, and that he would, because they were his patients, that he would prefer that if there was [sic] any drastic changes that I'd discuss them with him.

Id.

As for why he did not refuse to see the patients until he could see their urine drug screen results, Respondent explained:

> Well, initially, number one, they're established patients. Number two is that it's not necessarily a requirement to have urine drug screens every time you see the patient. Therefore . . . you can have . . . you have judgment. It's up to me to decide whether okay, I'll see this patient, or it is definitely a . . . requirement for me to have the urine screens.

Id. at 640.

As for how he knew that the patients were established patients, Respondent testified that the office manager gave him "printouts of the patient's prior history . . . what he had decided to

[25] Respondent also maintained that after his first day, he told the staff that he "wanted to have access to the urinalysis" and "access to the[] full . . . EMR." Tr. 687. He also wanted "advance knowledge of which patients [he] would be seeing" and "to have the MAPS there prior to . . . coming to the office." *Id*. Respondent testified that when he showed up on March 19, 2015, his instructions "were not" followed. *Id*.

However, later during cross-examination, Respondent testified that "for every patient I got [a] MAPS" and "[b]efore I saw any patient I was able to get the MAPS" without specifying that he got MAPS reports only on March 19, 2015. *Id*. at 692. While on cross-examination, Respondent reiterated that the UDSs were missing when asked what else was missing "apart from the urinalysis records," "I didn't think anything was missing off of the top of my head. . . ." *Id*. at 693.

[26] Respondent also testified that he was told that he would have access to the urine drug screens "either later on that day or even the next visit." Tr. 639.

treat." *Id*. Respondent testified that he took "into account the patients' medical records and prior history." *Id*. Asked what he was looking at based on the videos which show him flipping through pages during BCI 1's visits and looking at a tablet during BCI 2's visit, Respondent testified that:

> [t]he second time I came, and I think that's with [BCI 2], it was all mixed up. It was that I got part of the medical records [that] were given to me through the printout that [the] office manager gave me, and then . . I had limited access via . . . my computer, but because it was not the computer established with [the] EMR, I can [sic] only get access to certain areas of the patients' medical records.

Id. at 641. Respondent then testified that "the paper was the prior medical history as far as that goes" for BCI 1 and the tablet had "some additional information on him." *Id.*

Addressing BCI 1's first visit, Respondent testified that he "definitely" recalled the visit and that "[i]t was very memorable" as "the language that he was using was inappropriate . . . . I don't think that anybody talks to their physician, yeah, brother, yeah, you know, in a hot month he's going to be back. I think that no one talks like that, number one." *Id*. at 642. Respondent then explained that this language elicited this reaction because Gladwin, Michigan "is like Leesburg[,] [Virginia] 40 or 50 years ago. So, when I go to Gladwin, it's like I am a sore thumb standing out." *Id*. at 642-43.

Asked by the CALJ what he meant by that, Respondent testified: "I mean there are no African-American people there, period." *Id*. at 643. Then asked by his counsel if he was "suggesting that [he was] treated differently because of [his] race by" BCI 1, Respondent answered: "There's no other way I could say it because I can't see him saying those things if I were not African-American." *Id*.

Asked by his counsel what he was "feeling about some of the statements he made and whether . . . he was cooperating as a patient with" him, Respondent testified that the "main

thing" was "to try to connect [with the patient] on a human level." *Id*. Continuing, Respondent explained that "you want to talk to the patient, you want to let them know that you're a regular person, you're there to take care of them, you're there to help them out. You're no different than they are. So you want to initially just establish a rapport with the patient." *Id*. at 643-44. Respondent further explained that:

> [i]f they [sic] feel comfortable with you, then they [sic] can feel comfortable accepting what you advise them to do, your orders, whatever it may be. But if they [sic] feel that you are coming from a condescending type of attitude and you're there to bigfoot them, them . . . they [sic] might not be as receptive to following your plan.

Id. at 644.

Addressing some of the dialogue at BCI 1's first visit with him, Respondent was asked to explain "[w]hat [was] going through [his] mind when" BCI 1 said that "I take Norco for my back and I take Xanax on the weekends." *Id*. Respondent testified:

> Multiple things. You know, I'm thinking that he was taking the Norco for his back pain. The Xanax is, which was for anxiety which was previously diagnosed from Dr. Vora's records, and that's my impression of that. I would think, . . . anybody would – I don't think it's unreasonable to say that when he says I'm taking Norco for my back that it's for back pain. I don't think that's unreasonable.

Id. at 644-45.

As for his subsequent question to BCI 1 ("Okay, so you have back pain, some anxiety?"), Respondent explained that, in his mind, he viewed BCI 1's answer of "I guess," "as an affirmative answer" to his question, and that BCI 1was confirming the diagnoses of back pain and anxiety which were documented in the patient record. *Id.* at 645. Respondent also testified that prior to asking these questions, he had looked through the medical record and noticed both diagnoses, *id*. at 645, and that he believed the diagnoses were substantiated as he had no other reason to believe that the medical records were not legitimate as far as that goes." *Id*. at 645-46.

On questioning by the CALJ, Respondent testified that he knew "[z]ero" about Dr. Vora before going to the clinic and "[t]hat's the way locums works." *Id*. at 646. The CALJ then asked Respondent if it was clear to him "after [he] started seeing patients that [he was] doing pain management?" *Id*. at 646-47. Respondent answered:

> At that time, I went specifically to Dr. Vora and I said this is not really what I had signed up for, was just to see pain patients. You know, however, as a matter of professional courtesy, I said okay, you know, I'll do this, but this is not what I signed up for. I want to do something else. This is not for me per se.

Id. at 647.

Suggesting that Respondent "almost want[ed] to have it both ways" in that "[o]n the one hand," he was claiming that he "didn't understand anything about this and . . . didn't know what to look for and . . . didn't have . . . access to the records[,] [b]ut on the other hand . . . talked about [his] extensive training . . . in the science of pain management," the CALJ asked "which one is it?" *Id*. at 649. Respondent answered: "when you say access, that is like EMR . . . Electronic Medical Record. That is something that you have to have a password for. So I am reliant upon somebody else to provide those for me as far as that goes. And as far as my fellowship training, pain is just part of that. It's not the only thing about interventional radiology or neuroradiology." *Id*. at 649-50.

After Respondent acknowledged that as an interventional radiologist he would not perform a procedure (such as an epidural) in a complex case without the necessary tools, the CALJ again asked Respondent to explain why, given his training on prescribing opioids, he was willing to prescribe pain medication without "more access" to the medical records. *Id*. at 650-51. Respondent answered:

> . . . This is the way it works. With pain management, first, you have to go conservative. . . . You can go three months and you can see a patient and not perform a procedure. So that's not unreasonable. It's not unreasonable for a physician to see a

> patient for three months, and then after that three months, if they're just getting medication, you have to ask them if they want or if they are amenable to a procedure.
>
> So it's not like you – because that's not the way medicine works. You first start out conservatively. Then after you start out conservatively, if the pain is not being controlled, it's over three to four months, then you offer them a procedure. If they are not amenable to the procedure, you are supposed to discharge or refer them to another physician or not see them. It's their choice really.

Id. at 651-52.

Returning to the dialog of BCI 1's first visit, Respondent testified that when he asked how long BCI 1 had his lower back pain and BCI 1 said "Uh, probably 10 years," he believed that BCI 1 "has chronic back pain, degenerative disc disease," that this is "the most common low back pain diagnosis," and that he took BCI 1's statement "as an affirmative." *Id*. at 653. Then asked what BCI 1's statement "[m]ostly just stiff" meant to him, Respondent answered:

> The thing when you're evaluating a patient, and again, this patient, he's stating that he's having difficulty reading. You do not want patients coming in using medical terminology. You want them to describe it. If they start using medical terminology during the office visit, you can get suspicious that they're either Googling it or they're trying to, you know, skew their answers to make it seem like they have these certain illnesses.

Id. at 653-54. Respondent added that "mostly just stiff . . . means back pain" to him. *Id*. at 654.

As for his questioning BCI 1 as to whether he had "any muscle spasms with the pain" and BCI 1's response to the effect that "[i]t gets tight . . . so I don't know . . . I don't know what the word is for that. Stiff," Respondent testified that "[t]o me, when you say tight . . . that it would be indicative of muscle spasm." *Id*. Respondent further explained that "[t]here's various ways that people describe . . . low back pain and that's one of them, in addition to muscle spasm." *Id.* at 654-55. Respondent also asserted that BCI 1's failure to deny muscles spasms also played into his belief that he had muscle spasms. *Id*. at 655.

As for his asking BCI 1 if he "ever ha[s] to walk with a limp because [his] pain gets so bad," Respondent explained that "you want to know the degree of pain, if it's causing him a lifestyle type of change. You're trying to measure how severe the pain is." *Id*. As for BCI 1's answer ("No, I strut a little bit. Does that count?"), Respondent answered that he considered "the language that he's using . . . strut. I would consider that a limp . . . at the very least abnormality of his gait." *Id*. As for why someone would answer his question this way, Respondent testified: "[a]gain, I'm trying to get to know the patient. You know, for him, with him. I just took it as that he did walk with . . . he had abnormality of his gait." *Id*. at 655-56.

Addressing his asking BCI 1 if he had ever fallen and BCI 1's response ("I'm a grown-ass man. Yeah, I've fallen."), Respondent testified that "it's very difficult to determine what he's trying to say. However, when someone says that they have fallen, to me, that means muscle weakness." *Id*. Respondent then recited BCI 1's answer to his question as to whether the latter had lost muscle strength ("I mean, just getting older, what not. I don't know how you, you know."), and Respondent's counsel asked if he felt "like the patient in this case was being evasive or answering your questions in a straight-up manner?" *Id*. at 656. Respondent answered: "[t]here are multiple things that are going through my mind. Number one, I think he's trying to overcompensate. He's using a lot of slang. . . ." *Id*.

Asked by the CALJ what he meant by his use of the term "overcompensate," Respondent testified: "Like I don't think that he's used to seeing somebody like myself . . . evaluate him." *Id*. at 657. Then asked by the CALJ what he meant by "somebody like yourself," Respondent answered: "An African-American. I don't think that he's . . . I just can't see a person who comes to a doctor's office using the language that he does." *Id*. at 657. Respondent then testified that he had issues with his race while at the Gladwin office as "[t]here were times that

some of the patients did not want me to touch them. So, you know, there's nothing I can do about that as far as that goes, so it can be, you know." *Id.* Continuing, Respondent testified that "[t]he only reason why I could deduce is that . . . I'm African-American." *Id.* Respondent then testified that patients had not only said that they did not want him to touch him but also that they "don't like black people." *Id.* Asked when he encountered these persons, Respondent testified that "it happened twice. It happened right before [BCI 2], and then it happened . . . two or three patients prior to seeing [BCI 1] . . . [t]he second time." *Id.* at 658.

Respondent did not, however, assert that either BCI 1 or BCI 2 acted in this fashion. While Respondent further testified that this had an effect on how he interacted with patients, he then explained that this led him to "want to . . . instill trust in the patients that I know what I'm doing and that I'm there to help them." *Id.*

As for the portion of BCI 1's first visit when Respondent asked the former to stand up and point to the part of his back that hurts the most, Respondent asserted that "he had his coat on his arm" and that he did not "believe" that BCI 1's testimony that he was wearing a coat during the physical exam "to be credible." *Id.* at 658-59. Respondent also maintained that BCI 1 "had some type of a thick shirt on" and "when I asked him to turn around, I lifted up his shirt and then I pressed on his back." *Id.* at 659. Respondent then reiterated that he "personally press[ed] on [BCI 1's] back" and testified that when he did so, he "was feeling tightness, feeling . . . whether he was going to elicit some pain. That's it. Muscle tone, spasm." *Id.*

As found above, as BCI 1 pointed to his back, he stated "[m]ostly just stiff." GX 3, at 9. Respondent testified that he took this statement "as pain." Tr. 659. Respondent then explained that he asked BCI 1 if his pain shot anywhere or was localized because he "wanted to see if [BCI

1] had any nerve symptoms" which would indicate "[t]hat he ha[d] radiculopathy" or "degenerative disc disease." *Id*. at 660.

As also found above, BCI 1 said that his pain was localized. GX 3, at 9. Respondent testified that this statement "could mean a lot of things," including "that he had a herniated disc," that "it could be a degenerative disc, or it could be a narrowing of his neuroforamina." Tr. 660. Respondent then testified that "[y]ou can feel a herniated disc" but not degenerative disc disease with your finger. *Id*. at 660-61.

Respondent further testified that BCI 1's "prior medical records" showed that he had been referred to radiology. *Id*. at 660-61. However, while the "Orders" section of Dr. Vora's progress note for BCI 1's December 15, 2014 visit contain the notations "Radiology" and "lumbar spine," GX 10, at 3, there is no radiology report in BCI 1's patient file.[27] *See generally* GX 10.

As for the abduction/adduction test he performed, Respondent explained that his purpose was to determine muscle strength and referred pain, which he explained that "many times, if you lift up your arms, you also have to contract your low back, and sometimes that can lead to referred pain." *Id*. at 661-62. However, as the video shows, when Respondent performed this test on BCI 1, he did not ask if it caused pain and BCI 1 made no comment to the effect that it caused him pain.[28] *See* GX 3, at 9; *see also* GX 3, Video 5, at 14:48:06-12.

Respondent testified that he asked Respondent if he smoked because "many times cigarette smokers . . . can have a problem with healing" and "if you're planning on doing a

[27] Respondent also testified that "you can" see degenerative disc disease on an X-ray. Tr. 661. Respondent did not, however, testify that he reviewed either an X-ray or radiology report at either of BCI 1's visits.

[28] Likewise, when Respondent performed this test at BCI 1's second visit, he did not ask BCI 1 if it caused pain and BCI 1 did not complain that it caused pain. GX 5, at 4.

procedure, you want them to cease smoking." *Id*. at 662. As for why he asked BCI 1 if he used marijuana, Respondent explained that if BCI 1 had acknowledged marijuana use, you would want to know if he was certified by a physician and had been prescribed medical marijuana as well as to "get a general history of his use of narcotics and drugs." *Id*. at 662-63.

Next, Respondent explained that he asked BCI 1 about his drinking because BCI 1 said "he's on Xanax and he does it on the weekends, and he relates it to his drinking." *Id*. at 663. Respondent then explained that "Dr. Vora had established a pain management plan for him," and "reading through the notes . . . it [the reason for Xanax] could have been twofold, that he was worried about his anxiety, which was documented that he had anxiety, or he could have worried about whether he was going to go into DTs if he stopped drinking." *Id*. Respondent testified that he agreed with Dr. Christensen's statement that it is sometime appropriate to prescribe benzodiazepines to prevent delirium tremens. *Id*. at 663-64. Respondent also testified that, in his mind, BCI 1's statement that he took Xanax to keep him from drinking too much on the weekends meant that BCI 1 "is not educated on . . . his medical condition," that "[h]e doesn't really know what's going on," and that "Dr. Vora has not told him exactly that he's on his Xanax for not only his anxiety but also for the potential of going into DTs." *Id*. at 664. Respondent added: "And that's how I viewed reading the medical record." *Id*.

However, on cross-examination, Respondent testified that he did not create a plan to address BCI 1's drinking, because "in [his] opinion, the plan was already enacted by Dr. Vora" and that plan "was giving the Xanax for both the possibility of DTs and the anxiety that that was documented in [the] prior notes." *Id*. at 690. Respondent denied that he left the issue "unaddressed," explaining that his "impression . . . was that if he felt that he was going into

withdrawals [sic] he would take the Xanax." *Id*. at 691-92. Respondent admitted, however, that he never asked Dr. Vora if this was his plan. *Id*. at 692.

As for why he prescribed carisoprodol to BCI 1, Respondent testified that "in his prior medical records, he was getting Baclofen . . . a muscle relaxant. That's the reason why I had given him the Soma." *Id*. Respondent then acknowledged that while Baclofen treats muscle spasms, it is not a controlled substance. *Id*. at 665.

Next, Respondent offered his explanation regarding BCI 1's statement that "[t]hey're worth a lot of money on the street" and his response of "[t]hat's the whole point. They're pure. You know there is nothing cut down about them. So when you're selling them – its like you know – the person buying – legit." *Id*. at 665-666 (citing GX3, at 14). Asked what his reason was for engaging in this conversation, Respondent maintained: "Well, it's just like educating him, you know, what is going on, why people are seeking this drug. It's not like I'm trying to tell him to go out and sell his drugs." *Id*. at 666. Then asked whether BCI I "ever admit[ted] to [him] at any point during the interaction that he was diverting his controlled substances," Respondent answered: "No. Let's see." *Id*.

As for what action Respondent felt was necessary after BCI 1's subsequent admission that he had traded drugs with his neighbor, Respondent testified that "number one, you want to treat them, you want to give them a chance to be able to rectify their behavior as far as that goes. And if he continued with that, I would have just discharged him." *Id*. As for how he would have determined if BCI I had continued this behavior, Respondent answered: "Number one, I would have, you know, inquired about that. And I would have seen, you know, as far as the MAPS, whatever he's taking in the MAPS." *Id*. at 667.

The CALJ then asked Respondent why he discussed the street value of the drugs that he was prescribing to BCI 1. *Id*. Initially, Respondent testified that "it was an inappropriate conversation" but that he "was really trying to be accepted, trying to relate to the patient. It was a mistake." *Id*. Pressed on the issue, Respondent testified: "Again, it's like, I mean, I can honestly just say that I just wanted for him to feel comfortable for me. It was wrong. I admit that. It was something that I should not have said." *Id*.

Asked by the CALJ whether he "wanted to be [BCI 1's] friend," Respondent answered "[y]es" and added that he "wanted" BCI 1 to "trust" and "like" him and "to be able to say that this guy cares about me, he wants to help me." *Id*. at 668. Then asked by the CALJ "if you wanted him to be your friend, why would you tell him that he could sell his drugs on the street for a lot of money," Respondent answered: "I wasn't telling him to sell the drugs." *Id*. The CALJ then said: "You just told him what the value was," prompting Respondent's counsel to object that the question was argumentative in that it's "premise . . . assumed that he was educating him on how to sell drugs on the street." *Id*. at 669. While the CALJ overruled the objection, he did not pursue this line of questioning. *Id*.

Respondent subsequently testified that he, and not BCI 1, had engaged in the conversation about the street value of the drugs. *Id*. at 670. However, he then revised his testimony to state: "The thing I was trying to convey when I look at my statement is that I mention the pharmaceutical companies. And . . . I'd say most physicians feel that the pharmaceutical companies are . . . getting rich off the patients like himself. And that's why I said that." *Id*. at 670-71. Respondent then maintained that when he stated that "these scripts . . . that you are going to get would be like 6 or 7 hundred dollars. You know the pharmaceutical

company are making bank," he was referring to the pharmaceutical value and not the street value. *Id.*

Addressing the note he prepared for BCI 1's first visit, Respondent testified that he wrote that Respondent had degenerative disc disease for approximately ten years because BCI 1 "had it [low back pain] for 10 years" and "[i]t would be consistent with degenerative disc disease of his low back." *Id.* at 671. As for why he noted that BCI 1 had associated muscle spasm, Respondent explained that BCI 1 "was getting Baclofen. So the mere fact that he's getting Baclofen from his prior medical records, I would say that the Baclofen which is for muscle spasm." *Id.* at 672. Respondent also maintained that "[t]he physical exam that Dr. Vora gave and . . . my examination" were other reasons why he thought BCI 1 could have been getting Baclofen. *Id.*

As for the notation that BCI 1 walked with a "slight limp," Respondent testified that "to me, it looked like he walked with a limp." *Id.* As for why he noted "moderate point tenderness," Respondent maintained that "when I palpated or pushed on his lower back, I thought that he had moderate point tenderness that was localized." *Id.* Respondent also maintained that he read Dr. Vora's medical records for BCI I and "agreed with his management and I was just going to continue that until I got to know the patient better." *Id.* at 673.

After stating his diagnoses and noting that BCI 1"was previously diagnosed with" anxiety, Respondent explained that he continued the Norco and Xanax prescriptions "[f]or the reasons that I previously mentioned" and that BCI 1 "had documented anxiety and I was worried about him going into DTs." *Id.*

Turning to BCI 1's second visit, as found above, after exchanging pleasantries, Respondent asked: "So how is everything been going with your pain?" and BCI 1 replied:

"[g]reat, yup, everything is cool?" GX 5, at 4; Tr. 674. Respondent testified that, in his mind, BCI 1's answer meant "that the regimen or the plan of his management is working. You want the patient to not have any back pain, or you don't want them to, or the pain to be more tolerable." Tr. 674. Respondent also testified that he asked BCI 1 to walk back and forth to see if he had a limp and that he "noticed a limp." *Id.*

As for why Respondent had BCI 1 point to where it hurt in his back, Respondent testified that he did this "[j]ust to gauge . . . the level of his back pain and to see if he had any muscle tightness, the tone, to see if it shot anywhere, if he had any progression of his disease." *Id.* Respondent maintained that at this point, he palpated BCI 1's back, and when asked if he did it through BCI 1's clothing, Respondent testified that "[w]hat I would do is I'd lift the back of his shirt up and then I'd push on his back." *Id.* at 675.

As for BCI 1's statement that "I got stiffness pretty much like right down there," GX 5, at 4, Respondent explained that he interpreted this as "he has back pain. I'm specifically asking him about back pain. I'm, you know, asking him about that and, to me, when he responds, to me, that means that he has low back pain." Tr. 675. As for why he performed the arm adduction and abduction tests, Respondent again testified that he did these tests "to see if he had referred pain, to check out his upper body musculature, and to see if he had good muscle tone. *Id.*

As found above, Respondent then asked BCI 1 to "rate [his] pain on a scale of one to ten today"; BCI 1 responded: "I am good today. I am good today." GX 5, at 4. Asked why he still prescribed medications to BCI 1 "even though he's just failed to give you a pain score," Respondent explained:

> Well, number one, pain waxes and wanes. So he has had this chronic pain for 10 years. This might be just a time that when he comes into the office he might have just taken his medication, that he's okay.

> Usually . . . if the patient takes the medication prior to coming to the office . . . he won't have as much pain.

Tr. 676.

Next, Respondent testified that on March 19, 2015, he still "did not" have access to the urine drugs screens because "[t]hey still were saying that there was a computer issue." *Id.* Respondent maintained that he complained about his lack of access to the urine drug screens and "said that I needed to have these and that . . . that's part of the treatment for the patient." *Id.* at 676-77. As for why he just did not refuse to see patients that day, Respondent explained that "it's not a requirement necessarily to have the urinalysis, but . . . for him, but the key to me about that is to make sure that I eventually do get it." *Id.* at 677. Respondent, however, testified that he never saw a urinalysis test result for BCI I. *Id.* at 678.

Noting Dr. Christensen's testimony that BCI 1's second visit with Respondent "was only about two minutes," Respondent's counsel asked him why it was "so brief." *Id.* at 677. Respondent testified that he "had a[n] incident with a patient prior to [BCI 1], and . . . I'm a human being . . . as far as that goes," and that the incident involved "a patient that did not want me to examine her" because of his race. *Id.* Asked why this would affect his treatment of BCI 1, Respondent answered: "Well, I mean, again, it's hard to describe when somebody doesn't think of you as an equal, and that affects you." *Id.* Respondent then asserted that "[j]ust in general from just the language that [BCI 1] used during the examination," he did not feel like BCI 1 was treating him "as an equal." *Id.* at 678.

Addressing Dr. Christensen's testimony that he did not see evidence that Respondent did a cranial nerves examination yet documented having done so in the March 19 visit note, Respondent's counsel asked: "[w]hy put down in the record that his CN were intact . . . ?" *Id.* Respondent answered:

> Okay. First of all, you can indirectly evaluate the cranial nerves. Like the facial nerve, if he has a facial palsy . . . one his cheeks is [sic] droopy, or his eyelid is not, it's like droopy also, that is indication of an abnormality of one of the cranial nerves. If he . . . has speech patterns similar to somebody who is deaf, that would be indicative of a cranial nerve issue. So that's why. That's it. So you don't necessarily have to, in order to say that the cranial nerves are intact, to directly palpate.

Id. at 679.

As found above, Respondent also documented in the March 19 visit note "2+ pulses throughout" and Dr. Christensen testified that neither the video nor the transcript show that Respondent took BCI 1's pulses. GX 10, at 32; Tr. 433-35. Asked why he made the notation, Respondent testified: "On the radial pulse is the pulses in the wrist. Now, when I have the patient lift up their arms, I'm at the same time pinching their wrist and I'm feeling their pulse." Tr. 678-79.

As for BCI 2, Respondent testified that he reviewed her medical file including the records created by both Dr. Vora and Dr. R. prior to treating her and that he had no reason to not believe the statements in her medical record. *Id*. at 680. He further testified that he "reviewed [Dr. R.'s] physical and . . . what she gave the patient" and the pain clinic history questionnaire. *Id*. at 681.

As found above, after exchanging pleasantries, Respondent asked BCI 2 "to tell [him] what's going on" and she replied: "just here for refills." *Id*. Asked what BCI 2's response indicated to him, Respondent testified: "I mean, it's subjective as far as that goes, it's depending on, you know, I perceive it as that she came in to get her examination and that she was coming in there to have her pain evaluated." *Id*. at 681-82. Respondent also testified that BCI 2's statement that "I feel great today" meant to him "that she's saying to me that the management that she's getting is working." *Id*.

Respondent then testified that he believed that he knew BCI 2's pain score from her previous visit with Dr. R. and that based on the Pain Clinic History Questionnaire, he believed her pain was "at least a 4," which was the rating BCI 2 listed on the form as her usual pain level. *Id*. at 683; *see also* GX 11, at 23.

As for his decision to increase the Norco and decrease the Soma from the quantities prescribed by Dr. R., Respondent testified that "she was getting 120 of the Soma," and in his opinion, that was "too high." *Id*. at 683. Respondent further testified that "Soma can be an anti-anxiety medication" and "can cause you to become drowsy," and that, in his understanding, "the most that you can prescribe within a 30-day period is 90" and "she's overmedicated." *Id.* Respondent further maintained that he "looked at the MAPS and the MAPS said that she had gotten Xanax the prior month. And that, since I was seeing her, I was not going to write the prescription for Xanax." *Id*. at 683-84. Respondent added that he "didn't notice a refill" in the MAPS report and that he "didn't realize you could get refills." *Id*. at 684.

Respondent's counsel then pointed out that "the MAPS report doesn't show the prescription by Dr. [R.] for Xanax" and asked if he "look[ed] at another MAPS report somewhere?" *Id*. Respondent testified: "No, I thought that that was the whole point. I wasn't going to, no matter what, I wasn't going to prescribe her Xanax." *Id*.

As for why he increased BCI 2's Norco, Respondent testified: "that the reason why she's on such a high dose of Soma is that she's trying to control the pain through the Soma, and I just thought that, in my judgment, that was too much to be giving her at that time." *Id*. Respondent then testified that he thought BCI 2's Soma prescription was dangerous, "so [he] decreased it to 60 and . . . increased the Norco to 60, which she prior had been getting from Dr [R]." *Id*. at 685.

Respondent also maintained that he was aware that Dr. R. had previously reduced BCI 2's Norco prescription to 5 dosage units. *Id*.

Respondent was then asked by his counsel why he increased the Norco prescription "if [he] saw that the other doctor had prescribed less?" *Id*. Respondent answered:

> Well, the point being was that generally you want to, if you're going to wean a patient off of a medication, again, it's unique to each patient, but you can wean like 10 percent a week, 10 percent a month, but you have to gauge, or the patient has to be monitored. . . . And with that, I wanted to make sure that her pain was under control.

Id.

Respondent further testified that after his first day in Dr. Vora's office, he tried to contact a psychiatrist because "many of these patients needed to be followed for the Xanax, for the anti-anxiety diagnosis." *Id*. at 685-86. Respondent testified that there was "no one" in the phonebook for Gladwin and while he "Google[d] psychiatrists in" other cities, "[t]here's this big procedure when you're trying to get a patient to see a psychiatrist" which involves "arrang[ing] an appointment with the psychologist" who evaluates whether the patient needs to see a psychiatrist. *Id*. at 686. Respondent testified that he made these phone calls because he "wasn't going to continue to see the patients that were on Xanax" and "did not want to keep prescribing Xanax." *Id*.

Respondent also testified that because his instructions regarding obtaining access to the EMR and the urine drug screen results were not followed, he "told them that I cannot do this anymore." *Id*. at 687. Asked if he "recognize[d] . . . that there were some deficiencies in how [he] treated the patients at Dr. Vora's office," Respondent answered "yes." *Id*. at 688. As for what he could "do better," Respondent said "cut down the number of patients," "make sure" he had "full access to all the records," "make sure that everything was set up for, you know, I needed to offer them you know, procedures," and to "let the patients know that there was going

to be an African-American there and that if they didn't want to come, that's their choice." *Id.* at 688-89. Respondent also testified that he is no longer working as a *locum tenens* because he has not found a "satisfactory" job. *Id*. at 689. He then explained that "I want to do radiology" and "I do not really want to do pain management. . . . But right now the only thing that's open is pain management." *Id.* Asked if it is his "desire to ever engage in office-based pain management treatment again," Respondent answered: "That's not my goal at all." *Id.*

On cross-examination, the Government asked Respondent why he "still prescribed a 30-day supply of controlled substances" rather than "a lesser day . . . supply" at each of the three undercover visits "given [his] uncomfortableness with not having [the] urinalysis results." *Id.* at 693. Respondent answered: "[f]irst of all, you can never just have the patient go cold turkey for any type of narcotic." *Id*. Government counsel reminded Respondent that he "didn't say cold turkey" and he had "said a lesser number." *Id.* Respondent answered:

> So what would they, if I'm not going to be there or they're not going to be seen for a month, what would they do - - from my standpoint, this is rhetorical, is that if you do give a lesser amount . . . they run out. Then they're going to self-medicate if they run out and they don't have access. And then if the patient runs out, they go into withdrawals, they might be driving, then they might cross the median, they could kill somebody. So that's my concern of like saying okay, I'm going to just give you 10."

Id. at 693-94.

When the Government suggested that Respondent could have "had the patient return or . . . could have phoned in the additional pills later," Respondent testified that "[y]ou can't phone in Norco" and that "he'd go in[to] withdrawal from the Norco." *Id.* at 694. Respondent then testified that he "would have to weigh the costs and the benefits" and that if "a patient has been on it for an extended period of time and then you decide to just stop them, . . . they're going to have withdrawals." *Id.* After the Government asked if "it would be too inconvenient for them to return," Respondent answered: "It's like this is – you guys know where you're at. It's Gladwin

as far as that goes." *Id.* at 694-95. Then asked how hard it would be "to get back to the doctor's office" if "only 3,000 people" live in Gladwin, Respondent answered: "It only takes one accident. That's it. I'm just saying for me, I just used my – I did not want patient to go into withdrawals. I didn't feel comfortable not giving him medication." *Id.* at 695,

Addressing BCI 1's February 19, 2015 prescriptions, the Government asked Respondent whether he believed, at the time he issued each of the prescriptions, that the prescriptions were "for a legitimate medical purpose within the usual course of professional practice and the Michigan standard of practice?" *Id.* Respondent generally testified that he did believe the prescriptions were lawful, although he acknowledged that "[i]t was a mistake" to prescribe Soma to BCI 1. *Id.* at 696. Respondent then explained that by this, he meant that he "wasn't as aware of the holy trinity"; he further explained that with the patients that "I'd come in contact with, this holy trinity was not that . . . common for me. . . So I wasn't that familiar with that. So, when I wrote these out, I wrote it out in good faith. I was not as knowledgeable as I should have been." *Id.* at 696-97.

While Respondent admitted that it was a mistake to prescribe Soma to BCI 1 because he was on a different non-controlled muscle relaxant, he again testified that if "I had been more knowledgeable about the holy trinity, I would not have given him the Soma." *Id.* at 697. Respondent nonetheless believed that prescription was issued for a legitimate medical purpose and in the usual course of professional practice "[b]ased on the medical records from Dr. Vora and his history he gave me." *Id.*

Respondent offered testimony to the same effect with respect to the three prescriptions he issued to BCI 1 at the March 19, 2015 visit, testifying that he believed that he wrote the prescriptions "in good faith" and "[b]ased on Dr. Vora's history, what he told me." *Id.* at 698-

99. While Respondent again admitted that the Soma prescription was a mistake, he testified that he "wrote it under good faith," that "I wasn't trying to write something that was illegal," and that "I wasn't trying to have somebody get something that . . . they shouldn't have gotten." *Id*. at 699.

Finally, Respondent testified that both the Norco and Soma prescriptions he issued to BCI 2 were for a legitimate medical purpose, and within both the usual course of professional practice and the Michigan Standard of Practice. *Id*. at 699-700.

DISCUSSION

Section 303(f) of the Controlled Substances Act (CSA) provides that "[t]he Attorney General may deny an application for [a practitioner's] registration . . . if the Attorney General determines that the issuance of such registration . . . would be inconsistent with the public interest." 21 U.S.C. § 823(f). With respect to a practitioner, the Act requires the consideration of the following factors in making the public interest determination:

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

Id.

"[T]hese factors are . . . considered in the disjunctive." *Robert A. Leslie, M.D.*, 68 FR 15227, 15230 (2003). It is well settled that "I may rely on any one or a combination of factors, and may give each factor the weight [I] deem[] appropriate in determining whether . . . an

application for registration [should be] denied." *Paul H. Volkman*, 73 FR 30630, 30641 (2008) (citing *id.*), *pet. for rev. denied*, *Volkman v. DEA*, 567 F.3d 215, 222 (6th Cir. 2009); *see also MacKay v. DEA*, 664 F.3d 808, 816 (10th Cir. 2011); *Hoxie v. DEA*, 419 F.3d 477, 482 (6th Cir. 2005). Moreover, while I am required to consider each of the factors, I "need not make explicit findings as to each one." *MacKay*, 664 F.3d at 816 (quoting *Volkman*, 567 F.3d at 222 (quoting *Hoxie*, 419 F.3d at 482)).[29]

The Government has the burden of proving, by a preponderance of the evidence, that the requirements for denial of an application pursuant to 21 U.S.C. § 823(f) are met. 21 CFR 1301.44(d). However, once the Government has made a *prima facie* showing that issuing a new registration to the applicant would be inconsistent with the public interest, an applicant must then present sufficient mitigating evidence to show why he can be entrusted with a new registration. *Medicine Shoppe-Jonesborough*, 73 FR 364, 387 (2008) (citing cases), *pet. for rev. denied*, 300 Fed. Appx. 409 (6th. Cir. 2008); *see also MacKay*, 664 F.3d at 817.

Having considered all of the factors, I find that the Government's evidence with respect to Factors Two and Four satisfies its *prima facie* burden of showing that granting Respondent's application would be inconsistent with the public interest.[30] I further find that Respondent has failed to produce sufficient evidence to rebut the Government's *prima facie* case.

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

[30] As to Factor One, while on December 13, 2016, the Michigan Board imposed a summary suspension of Respondent's medical license, on February 16, 2017, the Board entered into a Consent Order and Stipulation which dissolved the summary suspension while limiting Respondent's authority to "obtain, possess, prescribe, dispense or administer any . . . controlled substance . . . except in a hospital or other institutional setting." However, while Respondent does possess limited state authority as required to be registered under 21 U.S.C. § 823(f), the Board has not made a recommendation to the Agency in this matter. Moreover, as the Agency has long held, this partial restoration of Respondent's state authority is not dispositive of the public interest inquiry. *See Mortimer Levin*, 57 FR 8680, 8681 (1992) ("[T]he Controlled Substances Act requires that the Administrator . . . make an independent

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

Under a longstanding DEA regulation, a prescription for a controlled substance is not "effective" unless it is "issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 CFR 1306.04(a). *See also* Mich. Comp. Laws § 333.7333(1) ("As used in this section, 'good faith' means the prescribing of a controlled substance by a practitioner licensed under section 7303 in the regular course of

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determination [from that made by state officials] as to whether the granting of controlled substance privileges would be in the public interest."). *See also* 21 U.S.C. § 802(21) (defining "the term 'practitioner' [to] mean[] a . . . physician . . . or other person licensed, registered or otherwise permitted, by . . . the jurisdiction in which he practices . . . to distribute, dispense, [or] administer . . . a controlled substance in the course of professional practice").

To be sure, the Agency's case law contains some older decisions which can be read as giving more than nominal weight in the public interest determination to a State Board's decision (not involving a recommendation to DEA) either restoring or maintaining a practitioner's state authority to dispense controlled substances. *See, e.g.*, *Gregory D. Owens*, 67 FR 50461, 50463 (2002) (expressing agreement with ALJ's conclusion that the board's placing dentist on probation instead of suspending or limiting his controlled substance authority "reflects favorably upon [his] retaining his . . . [r]egistration, and upon DEA's granting of [his] pending renewal application"); *Vincent J. Scolaro*, 67 FR 42060, 42065 (2002) (concurring with ALJ's "conclusion that" state board's reinstatement of medical license "with restrictions" established that "[b]oard implicitly agrees that the [r]espondent is ready to maintain a DEA registration upon the terms set forth in" its order).

Of note, these cases cannot be squared with the Agency's longstanding holding that "[t]he Controlled Substances Act requires that the Administrator . . . make an independent determination [from that made by state officials] as to whether the granting of controlled substance privileges would be in the public interest." *Levin*, 57 FR at 8681. Indeed, neither of these cases even acknowledged the existence of *Levin*, let alone attempted to reconcile the weight it gave the state board's action with *Levin*. While in other cases, the Agency has given some weight to a Board's action in allowing a practitioner to retain his state authority even in the absence of an express recommendation, *see Tyson Quy*, 78 FR 47412, 47417 (2013), the Agency has repeatedly held that a practitioner's retention of his/her state authority is not dispositive of the public interest inquiry. *See, e.g., Paul Weir Battershell*, 76 FR 44359, 44366 (2011) (citing *Edmund Chein*, 72 FR 6580, 6590 (2007), *pet. for rev. denied*, *Chein v. DEA*, 533 F.3d 828 (D.C. Cir. 2008)).

As to Factor Three, I acknowledge that there is no evidence that Respondent has been convicted of an offense under either federal or Michigan law "relating to the manufacture, distribution or dispensing of controlled substances." 21 U.S.C. § 823(f)(3). However, there are a number of reasons why even a person who has engaged in criminal misconduct may never have been convicted of an offense under this factor, let alone prosecuted for one. *Dewey C. MacKay*, 75 FR 49956, 49973 (2010), *pet. for rev. denied*, *MacKay v. DEA*, 664 F.3d at 822. The Agency has therefore held that "the absence of such a conviction is of considerably less consequence in the public interest inquiry" and is therefore not dispositive. *Id*.

As for Factor Five, the Government made no allegations that implicate Factor Five. Nor did it claim that Respondent's false testimony on certain issues implicates Factor Five.

professional treatment to or for an individual who is under treatment by the practitioner for a pathology or condition other than that individual's physical or psychological dependence upon or addiction to a controlled substance, except as provided in this article."); *id.* § 333.7401 ("A practitioner licensed by the administrator under this article shall not dispense, prescribe, or administer a controlled substance for other than a legitimate and professionally recognized therapeutic or scientific purposes or outside the scope of practice of the practitioner . . . .").[31]

Under the CSA, it is fundamental that a practitioner must establish a bonafide doctor-patient relationship in order to act "in the usual course of . . . professional practice" and to issue a prescription for a "legitimate medical purpose." *See United States v. Moore*, 423 U.S. 122, 142-43 (1975); *United States v. Lovern*, 590 F.3d 1095, 1100-01 (10th Cir. 2009); *United States v. Smith*, 573 F.3d 639, 657 (8th Cir. 2009); *see also* 21 CFR 1306.04(a) ("An order purporting to be a prescription issued not in the usual course of professional treatment . . . is not a prescription within the meaning and intent of [21 U.S.C. § 829] and . . . the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances."). As the Supreme Court has explained, "the prescription requirement . . . ensures patients use controlled substances under the supervision of a doctor so as to prevent addiction and recreational abuse. As a corollary, [it] also bars doctors from peddling to patients who crave the drugs for those prohibited uses." *Gonzales v. Oregon*, 546 U.S. 243, 274 (2006) (citing *Moore*, 423 U.S. 122, 135, 143 (1975)).

Both this Agency and the federal courts have held that establishing a violation of the prescription requirement "requires proof that the practitioner's conduct went 'beyond the bounds of any legitimate medical practice, including that which would constitute civil negligence.'"

[31] As the CALJ noted, the Government did not cite this provision in the Show Cause Order or in its post-hearing brief. R.D., at 73-74. I find, however, that this provision imposes the same standard as 21 CFR 1306.04(a).

Laurence T. McKinney, 73 FR 43260, 43266 (2008) (quoting *United States v. McIver*, 470 F.3d 550, 559 (4th Cir. 2006)). However, as the Sixth Circuit (and other federal circuits have noted), "'[t]here are no specific guidelines concerning what is required to support a conclusion that an accused acted outside the usual course of professional practice. Rather, the courts must engage in a case-by-case analysis of the evidence to determine whether a reasonable inference of guilt may be drawn from specific facts.'" *United States v. August*, 984 F.2d 705, 713 (6th Cir. 1992) (citations omitted) (quoted in *United States v. Singh*, 54 F.3d 1182, 1187 (4th Cir. 1995)).

Thus, in *Moore*, the Supreme Court held the evidence in a criminal trial was sufficient to find that a physician's "conduct exceeded the bounds of 'professional practice,'" where the physician "gave inadequate physical examinations or none at all," "ignored the results of the tests he did make," "took no precautions against . . . misuse and diversion," "did not regulate the dosage at all" and "graduated his fee according to the number of tablets desired." 423 U.S. at 142-43.

However, as the Sixth Circuit has explained, "[o]ne or more of the foregoing factors, or a combination of them, but usually not all of them, may be found in reported decisions of prosecutions of physicians for issuing prescriptions for controlled substances exceeding the usual course of professional practice." *United States v. Kirk*, 584 F.2d 773, 785 (6th Cir. 1978). *See also United States v. Hooker*, 541 F.2d 300, 305 (1st Cir. 1976) (affirming conviction under section 841 where physician "carried out little more than cursory physical examinations, if any, frequently neglected to inquire as to past medical history and made little to no exploration of the type of problem a patient allegedly" had and that "[i]n light of the conversations with the agents, the jury could reasonably infer that the minimal 'professional' procedures followed were designed only to give an appearance of propriety to [the] unlawful distributions"); *United States*

v. Tran Trong Cuong, 18 F.3d 1132, 1139 (4th Cir. 1994) (holding evidence sufficient to find physician prescribed outside of professional practice in that "in most cases the patients complained of such nebulous things as headaches, neckaches, backaches and nervousness, conditions that normally do not require . . . controlled substances," physician was "aware that some of the[] patients were obtaining the same drugs from other doctors," "[m]ost of the patients were given very superficial physical examinations," and patients were not "referred to specialists"); *United States v. Bek*, 493 F.3d 790, 799 (7th Cir. 2007) (upholding convictions; noting that the evidence included "uniform, superficial, and careless examinations," "exceedingly poor record-keeping," "a disregard of blatant signs of drug abuse," "prescrib[ing] multiple medications having the same effects . . . and drugs that are dangerous when taken in combination"); *United States v. Feingold*, 454 F.3d 1001, 1010 (9th Cir. 2006) ("[T]he *Moore* Court based its decision not merely on the fact that the doctor had committed malpractice, or even intentional malpractice, but rather on the fact that his actions completely betrayed any semblance of legitimate medical treatment."); *United States v. Joseph*, 709 F.3d 1082, 1104 (11th Cir. 2013) (upholding conviction of physician where "record establishe[d] that [physician] prescribed an inordinate amount of certain controlled substances, that he did so after conducting no physical examinations or only a cursory physical examination, that [physician] knew or should have known that his patients were misusing their prescriptions, and that many of the combinations of prescriptions drugs were not medically necessary").[32]

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

The CALJ found that Respondent violated 21 CFR 1306.04(a) with respect to each of the prescriptions issued to both investigators. I agree. Even considering the evidence that Respondent practiced at the clinic on a *locum tenens* basis and that both investigators had previously been seen by other physicians at the clinic, who documented findings in the medical records that, in some respects, tended to support the diagnosis of conditions that may justify the prescribing of controlled substances, I nonetheless conclude that the weight of the evidence supports the conclusion that Respondent lacked a legitimate medical purpose and acted outside of the usual course of professional practice when he issued the prescriptions. 21 CFR 1306.04(a).

BCI 1's Prescriptions

With respect to BCI 1's first visit, the CALJ credited Dr. Christensen's testimony that the combination of drugs that Respondent prescribed (Norco, Xanax and carisoprodol), otherwise known as the Holy Trinity, has both a very high abuse potential because of its "euphoric" effects and creates a high risk of "respiratory depression," especially in a patient who admits to drinking alcohol. Tr. 397-98. The CALJ also credited Dr. Christensen's testimony that, under the standard of care, the Investigator's admission of alcohol use required Respondent to not prescribe the Xanax.[33] Tr. 395-96. While Respondent agreed with Dr. Christensen's testimony that prescribing Xanax is medically appropriate to prevent delirium tremens, a condition caused by withdrawal from alcohol, and testified that he was simply following Dr. Vora's plan, which he believed involved prescribing Xanax to both treat the Investigator's anxiety and to prevent

"Accordingly, under the public interest standard, DEA has authority to consider those prescribing practices of a physician, which, while not rising to the level of intentional or knowing misconduct, nonetheless create a substantial risk of diversion." *MacKay*, 75 FR at 49974; *see also Patrick K. Chau*, 77 FR 36003, 36007 (2012).

[33] Dr. Christensen also testified that a physician in primary care should refer a patient who admits to alcohol use to an addiction specialist or counselor. Tr. 396. Dr. Christensen did not, however, testify as to whether the standard of care would require a pain management specialist to refer the patient, and, in any event, it is unclear whether Respondent should be treated as a primary care physician or as a pain management specialist.

DTs, Respondent admitted that he never asked Dr. Vora if he was prescribing Xanax for the latter purpose. *Id*. at 692.

Moreover, even though Dr. Vora's progress notes list a diagnosis of anxiety, and Dr. Christensen testified that a physician can trust the medical documentation of another physician if "the elements of a diagnosis are met," he did not agree "with any diagnosis of anxiety." *Id*. at 516-17. Dr. Christensen also testified that BCI 1's statement that he "take[s] Xanax on the weekends . . . does not appear to be [that of] someone who's complaining about an anxiety diagnosis who's being prescribed Xanax for a documented anxiety disorder." *Id*. at 379. And Dr. Christensen testified that if there was a diagnosis of anxiety disorder, "a reasonable practitioner . . . would want to know" what treatments had been tried. *Id*. at 381. However, Respondent made no such inquiry.

As for Respondent's prescribing of carisoprodol at the first visit, a muscle relaxant which is also a schedule IV drug with sedative effects and Respondent's statements that he was going to prescribe this drug for muscle spasms, Dr. Christensen testified that muscle spasms would be diagnosed by palpating the patient but that he did not see evidence that Respondent had done so. Tr. 399. By contrast, Respondent, in addition to asserting that he interpreted BCI 1's statements that his back was stiff with the presence of muscle spasms, also testified that he lifted up BCI 1's shirt and palpated his back at this visit. *Id*. at 659. However, BCI 1testified that neither he nor Respondent lifted up the clothing that he was wearing and Respondent never palpated his back. *Id*. at 175. Yet Respondent documented in the visit note a physical exam finding of "[m]oderate point tenderness to low back." GX 10, at 31. Moreover, Respondent, at another point in his testimony, explained that he prescribed carisoprodol because Dr. Vora had previously prescribed

Baclofen, a non-controlled muscle relaxant to BCI 1. Tr. 665. He also testified that the prescription was a "mistake." *Id.*

Dr. Christensen opined that the Soma prescription was "not appropriate." *Id.* at 420. He explained that the drug is "indicated for short-term treatment of muscle spasms," but that "there is no documentation of this" condition. *Id.* Dr. Christensen further explained that Soma was "contraindicated with this patient's history." *Id.*

Notably, the CALJ found BCI 1's testimony "fully credible" as to all issues. R.D. 14 By contrast, the CALJ found Respondent's testimony on the issue of why he prescribed the carisoprodol, to be "not just a little confusing" and "not convincing." *Id.* at 54. Based on the CALJ's credibility findings, I find that Respondent's testimony that he lifted up BCI's clothing and palpated BCI 1's back was false, that Respondent had no basis for documenting in the visit note a finding of moderate point tenderness, and that Respondent falsified BCI 1's medical record.

Thus, notwithstanding that BCI 1's records showed that Dr. Vora had diagnosed him with muscle spasms and the somewhat ambiguous statements made by BCI 1 as to his condition, I conclude that the weight of the evidence supports the conclusion that Respondent acted outside of the usual course of professional practice and lacked a legitimate purpose when he prescribed carisoprodol to BCI 1. 21 CFR 1306.04(a). While Dr. Christensen testified that a physical exam is not required at a follow-up visit and a subsequent physician can rely on a diagnosis of another physician if there is evidence that a pertinent examination had previously been performed, I reject Respondent's defense that he reasonably relied on the examinations as documented by Dr. Vora and that while "we now know" that Dr. Vora's records "were largely false, Respondent had no indication that this was the case." *See* Resp.'s Post-Hrng. Br. 30.

First, as found above, BCI 1 told Respondent that he had asked Dr. Vora for a couple of extra pills, and based on the statements Respondent made regarding the quantity of the prescriptions (66 pills for both Norco and Xanax) written by Vora, I find that Respondent clearly knew that Vora had given extra pills to BCI 1, thus calling into question the legitimacy of Vora's prescribing as well as his recordkeeping. Moreover, Respondent falsified the visit note to indicate a finding of moderate point tenderness, and in this proceeding, he falsely testified that he lifted up BCI 1's clothing and palpated his back. Unexplained by Respondent is why, if he reasonably relied on Vora's records and had "no indication" that they "were largely false," he proceeded to create his own set of false physical exam findings and gave false testimony at the hearing. Indeed, Respondent's testimony and his falsification of BCI 1's visit note support the conclusion that Respondent did not merely make a mistake when he prescribed carisoprodol but that he knowingly diverted controlled substances when he prescribed the drug (as well as alprazolam and Norco) to BCI 1. 21 CFR 1306.04(a).

As for the Norco prescription, Dr. Christensen noted that on his initial intake form, BCI 1 had listed "refills" as his reason for visit and that on the medical history form, BCI 1 did not check off any symptom listed on the form, let alone those that are relevant in assessing lower back pain. Tr. 410; *see also* GX 10, at 17, 19. He further explained that the standard of care required that Respondent obtain a family history of psychiatric and substance abuse disorders to rule out substance abuse as the reason BCI 1 was seeking medication. *Id.* at 413. While Dr. Christensen acknowledged that BCI 1 had been seen by Dr. Vora, he testified that if the medical record is incomplete, a subsequent physician must obtain the missing history which is relevant to the patient's complaint, especially if the treatment plan involves controlled substances. *Id.* at 411-12. *See also id.* at 489 ("the first thing you should do is take a history" that is relevant to the

complaint). Dr. Christensen also testified as to the various items, which under the standard of care in Michigan, should be addressed in taking a pain patient's history, including addressing the onset of the pain, the duration of the pain, factors that aggravate or relieve the pain, what brings the pain on, the severity of the pain, and how the pain affects the patient's function. *Id*. at 374.

Notably, the visit notes created by Dr. Vora contained no discussion of these issues other than to note that the onset date of BCI 1's back pain was 12/15/2014. *See* GX 10, at 1(Jan. 12, 2015 note); *id*. at 3 (Dec. 15, 2014 note); *see also id.* at 5 (Nov. 10, 2014 note which lists back pain and back stiffness as patient's complaint but no other information). Moreover, while Respondent proceeded to ask BCI 1 as to how long he had back pain, whether he got muscle spasms with the pain, whether he walked with a limp, whether he had any loss of muscle strength, and whether the pain shot anywhere or was just localized, even when BCI 1's answers were ambiguous, Respondent accepted them with no further questioning. He did not ask questions that would clarify whether BCI 1's purported pain was caused by an injury, question BCI 1 about any prior treatments he received, nor clarify what BCI 1 meant when he said he was mostly just stiff. And while Respondent asked BCI 1 if he smoked, used marijuana, and was a social drinker, even after BCI 1 replied that he took Xanax to keep from drinking too much on the weekends, Respondent asked no further questions to determine the extent of Respondent's alcohol use.

As for Respondent's physical exam, it is acknowledged that Dr. Vora's visit note for BCI 1's December 15, 2014 visit documented the performance of a physical exam and that Dr. Christensen acknowledged that this would be an appropriate exam on a follow-up visit.[34]

[34] As found above, Dr. Vora made no physical exam findings pertinent to BCI 1's complaint of back pain at his first visit (Nov. 2014), and Dr. Christensen was not asked if the findings made by Dr. Vora in the December 2014 visit establish that an appropriate physical exam was performed as part of the initial evaluation of BCI 1's complaint. For

However, even assuming that the findings documented in the December 2014 visit note establish that Dr. Vora performed an appropriate physical exam, as well as acknowledging that a physical exam is not necessarily required at a follow-up visit and that a subsequent physician can rely on the medical record absent some indication that the record is not truthful, Respondent nonetheless documented various findings of a physical exam when the evidence shows he did not perform the tests necessary to make those findings. These include not only his finding of moderate point tenderness as well as his findings that BCI 1's cranial nerves IV-XII were intact. *Compare* GX 10, at 31, *with* Tr. 416 (testimony of Dr. Christensen noting no evidence of palpation of BCI 1's lower back) and *id*. at 417-19 (testimony of Dr. Christensen noting no evidence of testing of BCI 1's cranial nerves).

Moreover, even as to the tests Respondent did perform, Dr. Christensen's testimony suggests that Respondent was just going through the motions, as the arm abduction/adduction test he did do is not used to assess lower back pain but rather nerve issues in the thoracic and cervical spine. *Id.* at 386. Indeed, while Respondent asserted that his purpose in doing this test was to establish if BCI 1 had "referred pain," *id*. at 661, he did not ask BCI 1 if it caused pain, and BCI 1 did not complain that it caused pain at either visit. GX 3, at 9; GX 5, at 4.

Thus, Respondent did not simply rely on Dr. Vora's physical exam findings but deemed it necessary to document his own false findings to support his decision to prescribe Norco to BCI 1. Respondent also gave false testimony when he asserted that he had actually palpated BCI 1.

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purposes of this discussion, I assume, without deciding, that the December 2014 physical exam findings establish that Dr. Vora performed an appropriate exam, whether the visit is viewed as an initial evaluation or a follow-up.

I also assume, without deciding, that at the time he commenced his February 2015 *locum tenens* service at Dr. Vora's clinic and prior to his interaction with BCI 1, Respondent did not have sufficient information to conclude that Dr. Vora was not engaging in the legitimate practice of medicine. *See* Tr. 532 (testimony of Dr. Christensen that it was reasonable to trust Dr. Vora's documentation absent an indication that the records were not truthful).

Moreover, the statements made at various points in his interaction with BCI 1show that Respondent knew that BCI 1 was not a legitimate pain patient. These include:

> BCI 1's statement that he took Xanax because it kept him from drinking too much moonshine on the weekends;
>
> BCI 1's statement that the drugs he was getting from Respondent were "worth a lot of money on the street" and Respondent's explanation that this is because the drugs are "pure" and "there is nothing cut down about them. So when you're selling them" followed by BCI 1's statement that "it's a little safer to do it that way" and Respondent's acknowledgement that this was "right";[35]
>
> BCI 1's statements that "a couple of times" he had "r[u]n out of pills" and had to "trade with [his] neighbor," as well as his statement that he asked Dr. Vora "for a couple extra" pills which he gave back to his neighbor;[36]
>
> and after Respondent asked BCI 1 "but 66" [the quantity of Dr. Vora's previous Norco prescription] what's that about?"; BCI 1's statement that "I can't be paying – buying them on the street."

As further evidence that Respondent knew that BCI 1 was likely engaged in either abuse or diversion of controlled substances, BCI 1's MAPS report[37] showed that he had obtained alprazolam from four different prescribers, including prescribers whose offices were in Detroit and Marquette, 400 miles apart. GX 10, at 23. Notably, while Respondent testified that on his first day at the clinic, he did not have access to urine drug screen reports, he also testified that he would request and the staff "would give" him "printouts of the charts"; he also testified that "I

[35] As for his statement that the prescriptions he was giving BCI 1 "would be like 6 or 7 hundred dollars," Respondent initially testified that "it was an inappropriate conversation" but that he was "trying to relate to the patient," only for him to claim that he "wasn't telling him to sell the drugs" and that he was trying to convey that it was "the pharmaceutical companies" that were "getting rich off the patients like himself." However, even were I to credit Respondent's latter explanation that he discussed the high prices of drugs as being caused by the drug companies making lots of money, his subsequent explanation to BCI 1 that the reason the drugs were worth a lot of money is because "[t]hey're pure" and "there is nothing cut down about them," leaves no doubt that Respondent understood that BCI 1 was not a legitimate patient.

[36] Of further note, while BCI 1 entered into a Controlled Substances Management Agreement, which prohibited him from sharing, selling or trading his medication, and Dr. Christensen testified that "at a minimum," a reasonable practitioner would tell the patient that this is illegal and that if this was to happen again, the physician "would not be able to prescribe" any more controlled substances. Tr. 403, 406.

[37] The report was dated October 29, 2014. GX 10, at 23.

had at the very least to have the MAPS." Tr. 638. At no point did Respondent deny that he had received BCI 1's MAPS report at the time of the first visit, nor did he offer testimony that he did not review BCI 1's MAPS report. As Dr. Christensen explained, the "high geographic distance between [the] providers" and the "multiple providers" listed on BCI 1's MAPS report are "signs of doctor shopping" and "diversion or misuse." *Id.* at 414.

Dr. Christensen opined that based on his review of the video, the transcript, and BCI 1's medical file, Respondent's issuance of the Norco prescription was inappropriate because "[t]here was no documentation of moderate to moderately severe pain." *Id.* at 419-20. Dr. Christensen also explained that the evidence created "concern about another underlying diagnosis," *i.e.*, substance abuse, "that would have mandated either a referral or not writing the [Norco] prescription." *Id.*

Dr. Christensen thus opined, and the CALJ agreed, that none of the three prescriptions Respondent wrote for BCI 1 on February 19, 2015 were issued for a legitimate medical purpose by a practitioner acting in the usual course of his professional practice. Tr. 425-26. I agree.

As for BCI 1's second visit, as Dr. Christensen noted, when Respondent asked about his pain level, the former replied that "everything is cool." Tr. 428. Dr. Christensen also noted that when Respondent then asked BCI 1 to rate his pain on a 1-10 scale, BCI 1 simply replied: "I'm good today." *Id.* Dr. Christensen testified that these were "non-responsive" and "evasive answer[s], which can be signs of drug-seeking behavior." *Id.* at 430-31.[38]

[38] I have considered Respondent's testimony that he interpreted BCI 1's answer to his question, "[s]o how is everything going with your pain" ("great, yup, everything is cool"), as meaning "that the regimen or the plan of his management was working." Tr. 674. I have also considered Respondent's testimony that he interpreted BCI 1's answer - when asked to rate his pain on a scale of one to ten - of "I am good today," as "pain waxes and wanes" and "[t]his might be just a time when he comes into the office [and] he might have just taken his medication." *Id.* at 676.

Even were I to consider this testimony without regard to the CALJ's findings that Respondent's testimony was generally not credible, which I decline to do, Respondent did not ask any further questions to probe why BCI 1 answered his questions as he did, nor ask BCI 1 when he last took his medication. Also, as Dr. Christensen testified,

Dr. Christensen further explained that a reasonable practitioner would have asked BCI 1 about his function level, side effects of the medication, and inquired about any aberrant behaviors. *Id*. at 429. Yet none of this was done. Moreover, the entire interaction between BCI 1 and Respondent lasted less than two minutes, and while a physical exam is not necessarily required on a follow-up visit, Respondent nonetheless performed an exam. Significantly, his examination was limited to having BCI 1 walk back and forth and performing the arm abduction/adduction test, which as previously explained, tests for nerve damage in the thoracic and cervical spine and not nerve damage in the lower back. As Dr. Christensen explained, the examination was not adequate to support medical decision making and that this "was a negative evaluation for moderate to moderately severe pain." *Id*. at 431, 429.

Also, as Dr. Christensen explained, Respondent again falsified the visit note by documenting physical exam findings when he did not perform the tests necessary to make those findings. *Id*. at 433-35. Dr. Christensen specifically identified the findings of "moderate point tenderness to low back," "cranial nerves 2 through 12 intact," "2+ pulses throughout," and "2/2 reflexes" as not supported by tests, and he further explained that there were no findings to support the diagnoses of degenerative disc disease in the lumbar area, anxiety, and muscle spasm. *Id*. at 447.

While Respondent testified that he palpated BCI 1's back, here again, BCI 1 credibly testified that he did not do so. Moreover, as for Respondent's testimony that "you can indirectly

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Respondent did not engage in anything close to a meaningful assessment of how the pain affected BCI 1's level of function, whether there were side effects, or ask about aberrant behavior. I thus find Respondent's testimony on these issues not credible.

Respondent also explained that the reasons he made various comments to BCI 1 was because he felt the latter's comments to him were racially motivated and created a situation where he had to work to gain BCI1's trust. Tr. 658. He also testified that he encountered racial animus from several other patients. *Id.* The CALJ rejected Respondent's contention, noting that "[t]here was no evidence of any tension in any of the three office visits in the video recordings or the transcripts" and that this does not excuse his violations of federal law. R.D. at 84-85. I agree.

evaluate the cranial nerves" by looking for facial palsy and if "speech patterns [are] similar to somebody who is deaf," *id*. at 678-79, Dr. Christensen testified that an examination of a patient's cranial nerves is far more extensive than what Respondent claim is required. *See id*. at 417-19. As for Respondent's claim that he assessed BCI 1's radial pulse when he performed the arm abduction/adduction test by pinching his wrist, Dr. Christensen testified that a finding of "2+ pulses throughout" also requires testing of the pulse in the lower extremities. *Id*. at 434-35. There is, however, no evidence that Respondent touched BCI 1's lower extremities. While Respondent also documented findings of "2/2 reflexes" and "Full RoM," Respondent offered no testimony as to how he accomplished the tests necessary to make these findings and the video provides no evidence that he did so. Thus, the evidence shows that Respondent again falsified BCI 1's medical record when he documented findings that would support prescribing Norco and carisoprodol. Moreover, there are no findings in the March 19 (or the February 19) visit note that support a diagnosis of anxiety and the prescribing of alprazolam.

Accordingly, based on the medical record, the video and transcript of the visit, Dr. Christensen's testimony, and the inferences to be drawn from Respondent's false testimony, I conclude that Respondent lacked a legitimate medical purpose and acted outside of the usual course of professional practice when he issued each of the three March 19, 2015 prescriptions to BCI 1. 21 CFR 1306.04(a).

BCI 2's Prescriptions

The CALJ also concluded that Respondent violated 21 CFR 1306.04(a) when he issued the Norco and Carisoprodol prescriptions to BCI 2. R.D. 84. I agree.

As found above, in responding to Respondent's instruction to tell him how she was doing and how she was feeling, BCI 2 stated that she was "[j]ust here for refills," that she was

"feel[ing] great today," and "actually," she had "been doing really good" and "ha[d] no complaints." GX 7, at 2. Dr. Christensen testified that the statement that she had "no complaints" did "not mean anything" and that Respondent did not determine whether BCI 2 had "been taking the medication and if the medication is the reason . . . for how she feels." Tr. 450. According to Dr. Christensen's unrefuted testimony, under the standard of care, Respondent was required to follow-up this exchange by asking BCI 2 if she had "been taking the medications," as well as by asking about her "pain level, activity level, side effects," and inquire as to whether she was engaged in any aberrant behavior. *Id.*

Dr. Christensen noted that BCI 2 denied that she had muscle spasms and when asked "when does it hurt the most," her answer was that "sometimes" when she was asleep and her alarm went off, she would twist to turn off her alarm and screw her back up, but that this had not "happened in a very long time" and she had "been doing really well." Tr. 454. Dr. Christensen testified that this discussion did not support a finding "of a moderate or higher pain level" and that a reasonable practitioner would ask a patient who said she was not having pain if she was taking her medication and evaluate based on her answer. *Id*. at 454-55.

Dr. Christensen noted that while BCI 2's records listed a complaint of lower back pain, she did not check any of the symptoms of muscle, joint or bone pain listed on the Medical History Form. *Id*. at 456; *see also* GX 11, at 10. He also observed that, on this form, she had listed Norco, Ambien, and Xanax as her current medications. He then explained that Norco and Xanax is a potentially dangerous combination and that Ambien causes side effects and creates risks similar to benzodiazepines, that this combination of drugs raises the concern as to why it "is being prescribed or taken," and if "there was a legitimate diagnosis for" the prescriptions. Tr. 457-58.

With respect to the pain clinic history questionnaire, Dr. Christensen noted that BCI 2 had listed her pain level as ranging from "0 to 4," but did not circle such items as its location, what made her pain worse, how the pain made her feel, and whether pain levels she listed were with or without medication. *Id*. at 461-62; *see* GX 11, at 23. He further observed that while BCI 2 indicated on the form that she used alcohol, she did not provide any information as to the extent of her drinking. *Id.* at 462; GX 11, at 24. He then explained that, under the standard of care, Respondent was required to obtain this information because the amount of her drinking could increase the side effects and risks from the combination of drugs she was prescribed. *Id.* Notably, Respondent did not ask BCI 2 any question about her use of alcohol.

Dr. Christensen further observed that Respondent documented various findings in the progress note even though the video evidence shows that he had no basis to do so. Specifically, Respondent made a finding of "point tenderness to right lower back," notwithstanding that he never palpated BCI 2. Tr. 464-65; GX 11, at 35. Dr. Christensen further noted that BCI 2 "said she was good and she was great and there was no problem." Tr. 464.

As for Respondent's finding that the pain "shoots to left hip," Dr. Christensen testified that BCI 2 did not complain that her pain radiated or shot to her left hip, and, in fact, when BCI 2 was asked "to point to where it is," she pointed to her right hip area. *Id*. at 465, 285, 572. Indeed, BCI 2 said that "it just stays there." GX 7, at 3. As for Respondent's finding of "Full Rom," while Dr. Christensen acknowledged that he performed the abduction/adduction test on BCI 2's arms, he did not perform any other range of motion testing. Tr. 465. Dr. Christensen also noted that Respondent did not perform the tests necessary to make his findings of "CN II – XII intact," "2+ pulses throughout,"[39] and "2/2 reflexes." *Id.* at 465-66. He further observed that

[39] For the same reasons that I rejected Respondent's testimony that he made this finding with respect to BCI 1 based on the arm abduction/adduction tests he performed, I reject it with respect to BCI 2 as well.

while Respondent diagnosed BCI 2 as having muscle spasms, he did not palpate her and she specifically denied having spasms; he also noted that there was no documentation for his diagnosis of "abnormal gait periodically," and BCI 2 denied that the pain caused her to limp. *Id.* at 467; GX 7, at 3-4.

As found above, on January 23, 2015, Dr. R. had issued BCI 2 prescriptions for 30-day quantities of both Xanax and Ambien, with each prescription providing for four refills. Thus, when Respondent prescribed Norco and carisoprodol to BCI 2, she had current prescriptions for four different controlled substances. As Dr. Christensen explained, this combination of sedatives is "a highly addictive and dangerous combination." Tr. 474.

Respondent justified his prescribing, maintaining that he reviewed the medical records created by Dr. Vora and Dr. R., including the latter's "physical and . . . what she gave the patient." *Id.* at 681. However, in the January 23, 2015 visit note, Dr. R. indicated that she was issuing both Ambien and Xanax prescriptions, each of which provided for four refills. Moreover, the prescriptions were in the file, each clearly indicated that four refills were authorized, and, in contrast to his testimony that the medical files did not contain the UDS results, Respondent made no claim that the prescriptions were not in the files.

Moreover, while Dr. Christensen testified that that Dr. R.'s documentation of her January 23, 2015 examination reflected an appropriate examination based on BCI 2's complaint of lower back pain (as documented on her chart), notably, at BCI 2's Feb. 19 visit (which immediately preceded her visit with Respondent), Dr. R. had reduced the Norco prescription from 60 dosage units to five dosage units (a five-day supply), doing what Dr. Christensen explained was "a planned taper." Tr. 577; see also GX 11, at 30. Yet Respondent increased BCI 2's Norco prescription back up to 60 dosage units even though BCI 2 never once claimed that she was

currently in pain and, indeed, made statements that she was "feel[ing] great," that she had "been doing really good" and "ha[d] no complaints," that "like right now I have like nothing. I feel good. I have good days and bad," and even when she identified when it hurt her the most, she added: "But I haven't had that happen in a very long time like literally I have been really doing well."

Although Dr. Christensen acknowledged that these statements could be an indication that BCI 2's condition was well managed with her medication, he explained that it was not reasonable for Respondent to conclude that her medication regimen was appropriate given that Respondent did not ask her if she was taking her medication and how much medication she was taking. Tr. 563-64. Moreover, while Respondent testified that he had reviewed what Dr. R. had prescribed to BCI 2, he did not issue the same prescriptions but rather increased her Norco prescription back up to 60 dosage units.

As Dr. Christensen explained, while there was some discussion between Respondent and BCI 2 as to why he had decreased the carisoprodol prescription, there was no discussion between the two as to why he increased the Norco prescription. *Id*. at 576. Notably, Dr. Christensen explained that the standard of care in Michigan includes "the principle of informed consent," which requires a physician to explain why the physician is "making a major change" in a patient's controlled medications and the risks involved. *Id*. at 577. He testified that while Respondent's decision to decrease BCI 2's carisoprodol prescription was reasonable, it was "not a rational therapeutic choice" to increase her Norco "to maintain the analgesic effect" of her carisoprodol. *Id*. at 580. Indeed, he testified that BCI 2 should have been on "neither" drug. *Id*. at 580-81.

As for why he increased BCI 2's Norco prescription, Respondent testified that he was aware that Dr. R. had previously reduced it to five dosage units, but that he "wanted to make sure her pain was under control." *Id*. at 685. However, as found above, BCI 2 generally denied having pain and certainly denied having had recent pain. Moreover, Respondent did not ask her if she was even taking the medications that Dr. R. had prescribed, let alone assess how her pain affected her ability to function, whether she had side effects from the medications, and whether she was engaged in any aberrant behavior.[40]

Dr. Christensen opined that Respondent lacked a legitimate medical purpose and acted outside of the usual course of professional practice in issuing the Norco and carisoprodol prescriptions to BCI 2. I agree. Based on Dr. Christensen's testimony that Respondent's evaluation was totally inadequate, his testimony that increasing the Norco prescription was not a rational therapeutic choice, that the combinations of drugs prescribed to BCI 2 was highly addictive and dangerous, and Respondent's falsification of the visit note to reflect various findings to support the prescribing of controlled substances when he failed to perform the necessary tests and BCI 2 made no complaint of pain, I conclude that the record as a whole supports the conclusion that Respondent did not simply engage in malpractice, but knowingly issued the prescriptions in violation of 21 CFR 1306.04(a).

Issuance of Prescriptions That Did Not Include the Patient's Address

In addition to the violations of the CSA's prescription requirement, the record supports a finding that Respondent violated 21 CFR 1306.05(a) when he failed to include the patient's address on each of the eight prescriptions at issue in this matter. Under this regulation, "[a]ll

[40] As found above, Respondent claimed that he was denied access to the urine drug screens at both visits, and thus, this means of determining if the patients were engaged in aberrant behavior was unavailable. Asked why he nonetheless prescribed 30-day quantities of narcotics such as hydrocodone, Respondent testified that "you can never just have the patient go cold turkey for any type of narcotic" and "if the patient runs out, they [sic] go into withdrawals [sic]." Tr. 693-94. Yet BCI 2 had been already tapered off of Norco by Dr. R.

prescriptions for controlled substances . . . shall bear the full name and address of the patient." *Id*. § 1306.05(a). This regulation further provides that "the prescribing practitioner is responsible in case the prescription does not conform in all essential respects to the law and regulations." *Id*. § 1306.05(f). As found above, Respondent failed to include the patient's address on each of the eight prescriptions he issued to BCI 1 and BCI 2 and thus violated section 1306.05(a) as well.

SUMMARY of FACTORS TWO AND FOUR

As for Respondent's evidence of his experience as a dispenser of controlled substances, it includes the testimony of Dr. Scott that, pursuant to the order of the Michigan Board, she had supervised Respondent beginning around April 2014 for a period of one year, that she reviewed about 10 of his pain clinic patient charts, and that she "did not have any problems with" them. Tr. 605, 610. Dr. Scott's testimony does not, however, refute the proof of the specific violations found above. Moreover, Dr. Scott's testimony suggests that the prescribing violations which have been proven on the record of this case occurred during the period in which Respondent was under a Board-imposed probation. As for Respondent's prescribing at the detention facility, Dr. Scott offered no testimony that he has treated any of the facility's patients with narcotics and Respondent himself acknowledged that "not that much" of his work at the facility involves prescribing narcotics. Although Respondent also maintained that a small portion of his work at the facility involves prescribing "anti-psychotics" when psychiatrists are not at the facility, he offered no evidence that any of this prescribing involves controlled substances. Finally, while Respondent also testified that prescribing narcotics was part of his training in his fellowships, the

manner in which he prescribed to the investigators suggests that he did not learn very much about the proper prescribing of controlled substances. [41]

In any event, even assuming that Respondent has complied with federal law with respect to every other controlled substance prescription he has issued in the course of his professional career, Respondent's experience evidence does not refute my findings that he lacked a legitimate medical purpose and acted outside of the usual course of professional practice in issuing each of the eight different prescriptions and that he knowingly diverted controlled substances. *See* 21 CFR 1306.04(a). I therefore conclude that the evidence with respect to Factors Two and Four establishes that Respondent "has committed such acts as would render his registration . . . inconsistent with the public interest." 21 U.S.C. § 824(a)(4).

SANCTION

Where, as here, the Government has established grounds to revoke a registration or deny an application, a respondent must then "present[] sufficient mitigating evidence" to show why he can be entrusted with a new registration. *Samuel S. Jackson*, 72 FR 23848, 23853 (2007) (quoting *Leo R. Miller*, 53 FR 21931, 21932 (1988)). "'Moreover, because "past performance is the best predictor of future performance," *ALRA Labs, Inc. v. DEA*, 54 F.3d 450, 452 (7th Cir. 1995), [DEA] has repeatedly held that where [an applicant] has committed acts inconsistent with the public interest, the [applicant] must accept responsibility for [his] actions and demonstrate that [he] will not engage in future misconduct.'" *Jayam Krishna-Iyer*, 74 FR 459, 463 (2009) (quoting *Medicine Shoppe*, 73 FR 364, 387 (2008)); *see also Jackson*, 72 FR at 23853; *John H. Kennedy*, 71 FR 35705, 35709 (2006); *Cuong Tron Tran*, 63 FR 64280, 64283 (1998); *Prince George Daniels*, 60 FR 62884, 62887 (1995).

[41] As for the testimony of Ms. Clemmons, she worked for Respondent for a brief period of time, and she offered only generalized testimony about procedures at his clinic which does not address the specific violations alleged in this matter.

An applicant's acceptance of responsibility must be unequivocal. *See Lon F. Alexander*, 82 FR 49704, 49728 (2017) (collecting cases). Also, an applicant's candor during both an investigation and the hearing itself is an important factor to be considered in determining both whether he has accepted responsibility as well as the appropriate sanction. *Michael S. Moore*, 76 FR 45867, 45868 (2011); *Robert F. Hunt, D.O.*, 75 FR 49995, 50004 (2010); *see also Jeri Hassman*, 75 FR 8194, 8236 (2010) (quoting *Hoxie v. DEA*, 419 F.3d 477, 483 (6th Cir. 2005) ("Candor during DEA investigations, regardless of the severity of the violations alleged, is considered by the DEA to be an important factor when assessing whether a physician's registration is consistent with the public interest[.]")), *pet. for rev. denied*, 515 Fed.Appx. 667 (9th Cir. 2013).

While a registrant must accept responsibility for his misconduct and demonstrate that he will not engage in future misconduct in order to establish that his registration would be consistent with the public interest, DEA has repeatedly held that these are not the only factors that are relevant in determining the appropriate disposition of the matter. *See, e.g., Joseph Gaudio*, 74 FR 10083, 10094 (2009); *Southwood Pharmaceuticals, Inc.*, 72 FR 36487, 36504 (2007). Obviously, the egregiousness and extent of an applicant's misconduct are significant factors in determining the appropriate sanction. *See Jacobo Dreszer*, 76 FR 19386, 19387-88 (2011) (explaining that a respondent can "argue that even though the Government has made out a *prima facie* case, his conduct was not so egregious as to warrant revocation"); *Paul H. Volkman*, 73 FR 30630, 30644 (2008); *see also Paul Weir Battershell*, 76 FR 44359, 44369 (2011) (imposing six-month suspension, noting that the evidence was not limited to security and recordkeeping violations found at first inspection and "manifested a disturbing pattern of

indifference on the part of [r]espondent to his obligations as a registrant"); *Gregory D. Owens*, 74 FR 36751, 36757 n.22 (2009).

So too, the Agency can consider the need to deter similar acts, both with respect to the respondent in a particular case and the community of registrants. *See Gaudio*, 74 FR at 10095 (quoting *Southwood*, 71 FR at 36503). *Cf. McCarthy v. SEC*, 406 F.3d 179, 188-89 (2d Cir. 2005) (upholding SEC's express adoption of "deterrence, both specific and general, as a component in analyzing the remedial efficacy of sanctions").

The CALJ found that Respondent has refused to accept responsibility for his misconduct. R.D. at 91. As the CALJ explained, "[f]ar from offering an unequivocal acceptance of responsibility . . . Respondent offered excuses for his conduct that smacked more of contrivance than contrition." *Id*. Indeed, Respondent specifically denied that he violated 21 CFR 1306.04(a) with respect to any of the prescriptions. I therefore agree with the CALJ that Respondent has failed to accept responsibility for his misconduct.

Given the egregious nature of his misconduct, which involves the knowing diversion of controlled substances, Respondent's failure to acknowledge his misconduct provides reason alone to conclude that he has not rebutted the Government's *prima facie* case.[42] Indeed, this Agency has explained that because the knowing diversion of controlled substances strikes at the core of the CSA's purpose, the Agency will not grant an application (or continue a registration) where the evidence shows that a practitioner has engaged in even a single act of the knowing diversion of a controlled substance and the practitioner refuses to acknowledge his/her misconduct. *See Samuel Mintlow*, 80 FR 3630, 3653 (2015) (citing *Dewey C. MacKay*, 75 FR

[42] Even had Respondent accepted responsibility, his evidence which is arguably relevant on the issue of remediation is not adequate to assure me that he can be entrusted with a registration. As found above, his evidence simply amounts to his promise to do better in the future and his non-binding desire that "I do not really want to do pain management . . . But right now the only thing that's open is pain management." Tr. 688-89. Thus, his promise is no more than a "goal." *Id*. at 689.

49956, 49977 (2010) (citing *Krishna-Iyer*, 74 FR 459, 463 (2009) and *Alan H. Olefsky*, 57 FR 928, 928-29 (1992))). Moreover, while the Agency's interest in specific deterrence is not triggered (because I deny his application), the Agency's interest in deterring other practitioners who contemplate diverting controlled substances is manifest.

I therefore conclude that granting Respondent's application for a registration "would be inconsistent with the public interest." 21 U.S.C. § 823(f). Accordingly, I will order that his pending application be denied.

ORDER

Pursuant to the authority vested in me by 21 U.S.C. § 823(f) and 28 CFR 0.100(b), I order that the application of Garrett Howard Smith, M.D, for a DEA Certificate of Registration as a practitioner, be, and it hereby is, denied. This Order is effective immediately.

Dated: April 17, 2018.

Robert W. Patterson,

Acting Administrator.

[FR Doc. 2018-09020 Filed: 4/27/2018 8:45 am; Publication Date: 4/30/2018]