

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

JOSE VILLAVICENCIO, M.D.,		CASE NO. 12CV-11628
Appellant,		JUDGE SHEWARD
vs.		
STATE MEDICAL BOARD OF OHIO,		
Appellee.		

**DECISION AND JUDGMENT ENTRY AFFIRMING ORDER ISSUED
SEPTEMBER 13, 2012 BY STATE MEDICAL BOARD OF OHIO**

NOTICE OF FINAL, APPEALABLE ORDER

SHEWARD, J.

This case is a Revised Code 119.12 administrative appeal, by Jose Villavicencio, M.D. (Appellant), from an Order issued by the State Medical Board of Ohio on September 13, 2012. In the Order, the Board permanently revoked Appellant's certificate to practice medicine and surgery in Ohio. The record that the Board has certified to the Court reflects the following facts and procedural history.

Facts and Procedural History

Appellant earned a medical degree in 1987 from the University of the Philippines College of Medicine. *Transcript (T.) 13-14, 440*. After working for several years as a physician in the Philippines, Appellant immigrated to the United States in 1990. *T. 440-441, 1188*. In 1993, Appellant completed a three-year residency in internal medicine at the Detroit Medical Center in Detroit, Michigan. *T. 14-16, 441, 1503*.

After Appellant completed his internal-medicine residency, he worked for three years as a physician in Virginia. *T. 14*. From 1997 to 2010, Appellant was employed by Premier

Healthcare Services out of Dayton, Ohio, working in various emergency departments throughout Ohio. *T. 12, 18-19, 455.* During those thirteen years, Appellant worked more than 20,000 hours as an emergency-room physician. *T. 14, 28, 107, 1221.*

Appellant has been licensed to practice medicine in Ohio since 1996. *T. 12.* On the Medical Board's website, Appellant has identified his practice specialties as family practice, addiction medicine, and emergency medicine. *T. 16.* In 1995, Appellant became board-certified by the American Board of Internal Medicine. *T. 14-15, 441-442.* In 2010, he became board-certified by the American Board of Addiction Medicine. *T. 15, 441-444.*

Since 2004, Appellant has operated his own medical practice in the German Village neighborhood in Columbus, Ohio, having transitioned from emergency-room medicine to family practice. *T. 11, 14, 18-21, 24, 1200, 1528.* Appellant holds active medical licenses in Kentucky, Ohio, and West Virginia. *T. 12-13.*

By Notice of Opportunity dated April 13, 2011, the State Medical Board of Ohio notified Appellant that the Board proposed to take disciplinary action against Appellant's medical license, arising out of his care and treatment of sixteen specific patients from 2005 to 2008. The Board alleged that Appellant inappropriately treated the patients, particularly in the prescription of controlled substances, and that he failed to appropriately document his treatment of the patients. More precisely, the Board alleged that Appellant:

- § Excessively and/or inappropriately prescribed medications;
- § Prescribed controlled substances without appropriately pursuing or documenting the pursuit of alternative non-narcotic therapies;
- § Failed to record the reasons for prescribing medication and/or the need/reason for multiple medications;
- § Failed to perform and/or document the performance of appropriate physical examinations/evaluations;

- § Failed to use and/or document appropriate diagnostic testing or other evaluation methods;
- § Failed to devise and/or document treatment plans;
- § Failed to periodically reassess or document the reassessment of the effectiveness of the treatment of illnesses;
- § Failed to adequately/appropriately diagnose and/or document an adequate/appropriate diagnosis of the patients' medical conditions;
- § Failed to document adequate findings to support the diagnoses;
- § Repeatedly/continually treated patients without making appropriate and/or timely referrals to specialists;
- § Failed to keep and maintain adequate records; and
- § Kept records that frequently were verbatim from one office visit to another and from one patient to another.

In the Notice of Opportunity, the Board described, in detail, Appellant's treatment of the sixteen patients, ten of whom had died due to multiple drug intoxication.

In the Notice of Opportunity, the Medical Board alleged that Appellant's acts, conduct, and/or omissions, as described in the Notice of Opportunity, constituted the following:

"Failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as set forth in R.C. 4731.22(B)(2);

"A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as set forth in R.C. 4731.22(B)(6); and

"[V]iolating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as set forth in R.C. 4731.22(B)(20). The Board identified the following three rules: Ohio Adm. Code 4731-11-02(D), Ohio Adm. Code 4731-21-02, and Ohio Adm. Code 4731-27-01.

The Board advised Appellant that he was entitled to a hearing on the charges. On May 10, 2011, Appellant requested a hearing.

In January 2012, a Hearing Examiner conducted a seven-day hearing on the Medical Board's charges against Appellant. The State presented the expert medical testimony of Robert B. Kelly, M.D, who is board-certified by the American Board of Family Practice, and whom the parties stipulated to be an expert in family medicine. *T. 471-474*. At the request of the Board, Dr. Kelly had reviewed the records for the sixteen patients and had prepared a report on his findings and opinions. *T. 473-474; State's Ex. 18*.

Over the course of several days, Dr. Kelly testified at length about Appellant's care and treatment of the sixteen patients, and about Appellant's documentation of his care and treatment of the sixteen patients. Dr. Kelly testified that Appellant's medical records lacked important information, such as adequate histories, examinations, diagnoses, and treatment plans. *T. 478-483, 497, 499-501, 505, 1062-1063, 1343-1344, 1410-1412, 1431-1433*. Dr. Kelly testified that Appellant's practices violated the applicable minimal standards of care. *T. 481, 483, 487-488, 491-499, 505-506, 512-516, 519-525, 527-559, 561-565, 567-569, 571-574, 578-581, 583-584, 586-594, 596, 599-605, 608-610, 612-614, 616-622, 625, 629, 633, 635, 637-639, 641-643, 650, 654, 662, 665-666, 673, 683-685, 700, 702, 709-711, 713, 715-716, 738, 742-744, 746-747, 755, 758*. Dr. Kelly testified that Appellant's actions in the prescribing of controlled substances, and in the documentation of the prescribing of controlled substances, were a departure from and failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. *T. 945-947*.

Appellant admitted that his medical records did not always include all of the information that should have been included for proper documentation. *T. 60-62, 77, 118, 121-122, 124, 142-*

143, 147-149, 204-205, 238-239, 257-258, 320, 342-343, 388-389, 391-392, 407-408, 1227-1228. Appellant conceded that the minimal standards of care required that such information be included in the medical records. *T. 118, 121-122, 124, 147-149, 257-258, 320, 388-389, 407-408.*

On July 12, 2012, the Hearing Examiner issued a 164-page Report and Recommendation, containing an exhaustive summary of the evidence presented at the hearing, as well as detailed findings of fact and conclusions of law. The Hearing Examiner concluded that, on multiple occasions in the course of Appellant's care and treatment of the sixteen patients, he violated the Medical Board's rules for utilizing controlled substances for intractable pain (Ohio Adm. Code 4731-21-02), and that he failed to meet the minimal standards of care in his treatment of the patients and in the selection and administration of their medications, in violation of R.C. 4731.22(B)(2) and (B)(6). The Hearing Examiner recommended that the Board permanently revoke Appellant's medical license, and provided the following rationale for that recommendation:

In an attempt to explain the practice deficiencies that are evident in this case, Dr. Villavicencio described himself as inexperienced and naïve when he opened his family-medicine practice in 2004 and while he was treating these 16 patients between 2005 through 2008. He also stated that he was "learning on the job." He further stated that he continued to learn and improve his care and his medical practice.

The evidence demonstrates that Dr. Villavicencio's knowledge in the area of pain management (and treating chronic pain patients) did improve somewhat over time, and his office policies and practices have changed since opening his practice. Moreover, the Hearing Examiner accepts that Dr. Villavicencio's transition to private practice involved a "learning curve" with respect to the management of a medical practice.

However, the Hearing Examiner is not convinced that the substandard care that Dr. Villavicencio provided to these patients can be explained away in such a manner. Further the Hearing Examiner is not convinced that Dr. Villavicencio was inexperienced or naïve when he treated these patients between 2005 and

2008. In fact, the Hearing Examiner finds Dr. Villavicencio's testimony in this regard wholly unconvincing and not credible. Several factors support this conclusion:

- Dr. Villavicencio practiced for a number of years as a physician before opening his own medical practice. During at least seven of those years, he saw many patients in multiple emergency rooms.
- Dr. Kelly testified convincingly that emergency-room physicians provide care and treatment to chronic pain patients, as well as drug-seeking patients, among others. Thus, in Dr. Villavicencio's work as an emergency-room physician before opening his medical practice, he must have encountered chronic pain patients as well as drug-seeking patients.
- Dr. Villavicencio chose to accept chronic pain patients such that 90 percent of his patient base between 2005 and 2008 consisted of chronic pain patients.
- Dr. Villavicencio attended two courses on pain management in 2006, and possibly other courses before the end of 2008. Thus, Dr. Villavicencio gained specific knowledge about treating chronic pain patients.
- Dr. Villavicencio asserted that he had contacted family physicians and pain management physicians, seeking their advice. Thus, Dr. Villavicencio learned even more about treating chronic pain patients and the practice of family medicine.

Moreover, Dr. Villavicencio admitted that he knowingly gave "special treatment" to Patients 8 and 14, and treated Patient 9 differently because he was sympathetic to her. There was nothing inexperienced or naïve in that regard - he issued "special treatment" prescriptions to those patients voluntarily.

Dr. Villavicencio provided care and treatment to Patients 1 through 16 that were below the standard of care. His substandard care was poor in numerous respects, which are chronicled in the Findings of Fact. Moreover, this was not isolated conduct. Numerous patients were involved and it took place over multiple years. These patients were adversely affected as well.

Dr. Villavicencio presented mitigating evidence - his own testimony and current policies and forms used in his medical practice - to demonstrate that he has changed his office procedures and his approach to treating chronic pain patients. The changes reflect improvements. Yet, the evidence overwhelmingly demonstrates that Dr. Villavicencio placed patients in serious danger.

Moreover, Dr. Villavicencio provided questionable, self-serving testimony during the hearing. For example, he recalled in 2012 that Patients 2 and 15 brought old

medicine bottles or other proof of prior medications to their appointments in 2005, but did not document such events at the time they occurred. Also, he recalled that, during a gap in his treatment of Patient 5 in 2006, the patient had been working in Kentucky, although nothing in the medical record would substantiate that claim. Additionally, he did not appear truthful during the hearing. For example, he provided conflicting testimony about whether Patient 11 was terminated from the medical practice. Furthermore, Dr. Villavicencio's attempt to explain away his notation that Patient 16 was "caught selling cocaine" was disingenuous.

The evidence overwhelmingly establishes that Dr. Villavicencio's treatment of these patients placed them in serious danger. A physician who practiced in such a manner forfeits his or her privilege to practice medicine and surgery in this state. Dr. Villavicencio's certificate should be permanently revoked. *Report and Recommendation, July 12, 2012, pp. 162-164.*

Appellant filed objections to the Report and Recommendation of the Hearing Officer.

On September 12, 2012, the Medical Board met to consider Appellant's case. The following is an excerpt of the pertinent minutes of that meeting:

Dr. Mahajan directed the Board's attention to the matter of Jose Villavicencio, M.D. He advised that objections were filed and have been previously distributed to Board members. ***

[Assistant Attorney General] Bockbrader stated that Dr. Villavicencio is correct that there is no allegation that Dr. Villavicencio caused the death of these patients, and the Hearing Examiner appropriately made no such finding. Ms. Bockbrader stated that the issue in this case is whether Dr. Villavicencio violated the minimal standards of care with the 16 patients in question.

Dr. Steinbergh moved to approve and confirm [the Hearing Examiner's] Findings of Fact, Conclusions of Law, and Proposed Order in the matter of Jose Villavicencio, M.D. Mr. Hairston seconded the motion.

Dr. Mahajan stated that he would now entertain discussion in the above matter.

Dr. Madia briefly reviewed Dr. Villavicencio's career. Dr. Madia stated that in 2004, Dr. Villavicencio opened his private practice in Columbus and was eventually seeing 20 to 30 patients per day. Dr. Madia stated that one red flag about Dr. Villavicencio's practice was that, although the practice was primary

care internal medicine, 90% of his patients were chronic pain patients. Dr. Madia stated that, although a legal definition of a pain clinic did not exist at that time, one would have to consider the practice to have been a pain clinic. Dr. Madia noted Dr. Villavicencio's testimony that he had not been prepared to treat patients with chronic pain, but he slowly learned and took some courses. One reason Dr. Villavicencio had so many pain patients was the recent closure of the Ohio State University pain management clinic, whose patients were diverted to Dr. Villavicencio.

Dr. Madia continued that Dr. Villavicencio used two kinds of medical record: Handwritten progress notes and electronic medical records. Dr. Madia observed that Dr. Villavicencio's records show identical notes, even with the same grammatical errors, for different patients and for different visits by the same patient. Dr. Madia stated that such records cannot be trusted or relied upon.

Dr. Madia briefly reviewed the career of the State's expert, Dr. Kelly, including his current position as Assistant Director of the family practice residency program at the Cleveland Clinic. Dr. Madia noted that Dr. Kelly takes pain management courses every year and has experience in managing chronic pain as a family physician. Dr. Kelly was unable to access Dr. Villavicencio's electronic medical records, but he reviewed the progress notes for all 16 patients and concluded that he could not rely on what he was reading due to the repetitive nature of the notes.

Dr. Madia briefly reviewed some of the patients in question. Dr. Madia stated that Patient 1 presented to Dr. Villavicencio with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), back pain, and a skin rash. Dr. Villavicencio did not treat Patient 1's COPD, but did treat her back pain [*sic*] with narcotics, Xanax, and Valium.

Patient 2, who was in an automobile accident, also presented to Dr. Villavicencio with back pain. Dr. Villavicencio ordered an MRI, but does not note the results of the MRI in the progress notes. Dr. Villavicencio prescribed narcotics for Patient 2.

Patient 9 was a 48-year-old female with a history of back pain and weakness on one side. Dr. Villavicencio diagnosed a cerebrovascular accident and lumbar spondylosis, and prescribed narcotics. On Patient 9's third and fourth visits, Dr. Villavicencio put her on Coumadin, but there is no documentation of why Coumadin was prescribed. Also, there is no documentation that Dr. Villavicencio checked Patient 9's PT level each month, which must be done for patients on Coumadin. Dr. Villavicencio also continued to increase Patient 9's narcotics dosage with no reason documented in the record. Patient 9 died of an overdose of cocaine and Fentanyl four days after her last visit with Dr. Villavicencio.

Patient 15 was a 13-year-old diabetic female. Dr. Madia stated that Patient 15's record makes no mention of who is treating her diabetes. Dr. Madia also

commented that he does not know many internists who will see a 13-year-old patient. Instead of treating Patient 15's diabetes, Dr. Villavicencio treated her back pain and prescribed narcotics on the first visit, adding Xanax and Ambien later. Dr. Madia stated that treating a 13-year-old patient with narcotics, Xanax, and Ambien is below the standards of care and, in light of Patient 15's diabetes, could have been a life-threatening situation.

Patient 10 died of a drug overdose of cocaine, alcohol, and methadone. Dr. Madia noted that Dr. Villavicencio did not prescribe methadone to Patient 10 and it must have been obtained from a different source.

Dr. Madia stated that there were several occasions with these 16 patients when the urine test was positive for something Dr. Villavicencio had not prescribed, and therefore the patient must have been receiving medications from multiple physicians. Dr. Madia stated that this is a clear indication that the patient is addicted and possibly diverting medications, yet Dr. Villavicencio took no action. Dr. Madia stated that Dr. Villavicencio could have helped these patients by referring them to a pain specialist, an addictionologist, or to law enforcement.

Dr. Madia concluded that Dr. Villavicencio's practice was well below the standards of care as applied at the time he was treating the patients. Dr. Madia stated the [*sic*] Dr. Villavicencio did harm to these patients. Dr. Madia stated the [*sic*] he fully agrees with the Proposed Order of permanent revocation.

Dr. Steinbergh noted that the Board has taken action on physicians based on conduct far older than the conduct in question in this case. Dr. Steinbergh stated that Dr. Villavicencio rendered the care in question from 2005 to 2008, and he was cited by the Board in April 2011. Dr. Steinbergh stated that this is not an unusual timeframe, stating that the Board builds a case when it learns of potential violations regardless of when the care in question took place.

Dr. Steinbergh stated that she agrees with the Findings of Fact, Conclusions of Law, and the Proposed Order of permanent revocation in the matter of Dr. Villavicencio.

Dr. Ramprasad noted previous comments regarding the standard of care now as compared to the standard of care at the time that Dr. Villavicencio treated these patients. Dr. Ramprasad observed that Patient 4 had two prescriptions at a cost of \$1,200.00, yet the patient could not afford x-rays. Dr. Ramprasad stated that Patient 8 received increasing dosages of medication even though Dr. Villavicencio knew the patient was using street drugs. Dr. Ramprasad stated that Patient 11 received excessive doses of oxycodone, morphine, and methadone each day. Dr. Ramprasad stated that these actions are below the standard of care regardless of the time period. *Board Minutes, Sept. 12, 2012, pp. 20824-20831.*

At the conclusion of the discussion, the Medical Board voted, unanimously, to permanently revoke Appellant's medical license. On September 12, 2012, the Board journalized an Order in which the Board permanently revoked Appellant's medical license. By letter dated September 12, 2012, and mailed to Appellant on September 13, 2012, the Board certified its Order to Appellant.

On September 17, 2012, Appellant appealed the Medical Board's Order to this Court pursuant to R.C. 119.12. On October 18, 2012, the Court denied Appellant's motion for a suspension of the Order pending determination of this appeal, having determined that Appellant failed to establish that he would suffer an "unusual hardship" as provided in R.C. 119.12, and having further determined that a suspension of the Order would present a risk to the health, safety, and welfare of the public.

Standards of Appellate Review

In an appeal pursuant to R.C. 119.12 from an order of the Medical Board, the court of common pleas is bound to uphold the order if it is supported by reliable, probative, and substantial evidence and is in accordance with law. *Leak v. State Med. Bd.*, 10th Dist. No. 09AP-1215, 2011-Ohio-2483, ¶ 8, discretionary appeal not allowed, 129 Ohio St. 3d 1505, 2011-Ohio-5358. "Reliable" evidence is dependable; that is, it can be confidently trusted. *Our Place, Inc. v. Ohio Liquor Control Comm.*, 63 Ohio St. 3d 570, 571 (1992). In order to be "reliable," there must be a reasonable probability that the evidence is true. *Id.* "Probative" evidence is evidence that tends to prove the issue in question; it must be relevant in determining the issue. *Id.* "Substantial" evidence is evidence with some weight; it must have importance and value. *Id.*

The Supreme Court of Ohio has recognized that the General Assembly granted the Medical Board a significant measure of discretion in its disciplinary proceedings. See *Arlen v.*

State, 61 Ohio St. 2d 168, 174 (1980). In *Farrand v. State Med. Bd.*, 151 Ohio St. 222, 224 (1949), the Supreme Court stated the policy reason behind this broad grant of discretion:

*** The purpose of the General Assembly in providing for administrative hearings in particular fields was to facilitate such matters by placing the decision on facts with boards or commissions composed of [persons] equipped with the necessary knowledge and experience pertaining to a particular field. ***

When reviewing a Medical Board order, a court must accord due deference to the Board's interpretation of the technical and ethical requirements of its profession. *Pons v. Ohio State Med. Bd.*, 66 Ohio St. 3d 619, syllabus (1993). In addition, a reviewing court must “give due deference to the administrative resolution of evidentiary conflicts.” *Smith v. State Med. Bd.*, 10th Dist. Nos. 12AP-234 and 12AP-235, 2012-Ohio-4423, ¶ 11, quoting *Univ. of Cincinnati v. Conrad*, 63 Ohio St. 2d 108, 111 (1980). Moreover, a reviewing court “will not substitute its judgment for the board’s where there is some evidence supporting the board’s order.” *Harris v. Lewis*, 69 Ohio St. 2d 577, 579 (1982).

With these standards in mind, the Court will address the arguments raised by Appellant in support of this appeal.

Analysis

Appellant has asserted three assignments of error in support of this appeal.

Appellant’s first assignment of error is that the State’s expert witness, Dr. Kelly, was not qualified to express opinions about the minimal standards of care that applied to Appellant’s medical practice. Although Appellant asserted this argument in his initial brief, he did not maintain this argument in his reply brief, which he filed in response to the Medical Board’s brief. It would therefore appear that Appellant may have abandoned this argument. Nevertheless, the Court will address the argument.

Appellant questions whether there was reliable, probative, and substantial evidence in the form of testimony supporting the Medical Board's Order. "Although such evidence need not be heard by the board in the form of expert testimony, when the board does hear expert testimony, the expert must be capable of expressing an opinion grounded in the particular standard of care applicable to the area of practice for the physician facing discipline." *Leak, supra*, ¶ 12. In civil litigation, the legislature has enacted a statutory provision that a person is not competent to testify unless he or she practices in the "same or a substantially similar specialty as the defendant." R.C. 2743.43(A)(3). "The court shall not permit an expert in one medical specialty to testify against a health care provider in another medical specialty unless the expert shows both that the standards of care and practice in the two specialties are similar and that the expert has substantial familiarity between the specialties." *Id.* The rationale behind this rule is that a medical expert is not entitled to be qualified as an expert in every medical field, simply because he or she is well-educated and well-credentialed. *Griffin v. State Med. Bd.*, 10th Dist. No. 09AP-276, 2009-Ohio-4849, ¶ 13, discretionary appeal not allowed, 124 Ohio St. 3d 1417, 2009-Ohio-6816.

Appellant's area of practice, and the specialty in which he is board-certified, is internal medicine. Dr. Kelly's area of practice, and the specialty in which he is board-certified, is family medicine. Thus, it was incumbent upon Dr. Kelly, as the State's expert medical witness, to demonstrate that the standards of care in internal medicine and family medicine are similar, and that Dr. Kelly has substantial familiarity with both medical specialties.

Dr. Kelly testified:

My own specialty is family medicine, but I am very familiar with primary care internal medicine, and I would apply the same standards to primary care internal medicine as I would to family medicine in terms of the documentation of care of adults.

*** I've practiced alongside of primary care internists in a variety of settings. I have seen their charts. We're basically doing the same care for the same patients in terms of adult patients that we're treating. So I don't think the standards are different.

*** I practice alongside in a number of settings with -- with primary care internists. And so I've taken care of their patients in that kind of group setting and seen what type of documentation they do. There is -- There is a certain difference in style often between internal medicine and family medicine, but the minimum standards for documentation, I -- I think, are the same. That's my opinion anyway. *T. 779-780.*

*** I am familiar with lots of family physicians and primary care internists in terms of how people practice and what the range is of their behavior in practice, in prescribing, in documenting. And so I have the experience to basically compare Dr. Villavicencio's prescribing and documentation to quite a large number of other similar physicians in similar circumstances with similar problems. And in that way, I can, I believe, render an opinion about whether his care in this case meets a minimal standard. *T. 783.*

*** There are people that document extensively and at great length. There are people that are much more efficient and say less, but still capture an adequate amount of information in terms of the documentation.

So if we're just talking about documentation, there is a range of what is acceptable. If you are within that range, then you meet the standard. If you're below that range, you don't meet the standard. And where you draw that line between doesn't meet and just meets is -- is an opinion. I am giving you my opinion about where that line is. *T. 783-784.*

*** So if we're talking about primary care internal medicine and family medicine, the major differences are that in family medicine, the major differences are that in family medicine, we are seeing people of all ages; whereas in primary care internal medicine, we are just seeing adults. Other than that, the standards that I would apply would be essentially the same. *T. 1405-1406.*

Dr. Kelly thereby demonstrated that the standards of care in internal medicine and family medicine are similar, and that he has substantial familiarity with both medical specialties. The only difference between internal medicine and family medicine, as Dr. Kelly testified, is that internists treat adults and family practitioners treat adults and children. Consequently, as Dr. Kelly demonstrated, the minimal standards of care for the treatment of adults are the same for internists and for family practitioners. Accordingly, Dr. Kelly was qualified to express opinions about the minimal standards of care that applied to Appellant's medical practice. Appellant's first assignment of error is not well taken.

In Appellant's second assignment of error, he argues that the Hearing Examiner deprived Appellant of a fair hearing by admitting evidence of the patient deaths. This is actually a three-part argument. First, Appellant asserts, the Franklin County Coroner's Reports pertaining to the patient deaths (State's Exhibits 1A, 4A, 5A, 7A, 8A, 9A, 10A, 12A, 13A, and 16A) were not properly authenticated and therefore should not have been admitted into evidence. Second, Appellant asserts, R.C. 313.19 precluded the Franklin County Coroner's Reports from being admitted into evidence as proof that the deaths occurred. Third, Appellant asserts, even if the Franklin County Coroner's Reports were properly authenticated, and even if R.C. 313.19 did not preclude their admission into evidence, the evidence of the patient deaths is irrelevant and prejudicial.

As a general rule, administrative agencies are not bound by the Ohio Rules of Evidence. *Smith, supra*, ¶ 14; *Beach v. Ohio Bd. of Nursing*, 10th Dist. No. 10AP-940, 2011-Ohio-3451, ¶ 37; *Holzhauser v. State Med. Bd.*, 10th Dist. No. 06AP-1031, 2007-Ohio-5003, ¶ 19, discretionary appeal not allowed, 117 Ohio St. 3d 1407, 2008-Ohio-565. The Franklin County

Coroner's Reports, however, were certified copies of public records, and they were therefore admissible as self-authenticating documents pursuant to Evid. R. 902(4).

Revised Code R.C. 313.19 provides in its entirety:

The cause of death and the manner and mode in which the death occurred, as delivered by the coroner and incorporated in the coroner's verdict and in the death certificate filed with the division of vital statistics, shall be the legally accepted manner and mode in which such death occurred, and the legally accepted cause of death, unless the court of common pleas of the county in which the death occurred, after a hearing, directs the coroner to change his decision as to such cause and manner and mode of death.

Contrary to Appellant's assertion, R.C. 313.19 does not state that a coroner's report may not be admitted into evidence as proof that a death occurred. Indeed, the statute provides that the cause of death, as stated in a coroner's report, shall be the legally accepted cause of death, unless the common pleas court of the county in which the death occurred, after a hearing, directs the coroner to change his (or her) decision as to the cause of death. There is no evidence that any of the Franklin County Coroner's Reports in this case were changed pursuant to the statute.

Revised Code 313.19 therefore did not preclude the Franklin County Coroner's Reports from being admitted into evidence as proof that the deaths occurred.

Appellant contends that it is irrelevant that the patients died. The Court must disagree. Evidence that the patients died is relevant, for example, to show the current condition of the patients, to explain why certain patients did not return to see Appellant for further treatment, and to explain why certain patient records terminated. The Notice of Opportunity alleged that Appellant failed to address signs of possible addiction in his patients. Some of the patients who died (of multiple drug intoxication) had appointments with Appellant within days preceding their deaths. Appellant's assessment of patients' conditions shortly before they died was relevant, as was the fact that they died within days of being assessed by Appellant.

Evidence that the patients died is also relevant to the issue of Appellant's credibility. Throughout the hearing below, Appellant maintained that he was too trusting of his patients. Even if Appellant was naïve when he opened his family practice in 2004, as he has asserted throughout the proceedings below and in this appeal, the ensuing deaths of his patients, by multiple drug intoxication, might have caused a prudent physician to reassess his practices and become more vigilant in addressing signs of abuse and addiction. Appellant testified that the deaths of his patients caused him to reevaluate his practices, and yet, he continued to engage in dangerous prescribing practices even after several patients had died from multiple drug intoxication. Evidence that Appellant's patients died is relevant.

Appellant asserts that it was prejudicial to his case for the Hearing Examiner to admit evidence of the deaths, because "[t]he record clearly reflects that the permanent revocation of [Appellant's] Ohio medical license resulted from the inclusion of this irrelevant inflammatory information." The record does not so reflect. In the Notice of Opportunity, there is no allegation that Appellant caused the death of any of his patients. In the Report and Recommendation, the Hearing Examiner made no finding that Appellant caused the death of any of his patients. At the Medical Board's meeting on September 12, 2012, the Assistant Attorney General echoed that fact and stated that the issue in the case was whether Appellant violated the minimal standards of care with respect to the sixteen patients. The Board's discussion of Appellant's case, set forth above, demonstrates that that the Board permanently revoked Appellant's medical license, not because his patients died, but because he failed to meet the minimal standards of care in his treatment of his patients. Appellant's second assignment of error is not well taken.

Appellant's third assignment of error is that the Medical Board violated Appellant's due-process rights by waiting approximately three years after the end of the alleged violations period

(2005 to 2008) to bring formal charges against him. Appellant asserts that, “had [he] known in 2008 that his Ohio medical license would be revoked, he would not have invested the next four years of his life into building his practice and rehabilitating his office building.” Appellant’s assertion is not well taken, for the following reasons.

There is no *per se* statute of limitations in R.C. 4731.22. *Griffin, supra*, ¶ 9. The Tenth District Court of Appeals has held that administrative agencies must give licensees a fair hearing and determination as expeditiously as possible under the circumstances, but the Court of Appeals has never imposed a *per se* time limitation upon an agency. *Id.* Agencies are free to set their own parameters regarding time limitations, but this is purely voluntary. *Id.* Thus, when evaluating a due-process argument within the context of an agency’s delay in bringing formal charges against a professional license holder, there is no precise standard. *Id.* In the absence of a specified time limit, a reviewing court must focus its analysis on whether the licensee suffered any material prejudice as a result of the agency’s delay. *Id.* Therefore, unless Appellant can demonstrate material prejudice as a result of the Medical Board’s delay in bringing formal charges against him, the Court cannot hold that the Board violated his due-process rights. *Id.*; *Taylor v. State Med. Bd.*, 10th Dist. No. 10AP-262, 2010-Ohio-5560, ¶ 27.

In determining whether Appellant has demonstrated material prejudice as a result of the Board’s delay in bringing formal charges against him, the Court observes that the three-year delay between 2008 (the end of the alleged violations period) and April 13, 2011 (the date of the Notice of Opportunity) was caused by Appellant himself.

On October 8, 2008, the Medical Board, exercising its investigative authority, subpoenaed Appellant to appear for a deposition on November 19 and 20, 2008. Appellant

appeared for the investigatory deposition with counsel and requested the opportunity to record the deposition. The State's attorney denied the request. The deposition was cancelled.

On December 5, 2008, Appellant filed a civil action in this Court, Case No. 08CV-17352, seeking injunctive relief to prohibit the Medical Board from taking Appellant's investigatory deposition. On December 10, 2008, this Court (acting through another judge) issued a temporary restraining order prohibiting the Board from taking the deposition. Appellant moved the Court for a preliminary injunction prohibiting the Board from taking the deposition. On February 5, 2009, a magistrate denied Appellant's motion for a preliminary injunction. Pursuant to Civ. R. 53(D)(4)(a), the magistrate's decision was not effective unless and until adopted by the Court. On February 19, 2009, Appellant filed objections to the magistrate's decision and requested that the Court issue a preliminary injunction. The Board opposed Appellant's objections and then waited for a decision from the Court on Appellant's motion for a preliminary injunction.

In orders issued on December 9, 2009, March 23, 2010, and November 9, 2010, the Court observed that Appellant's objections to the magistrate's decision remained pending, and that the parties had discussed, at various status conferences, the need for the Court to rule on the objections.

When no decision was forthcoming from the Court, the Medical Board proceeded without Appellant's investigatory deposition and retained Dr. Kelly to review Appellant's medical records. On March 21, 2011, Dr. Kelly issued his report to the Board. Three weeks later, on April 13, 2011, the Board issued its Notice of Opportunity to Appellant.

Consequently, from December 5, 2008 (when Appellant filed the injunction action in this Court) until April 13, 2011 (when the Medical Board formally charged Appellant), there was litigation pending in this Court (which is still pending in this Court), in which Appellant sought

to enjoin the Board from taking Appellant's investigatory deposition. Appellant cannot demonstrate that he suffered material prejudice as a result of the Board's delay in bringing formal charges against him, when Appellant's own actions were the cause of the Board's delay. It is disingenuous for Appellant to assert that he "relied on the Board's silence as assurance that his Columbus, Ohio medical practice was not in regulatory jeopardy." The Board was anything but silent when it attempted to take Appellant's investigatory deposition and thereafter opposed his attempts to prevent the deposition by prosecuting the injunction action in this Court.

Appellant has not demonstrated that he suffered material prejudice as a result of the Medical Board's delay in bringing formal charges against him. Appellant's third, and final, assignment of error is therefore without merit.

The Court has reviewed all of the evidence before the Medical Board. Having done so, the Court finds that the Board's Order is supported by reliable, probative, and substantial evidence and is in accordance with law. Dr. Kelly's testimony provides reliable, probative, and substantial evidence that, in Appellant's treatment of the sixteen patients, he failed to maintain minimal standards applicable to the selection or administration of drugs, a violation of R.C. 4731.22(B)(2), he failed to conform to minimal standards of care of similar practitioners under the same or similar circumstances, a violation of R.C. 4731.22(B)6), and he violated the Medical Board's rules regarding the utilization of controlled substances for intractable pain, a violation of R.C. 4731.22(B)(20). Pursuant to R.C. 4731.22(B), the Board was authorized to impose the sanction of permanent revocation.

Conclusion

Upon consideration of the entire record, the Court finds that the Order issued on September 13, 2012 by the State Medical Board of Ohio, permanently revoking Appellant's

certificate to practice medicine and surgery in Ohio, is supported by reliable, probative, and substantial evidence and is in accordance with law. The Order is therefore **AFFIRMED**.

This is a final, appealable Order. Costs to Appellant. Pursuant to Civ. R. 58(B), the Franklin County Clerk of Courts shall serve notice of this judgment and its date of entry upon all parties.

It is so **ORDERED**.

Copies electronically to:

DOUGLAS E. GRAFF, ESQ. (0013222), JOHN A. IZZO, ESQ. (0061779), LEVI J. TKACH, ESQ. (0086025), Counsel for Appellant

KATHERINE BOCKBRADER, AAG (0066472), KYLE C. WILCOX, AAG (0063219), Counsel for Appellee

Franklin County Court of Common Pleas

Date: 07-29-2013
Case Title: JOSE VILLAVICENCIO MD -VS- OHIO STATE MEDICAL BOARD
Case Number: 12CV011628
Type: DECISION/ENTRY

It Is So Ordered.

A handwritten signature in black ink, "Richard S. Sheward", is written over a blue circular seal. The seal contains the text "FRANKLIN COUNTY OHIO" around the top and "ALL THINGS ARE" around the bottom.

Judge Richard S. Sheward

Court Disposition

Case Number: 12CV011628

Case Style: JOSE VILLAVICENCIO MD -VS- OHIO STATE
MEDICAL BOARD

Case Terminated: 18 - Other Terminations

Final Appealable Order: Yes

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

JOSE VILLAVICENCIO, M.D.	:	
	:	
Appellant,	:	
	:	Case No. 12-CVF-011628
	:	
v.	:	JUDGE SHEWARD
	:	
STATE MEDICAL BOARD OF OHIO	:	
	:	
Appellee.	:	

ENTRY DENYING MOTION TO STAY AGENCY ORDER

This action is an administrative appeal of an order of the State Medical Board of Ohio (“Board”), which permanently revoked Dr. Jose Villavicencio’s license to practice medicine in the State of Ohio. Dr. Villavicencio filed a motion in this appeal on September 21, 2012, to stay the Board’s Order. The Board filed a memorandum in opposition on September 25, 2012, and an oral hearing was held on September 26, 2012. Both parties presented documentary evidence in support of their arguments.

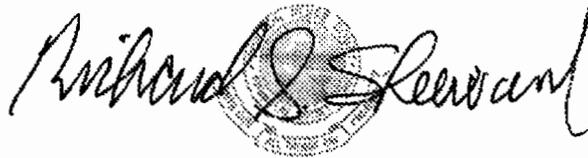
After consideration of the evidence and arguments in this matter, the Court found that Dr. Villavicencio failed to establish that he will suffer an “unusual hardship” as provided in R. C. 119.12. The Court further found that a suspension of the Board’s Order would present a risk to the health, safety, and welfare of the public. For these reasons, Appellant Villavicencio’s September 21, 2012 motion for a stay is DENIED.

Judge Richard S. Sheward

Franklin County Court of Common Pleas

Date: 10-18-2012
Case Title: JOSE VILLAVICENCIO MD -VS- OHIO STATE MEDICAL BOARD
Case Number: 12CV011628
Type: ENTRY

It Is So Ordered.

A handwritten signature in cursive script, reading "Richard S. Sheward", is written over a circular, embossed seal. The seal is partially obscured by the signature but appears to be the official seal of the court.

Judge Richard S. Sheward

Court Disposition

Case Number: 12CV011628

Case Style: JOSE VILLAVICENCIO MD -VS- OHIO STATE MEDICAL BOARD

Motion Tie Off Information:

1. Motion CMS Document Id: 12CV0116282012-09-2199980000

Document Title: 09-21-2012-MOTION TO STAY

Disposition: MOTION DENIED

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

JOSE VILLAVICENCIO, M.D.

Plaintiff,

v.

STATE MEDICAL BOARD OF OHIO,

Defendant.

Case No.

JUDGE

STATE MEDICAL BOARD
OF OHIO
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NOTICE OF APPEAL

Jose Villavicencio, M.D. ("Dr. Villavicencio"), Appellant, hereby gives Notice of Appeal on questions of law and fact to the Court of Common Pleas, Franklin County, Ohio, pursuant to Chapter 119 of the Ohio Revised Code from the Decision of the State Medical Board of Ohio ("Board") dated September 12, 2012, (mailed September 13, 2012) against Dr. Villavicencio. A copy of the Board Order is attached hereto as Exhibit A.

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

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

II. Appellant was denied substantive due process in violations of the Ohio and United States Constitutions when the State knowingly presented evidence to the Board that included information outside of the charges set forth in the citation issued against the Appellant;

III. The Appellant was denied substantive due process under both the Ohio and the United States Constitutions when the citation of claims against Appellant deliberately included

STATE MEDICAL BOARD
OF OHIO
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information for which there was no claim of wrongdoing, but was done solely for the purpose of improperly influencing the Board;

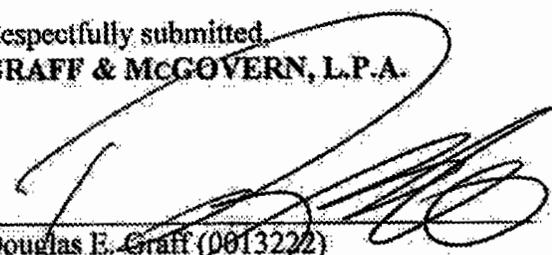
IV. Appellant was denied substantive due process rights under Ohio and the United States Constitutions when the Board considered factors beyond the Notice of Opportunity of Hearing sent to Appellant during the Board's deliberation of the Report and Recommendation of the Hearing Examiner;

V. Appellant was denied substantive due process rights and equal protection under the Ohio and United States Constitutions when the Board fully failed to consider the Motions of Appellant;

VI. Further, and without limiting the generality of the foregoing, Appellant contends that the Entry of Order and the related investigation and hearing conducted by the Board violated the protections afforded to the Appellant pursuant to the Constitution of the State of Ohio and the Constitution of the United States including, without limitation, the due process and equal protection rights thereof.

Appellant reserves the right to add additional assignments of error and grounds for appeal, factually and under the Ohio Administrative Code, the Ohio Revised Code, the Ohio Constitution and the United States Constitution, once the transcript of proceedings has been completed and counsel has an opportunity to review the record.

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


Douglas E. Graff (0013222)
Levi J. Tkach (0086025)
604 East Rich Street
Columbus, Ohio 43215-5341

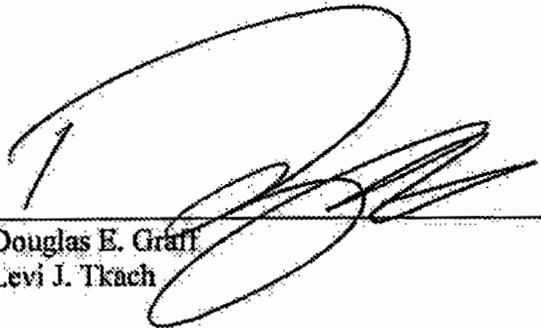
STATE MEDICAL BOARD

(614) 228-5800
(614) 228-8811 (Fax)
Doug@Grafflaw.com
Counsel for Appellant, Jose Villavicencio, M.D.

CERTIFICATE OF SERVICE

I hereby certify that the original of this NOTICE OF APPEAL was delivered to the Ohio State Medical Board, 30 East Broad Street, Third Floor, Columbus, OH 43215 on the 17th day of September, 2012. I further certify that a true and accurate copy of the foregoing NOTICE OF APPEAL was sent by regular U.S. mail, postage prepaid, on the on the 17th day of September, 2012, to:

Kyle Wilcox, Esq.
Assistant Attorney General
Office of the Attorney General
Health and Human Services Div.
30 East Board Street, 26th Floor
Columbus, OH 43215



Douglas E. Graff
Levi J. Tkach

STATE MEDICAL BOARD
OF OHIO
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STATE MEDICAL BOARD
OF OHIO
2012 SEP 20 AM 10:45

State Medical Board of Ohio

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

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

September 12, 2012

Jose Villavicencio, M.D.
1763 South High Street
Columbus, OH 43207

RE: Case No. 11-CRF-046

Dear Doctor Villavicencio:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Gretchen L. Petrucci, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on September 12, 2012, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

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

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

THE STATE MEDICAL BOARD OF OHIO



J. Craig Strafford, M.D., M.P.H.
Secretary

JCS:baj
Enclosures

CERTIFIED MAIL NO. 91 7199 9991 7030 3382 8541
RETURN RECEIPT REQUESTED

cc: Douglas E. Graff, Esq.
CERTIFIED MAIL NO. 91 7199 9991 7030 3382 8558
RETURN RECEIPT REQUESTED

Mailed 9-13-12

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Gretchen L. Petrucci, State Medical Board Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on September 12, 2012, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Jose Villavicencio, M.D., Case No. 11-CRF-046, as it appears in the Journal of the State Medical Board of Ohio.

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

(SEAL)



J. Craig Strafford, M.D., M.P.H.
Secretary

September 12, 2012

Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

CASE NO. 11-CRF-046

JOSE VILLAVICENCIO, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on September 12, 2012.

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

It is hereby ORDERED that:

The certificate of Jose Villavicencio, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

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

 J. Craig Strafford, M.D., M.P.H.

J. Craig Strafford, M.D., M.P.H.
Secretary

(SEAL)

September 12, 2012

Date

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BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of

*

Case No. 11-CRF-046

Jose Villavicencio, M.D.,

*

Hearing Examiner Petrucci

Respondent.

*

REPORT AND RECOMMENDATION

Basis for Hearing

By letter dated April 13, 2011, the State Medical Board of Ohio ("Board") notified Jose Villavicencio, M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action on allegations that, between 2005 and 2008, Dr. Villavicencio provided care and treatment to Patients 1 through 16, as identified on a patient key, and that he inappropriately treated them and/or failed to appropriately document his treatment of them. The Board alleged that Dr. Villavicencio:

- Excessively and/or inappropriately prescribed medications;
- Prescribed controlled substances without appropriately pursuing or documenting the pursuit of alternative non-narcotic therapies;
- Failed to record the reasons for prescribing medication and/or the need/reason for multiple medications;
- Failed to perform and/or document the performance of appropriate physical examinations/evaluations;
- Failed to use and/or document appropriate diagnostic testing or other evaluation methods;
- Failed to devise and/or document treatment plans;
- Failed to periodically reassess or document the reassessment of the effectiveness of the treatment of illnesses;
- Failed to adequately/appropriately diagnose and/or document an adequate/appropriate diagnosis of the patients' medical conditions;
- Failed to document adequate findings to support the diagnoses;
- Repeatedly/continually treated patients without making appropriate and/or timely referrals to specialists;
- Failed to keep and maintain adequate records; and
- Kept records that frequently were verbatim from one office visit to another, and from one patient to another.

The Board further alleged that Dr. Villavicencio’s acts, conduct, and/or omissions constitute the following:

- “Failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as set forth in Section 4731.22(B)(2), Ohio Revised Code;
- “A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as set forth in Section 4731.22(B)(6), Ohio Revised Code; and
- “[V]iolating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the Board,” as set forth in Section 4731.22(B)(20), Ohio Revised Code. The Board identified the following three rules: Rule 4731-11-02(D), Rule 4731-21-02 and Rule 4731-27-01, Ohio Administrative Code.

Accordingly, the Board advised Dr. Villavicencio of his right to request a hearing in this matter. On May 10, 2011, Dr. Villavicencio requested a hearing. (State’s Exhibits (“St. Exs.”) 20, 20A)

Appearances at the Hearing

Mike DeWine, Attorney General, and Katherine J. Bockbrader and Kyle C. Wilcox, Assistant Attorneys General, on behalf of the State of Ohio. Douglas E. Graff and Levi J. Tkach, Esqs., on behalf of Dr. Villavicencio.

Hearing Dates: January 17, 18, and 23-27, 2012

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PROCEDURAL MATTERS

During the hearing in this matter, the Hearing Examiner asked counsel for the State to provide a corrected copy of State’s Exhibit 7A and asked counsel for Dr. Villavicencio to provide a corrected copy of Respondent’s Exhibit DD. (Hearing Transcript (“Tr.”) at 1488-1489, 1712) Those exhibits were provided to the Hearing Examiner after the hearing concluded and the Hearing Examiner admitted them into evidence. The hearing record closed on February 1, 2012.

SUMMARY OF THE EVIDENCE

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

Background

1. Jose Villavicencio, M.D., earned his medical degree from the University of the Philippines in 1987. He worked as a physician in the Philippines for a few years. Afterward, he came to the United States. In 1993, he completed an internal-medicine residency at the Detroit Medical Center in Detroit, Michigan. (Tr. at 13-15, 440-441, 1188; Respondent's Exhibit ("Resp. Ex.") DD at 1)
2. Thereafter, Dr. Villavicencio worked in Virginia for three years. From 1997 to 2010, Dr. Villavicencio was employed by Premier Healthcare Services, working in various emergency departments in Ohio. Dr. Villavicencio testified that, during those 13 years, he had worked more than 20,000 hours. He further testified that most of the emergency rooms where he worked were Level III trauma centers. (Tr. at 14, 28, 107, 455, 1221, 1503)
3. From 2004 to the present, Dr. Villavicencio has operated his own medical practice in Columbus, Ohio. (Tr. at 14; Resp. Ex. DD at 1)
4. Dr. Villavicencio became certified by the American Board of Internal Medicine in 1995 and became certified by the American Board of Addiction Medicine in 2010. Additionally, he was certified as a medical review officer in 2008 or 2009. Moreover, Dr. Villavicencio was certified as an independent medical examiner, but that certification has since lapsed. Dr. Villavicencio holds active medical licenses in Kentucky, Ohio, and West Virginia. (Tr. at 12, 14-16, 441-444, 1664; Resp. Ex. DD at 1, 4)

State's Expert – Robert B. Kelly, M.D

5. Robert B. Kelly, M.D., earned his medical degree in 1980 from the University of Virginia. He completed a residency in family medicine at Brown University in 1983. He also completed a two-year fellowship program in family medicine at Case Western Reserve University in 1987. Also, in 2004, Dr. Kelly completed a program in Medical Acupuncture for Physicians at University of California, Los Angeles, School of Medicine. (St. Ex. 19; Tr. at 470)
6. Dr. Kelly was a faculty member at Fairview Hospital's Department of Family Medicine in Cleveland, Ohio; a faculty member at State University of New York's Department of Family Medicine in Stony Brook, New York; and a department chairman at Case Western Reserve University in Cleveland, Ohio. Moreover, Dr. Kelly has numerous years of teaching experience, has published numerous articles, has been involved in research, and has obtained numerous grants. (St. Ex. 19 at 2, 4-17; Tr. at 794-795)
7. Currently, Dr. Kelly is a faculty member at the Cleveland Clinic's Center for Family Medicine, a medical practice that also is a teaching and learning environment for medical residents and students. His current medical practice has patients of all ages who have a "fairly typical mix of primary care problems," and patients who seek acupuncture. Dr. Kelly estimated that two to three percent of his patients are chronic pain patients. Dr. Kelly is also an associate residency

director of the family-practice residency at the Cleveland Clinic. (St. Ex. 19 at 1-2; Tr. at 472-473, 792-794, 811-815, 818)

Dr. Kelly noted that, every year, he attends conferences related to pain management, including identification of drug-seeking patients. (Tr. at 829-830)

8. Dr. Kelly holds an active medical license in Ohio, and previously held medical licenses in Rhode Island and New York. Dr. Kelly is board-certified by the American Board of Family Practice and the American Board of Medical Acupuncture. (St. Ex. 19 at 3; Tr. at 470, 471)
9. Dr. Kelly was qualified as an expert in family medicine in this matter. He explained that family-medicine practitioners treat patients of all ages and that primary-care, internal-medicine practitioners treat adults. Dr. Kelly stated that he has practiced with primary-care internists in a variety of settings and is familiar with “lots” of family-medicine and internal-medicine practitioners. He testified that, although he is a family-medicine practitioner, he basically provides the same care for the same types of adult patients as an internal-medicine practitioner. Therefore, Dr. Kelly stated that the standard of care is the same for an internal-medicine practitioner and a family-medicine practitioner. With regard to documentation, Dr. Kelly stated that he has seen the documentation of internal-medicine practitioners and, although there is a difference in style between internal-medicine and family-medicine practitioners, the minimal standards for documentation are the same. (Tr. at 474, 779-780, 783, 1406, 1430)

Dr. Villavicencio’s Medical Practice, 2005-2008

10. Dr. Villavicencio described his gradual transition from being an emergency-room physician to a family-practice physician:

The – The change * * * from emergency medicine to family practice was in little steps. It happened in stages. Actually, I was a full-time physician for Premier, which is one of the biggest emergency medicine groups in Ohio. I was a full-time physician for them until about two years ago. But – But I would – I think that – that we got our occupancy permit in late 2004, and then we opened one or two days a week in 2005, and I would continue working as an emergency room doctor as the practice builds up because it’s –

* * *

– just – just difficult to – to jump immediately into that, open a clinic and be there and have nobody come in. So I – I scheduled around my work as an emergency room doctor.

(Tr. at 18-19)

11. Dr. Villavicencio testified that, between 2005 and 2008, he was a solo practitioner. He stated that he had started his practice with an office manager and then later added two medical assistants.

Dr. Villavicencio did not have a nurse or physician assistant working at his medical practice between 2005 and 2008. (Tr. at 20-21, 24, 1200, 1528)

12. Additionally, Dr. Villavicencio stated that, between 2005 and 2008, his solo practice grew to the point where he saw 20-30 patients each day and worked there three or four days each week. He originally accepted walk-in patients. (Tr. at 25-26, 1189)
13. Dr. Villavicencio testified that, between 2005 and 2008, he treated patients of all ages. He estimated that roughly 90 percent of his patients were chronic pain patients. He also stated that approximately 40 percent of his patients did not have insurance. (Tr. at 32, 1194, 1196, 1512, 1687)
14. Dr. Villavicencio testified regarding his experience with pain patients at the time he began his solo practice:

Well, actually, you know, I never had any experience in pain management when I – when I started out. As a matter of fact, I did not want to do pain management. I was an emergency room doctor and I am comfortable with treating patients in acute pain, but – but not – not patients in chronic pain. As a matter of fact, I – I was very stingy with prescribing narcotics at that point in time.

But in '06, that was when the Ohio [State University] pain management clinic closed and they were closed for about two years. And they actually sent me some patients with a note stating that these patients are stable, they have been worked up, they have had interventions done, but now they're just on chronic pain medication prescribing, so we want you to take over that because we are closing the clinic. So that was how I got started in pain management.

(Tr. at 29-30; See, also, Tr. at 1190-1191, 1193)

15. Furthermore, Dr. Villavicencio testified that, when he opened his private practice, emergency-medicine physicians were being told that pain is an undertreated condition and pain-management physicians were encouraging emergency-medicine physicians to not undertreat pain.¹ Also, he explained that, in 2006, he was told, "it's okay for you to prescribe long-term and short-acting narcotics." (Tr. at 29, 49, 460)
16. Dr. Villavicencio stated that, between 2005 and 2008, he was not a pain specialist, but he co-managed pain patients with pain specialists, which included prescribing medications for them. He also explained that he provided trigger-point and intra-articular injections to his patients. (Tr. at 1515-1518, 1692-1693)

¹Dr. Kelly testified similarly, stating that, from 2004 through 2006, the under-treatment of pain was discussed much. (Tr. at 831)

Dr. Villavicencio's Medical Records, 2005-2008

17. Dr. Villavicencio explained that, between 2005 and 2008, his medical records were maintained in electronic and paper charts. He used an electronic system called "SpringCharts." (Tr. at 21-24, 460-461)
18. However, the patients' electronic and paper charts were not identical; they differed in two respects. First, certain information was added to the "patient capsule" section in the electronic chart. That section included the patient's name, address, past medical history, social history, a problem list, medications, prior surgeries, pending tests, hepatitis status, and HIV status. The patient capsule was not included in the paper chart. Second, at each office visit, the patient initially met with Dr. Villavicencio's staff. The information gathered by the staff was recorded in a note section in the paper chart,² but was not typically included in the electronic chart. That information included, among other things, the patient's level of pain, blood pressure, pulse, over-the-counter medications, payments, and billing information. Dr. Villavicencio explained that he had transferred certain information from his staff's notes into his progress notes, but his electronic system had not allowed him also to transfer the patient's level of pain. (Tr. at 22, 461-462, 1200, 1210-1215, 1521-1522, 1527-1528, 1573, 1687-1688)
19. Some of the information that Dr. Villavicencio maintained in his office concerning Patients 1 through 16 is missing from State's Exhibits 1-16. The medical records admitted as exhibits in this proceeding are copies of the paper charts for Patients 1 through 16. Dr. Villavicencio explained that he had given the Board the paper charts of the requested medical records, but did not provide the "patient capsule" in the electronic system. He testified initially that he was unable to print the patient capsule and then testified later that he *can* print the capsule, but he did not submit it. (Tr. at 21-22, 41-44, 1210-1214)
20. Dr. Villavicencio testified that he reviewed his staff's notes every time a patient came in. He further stated that he spoke with his patients and examined them at every office visit, which included a review of systems and physical examination. He testified that he personally input information into the electronic system in the form of progress notes as he met with the patient, and then later a paper copy of the progress notes was placed in the paper chart. (Tr. at 23-24, 1235-1236, 1520-1521, 1573-1574)
21. Dr. Villavicencio used a "SOAP" format for his progress notes, listing subjective information, objective information, his assessment, and his treatment plan. Also, with his progress notes, he generally used one template. Then, he would copy and paste the physical examination information and change any particular points based on his findings. He acknowledged that the objective portion of his progress notes could be very similar, and could include the same typographical errors. (Tr. at 39-40, 107-108, 1223, 1238-1239, 1572-1573)
22. Dr. Villavicencio pointed out that the SpringChart system did not allow him to specify with respect to each prescription why the medication was prescribed. (Tr. at 1229)

²For ease of reference, this section of Dr. Villavicencio's medical records is referred to as the "staff's notes."

23. Dr. Villavicencio noted that, between 2005 and 2008, he had difficulties obtaining medical records from his patients' prior physicians. He explained that part of the difficulty related to not having the manpower to "track down" the prior physicians and then incorporate the records into his records. (Tr. at 461)

General Opinions about Dr. Villavicencio's Documentation in the Medical Records

Opinion of Dr. Kelly Regarding Documentation

24. Dr. Kelly did not criticize the electronic system, the use of templates, or the copy-forward methodology used by Dr. Villavicencio. Dr. Kelly acknowledged that, with a template or copy-forward methodology, the medical records could be very similar to one another and contain repetitive text. However, Dr. Kelly questioned the accuracy of some information in the medical records for Patients 1 through 16 because the notations are nearly identical, including the same grammatical errors, within patient records and among different patient records. He also stated that there were other elements that led him to question the accuracy of the medical records, namely, the lack of variation in the notes and the fact that some information was repeatedly included in the notes when it was not expected. He stated that he "found it impossible to believe that, in fact, what was documented reflected what had actually happened in the visit." (Tr. at 507-509, 606-607, 798-803, 888-892, 936-944, 1306-1308, 1417-1418; St. Ex. 18 at 3-4) He explained further in the following testimony:

Well, even – even for people that have chronic pain, there are things that vary from time to time; and certainly from patient to patient there are things that vary. And so I think even – even for a physician that uses cut-and-paste techniques to create chart notes more efficiently, you would expect that whatever information was not correct would be modified, and additional information might be added, and some other information might be deleted to make the note accurate. And I just didn't see evidence of that.

I also saw examples, for – for instance * * * in some – of the patients of a visual acuity test being repeated several visits in a row, at least as it was documented, where there was no visual complaint and the vision was 20/20 at each of those visits. And I just don't believe that the vision was checked three visits in a row for someone with no complaints, with normal visit – vision the first time.

So it appeared to me as though this was being done to create a chart note without a lot of care as to the accuracy of the note. That was my impression.

(Tr. at 509-510)

25. Moreover, Dr. Kelly stated that the medical records for Patients 1 through 16 lacked important information. Dr. Kelly stated that Dr. Villavicencio's records lacked adequate

histories, examinations, diagnoses, and treatment plans. (Tr. at 1343-1344; St. Ex. 18) He explained that, in the assessment of the patients' pain, more documentation was needed:

That could include a numeric level. That could include other kinds of adjectives and descriptions of the pain, how severe it is, where it is, the frequency, associated symptoms, et cetera. That's what I find lacking in the – in these records. In a general way and in this visit and in other visits, it's generally lacking all through his records.

* * *

Now, there are examples where there's a little bit of information more than the typical note, but over – over most of these notes there's very, very little information of the – just in terms of the subjective description that he has made of the pain that the patient is experiencing.

(Tr. at 1062-1063) Dr. Kelly pointed out that the physician cannot simply rely on the staff's history; rather, the physician must gather information about the patient's pain, assess it, and document his or her own independent assessment. (Tr. at 1410-1412, 1431-1433)

Opinion of Dr. Villavicencio Regarding Documentation

26. Dr. Villavicencio testified that he had tended to do complete physical examinations of his patients even if patients were being seen for limited issues. He also stated that he had documented all of the information because of pressure from insurance companies. He stated that he regularly had examined the skin, lungs, heart and eyes of his patients, and that he could complete those examinations in under a minute. (Tr. at 1507-1508, 1511-1512)
27. However, Dr. Villavicencio acknowledged that his medical records did not always include all of the information that should have been included. He agreed that the standard of care required that additional information be included in the medical records. (Tr. at 60, 77, 118, 121, 122, 124, 142-143, 147-149, 165, 238-239, 257-258, 320, 342-343, 388-389, 391-392, 407-408, 1227) Below is a list of information that Dr. Villavicencio admitted should have been included:
 - Patient 1: A reason for diagnosing radiculopathy in June 2005 and what happened in September 2005 to the remaining OxyContin pills when Patient 1 received an early refill. (St. Ex. 1 at 43, 55; Tr. at 61, 77)
 - Patient 3: Information as to why Dr. Villavicencio switched from Kadian to OxyContin in May 2006. (St. Ex. 3 at 54; Tr. at 118)
 - Patient 4: Information as to why Dr. Villavicencio increased the dosage of Soma in July 2006. (St. Ex. 4 at 16; Tr. at 147-148)
 - Patient 7: An assessment at his first visit in October 2005 of how Patient 7's pain influenced his daily functions. (St. Ex. 7 at 64; Tr. at 203)
 - Patient 8: A reason for increasing the number of Xanax pills and Percocet pills prescribed in April 2006. (St. Ex. 8 at 42; Tr. at 238-239)

- Patient 9: A reason for increasing the number of Percocet pills prescribed in August 2005. (St. Ex. 9 at 33; Tr. at 257-258)
- Patient 10: The basis for confronting Patient 10 in December 2005 with multiple prescriptions from several providers. (St. Ex. 10 at 30; Tr. at 284-286)
- Patient 11: More information in mid-April 2005 to explain why Dr. Villavicencio chose to prescribe the medications and their dosages because the patient's magnetic resonance imaging ("MRI") findings were minimal. (Tr. at 317-319, 1699; St. Ex. 11 at 123)
- Patient 12: Explanations in December 2005 as to why Dr. Villavicencio prescribed Soma and why he switched from Avinza to MS Contin. (St. Ex. 12 at 75, 77; Tr. at 343)
- Patient 13: Details concerning Patient 13's nasal fracture. (St. Ex. 13 at 20; Tr. at 1275-1276)
- Patient 14: Dr. Villavicencio's clinical reasoning for switching from OxyContin to methadone in May 2006, and for adding Xanax and increasing the number of Percocet tablets in August 2006. Additionally, Dr. Villavicencio did not document his reason in November 2007 for discontinuing Zanaflex, which he had been prescribing to Patient 14 for more than two years. (St. Ex. 14 at 31, 46, 62, 66; Tr. at 386-389, 391-392)
- Patient 15: A description of the cyst diagnosed in November 2005, and his reason for doubling the dosage of Xanax in April 2007. (St. Ex. 15 at 62, 79; Tr. at 407-408, 1241-1244)

28. In the following excerpt, Dr. Villavicencio elaborated about his documentation in these patients' medical records:

I did my best in documentation, but I – I think that – that – that – I'm not trying to excuse the fact that it wasn't included there, but, you know, most of the time we treat patients with – with the concept that I'm not – I'm not doing a completely documented chart because I am going to be coming before the Medical Board. A lot of times it's just enough to jog my memory so I would remember something when they come to me [the] next time.

* * *

As a – As a private practitioner at that time with two employees, learning billing, learning medical records, receiving calls from the pharmacies, trying to talk to physicians, you know –

* * *

– the document does not show the entire story. A lot of times they say, "Oh, by the way" – when I am about to leave the – the room they say, "Oh, by the

way, Doc, you know, I was coughing up yellow phlegm.” So you go back and listen to the lungs, but at that point the – the chart was closed. So – So there’s issues. But for somebody who – who looks at them and who actually spent ten minutes with them in the room, I kind of – I kind of need just little bits and pieces to remind me of what happened last month.

(Tr. at 60-62; See, also, Tr. at 204-205)

General Information about Medications Prescribed to Patients 1 through 16

29. From a review of the medical records, Dr. Villavicencio prescribed a variety of medications to Patients 1 through 16. Below is a summary of many of those medications:

Long-acting opiate medications³

- Avinza is a long-acting narcotic, morphine. It is a Schedule II controlled substance. (Tr. at 63, 321, 337, 500)
- Duragesic is a long-acting fentanyl dispensed in a transdermal patch format. It is an opiate. (Tr. at 263, 639)
- Kadian is an extended-release morphine. (Tr. at 537, 582)
- MS Contin is a long-acting morphine. It is a Schedule II controlled substance. (Tr. at 149, 239, 321, 573-574; Resp. Ex. EE at 2-4)
- Methadone is a long-acting synthetic opiate. It is a Schedule II controlled substance. It is inexpensive. (Tr. at 219, 598-599; Resp. Ex. FF)
- Opana is an oxymorphone. (Tr. at 1122)
- OxyContin is a slow-release oxycodone and an opioid. It is a Schedule II controlled substance. It is expensive. (Tr. at 219, 1707; Resp. Ex. EE at 4-10)

Short-acting opiate medications

- Dilaudid (brand name of hydromorphone) is a short-acting pain medication. (Tr. at 548-549, 581, 601)
- Lortab and Vicodin contain hydrocodone and acetaminophen. Hydrocodone is a Schedule III opiate. They are short-acting medications. (Tr. at 369, 526-527, 530, 581, 1170, 1707)
- Percocet and Roxicet contain oxycodone and acetaminophen. They are Schedule II controlled substances. (Tr. at 46, 113, 219, 533, 1707)
- Propoxyphene is an opiate, Schedule IV controlled substance. One brand name of propoxyphene is Darvocet. (Tr. at 1267, 1695)
- Roxicodone is short-acting oxycodone. (Tr. at 546)

Benzodiazepines

- Restoril is a benzodiazepine. It is used as a sleep aid. (Tr. at 565)

³In this Report and Recommendation, the terms “opiate” and “opioid” are used interchangeably and without distinction.

- Valium (brand name of diazepam) is a benzodiazepine used to treat anxiety, panic attacks and muscle spasms. (Tr. at 553-555, 1361-1362, 1693)
- Xanax (brand name of alprazolam) is a benzodiazepine, a controlled substance, schedule III, and used to treat anxiety and panic attacks. Xanax can also be used to treat muscle spasms or as an adjunct for the treatment of pain. (Tr. at 46-47, 53-54, 553, 1004-1005, 1400)

Other medications

- Ambien is a non-benzodiazepine, sleep aid. (Tr. at 566)
- Cymbalta is an antidepressant. Also, it can be used as an adjunctive medication for certain types of pain, such as radiculopathy and neuropathic pain. (Tr. at 586, 1180)
- Depakote (brand name of valproate) is used to treat multiple conditions, including bipolar disorder, depression, neuropathic pain, and seizures. (Tr. at 224, 342, 1694)
- Elavil is a tricyclic antidepressant. To treat depression, it is prescribed at high dosages. It is also used in low doses for migraine prevention or as an adjunct to control pain, diabetic neuropathy and fibromyalgia. It can also be used as a sleep aid. (Tr. at 562-563, 1440-1441, 1445-1447, 1450)
- Motrin is an anti-inflammatory medication. It is used to treat pain. (Tr. at 139, 177)
- Naprosyn is an anti-inflammatory medication. It is used to treat pain. (Tr. at 139, 366, 421, 1538)
- Phenergan is used to treat nausea. It can also be used to potentiate or strengthen the effects of opiates for pain control. (Tr. at 124, 545, 1142, 1599)
- Remeron (brand name of mirtazapine) is a sleep aid. (Tr. at 224, 614)
- Robaxin is a muscle relaxant, used to treat muscle spasms. (Tr. at 177-178, 1052)
- Soma (brand name of carisprodol) is a muscle relaxant. It was a non-controlled substance between 2005 and 2008. (Tr. at 200, 709-710)
- Strattera is used for attention deficit hyperactivity disorder. (Tr. at 880)
- Topamax is used for seizures and used as a migraine prophylactic. (Tr. at 880)
- Trazadone is an antidepressant. It is used as a sleep aid. (Tr. at 1441)
- Ultracet is a combination of acetaminophen and Ultram. It is used to treat pain. It was a non-controlled substance between 2005 and 2008. (Tr. at 1694)
- Zanaflex is a muscle relaxant. (Tr. at 392)
- Zoloft is a selective serotonin reuptake inhibitor used to treat depression and anxiety. (Tr. at 335, 746)

Patient 1

(Medical record reflects treatment between June 2005 and November 2006, 17 months)

30. Patient 1, a female, was born in 1954. Patient 1 first saw Dr. Villavicencio on June 7, 2005, when she was 50 years old. At her first visit, Patient 1 complained of a rash. She reported a

medical history of breathing problems/chronic obstructive pulmonary disease (“COPD”), frequent cough, and back trouble. She reported that her current medications were “albuterol/oxygen.” Dr. Villavicencio diagnosed allergic reaction and COPD, and he prescribed Medrol dosepak (a short course of steroids), Atarax (an antihistamine), and doxycycline (an antibiotic). (St. Ex. 1 at 7, 57; Tr. at 482, 597)

31. In his progress note, Dr. Villavicencio documented the following about Patient 1’s first office visit:

South German Village Medical Center
1730 South High Street Columbus, OH 43207
(614) 444-5966

06/07/2006 Office Visit

S:
comes in for the first time with complaint of rash. Patient has had rash for 3 days, and the last time she had this, she responded to benadryl and steroid injection. Patient was thinking of going to the ER for a Benadryl shot but found out that we have our own injections here.
ROS: General: noncontributory. HEENT: noncontributory. Respiratory: noncontributory. Cardiovascular: noncontributory. Gastrointestinal: noncontributory. GenitoUrinary: noncontributory. Neuro-Muscular-Skeletal: noncontributory. skin: rash

O:
Vitals: 92 16 110/70

Normocephalic, atraumatic. EAC/TM's nLEOMI, PERL, Fundi benign. Neck supple s adenopathy. No JVD noted. No CVA tenderness. Heart mtr s m or g. Abdomen BS nI, nontender, no organomegaly or masses. Extremities: pulses symmetrical UE and LE's, motor strength symmetrical, cap refill < 2 sec extrem x 4. Neurological: CN II-XII nI. DTR's symmetrical, no sensory defects. gait nI. Skin: rash

A:
Dx:
Allergic Reaction 995.3
Copd 492.0

P:
Rx:
Medrol Dosepak as directed #1 pak of x0
Atarax 25mg i-ii po qid prn itching #30 of x1
Doxycycline 100mg I po bid #60 of x5

Follow-Up:
as needed
Date of Service: 06/07/2006
Last Modified: 06/07/2006

*STORIAN
-LUNG
-MRI
-BIA*

Patient: [REDACTED]
SPRINGFIELD

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State's Exhibit 1
Electronic Pg.57

(St. Ex. 1 at 57)

32. Patient 1’s chart contains two documents related to her medical treatment/evaluation before seeing Dr. Villavicencio. The first document is the last page of a lumbar spine MRI from 2003, which contained no findings or conclusions. The second document is a lung ventilation

and perfusion scan from 2005, which was "negative." It is not clear when those two records were provided to Dr. Villavicencio, although a facsimile header on the lung scan indicates that it may have been transmitted to him on the day of Patient 1's second office visit. (St. Ex. 1 at 58, 59)

- 33. Patient 1's second office visit was the day after her first office visit. She reported that her rash was likely because of nerves. She further reported that, previously, she had received Xanax for her nerves and Percocet for her chronic back pain. Dr. Villavicencio noted that Patient 1 was unwilling to undergo surgery for her back pain because of the COPD. Dr. Villavicencio diagnosed COPD, anxiety and neurodermatitis. He gave several injections to Patient 1 and prescribed one-month supplies of Xanax and Percocet. (St. Ex. 1 at 4, 56)
- 34. The following is Dr. Villavicencio's progress note from Patient 1's second office visit:

South German Village Medical Center
1738 South High Street Columbus, OH 43207
(614) 444-6888

06/08/2005 Office Visit

S:
comes in for an office visit. Patient decided that she will stay in Columbus instead of Zanesville. Patient looking for an apartment close to daughter [REDACTED]. Patient claims that her doctor would give her Xanax from time to time bec of her nerves - seen here yesterday for dermatitis which she now attributes to nerves. also has chronic back pain that is being treated with perocet QID. Patient unwilling to undergo surgery bec of COPD
ROS: General: noncontributory. HEENT: noncontributory. Respiratory: noncontributory. Cardiovascular: noncontributory. Gastrointestinal: noncontributory. GenitoUrinary: noncontributory. Neuro-Muscular-Skeletal: noncontributory. skin: rash, getting better

O:
Vitals: 88 18 110/70

Normocephalic, atraumatic. EAC/TM's n. EOMI, PERL, Fundi benign. Neck supple s adenopathy. No JVD noted. Chest clear to auscultation. Heart r/r s m or g. Abdomen BS nI, nontender, no organomegaly or masses. No CVA tenderness. Extremities: pulses symmetrical UE and LE's. motor strength symmetrical. cap refill < 2 sec extrem x 4. Neurological: CN II-XII nI. DTR's symmetrical, no sensory defects. gait nI. Skin: no rash

A:
Dx:
Copl 492.0
Anxiety 300.01
Neurodermatitis 698.3

P:
Rx:
Xanax 1mg i PO BID pm anxiety #60 if x0
Percocet 5/325 mg 1 PO QID #120 if x0
Follow-Up:
2 weeks
Date of Service: 06/08/2005
Last Mod/Ed: 06/08/2005

*BASRT
SSTITION*

*qu
[REDACTED]
MTN chrtg
4m Dexamethasone Injection
9ml Histadil Injection
(Atedax)
Hydroxyzine*

Patient: [REDACTED]
SOUTH GERMAN VILLAGE MEDICAL CENTER

*VStarr
33410 (90782)*

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South German Village Medical Center

35. Patient 1 returned a third time in June 2005 (two weeks after her second office visit). At that time, she stated that she had been to the emergency room because of stress and back pain. Dr. Villavicencio issued new prescriptions for Xanax and Percocet, both for 30-day supplies. He also added a diagnosis of radiculopathy and ordered an MRI. (St. Ex. 1 at 55)
36. Between July 2005 and November 2006, the following events occurred:
- Patient 1 obtained an MRI in early July 2005, but the medical chart contained only the final page of the report, which does not include any results.⁴ Dr. Villavicencio noted in a progress note that Patient 1 had multilevel degenerative disk disease with a mild broad-based disk bulge at L5-S1. Dr. Villavicencio later documented that Patient 1 had a “normal” MRI. (St. Ex. 1 at 46, 47)
 - Patient 1 executed a narcotic medication contract in July 2005. (St. Ex. 1 at 64)
 - Also in July 2005, Dr. Villavicencio switched Patient 1 from Percocet to Avinza. A few weeks later, Patient 1 reported her pain level as an “8” and asked to replace the Avinza with another medication that a relative had given her. Patient 1 returned the Avinza prescription and Dr. Villavicencio prescribed OxyContin. (St. Ex. 1 at 4, 45, 46; Tr. at 72)
 - In August 2005, Patient 1 reported that she was able to move around more and that she was losing weight as a result. Dr. Villavicencio prescribed OxyContin again. (St. Ex. 1 at 44)
 - In September 2005, Patient 1 reported having problems with her husband. Dr. Villavicencio conducted a urine drug screen, but there are no results in the chart. He doubled the OxyContin dosage and increased the Xanax dosage as compared to the prior month’s prescriptions. (St. Ex. 1 at 11, 43)
 - In January 2006, Dr. Villavicencio noted that Patient 1 continued to have low back pain, sought a refill, and reported that the medications were working. Also, he noted that the respiratory system was “noncontributory.” He diagnosed an upper respiratory infection and prescribed Zithromax, an antibiotic. (St. Ex. 1 at 35; Tr. at 1105)
 - In March 2006, Patient 1 reported a pain level of “9.” Dr. Villavicencio prescribed physical therapy, along with Xanax, Percocet, and OxyContin. Notes reflect that patient also had a urine drug screen that day. One note stated that it was positive for all medications prescribed by the office and another note stated that it was positive for oxycodone and negative for illegal substances. No laboratory results are in the chart. (St. Ex. 1 at 3, 33)
 - Patient 1 obtained an MRI of the lumbar spine in April 2006 and it indicated moderate degenerative disc disease most prominently at L5-S1, with diffuse bulging in the midline. MRIs in November 2006 reflect that Patient 1 had: (a) degenerative disc disease of the thoracic spine, with disc

⁴Dr. Villavicencio estimated that the cost of an MRI between 2005 and 2008 was \$325 or \$375. (Tr. at 1676)

protrusions at T7-8, T8-9, T9-10 and no canal stenosis or foraminal compromise; and (b) degenerative disc disease of the cervical spine with mild canal stenosis at C4-5, C5-6, and C6-7 and mild foraminal stenosis due to uncovertebral joint hypertrophy. (St. Ex. 1 at 17-19, 30)

- In May and June 2006, Dr. Villavicencio prescribed OxyContin, Percocet, Xanax, and Motrin after Patient 1 had received epidural steroid injections from another physician. Patient 1 reported that the second injection helped “a lot.” The May 31, 2006 medications were prescribed before her previous prescriptions would have run out. (St. Ex. 1 at 27-29)
- In September 2006, Patient 1 reported her pain level as “5” and reported that she had been involved in a car accident. Patient 1 asked for a temporary increase in OxyContin. Dr. Villavicencio increased the daily dosage of OxyContin. In October and November 2006, Patient 1 reported her pain level as “3” and “4,” respectively. The higher dosage of OxyContin was prescribed in October and November 2006 as well. (St. Ex. 1 at 1-2, 22)

37. Dr. Villavicencio ordered referrals for Patient 1 to pain specialists six times during his care and treatment of her – on August 17 and November 7, 2005, and January 7, April 5, June 22, and June 28, 2006. Also, he referred Patient 1 to physical therapy on January 1, 2006. (St. Ex. 1 at 2-4, 25, 27, 32, 35, 38, 44) The medical chart does not reflect that Patient 1 ever saw any of those pain specialists⁵ or received physical therapy. (St. Ex. 1)

38. Dr. Villavicencio documented discussions with Patient 1 about noncompliance issues:

- According to Dr. Villavicencio’s progress note dated November 7, 2005, Patient 1 obtained prescriptions for narcotics from multiple providers. Dr. Villavicencio documented that Patient 1 denied that she had obtained narcotics from multiple providers. He also documented that he would keep a “close eye” on her with pill counts, and he referred her to a pain specialist. (St. Ex. 1 at 38)
- In February 2006, Patient 1 still had not seen a pain specialist per Dr. Villavicencio’s referral in November 2005. He instructed Patient 1 that she had to call and see the pain specialist. (St. Ex. 1 at 34; Tr. at 83-84)
- Dr. Villavicencio documented that he would conduct a pill count in June 2006. (St. Ex. 1 at 28) The medical chart does not reflect that any pill counts were conducted, however.

⁵In May/June 2006, a different pain specialist provided epidural shots for Patient 1’s pain. There is no report from that pain specialist in the medical record. Dr. Villavicencio continued prescribing OxyContin, Percocet, Xanax, and Motrin to Patient 1 during that time period, without any changes in dosages. (St. Ex. 1 at 25, 28-29; Tr. at 84)

39. Over 17 months of treatment, Dr. Villavicencio continually prescribed various medications to Patient 1. Those prescriptions are summarized below:

Date	Relevant Medication	Dosages (no refills provided)	Comments ⁶	St. Ex. 1 Cite
6/8/05	Xanax Percocet	1 mg, 1 tablet twice a day, #60 5/325 mg, 1 tablet four times a day, #120		56
6/22/05	Xanax Percocet	1 mg, 1 tablet twice a day, #90 5/325 mg, 1 tablet four times a day, #120	Early refills. 45-day supply of Xanax prescribed.	55
7/6/05	Xanax Avinza	0.5 mg, 1 tablet twice a day 30 mg, 1 tablet each day, #30	Switch from short-acting to long-acting pain medication.	46
7/20/05	Avinza Xanax Percocet Motrin	30 mg, 1 tablet each day, #30 0.5 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120	Motrin added.	4, 45
8/17/05	Xanax Percocet OxyContin Motrin	0.5 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day, #120 20 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	Long-acting pain medication switched and dosages nearly tripled.	44
9/2/05	Xanax OxyContin	1 mg, 1 tablet twice a day, #40 40 mg, 1 tablet three times a day, #45	Early refills. Xanax and OxyContin dosages increased. Two-week supplies prescribed.	43
9/13/05	Xanax Percocet OxyContin Motrin	1 mg, 1 tablet twice a day, #40 5/325 mg, 1 tablet four times a day, #120 40 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	20-day supply of Xanax prescribed.	42
10/7/05	Xanax Percocet OxyContin Motrin	1 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day, #120 40 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	Early refills. Xanax dosage increased.	41
10/12/05	OxyContin Codiclear ⁷	40 mg, 1 tablet three times a day, #60 5/100, 1-2 teaspoons four times a day, #240 ml	Replacement prescription of OxyContin after pharmacy only dispensed 30 tablets from prior OxyContin prescription.	40
11/4/05	Codiclear	5/100, 1-2 teaspoons four times a day, #240 ml		39
11/7/05	Xanax Percocet OxyContin Motrin	1 mg, 1 tablet three times a day, #45 5/325 mg, 1 tablet four times a day, #60 40 mg, 1 tablet three times a day, #30 600 mg, 1 tablet four times a day, #120	15-day supplies of Xanax and Percocet prescribed. 10-day supply of OxyContin prescribed.	38
11/21/05	Xanax Percocet OxyContin	1 mg, 1 tablet three times a day, #45 5/325 mg, 1 tablet four times a day, #60 40 mg, 1 tablet three times a day, #60	15-day supplies of Xanax and Percocet prescribed. 20-day supply of OxyContin prescribed.	37

⁶Most of Dr. Villavicencio's prescriptions to Patients 1 through 16 were 30-day supplies, based on the dosing instructions. In this chart and others in this Report and Recommendation, any prescriptions that were other than 30-day supplies are specifically noted in the Comments Column.

⁷Codiclear is used to treat coughs and chest congestion. It contains an expectorant and the narcotic hydrocodone. (Drug Information Online, *Drugs.com*, <http://www.drugs.com>, accessed June 19, 2012)

Date	Relevant Medication	Dosages (no refills provided)	Comments	St. Ex. 1 Cite
12/7/05-2/1/06	Xanax Percocet OxyContin	1 mg, 1-2 tablets three times a day, #120 5/325 mg, 1 tablet four times a day, #120 40 mg, 1 tablet three times a day, #90	The Xanax dose was increased “temporarily” on 12/7/05, but the dosage never decreased. 20- to 40-day supply of Xanax prescribed. Early refills on 2/1/06.	34-36
3/1/06-8/23/06	Xanax Percocet OxyContin Motrin	1 mg, 1-2 tablets three times a day, #120 5/325 mg, 1 tablet four times a day, #120 40 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	Early refills on 5/31/06.	3, 23-25, 28, 29, 32, 33
9/21/06-11/16/06	Xanax Percocet OxyContin Motrin	1 mg, 1-2 tablets three times a day, #120 5/325 mg, 1 tablet four times a day, #120 40 mg, 2 tablets twice a day, #115 ⁸ 600 mg, 1 tablet four times a day, #120	28.75-day supply of OxyContin prescribed.	16, 21, 22

40. Patient 1 died on November 17, 2006, from “combined drug intoxication.” Patient 1 had a toxic level of oxycodone in her system. (St. Ex. 1A at 3, 7, 9)

Opinion of Dr. Kelly

41. With regard to Patient 1’s first office visit with Dr. Villavicencio, Dr. Kelly stated that Dr. Villavicencio did not document adequately an initial history, examination, diagnosis, and treatment plan. He stated that, with regard to the rash that was found, Dr. Villavicencio should have, at a minimum, identified where the rash was located and how it looked. With regard to the COPD diagnosis, he stated that a pulmonary examination should have been conducted and documented in order to diagnose COPD, and perhaps a spirometry or lung-function test ordered. He also stated that no smoking history or respiratory history was documented.⁹ In addition, Dr. Kelly opined that Dr. Villavicencio did not document a treatment plan for Patient 1’s COPD. He explained that typically treatment for COPD includes broncodialators and possibly other medications, a spirometry test, or a lung-function test. (Tr. at 481-484, 1301-1304; St. Ex. 18 at 2, 10)
42. Regarding Patient 1’s second office visit, Dr. Kelly raised three criticisms of Dr. Villavicencio’s care and treatment. First, Dr. Kelly pointed out that Dr. Villavicencio diagnosed neuro-dermatitis, which is typically an itchy rash that is scratched, but he also documented that Patient 1’s skin had no rash and also separately documented that the skin rash was getting better. Dr. Kelly stated that this documentation does not support changing the diagnosis from allergic reaction to neurodermatitis. Dr. Kelly concluded that the standard of care required Dr. Villavicencio to describe the appearance of the rash when making the neurodermatitis

⁸Dr. Villavicencio testified that, when he prescribed medications at “oddball” figures (e.g., such as the 115 OxyContin pills), it is because he had planned to try to lower it at the next visit. He further stated that it is never a permanent dosage level. (Tr. at 84-85)

⁹This is an error on the part of Dr. Kelly. In June 2005, Patient 1 indicated on her history form that she was a smoker and that her medications were albuterol/oxygen. (St. Ex. 1 at 7)

diagnosis. However, Dr. Kelly stated that Patient 1's report that she thought her rash was caused by her nerves could be justification for the new diagnosis. (Tr. at 485-486)

Second, Dr. Kelly found that there was insufficient justification for the diagnosis of anxiety. He stated that the standard of care required more information about the history of Patient 1's anxiety and how the anxiety affected her at that time. In addition, Dr. Kelly found that the Xanax dosage was "a lot," because the prescription was for an entire month even though the alleged manifestation of the anxiety (the rash) may have been improving. (Tr. at 487-489)

Third, Dr. Kelly opined that, contrary to the standard of care, Dr. Villavicencio did not document doing a musculoskeletal examination of Patient 1's back at her second office visit even though he had noted that she had chronic back pain, and he prescribed Percocet. He acknowledged that there is documentation of a neurological examination, but stated that there is no documentation of a range of motion test, tenderness, straight-leg raises, and motor strength. Additionally, Dr. Kelly noted that there is no diagnosis related to the Percocet prescription. Dr. Kelly described the Percocet prescription as a "fairly high initial prescription" because it was essentially a continuous supply of medication for one month. (Tr. at 491-492)

43. Next, Dr. Kelly addressed Patient 1's appointment at the end of June 2005. He concluded that the early refill of the Percocet and Xanax prescriptions in late-June 2005 did not appear to be appropriate. While Dr. Kelly found that Patient 1 had reported some history of increased pain at the late-June visit, he did not believe that the history or the examination of the patient was sufficient at that time. Dr. Kelly found that the examination of Patient 1 was the same as before, thus not warranting additional early refills. He concluded that, if Patient 1 had consumed all the Percocet previously prescribed, she would have taken eight tablets a day, which is inappropriate and a "red flag" for drug abuse or diversion. Moreover, Dr. Kelly found that Dr. Villavicencio prescribed a 45-day supply of Xanax that day when Patient 1 should have had a two-week supply left. Dr. Kelly stated that the standard of care required Dr. Villavicencio to document an inquiry of her use of the medications, his conversation with the patient, and an explanation of why he gave early prescriptions of Percocet and Xanax. Dr. Kelly found that Dr. Villavicencio violated the standard of care. (Tr. at 496-499)
44. Below is a list of other criticisms that Dr. Kelly raised with respect to Dr. Villavicencio's care and treatment of Patient 1. He found that these deficiencies were below the standard of care:
 - Dr. Villavicencio did not document a discussion or explain the basis for the switch to Avinza in July 2005 and the basis for giving the early refills of OxyContin and Xanax in September 2005. (Tr. at 506)
 - Dr. Villavicencio did not document a discussion with Patient 1 after she reported in July 2005 that she had taken a relative's medication and then requested that medication, and did not document a rationale for changing medications thereafter. (Tr. at 512-513)
 - Dr. Villavicencio did not document an explanation for tripling the opiate medication when he switched from Avinza to OxyContin in August 2005,

which is an issue especially since Patient 1 had reported improvements in her mobility at that same visit. (Tr. at 511; St. Ex. 18 at 4)

- There is no explanation for doubling the OxyContin dosage and increasing the Xanax dosage in September 2005. Dr. Kelly stated that the OxyContin dose prescribed in September 2005 was a six-fold increase in opiates over a very brief period of time, and there was no clear rationale for why the opiate increase was necessary. Dr. Kelly acknowledged that there was a notation that Patient 1 was having problems with her husband, but Dr. Kelly concluded that the note was not specific enough to explain the Xanax increase. (Tr. at 513-515; St. Ex. 18 at 4)
- There is no documentation of an examination to support the diagnosis of an upper respiratory infection in January 2006. Dr. Kelly stated that there was nothing in the history/chief complaint, the review of systems, or examination findings relative to an upper respiratory infection. (Tr. at 520-521; St. Ex. 18 at 6)

45. Dr. Kelly also noted that the increased OxyContin dosage that was prescribed in September 2005 was supposed to be temporary, but it continued for almost a year. Similarly, the increased dosage of Xanax prescribed in December 2005 was supposed to be temporary, but it continued through November 2006. He also pointed out that Dr. Villavicencio planned in November 2005 to conduct pill counts with Patient 1, but never documented doing them. (Tr. at 519-520; St. Ex. 18 at 6)
46. Dr. Kelly explained that, in a three-month period, Patient 1's opiate medications increased from an initial dose of 20 mg of oxycodone per day to 140 mg of oxycodone per day. He noted that the dosage was further increased to 180 mg of oxycodone per day in September 2006. Dr. Kelly opined that the level of the opiate prescriptions to Patient 1 and the rapid increase in the dosages were not justified by history or examination. Dr. Kelly stated that the opiate prescriptions were below the standard of care. (Tr. at 522, 1317-1318)
47. Dr. Kelly concluded that Dr. Villavicencio's care of Patient 1 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances. Also, he stated that Dr. Villavicencio's controlled substance prescribing and the documentation of his care of Patient 1 constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 10)

Opinion of Dr. Villavicencio

48. Dr. Villavicencio testified that he had prescribed Percocet to Patient 1 at her second office visit because she had seen a pain specialist and was having "a lot" of back pain at that time. Dr. Villavicencio acknowledged that, at Patient 1's second visit, he did not speak with Patient 1's former physician or order any imaging before prescribing Xanax and Percocet to Patient 1. (Tr. at 47, 51-52)

49. Dr. Villavicencio testified that it was “red flag” when Patient 1 returned in late-June 2005 (two weeks after he prescribed one-month supplies of medications) and stated that she needed more medication. He further stated that, at that time, he had not understood that her behavior was a “red flag.” He added that it is still difficult to determine whether such behavior is “aberrant drug behavior” or a sign of under-treatment. (Tr. at 59-60)
50. Dr. Villavicencio testified that, after confronting Patient 1 in November 2005 with allegations of multiple providers of medication, he gave Patient 1 the “benefit of the doubt,” but altered his treatment plan. (Tr. at 80-82)
51. Dr. Villavicencio testified that Patient 1 had not filled the July 6, 2005 prescription for Avinza at the time he issued the July 20 prescription for Avinza because he “would not give another 30 [tablets]” if she had filled the July 6 prescription. (Tr. at 69-71)
52. Dr. Villavicencio stated that Patient 1’s November 2006 MRI results reflect that she had a moderate level of osteophyte complex. (Tr. at 86)
53. Dr. Villavicencio admitted the following with regard to his care and treatment of Patient 1:
 - Dr. Villavicencio began treating Patient 1 in June 2005 for conditions that included rash, anxiety, COPD, and back pain. (Tr. at 1575)
 - Dr. Villavicencio prescribed long-acting and short-acting opiate medications, as well as other medications, both controlled and non-controlled. The Soma, COPD medications, and rash medications were non-controlled substances. (Tr. at 1575)
 - At times, Dr. Villavicencio failed to record all required information for the medications he prescribed. (Tr. at 1578)
 - The chart entries appeared verbatim from one visit to the next and identical to chart entries in other patient’s records from similar time periods. (Tr. at 1579)
 - According to Patient 1’s medical record, Dr. Villavicencio last treated Patient 1 in November 2006. (Tr. at 1584-1585)
54. Dr. Villavicencio disagreed with the following allegations:
 - The medical record lacks documentation to support the use of the controlled and non-controlled medications, or the increases in dosages. Dr. Villavicencio stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical record is taken into consideration (including the intake forms and his staff’s notes), he believes that his medical record is “better documented than * * * the allegations would suggest.” (Tr. at 1575-1576)
 - Although Dr. Villavicencio referred Patient 1 to specialists, he failed to take and/or document taking appropriate action when she failed to keep

the appointments. Dr. Villavicencio stated that he documented why she did not make the referrals – she had an unstable home situation, unsupportive home environment, and no means of transportation. (Tr. at 1579-1580)

- Dr. Villavicencio did not take and/or document taking appropriate action when he learned that Patient 1 was receiving controlled substances from more than one provider. Dr. Villavicencio testified that he addressed the issue with Patient 1 and that, at that time, he did not have “hard” evidence that she had gone to multiple providers (such as is presented on prescription reports). (Tr. at 1580, 1583)
- The initial dose of 20 mg of oxycodone per day and the increased dosages of oxycodone were below the standard of care. Dr. Villavicencio stated that the 20 mg per day of oxycodone was not an unusual initial dose because Patient 1 had been treated with narcotic medication previously. He added that the speed with which he increased the pain medication was not improper because Patient 1 had been to the emergency room multiple times. Finally, Dr. Villavicencio stated that the 140 mg of oxycodone per day was not concerning because it is a dosage that pain management specialists prescribe. (Tr. at 1585-1586)

Patient 2

(Medical record reflects treatment between August 2005 and June 2007, 22 months)

55. Patient 2, a male, was born in 1973. Patient 2 was involved in an automobile accident in 2001. Afterward, he was treated by another physician for a few months in 2001. (St. Ex. 2 at 13-16, 56-58, 61)
56. Patient 2 first saw Dr. Villavicencio on August 15, 2005, when he was 31 years old. At that time, Patient 2 reported that his low back pain was the result of a car accident in 2001, and that he had not taken oxycodone in the past four or five months. On his history form, Patient 2 listed that he had taken no medications in the month prior to his first visit. However, he indicated that he had taken OxyContin, Lortab, Soma, and Xanax in the six months prior to the first appointment with Dr. Villavicencio. He stated that his pain level was “9.” He also reported that he had high cholesterol. Dr. Villavicencio diagnosed low back pain and hyperlipidemia. He prescribed OxyContin, Lortab, Soma, and Xanax. He noted that Patient 2 would bring in the results of his prior physical therapy, and that Patient 2 claimed that he could not have an MRI because of metal plates/fragments. (St. Ex. 2 at 3, 24, 52)
57. Patient 2 executed a pain contract in August 2005, and again in May 2007. (St. Ex. 2 at 5-6, 59)
58. Patient 2 saw Dr. Villavicencio every month thereafter and complained of back pain. His pain levels were between “5” and “8” at nearly every office visit. Patient 2 reported that the medications were working and that, at times, he was doing well. Dr. Villavicencio prescribed OxyContin, Lortab, Soma and Xanax at each visit. (St. Ex. 2 at 29-51)

59. In December 2005, Dr. Villavicencio ordered an MRI. It was determined that Patient 2 could have an MRI of his back, despite the metal plates/fragments. Patient 2 obtained an MRI of the lumbosacral spine in February 2006. The MRI reflected that Patient 2 had disc degeneration, including a disc bulge that constituted a small central disc herniation. A second MRI was ordered in April 2007 and obtained in May 2007. It reflected that Patient 2 had an L5-S1 disc desiccation with disk protrusion abutting the S1 nerve root, mild facet arthropathy with mild narrowing, and S1-2 protruding disc. (St. Ex. 2 at 31, 45, 54, 55)
60. Dr. Villavicencio documented that physical therapy was discussed with Patient 2 in December 2005, but there are no details of that discussion, and no referral or order for physical therapy at that time. Additionally, Dr. Villavicencio noted in March 2006 that Patient 2 was told that, once he had insurance, “we will be getting PT, pain consult and [a nerve conduction velocity test].” (St. Ex. 2 at 43, 48; Tr. at 106)
61. In May 2007, Patient 2 reported a pain level of “8.” He also complained of pain in his low back and his left shoulder. Dr. Villavicencio increased the dosages of OxyContin, Lortab, and Xanax. He did not have the May 2007 MRI results at the time. (St. Ex. 2 at 1, 30)
62. Dr. Villavicencio made no referrals to pain management specialists or physical therapy for Patient 2 during his 22 months of treatment.¹⁰ There were no urine drug screens documented in the medical record. (St. Ex. 2)
63. Below is a summary of the medications that Dr. Villavicencio prescribed to Patient 2 between August 2005 and June 2007:

Date	Relevant Medication	Dosages (no refills provided)	Comments	St. Ex. 2 Citation
8/15/05-1/3/06	OxyContin Lortab Soma Xanax	40 mg, 1 tablet three times a day, #90 10/500 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 1 mg, 1 tablet three times a day, #90		47-52
1/24/06-12/5/06	OxyContin Lortab Soma Xanax	40 mg, 1 tablet three times a day, #90 10/500 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 1 mg, 1 tablet three times a day, #90	Early refills on 1/24/06. 10/10/06 appointment is two months after the prior appointment.	35-44, 46
1/2/07	OxyContin Lortab Soma Xanax	40 mg, 2 tablets twice a day, #105 10/500 mg, 1-2 tablets 4 times a day, #135 350 mg, 1 tablet four times a day, #105 1 mg, 1 tablet four times a day, #105	OxyContin, Lortab, Soma, and Xanax dosages increased. 26.25-day supplies of OxyContin, Soma and Xanax prescribed. 16.9- to 33.75-day supply of Lortab prescribed.	34
2/5/07 3/5/07 4/3/07	OxyContin Lortab Soma Xanax	40 mg, 1 tablet three times a day, #90 10/500 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 1 mg, 1 tablet three times a day, #90	OxyContin, Lortab, Soma, and Xanax dosages decreased on 2/5/07.	31-33

¹⁰Dr. Villavicencio stated that Patient 2 did not see a pain management specialist during the time that he treated Patient 2 because he had insurance coverage issues. Dr. Villavicencio added that he generally held back on prescribing if the patient had not been able to see the pain specialist. (Tr. at 104-106, 1596)

Date	Relevant Medication	Dosages (no refills provided)	Comments	St. Ex. 2 Citation
5/16/07	OxyContin Lortab Soma Xanax	40 mg, 1-2 tablet twice times a day, #120 10/500 mg, 1 tablet six times a day, #135 350 mg, 1 tablet three times a day, #90 1 mg, 1 tablet four times a day, #105	Six weeks since prior visit. OxyContin, Lortab, and Xanax dosages increased. 30- to 60-day supply of OxyContin prescribed, 22.5-day supply of Lortab prescribed. 26.25-day supply of Xanax prescribed.	30
6/19/07	OxyContin Lortab Soma Xanax	40 mg, 1 tablet three times a day, #90 10/500 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 1 mg, 1 tablet three times a day, #90	OxyContin, Lortab, Soma, and Xanax dosages decreased.	29

Opinion of Dr. Kelly

64. Dr. Kelly stated as follows with regard to Dr. Villavicencio's first office visit with Patient 2:

- The review of systems and physical examination recorded at the time of Patient 2's first office visit in August 2005 are identical to Patient 1's office visit on July 6, 2005.
- The dosage of OxyContin and Lortab were extremely high and unwarranted, especially since Patient 2 had reported that he had not taken oxycodone for four or five months. Dr. Kelly stated that, at the time of his first office visit, Patient 2 would have been an "opiate naïve" patient because he had not been taking opiates for several months.
- The prescribing of both Soma and Xanax, presumably as muscle relaxants, was not justified. Dr. Kelly stated that Dr. Villavicencio did not explain the basis for prescribing Xanax to Patient 2.
- The initial history, examination, diagnosis, and treatment plan were not documented adequately. Dr. Kelly explained that the types/aspects of pain, location of pain, range of motion, strength of the back, and neurologic findings (relative to reflexes, sensory, and motor skills) were needed in the medical record. Dr. Kelly acknowledged that Dr. Villavicencio noted some tenderness, negative straight-leg raises, and no lateralization of motor, sensory, or deep tendon reflexes. However, Dr. Kelly concluded that the history is nonetheless "skimpy."

(St. Ex. 18 at 11, 13-14; Tr. at 524-527)

65. Dr. Kelly noted that the review of systems and physical examination notes from other office visits were identical with one another and were also identical to notes in other patient's records. Dr. Kelly further stated that the doses of opioid medication included 120 mg of oxycodone and 40 mg of hydrocodone each day. He concluded that the documentation does not support the levels of pain medication prescribed. Similarly, Dr. Kelly stated that the medical record (i.e., symptoms or examination findings) did not justify increases in the

medications in May 2007. Dr. Kelly concluded that Dr. Villavicencio's care of Patient 2 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances. Also, he stated that Dr. Villavicencio's controlled substance prescribing and the documentation of his care of Patient 2 constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 12-14; Tr. at 525-527, 530, 1346-1347, 1356-1357)

Opinion of Dr. Villavicencio

66. Dr. Villavicencio agreed with the following:

- He began treating Patient 2 on August 15, 2005, for conditions including back pain, hyperlipidemia and/or neck pain. (Tr. at 1593)
- He prescribed long-acting and short-acting opiate medications as well as carisoprodol (Soma) and alprazolam (Xanax). (Tr. at 1593)
- He prescribed long-acting and short-acting opiate medications even though Patient 2, at times, advised that he was doing better. Dr. Villavicencio stated that, although Patient 2 stated that he was doing better, Dr. Villavicencio took into consideration information from his staff's notes and the patient's increased pain in prior weeks. (Tr. at 1593-1594)
- The chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. (Tr. at 1579, 1596)

67. Dr. Villavicencio disagreed with the following:

- The medical record lacks documentation to support the use of long-acting and short-acting opiate medications, as well as carisoprodol, alprazolam, and other medications, or the increases in dosages. Dr. Villavicencio stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical record is taken into consideration (including the intake forms and his staff's notes), he believes that his medical record is "better documented than * * * the allegations would suggest." (Tr. at 1575-1576, 1593)
- His dose of OxyContin (120 mg per day) at Patient 2's first visit was below the standard of care for Patient 2. Dr. Villavicencio testified that he believes that Patient 2 came with evidence that he had been getting long-acting and short-acting medications. Although he did not document any explanation for prescribing this level of oxycodone or have other information (e.g., MRI or records from another physician), Dr. Villavicencio recalled that Patient 2 brought his old medication bottles to the initial office visit. He also stated that Patient 2 had a physically demanding job. Additionally, Dr. Villavicencio explained that he did not try non-narcotic analgesics with Patient 2 because "I guess that he has already a history of being on

this for a while. That was the reason – * * * That was my way of thinking then.” He added that many times he started with short-acting medications unless there was proof that the patient is a chronic pain patient who had been taking long-acting medications as well as short-acting medications. (Tr. at 94-96, 98, 100, 1596-1598)

Patient 3

(Medical record reflects treatment between July 2005 and June 2008, 35 months)

68. Patient 3, a female, was born in 1981. She first saw Dr. Villavicencio on July 5, 2005, following a car accident. She was 24 years old. Dr. Villavicencio noted that she had had an x-ray of the cervical spine that was negative. Dr. Villavicencio diagnosed Patient 3 with low back pain, lumbar sprain, and cervical sprain. He prescribed Roxicet, Soma, and Motrin. Also, he ordered MRIs of the cervical spine and lumbar spine. (St. Ex. 3 at 67; Tr. at 111)
69. Patient 3 regularly saw Dr. Villavicencio between July 2005 and May 2008 and complained of low back pain. At each visit, her levels of pain were between 6 and 10, except in April 2008 her pain level was 5. On a number of occasions, Patient 3 reported that she was doing “ok” or “well.” Dr. Villavicencio prescribed various pain medications and Soma at each visit. Much of the time, he also prescribed an anxiolytic. (St. Ex. 3 at 1-5, 23-67)
70. Patient 3’s medical record reflects the following with regard to MRIs, physical therapy, and referrals:
 - In September 2005, Dr. Villavicencio noted that Patient 3 had obtained the ordered MRI, but then documented in November 2005 that Patient 3 was “told she needed MRI” after she had asked for “oxy.” (St. Ex. 3 at 60, 62)
 - In January, February, and March 2006, Dr. Villavicencio prescribed physical therapy for Patient 3. (St. Ex. 3 at 56-58)
 - In May 2006, Dr. Villavicencio referred Patient 3 to a pain management specialist. His staff later noted that Patient 3 was not compliant with that referral. (St. Ex. 3 at 54)
 - In April 2006, Dr. Villavicencio documented that Patient 3 had obtained the MRIs. In June 2006, his staff wrote a note, stating “Pt compliant w/MRI(s)?” At the next office visit in August 15, 2006, Dr. Villavicencio increased the dosage of OxyContin. (St. Ex. 3 at 4, 49, 52, 55)
 - In April 2007, Dr. Villavicencio referred Patient 3 to a pain management specialist, and her appointment was scheduled for May 2007. She did not keep the appointment. Dr. Villavicencio did not document any discussion of the issue with Patient 3 at her next appointment with him in May 2007. (St. Ex. 3 at 39-41)
 - In January and May 2008, Dr. Villavicencio re-referred Patient 3 to the pain management specialist. By the end of May 2008, which is when Patient 3’s medical record ends, she had not seen the pain management specialist. (St. Ex. 3 at 24, 28-30, 36)

71. Three urine drug screens were conducted while Dr. Villavicencio treated Patient 3, and they yielded the following results:
- A urine drug screen was conducted in July 2006 that was negative for opiates even though Dr. Villavicencio had prescribed Roxicet and OxyContin to Patient 3. At the next office visit, Dr. Villavicencio prescribed OxyContin, Roxicet, Soma, and Valium, and increased their dosages. There is no mention of the urine screen in the notes from that office visit. (St. Ex. 3 at 49, 50, 52)
 - In March 2007, a urine drug screen was positive for oxycodone and opiates, and negative for cocaine, amphetamines, marijuana, and PCP. The recorded results do not reflect if the sample was tested for Soma and Valium, which had been previously prescribed. (St. Ex. 3 at 3)
 - In February 2008, a urine drug screen was conducted with several inconsistent results: Soma and Valium were not detected, while Xanax (alprazolam), Dilaudid (hydromorphone), and hydrocodone were detected even though Dr. Villavicencio had not prescribed them. Patient 3 explained in March 2008 that she had “used Xanax and hydrocodone when she ran out of valium after her car got repossessed.” Dr. Villavicencio then prescribed OxyContin, Roxicet, Soma, and Valium to Patient 3 in March 2008. (St. Ex. 3 at 31, 32)
72. Dr. Villavicencio prescribed Maxalt to Patient 3 in June 2006. Maxalt is used to treat migraine headaches. Dr. Villavicencio did not note any complaint of headache on that date or in the recent past. Also, the review of systems reflects “no headache.” There is no related diagnosis listed either. (St. Ex. 3 at 52; Tr. at 541, 1599)
73. In November 2006, Dr. Villavicencio noted in the subjective section that “Patient [3] has wheezing.” In the review of systems, he noted no cough/wheezing/shortness of breath. He prescribed no medication for wheezing that day. (St. Ex. 3 at 46; Tr. at 123)
74. In February 2007, Dr. Villavicencio added Phenergan and continued to prescribe it through June 2008, the end of Patient 3’s medical record. (St. Ex. 3 at 23-43)
75. In April 2008, Patient 3 reported that she had run out of Percocet and Soma, and that she had taken someone else’s Vicodin. Dr. Villavicencio did not document any discussion of that issue with Patient 3, and he prescribed OxyContin, Roxicet, Soma and Valium that day. However, his staff noted that Patient 3 was warned about “toxicology issues.” (St. Ex. 3 at 2, 30)
76. Four weeks later, Dr. Villavicencio noted that Patient 3 was doing well on the current anxiolytic (Valium), but was unable to taper its use. (St. Ex. 3 at 28)
77. In June 2008, Dr. Villavicencio noted that he would not see Patient 3 until she became compliant by obtaining the MRIs and seeing the pain management specialist. (St. Ex. 3 at 1)

78. Dr. Villavicencio did not ever receive MRI results over the course of 35 months of medical treatment, and he stated that he does not believe that Patient 3 ever got the MRIs. Moreover, Patient 3 did not see any of the pain management specialists to whom she was referred. (Tr. at 115, 117, 127, 133, 134, 533; St. Ex. 3 at 28-30, 40)
79. Below is a summary of medications prescribed by Dr. Villavicencio to Patient 3 between July 2005 and June 2008:

Date	Relevant Medication	Dosages (no refills provided)	Comments	St. Ex. 3 Citation
7/5/05-8/15/05	Roxicet Soma Motrin	5/325 mg, 1 tablet four times a day, #60 350 mg, 1 tablet three times a day, #45 600 mg, 1 tablet four times a day, #60	15-day supplies prescribed.	64-67
8/29/05	Roxicet Soma Motrin Cymbalta	5/325 mg, 1 tablet four times a day, #60 350 mg, 1 tablet three times a day, #45 600 mg, 1 tablet four times a day, #60 60 mg, 1 tablet each day, #30	15-day supplies prescribed of Roxicet, Soma, and Motrin. 30-day supply of Cymbalta added.	63
9/20/05	Roxicet Soma Motrin Cymbalta	5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120 60 mg, 1 tablet each day, #30		62
10/17/05	Roxicet Soma	5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90		61
11/15/05-4/5/06	Roxicet Kadian Soma Valium	5/325 mg, 1 tablet four times a day, #120 50 mg, 1 tablet each day, #20 350 mg, 1 tablet three times a day, #90 5 mg, 1 tablet two times a day, #60	Kadian and Valium added. 20-day supply of Kadian prescribed. Opiate dosage more than doubled on 11/15/05. (Tr. at 537)	56-60
5/3/06-7/14/06	Roxicet OxyContin Soma Valium	5/325 mg, 1 tablet four times a day, #120 20 mg, 1 tablet three times a day, #90 350 mg, 1 tablet three times a day, #90 5 mg, 1 tablet two times a day, #60	Kadian changed to OxyContin on 5/3/06.	51-54
8/15/06	Roxicet OxyContin Soma Valium	5/325 mg, 1-2 tablets four times a day, #180 20 mg, 1-2 tablet twice times a day, #120 350 mg, 1 tablet four times a day, #120 5 mg, 1 tablet three times a day, #90	Roxicet, OxyContin, Soma, and Valium dosages increased.	49
9/25/06	Roxicet OxyContin Soma Valium	5/325 mg, 1 tablet four times a day, #120 20 mg, 1 tablet three times a day, #90 350 mg, 1 tablet three times a day, #90 5 mg, 1 tablet two times a day, #60	Roxicet, OxyContin, Soma, and Valium dosages decreased.	48
10/25/06 11/21/06	Roxicet OxyContin Soma Valium	5/325 mg, 1 tablet four times a day, #120 20 mg, 1 tablet three times a day, #90 350 mg, 1 tablet three times a day, #90 5 mg, 1 tablet two-three times a day, #75	Valium dosage increased.	46, 47
12/19/06	Roxicet OxyContin Soma Valium	5/325 mg, 1 tablet six times a day, #140 20 mg, 2 tablet twice a day, #105 350 mg, 1 tablet four times a day, #90 5 mg, 1 tablet two-three times a day, #85	Roxicet, OxyContin, and Soma dosages increased. 28.3- to 42.5-day supply of Valium prescribed.	45

Date	Relevant Medication	Dosages (no refills provided)	Comments	St. Ex. 3 Citation
1/23/07-4/16/07	Roxicet OxyContin Soma Valium Phenergan	5/325 mg, 1 tablet four times a day, #120 20 mg, 1 tablet three times a day, #90 350 mg, 1 tablet three times a day, #90 5 mg, 1 tablet two-three times a day, #75 25 mg, 1 tablet four times a day, #40	Roxicet, OxyContin, and Soma dosages decreased. 25- to 37.5-day supply of Valium prescribed. Phenergan added 2/19/07. 10-day supply of Phenergan prescribed.	41-44
5/16/07	Roxicet OxyContin Soma Valium Roxicodone Phenergan	5/325 mg, 1 tablet four times a day, #120 20 mg, 1 tablet three times a day, #90 350 mg, 1 tablet three times a day, #90 5 mg, 1 tablet three times a day, #90 15 mg, 1 tablet four times a day for breakthrough pain, #45 25 mg, 1 tablet four times a day, #40	Valium dosage increased. Roxicodone added. 10-day supply of Phenergan prescribed.	39
6/13/07 10/8/07 1/09/08-4/2/08	Roxicet OxyContin Soma Valium Phenergan	5/325 mg, 1 tablet four times a day, #120 20 mg, 1 tablet three times a day, #90 350 mg, 1 tablet three times a day, #90 5 mg, 1 tablet three times a day, #90 25 mg, 1 tablet four times a day, #40	Gaps in office visits between June 2007 and January 2008. 10-day supply of Phenergan prescribed.	30, 31, 35, 36-38
4/30/08	Roxicet OxyContin Soma Xanax Phenergan	5/325 mg, 1 tablet four times a day, #120 20 mg, 1 tablet three times a day, #90 350 mg, 1 tablet three times a day, #90 0.5 mg, 1 tablet three times a day pm, #90 25 mg, 1 tablet four times a day, #40	Valium switched to Xanax. 10-day supply of Phenergan prescribed.	28
5/28/08	Roxicet OxyContin Soma Valium Phenergan	5/325 mg, 1 tablet four times a day, #120 20 mg, 1 tablet three times a day, #90 350 mg, 1 tablet three times a day, #90 10 mg, 1 tablet three times a day, #75 25 mg, 1 tablet four times a day, #40	10-day supply of Phenergan prescribed.	23

Opinion of Dr. Kelly

80. Dr. Kelly noted the following with respect to Patient 3's first office visit:

- The review of systems and physical examination notes are identical to the documentation found in Patient 2's August 15, 2005 office visit and Patient 1's July 6, 2005 office visit.
- The history and examination were not documented sufficiently – a history of the type of pain, location, current symptoms, type of motion or sensory restriction, and neck examination were not included.
- It is not clear if the medications were prescribed that day for both the neck and lumbar strains.

(St. Ex. 18 at 15, 18; Tr. at 531-532, 1134-1135)

81. Additionally, Dr. Kelly stated that, during the course of treatment, there were a number of pain medication changes and dosage increases without any justifying documentation. He explained that such justification would include symptoms, examination findings, and a coordinating diagnosis. Similarly, Dr. Kelly noted that, when Maxalt was added in June

2006 and Phenergan was added in February 2007, Dr. Villavicencio did not document symptoms, review of systems, examinations, and diagnoses related thereto. (St. Ex. 3 at 14-15; Tr. at 535-538, 541-542, 544-547, 552-553, 554)

82. With regard to Patient 3's failure to see the pain management specialist after a referral in May 2006 and after other referrals, Dr. Kelly testified as follows:

Well, I – I think it's relevant not necessarily in a single instance [May 2006], but as a pattern over time. As I mentioned earlier, sometimes there are legitimate reasons – maybe financial, maybe transportation – that it's difficult for patients to get to the therapist, to get to a pain specialist. But when that's made a – when that is really a key recommendation, and despite giving the patient some time to do it they're not doing it, then it needs to be addressed in the relationship with the patient. And that may translate into some changing of prescribing.

So I think it's difficult to say that in one visit, that – that this visit is – is a problem; but over the trajectory of the care of the patient who doesn't do a lot of the things that's recommended, I – I would expect it to influence prescribing.

(Tr. at 539-540; See, also, Tr. at 1138-1140) Moreover, Dr. Kelly elaborated that he would expect the relatively high level of pain medications to be tapered to a lower level pending compliance with recommendations. (Tr. at 541)

83. With regard to the urine drug screen conducted in October 2006, Dr. Kelly stated that he could not be certain that the laboratory's test for opiates included oxycodone and, therefore, there is some question as to whether the results were consistent with the prior prescriptions to Patient 3. He further stated that, "unless the physician already knew what the 'OPIATES' meant for this lab, it would require that they find out. And if 'OPIATES' includes oxycodone, then you have a situation where you are prescribing something that the patient isn't taking, so that's a potential diversion situation. And if, in fact, the 'OPIATES' don't include oxycodone, then you might want to do that as a separate – separate or additional screen at some point, including a test for oxycodone." (Tr. at 543-544)
84. With regard to the urine drug screen conducted in February 2008, Dr. Kelly stated that the minimal standard of care required cessation of prescribing to Patient 3 and probably referral to a drug rehabilitation or detoxification center. He explained that Patient 3 was taking a lot of medications that were not prescribed to her and the screen indicated that the patient was abusing drugs. He acknowledged that Dr. Villavicencio discussed the February 2008 urine drug screen with Patient 3. However, Dr. Kelly found it inappropriate that Dr. Villavicencio imposed no consequence at that time. Similarly, Dr. Kelly found it inappropriate that Dr. Villavicencio made no changes in his treatment when Patient 3 reported taking another person's medication in April 2008. (Tr. at 549, 551-552, 1141-1142, 1144, 1146)
85. Dr. Kelly found that Dr. Villavicencio prescribed opiate medications for pain long-term (including a dosage of 80 mg of oxycodone per day), and prescribed Soma, Valium and

Phenergan long-term. Dr. Kelly opined that the documentation in the medical record did not support the prescribed doses of pain medication. Additionally, Dr. Kelly stated there were no consequences for nearly three years to Patient 3's noncompliance with testing, referral to physical therapy, referral to a pain management specialist, and abnormal urine screens. Dr. Kelly opined that, since Dr. Villavicencio did not receive an MRI or have compliance with referrals to specialists, his prescriptions to Patient 3 were below the standard of care. (St. Ex. 18 at 18; Tr. at 540, 1152)

86. Dr. Kelly concluded that Dr. Villavicencio's care of Patient 3 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances. Also, he stated that Dr. Villavicencio's controlled substance prescribing and the documentation of his care of Patient 3 constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 18)

Opinion of Dr. Villavicencio

87. Dr. Villavicencio testified that Patient 3 was taking narcotic medication at the time he first saw her in July 2005, and pointed to an "intake form" as the basis for that statement. (Tr. at 111-113; St. Ex. 3 at 7-12) The Hearing Examiner does not find that statement to be correct. The intake form was not dated, but it contains a reference to "1/07" in the footer of each page. Moreover, Patient 3 stated on the form that her age was 26 years old, and she would have been 26 years old in 2007. Additionally, when two other patients completed that same form, the ages listed on their forms were their ages in 2007, not earlier. (St. Ex. 6 at 9, St. Ex. 7 at 5) Thus, the Hearing Examiner concludes that Patient 3's intake form was completed in 2007. Moreover, the Hearing Examiner found no information in the medical record to reflect that Patient 3 was taking narcotic medication at the time she first saw Dr. Villavicencio.
88. Dr. Villavicencio acknowledged that, at Patient 3's initial visit, he did not document reviewing an x-ray of Patient 3, he did not recall reviewing an x-ray, and the chart reflects that he had only the patient's self-report upon which to base his diagnoses. (Tr. at 113-114)
89. Dr. Villavicencio agreed with the following:
- Dr. Villavicencio began treating Patient 3 on July 5, 2005, for conditions including back pain, lumbar sprain and cervical sprain. (Tr. at 1598)
 - He prescribed long-acting and short-acting opiate medications, as well as other medications, both controlled and non-controlled. (Tr. at 1598)
 - He referred Patient 3 to specialists and for physical therapy and testing, but there is no documentation that she ever complied with those referrals. He also agreed that, according to test results appearing in Patient 3's chart, on at least two occasions, tests of her urine showed negative results for controlled substances that he had prescribed. (Tr. at 119, 127, 130, 134)
 - The chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. (Tr. at 1579)

- Dr. Villavicencio documented that Patient 3 had wheezing, but also documented no wheezing in the chart on the same date. Dr. Villavicencio testified that Patient 3 had reported that she had had wheezing and he had reflected that in the subjective portion of the progress note. However, he heard no wheezing at the November 2006 office visit and therefore recorded the lack of wheezing in the review of systems section of the progress note. He pointed out that he did not prescribe any medication to Patient 3 for wheezing that day. (Tr. at 122-124)

90. Dr. Villavicencio disagreed with the following:

- The medical record lacks documentation to support the use of long-acting and short-acting opiate medications, as well as other medications, or the increases in dosages. Dr. Villavicencio stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical record is taken into consideration (including the intake forms and his staff's notes), he believes that his medical record is "better documented than * * * the allegations would suggest." (Tr. at 1575-1576, 1598)
- He prescribed Maxalt for Patient 3 even though the documentation in Patient 3's chart indicated that Patient 3 did not have the conditions for which he prescribed Maxalt (there is no documentation of a complaint or symptom of headache in the chart on that visit and the medical record documents no headache). Dr. Villavicencio stated that he prescribed Maxalt for headaches, and it is "very clear" from Patient 3's history that she had migraine headaches. (Tr. at 1599)
- Dr. Villavicencio prescribed Phenergan for Patient 3 despite conflicting and/or inconsistent documentation in the patient record (the medical record documents no nausea, vomiting, or diarrhea). He stated that he had prescribed Phenergan to potentiate the opiate medications prescribed. (Tr. at 1599)
- Dr. Villavicencio failed to address and/or document addressing Patient 3's noncompliance with clinical instructions throughout his care and treatment of Patient 3, and Dr. Villavicencio failed to address and/or document addressing the inconsistent test results as well as Patient 3's admission that she took controlled substances prescribed for others; instead, he continued to prescribe the same or escalating doses of controlled substances. Dr. Villavicencio testified that, "in looking at these records now, the reason why I increased [the OxyContin] when it came back negative [in the July 2006 urine drug screen] is because she probably explained to me that she ran out of medications." When asked if he had documented a discussion with Patient 3 regarding her failure to attend the May 2007 appointment with the pain management specialist, Dr. Villavicencio testified that he did document, in October 2007, that Patient 3 had lost her insurance. Dr.

Villavicencio testified that he believes he discussed the abnormal urine drug screen with Patient 3 in March 2008 and she reported that all of her medications (Roxicet, Soma and Valium) were inside her car at the time it was repossessed. Dr. Villavicencio stated that he did not attempt to wean Patient 3 off her medications in April 2008 because he “thought that she was being undertreated for pain. That’s why she ran out of the medications.” (Tr. at 120-121, 128-130, 132-133)

Patient 4

(Medical record reflects treatment between October 2005 and October 2006, 12 months)

91. Patient 4, a male, was born in 1973. Patient 4 first saw Dr. Villavicencio on October 12, 2005, when he was 32 years old. Patient 4 complained of low back pain, neck pain, and pain shooting down his right leg. Dr. Villavicencio documented that Patient 4 had no prior history of trauma or any imaging studies. His history form reflected that he had not seen a physician in the previous six months and was taking no medications. Dr. Villavicencio diagnosed low back pain, radiculopathy and anxiety. He prescribed Percocet, Soma, Naprosyn, Valium and Ultravate Cream (a topical steroid). Patient 4 executed a pain management contract at his first office visit. (St. Ex. 4 at 3-5, 29-31; Tr. at 558, 1600)
92. Patient 4 saw Dr. Villavicencio each month for 12 months, and he complained of low back pain at each visit. Patient 4 reported his pain levels as between “8” and “10.” He stated that the medications were working, and at times, stated that he was doing well otherwise. (St. Ex. 4 at 1-2, 13-29) A few notable events occurred during those 12 months:
 - In February 2006, Patient 4 stated that he was having trouble sleeping and he thought he might have fibromyalgia. Dr. Villavicencio diagnosed fibromyalgia. He increased the Valium dosage and prescribed Elavil, along with Percocet, Soma, Valium, and Motrin. (St. Ex. 4 at 25)
 - In March 2006, Patient 4 reported severe pain and requested a steroid shot, and a trigger-point injection was provided. An increased number of Percocet pills were prescribed. (St. Ex. 4 at 24)
 - In May 2006, Patient 4 reported that he had fallen from a ladder and was seen in the emergency room. Patient 4 also stated that a higher dose of Percocet (7.5 mg), six tablets a day, works for him. Dr. Villavicencio prescribed a higher dose of Percocet to Patient 4. (St. Ex. 4 at 18) There is no report from the emergency room in Patient 4’s medical record. (St. Ex. 4)
 - In May 2006, the staff noted that a urine drug screen was positive for “Percocet and all drugs from office.” There was no laboratory report in the medical record. (St. Ex. 4 at 2)
 - In October 2006, Patient 4 reported that he needed more medication for his low back pain. He also stated that he had obtained Imitrex (for migraine headaches) from a family member and taken it. Dr. Villavicencio increased the Percocet dosage and added MS Contin. (St. Ex. 4 at 13)

93. Over the 12 months of treatment of Patient 4, Dr. Villavicencio did not refer Patient 4 to a pain management specialist, order any physical therapy, or obtain any diagnostic/imaging tests. (St. Ex. 4)

94. Between October 2005 and October 2006, Dr. Villavicencio prescribed the following medications to Patient 4:

Date	Relevant Medication	Dosages (no refills provided)	Comments	St. Ex. 4 Citation
10/12/05	Percocet Naprosyn Soma Valium	5/325 mg, 1 tablet four times a day, #120 500 mg, 1 tablet twice a day, #60 350 mg, 1 tablet three times a day, #90 5 mg, 1 tablet three times a day, #100	33.3-day supply of Valium tablets prescribed.	29
11/9/05	Percocet Naprosyn Soma Valium	5/325 mg, 1 tablet four times a day, #120 500 mg, 1 tablet twice a day, #60 350 mg, 1 tablet three times a day, #90 10 mg, 1 tablet three times a day, #90	Valium dosage doubled.	28
12/7/05	Percocet Soma Valium Motrin	5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 10 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #28	7-day supply of Motrin prescribed.	27
1/10/06	Percocet Soma Valium Motrin	5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 10 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120		26
2/7/06	Percocet Soma Valium Motrin Elavil	5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 10 mg, 1-2 tablets three times a day, #120 600 mg, 1 tablet four times a day, #120 50 mg, 1 tablet at bedtime, #30	Valium dosage increased. 20- to 40-day supply of Valium prescribed.	25
3/8/06	Percocet Soma Valium Motrin Elavil	5/325 mg, 1 tablet four times a day, #150 350 mg, 1 tablet three times a day, #90 10 mg, 1-2 tablets three times a day, #90 600 mg, 1 tablet four times a day, #120 150 mg, 1 tablet at bedtime, #30	37.5-day supply of Percocet prescribed. Trigger-point injection given at this visit. (Tr. at 145-146) Elavil dosage increased.	24
4/5/06	Percocet Soma Valium Motrin Restoril	5/325 mg, 1 tablet four times a day, #150 350 mg, 1 tablet three times a day, #90 10 mg, 1-2 tablets three times a day, #90 600 mg, 1 tablet four times a day, #120 30 mg, 1 tablet at bedtime prn, #20	20-day supply of Restoril prescribed. Prednisone was also prescribed.	23
5/3/06	Percocet Soma Valium Motrin Restoril Ambien CR	5/325 mg, 1 tablet four times a day, #150 350 mg, 1 tablet three times a day, #90 10 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120 30 mg, 1 tablet at bedtime prn, #30 12.5 mg, 1 tablet at bedtime, #30	Ambien CR added.	19
5/31/06	Percocet Soma Valium Motrin Restoril Ambien CR	7.5/325 mg, 1 tablet four times a day, #180 350 mg, 1 tablet three times a day, #90 10 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120 30 mg, 1 tablet at bedtime prn, #30 12.5 mg, 1 tablet at bedtime, #7	Percocet dosage increased and 45-day supply prescribed. 7-day supply of Ambien CR prescribed.	18

Date	Relevant Medication	Dosages (no refills provided)	Comments	St. Ex. 4 Citation
6/28/06 7/25/06	Percocet Soma Valium Motrin	5/325 mg, 1 tablet four times a day, #180 350 mg, 1 tablet three times a day, #90 10 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	Percocet dosage decreased, and 45-day supply prescribed.	16, 17
8/23/06	Percocet Soma Valium Motrin	5/325 mg, 1 tablet four times a day, #180 350 mg, 1 tablet four times a day, #120 10 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	45-day supply of Percocet prescribed. Soma dosage increased.	15
9/29/06	Percocet Soma Valium Motrin	5/325 mg, 1 tablet four times a day, #180 350 mg, 1 tablet four times a day, #120 10 mg, 1-2 tablets three times a day, #120 600 mg, 1 tablet four times a day, #120	Valium dosage increased and 20- to 40-day supply prescribed.	14
10/31/06	Percocet Soma Valium Motrin MS Contin	5/325 mg, 1 tablet six times a day (not to exceed 7 in a day), #210 350 mg, 1 tablet four times a day, #120 10 mg, 1-2 tablets three times a day, #120 600 mg, 1 tablet four times a day, #120 30 mg, 1 tablet twice a day, #60	Percocet dosage increased and MS Contin added. 20- to 40-day supply of Valium prescribed.	13

95. Patient 4 died on November 3, 2006, from “acute intoxication by the combined effects of ethanol, morphine, diazepam [Valium], and amitriptyline [Elavil].” Patient 4 had high therapeutic levels of morphine and amitriptyline. (St. Ex. 4A at 1, 3, 8, 10)

Opinion of Dr. Kelly

96. With regard to the care and treatment of Patient 4, Dr. Kelly stated the following:

- At Patient 4’s first office visit, there were no findings in the documented history or examination to support a diagnosis of anxiety although it was diagnosed, and no findings to indicate Ultravate cream although it was prescribed.
- Dr. Villavicencio did not document enough information at the first office visit to identify the type of radiculopathy or to determine if Patient 4 even had radiculopathy.
- Numerous medication changes occurred (changing dosages or adding new medications) without adequate documentation of symptoms or examination findings that justified the medication changes. Some examples include: (a) no worsening pain, anxiety or muscle spasm symptoms were reported by Patient 4 in November 2005, but Dr. Villavicencio doubled the Valium dosage; (b) in April 2006, Dr. Villavicencio prescribed prednisone and Restoril without a documented rationale; (c) in July 2006, the Soma quantity was increased and the Elavil dosage was doubled without a documented rationale; and (d) in October 2006, Dr. Villavicencio added MS Contin without detailed documentation to justify its addition.

- Dr. Villavicencio diagnosed fibromyalgia in February 2006 without much history of the symptom patterns (including fatigue and sleep disturbance), and without conducting a trigger-point examination.
- Dr. Villavicencio prescribed Elavil at a “maximum dose” of 300 mg at bedtime. Dr. Kelly stated the maximum dose of Elavil for chronic pain is usually 150 mg per day. He further stated that, if Elavil was prescribed for depression, it was never diagnosed in Patient 4. If Elavil was prescribed for fibromyalgia, Dr. Kelly stated that it was acceptable although not documented sufficiently.

(St. Ex. 18 at 19-21; Tr. at 556, 558-563, 565, 567, 571, 574)

97. Dr. Kelly found that the major focus of Dr. Villavicencio’s care and treatment of Patient 4 included chronic pain. He pointed out that the long-term prescriptions included 30 mg of oxycodone and 40 mg¹¹ of Valium each day, and that 60 mg of morphine was added at the last office visit. Dr. Kelly concluded that the documentation in the chart does not support the prescribed doses of pain medication. Moreover, Dr. Kelly found there are portions of the notes that are just copied verbatim from prior visits and that match the same sections in the charts of Patients 1 through 3. (St. Ex. 18 at 21; Tr. at 1365-1367)
98. Dr. Kelly concluded that Dr. Villavicencio’s care of Patient 4 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances. Also, he stated that Dr. Villavicencio’s controlled substance prescribing and the documentation of his care of Patient 4 constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 21)

Opinion of Dr. Villavicencio

99. Dr. Villavicencio testified that, at the first office visit with Patient 4, he conducted a physical examination of Patient 4, including a straight-leg raising test that was negative. He further explained that he based his diagnosis of radiculopathy on what the patient had told him. He added, “[a] lot of patients complain of pain shooting down the leg, but I’ve done this for so long and, you know, one in a hundred will probably be positive.” Dr. Villavicencio explained that he did not explore other options (physical therapy, MRIs, etc.) for Patient 4 at that point in time because the patient did not have insurance then. (Tr. at 140-141, 143; St. Ex. 4 at 29)
100. Dr. Villavicencio stated that Patient 4 had “a lot of wheezing.” (Tr. at 146)

¹¹No Valium prescription issued by Dr. Villavicencio to Patient 4 was a 40 mg dose of Valium per day. The medical record reflects that Dr. Villavicencio started the Valium dosage at 15 mg per day. He then increased the dosage to 30 mg per day, and then increased it again to 30-60 mg per day. (St. Ex. 4 at 13-29)

101. Dr. Villavicencio agreed with the following:

- Dr. Villavicencio began treating Patient 4 in October 2005 for conditions including back pain, radiculopathy, acne, and anxiety. (Tr. at 1600)
- At Patient 4's first visit, Dr. Villavicencio diagnosed anxiety, although he failed to document any symptoms to support this diagnosis. Dr. Villavicencio further explained that he had based the anxiety diagnosis on Patient 4's past medical history, but he had not documented any information in the progress note that led him to that diagnosis. (Tr. at 142)
- He prescribed long-acting and short-acting opiate medications, as well as carisoprodol (Soma), diazepam (Valium), and other medications (both controlled and non-controlled). (Tr. at 1600)
- He failed to order appropriate tests to support his diagnoses or treatment and/or failed to make appropriate referrals. Dr. Villavicencio testified that he did not order tests because Patient 4 had problems with insurance, which was documented in the medical record. Moreover, Dr. Villavicencio stated that Patient 4 was compliant – he lost weight as advised, he showed an effort to obtain insurance, he did not come in for early refills, and he did not report any lost prescriptions. (Tr. at 1603)
- When Patient 4 admitted that he had used medication prescribed for another (Imitrex), Dr. Villavicencio failed to counsel and/or document that he counseled Patient 4 against using medication prescribed for another. Dr. Villavicencio explained that Imitrex is not addictive and has no street value. He added that he does not condone taking another's medication, but he understood why it happened particularly since Patient 4 had no insurance. (Tr. at 1604-1605)
- The chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. (Tr. at 1579)
- He prescribed 30 mg per day of oxycodone to Patient 4. Dr. Villavicencio stated that this occurred when Patient 4 fell from a ladder. (Tr. at 1605)
- He prescribed 40 mg per day of diazepam (Valium) to Patient 4. (Tr. at 1605)
- He prescribed morphine to Patient 4. Dr. Villavicencio explained that, at the October 2006 office visit, Patient 4 was limping and stooped over in pain. He commented that he had increased the Percocet dosage and prescribed MS Contin to alleviate the pain. (Tr. at 146, 150-151, 1605-1606)

102. Dr. Villavicencio disagreed with the following:

- He failed to document in the chart any symptoms or diagnosis to justify the prescription for Ultravate Cream. Dr. Villavicencio testified that Ultravate is not a medication that he typically prescribes. He added that Patient 4 had taken Ultravate before and had asked for it again. (Tr. at 1600-1602)

- The medical record lacks documentation to support the use of the controlled and non-controlled medications, or the increases in dosages. Dr. Villavicencio stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical record is taken into consideration (including the intake forms and his staff's notes), he believes that his medical record is "better documented than * * * the allegations would suggest." (Tr. at 1575-1576)

Patient 5

(Medical record reflects treatment between May and October 2006, five months)

103. Patient 5, a male, was born in 1978. Just prior to seeing Dr. Villavicencio, Patient 5 was treated by another physician. An MRI of Patient 5's lumbar spine was conducted in January 2006 and it showed minimal annular bulging at L4-L5. Patient 5's prior physician had prescribed him the following medications in January 2006: (a) Vicodin 7.5/750 mg, 1 tablet three times a day, #84; (b) Soma 350 mg, one tablet twice a day, #28 with one refill; and (c) Valium 5 mg, 1 tablet twice a day, #56. Additional prescriptions for those same medications were also issued by the prior physician and filled in February and April 2006, but the medical record does not reflect the full dosages. (St. Ex. 5 at 19, 34-35, 38-39, 40)
104. Patient 5 first saw Dr. Villavicencio on May 25, 2006, because Patient 5 believed that his prior physician did not understand his pain and would not give him the medication he needed. Patient 5 was 28 years old. Patient 5 complained of back pain and numbness, which had worsened following a car accident. He described his level of pain as "8." Additionally, Patient 5 reported that he was not working and that he had already received physical therapy. Patient 5 indicated that he was willing to pay cash if insurance was not accepted. Dr. Villavicencio diagnosed low back pain and radiculopathy, and ordered a nerve conduction study and electromyography. He prescribed Vicodin, Dilaudid, Kadian, Soma, Xanax, and Naprosyn. Dr. Villavicencio referred Patient 5 to a pain management specialist at his first office visit. Patient 5 also executed a pain management contract at his first office visit. (St. Ex. 5 at 1, 2, 18, 20-24)
105. Patient 5 saw the pain management specialist, who found lower back pain that was primarily facet-mediated,¹² acute cervical strain, depression and anxiety. The specialist recommended that the Kadian dosage be increased to 30 mg twice a day, Dilaudid be discontinued, and Vicodin be continued two or three times per day as needed for breakthrough pain. Additionally, the specialist recommended a urine drug screen, the addition of Effexor XR for Patient 5's depression and anxiety, and to wean Patient 5 off Xanax. Moreover, the specialist stated, "it is reasonable to manage his pain short-term with opioid analgesics; however, as we initiate treatment, would suggest weaning back as indicated." (St. Ex. 5 at 15-18)

¹²Dr. Kelly stated that "facet-mediated" refers to problems in the facet joints of the spine. He further stated that pain associated with this problem varies from not painful to very painful, depending on the patient. (Tr. at 1165)

106. Patient 5 saw Dr. Villavicencio on three additional occasions:

- Patient 5’s second office visit with Dr. Villavicencio was after the pain management specialist’s report. On this date, Patient 5 stated that the Kadian worked, but that he preferred to try OxyContin. Dr. Villavicencio documented that Patient 5 was told that he “would only be able to get oxy 20 [three times a day] unless he sees a pain specialist.” Dr. Villavicencio prescribed Vicodin, Dilaudid, OxyContin, Soma, Xanax, and Naprosyn. (St. Ex. 5 at 14)
- Patient 5 returned two and one-half months later, complaining of low back pain (pain level “9”), but otherwise doing well. There is no detailed information about Patient 5 during the two and one-half months that he did not see Dr. Villavicencio. Dr. Villavicencio prescribed medications and referred Patient 5 back to the pain management specialist. (St. Ex. 5 at 1, 13)
- At his final visit, Patient 5 reported low back pain (pain level “8”), but stated that he was otherwise doing well. Patient 5 stated that he wanted to see a different pain management specialist. (St. Ex. 5 at 1, 12)

107. No urine drug screens were done during the time that Dr. Villavicencio treated Patient 5. (Tr. at 173-174)

108. Dr. Villavicencio prescribed medications to Patient 5 at all four visits as listed below:

Date	Relevant Medication	Dosages (no refills provided)	Comments	St. Ex. 5 Cite
5/25/06	Vicodin HP Dilaudid Kadian Soma Xanax Naprosyn	10/660, 1 tablet four times a day, #120 2 mg, 1 tablet three times a day prn, #30 30 mg, 1 tablet each day, #30 350 mg, 1 tablet three times a day, #60 0.5 mg, 1 tablet twice a day, #60 500 mg twice a day, #60	10-day supply of Dilaudid prescribed. 20-day supply of Soma prescribed.	18
6/22/06	Vicodin HP Dilaudid OxyContin Soma Xanax Naprosyn	10/660, 1 tablet four times a day, #120 2 mg, 1 tablet three times a day prn, #21 20 mg, 1 tablet three times a day, #90 350 mg, 1 tablet three times a day, #60 1 mg, 1 tablet three times a day, #90 500 mg twice a day, #60	7-day supply of Dilaudid prescribed. Kadian switched to OxyContin per patient’s specific request. (Tr. at 162-163) 20-day supply of Soma prescribed. Xanax dosage was tripled.	14
9/5/06	Vicodin HP OxyContin Soma Xanax Naprosyn	10/660, 1 tablet four times a day, #120 20 mg, 1-2 tablets twice a day, #120 350 mg, 1 tablet three times a day, #60 1 mg, 1 tablet three times a day, #90 500 mg twice a day, #60	Seen nearly 11 weeks after last appointment. OxyContin dosage increased. 20-day supply of Soma prescribed.	13
10/10/06	Vicodin HP OxyContin Soma Xanax Naprosyn Cymbalta	10/660, 1 tablet four times a day, #120 20 mg, 1-2 tablets three times a day, #120 350 mg, 1 tablet three times a day, #60 1 mg, 1 tablet three times a day, #90 500 mg twice a day, #60 30 mg, 1 tablet each day for one week, then 60 mg each day thereafter, #7	Cymbalta added. 20-day supply of Soma prescribed.	12

109. Patient 5 died on October 14, 2006, as a result of “acute intoxication by the combined effects of oxycodone, diazepam and alprazolam.” Dr. Villavicencio did not prescribe diazepam (Valium) to Patient 5. (St. Ex. 5A at 1, 3, 8; St. Ex. 5 at 12-14, 18; Tr. at 175)

Opinion of Dr. Kelly

110. Dr. Kelly found that Dr. Villavicencio’s review of systems and physical examination notes were copies of prior visits notes and often identical to those from other patient records. Also, Dr. Kelly stated that the documentation of the initial evaluation lacked information about the frequency of Patient 5’s pain and numbness, the severity, what activities he was unable to do, and other details. Dr. Kelly concluded that the initial history, examination, diagnosis, and treatment plan were not documented adequately. (St. Ex. 18 at 23, 24; Tr. at 579-580, 1155-1158)
111. Dr. Kelly stated that Dr. Villavicencio’s initial prescriptions were a “large increase” in the controlled-substance regimen for Patient 5, and the prescriptions were not supported by the history and examination findings. He added that there was no indication for Xanax, and no justification for prescribing both Vicodin HP and Dilaudid at the same time. Moreover, he stated that Dr. Villavicencio did not follow the pain management specialist’s recommendations, and did not include an explanation for not following the recommendations. Dr. Kelly found that, instead, Dr. Villavicencio had replaced the Kadian with a higher dose of opiates, had increased the Xanax strength and frequency, and had decreased the Dilaudid dosage only slightly. Dr. Kelly explained that Dr. Villavicencio tripled the long-acting medication, which is not what the pain management specialist had recommended. (St. Ex. 8 at 22; Tr. at 580-582, 584, 1160-1162, 1164, 1167-1171, 1173-1174)
112. In the following exchange, Dr. Kelly explained the multiple reasons for relying on a pain management specialist:

Q. What is the purpose of sending a patient to – generally, to a pain specialist?

A. I think generally it’s to get their opinion about what might be an effective – if there needs to be more diagnostic evaluation. But often it’s – it’s more of an issue of therapeutic options. Typically, pain – pain specialists will do procedures that a primary care physician doesn’t do. So they may do nerve blocks, epidural steroid injections, other things. So often it’s for the use of those procedures as well as any other advice or recommendations.

Q. * * * When you send – When a physician sends a patient to a pain specialist, are they required to following their recommendations?

A. No. I mean, they’re – it’s a – it’s a consultation, so the consultation – the consultant recommends things essentially for their consideration, but it’s not – it’s not as though those are marching orders. But I think

when – when you go in a different direction, there’s – there should be a reason for that, and that reason should be documented.

(Tr. at 582-583; See, also, Tr. at 1175)

113. With regard to Patient 5’s September 2006 office visit (the third office visit), Dr. Kelly stated that Dr. Villavicencio should have inquired and documented why Patient 5 had not returned to the office sooner because, if Patient 5 had been taking the medication as prescribed, he would have run out much earlier than September 2006. Dr. Kelly added that, “This is enough medication that someone who stopped it abruptly would have opiate withdrawal, I would think. And so why hasn’t the patient called? Why hasn’t there been any kind of a question about it?” Moreover, Dr. Kelly stated that the patient may have obtained the medication during that period from somewhere else, or may have not taken the medication at all and diverted it. In addition, Dr. Kelly did not find any rationale for increasing the OxyContin dosage in September 2006. (St. Ex. 18 at 23; Tr. at 584-586, 1177)
114. In addition, Dr. Kelly found no rationale for adding Cymbalta in October 2006; he noted that the history reflected no real changes in Patient 5’s condition. Dr. Kelly presumed that the Cymbalta was prescribed as an adjunct medication to treat the patient’s pain because there was no diagnosis of depression, which is a condition that it also treats. (St. Ex. 18 at 23; Tr. at 586-587)
115. Dr. Kelly found that Dr. Villavicencio’s care of Patient 5 focused on chronic pain and included medication dosages of 80 mg of oxycodone, 40 mg of hydrocodone, and 3 mg of Xanax per day. He opined that the documentation does not support the initial choice of treatment, the later doses of pain medications or the rapid increase in the doses of opiate medications. Dr. Kelly concluded that Dr. Villavicencio’s care of Patient 5 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances. Also, he stated that Dr. Villavicencio’s controlled substance prescribing and the documentation of his care of Patient 5 constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 24; Tr. at 587-588, 1183, 1369-1371)

Opinion of Dr. Villavicencio

116. Dr. Villavicencio testified that he prescribed Cymbalta in October 2006 to Patient 5 for depression, although he did not list depression in the diagnoses. (Tr. at 168-169)
117. Dr. Villavicencio agreed with the following:
 - Dr. Villavicencio began treating Patient 5 in May 2006 for conditions including back pain and/or radiculopathy. (Tr. at 1606)
 - He prescribed long-acting and short-acting opiate medications, as well as other medications, both controlled and non-controlled. (Tr. at 1606)

- The chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. (Tr. at 1579)
 - Although Dr. Villavicencio referred Patient 5 to a specialist, Dr. Villavicencio failed to follow and/or document considering the prescribing recommendations of the specialist. Dr. Villavicencio explained that, instead, he prescribed "bioequivalent medications" because of other considerations – what the insurance company would cover and what the patient could tolerate. (Tr. at 1606-1607)
 - When Patient 5 indicated that he previously was treated by another doctor, but chose to establish with Dr. Villavicencio (alleging that his prior physician did not understand his pain and would not give him the medications he claimed he needed), and also agreed to pay cash if Dr. Villavicencio did not accept insurance, Dr. Villavicencio failed to discuss and/or document discussing this matter with Patient 5. Dr. Villavicencio stated that he did consider what Patient 5 had said, but he had concluded that Patient 5 was in chronic pain. Further, Dr. Villavicencio stated that he found that the prior physician's medications were all short-acting medications and that was why Patient 5 was in pain most of the day. (Tr. at 1608)
 - There are no treatment records for Patient 5 between June 22 and September 5, 2006, and there is no documentation of additional medication being prescribed and/or any documentation on how Patient 5 managed his pain for the approximately six weeks after his medication would have been exhausted. Dr. Villavicencio testified that he believes that he did discuss this gap in treatment with Patient 5, but he did not document it. Dr. Villavicencio added that Patient 5 was working in Kentucky for that period of time (where he had lived previously) and that Dr. Villavicencio had "no reason" to believe that Patient 5 was not getting some kind of narcotics while he was there. (Tr. at 1609)
 - Dr. Villavicencio prescribed up to 80 mg of oxycodone per day to Patient 5. Dr. Villavicencio testified that this patient was a chronic pain patient and 80 mg of oxycodone per day is not unusual or very high for such patients. (Tr. at 1610)
118. Dr. Villavicencio disagreed that the medical record lacks documentation to support the use of the controlled and non-controlled medications, or the increases in dosages. He stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical record is taken into consideration (including the intake forms and his staff's notes), he believes that his medical record is "better documented than * * * the allegations would suggest." (Tr. at 1575-1576)

Patient 6

(Medical record reflects treatment between May 2005 and June 2008, 37 months)

119. Patient 6, a male, was born in 1960. Patient 6 first saw Dr. Villavicencio on May 16, 2005, when he was 44 years old. Patient 6 complained about his back, which “gives out 2-3 [times]/year,” and of radicular pain down his left leg. Additionally, Patient 6 reported that he was working and had a history of wheezing. Patient 6’s history form does not describe any symptoms related to his back (it simply reflects “back trouble”), and it does not list any medications. Dr. Villavicencio diagnosed chronic lumbosacral sprain, sciatica, and asthma. He ordered an MRI and prescribed Ultracet, Motrin, and Robaxin among other things. Patient 6 executed a pain management contract at the first office visit (he executed another one in November 2005 as well). (St. Ex. 6 at 18, 29, 30, 112)
120. At Patient 6’s second visit, he reported that Ultracet did not improve the pain. Also, by that time, his request for insurance coverage for the MRI had been denied because there were no indications of neurological deficits or prior attempts to treat with “conservative therapy such as physical therapy/exercises or medications.” Patient 6 stated that he would obtain therapy in September after he stopped working.¹³ Dr. Villavicencio switched from Ultracet to Percocet and switched from Robaxin to Soma. (St. Ex. 6 at 6, 22-23, 111)
121. In July 2005, Patient 6 reported a pain level of “8+.” Dr. Villavicencio diagnosed low back pain in Patient 6. Dr. Villavicencio added Avinza and prescribed Percocet, Soma, and Motrin. (St. Ex. 6 at 110)
122. At the next office visit,¹⁴ Patient 6 reported that his pain level was “10” and that he was unable to tolerate Avinza. Patient 6 asked for OxyContin. Dr. Villavicencio documented that Patient 6 was aware of the “need to do drug screens and pill counts.” He switched Patient 6 to OxyContin. (St. Ex. 6 at 109)
123. In October 2005, Dr. Villavicencio documented that one of Patient 6’s hands was swollen and that Patient 6 had stiffness and pain. Dr. Villavicencio referred Patient 6 to physical therapy for his hand. (St. Ex. 6 at 107)
124. In November 2005, Patient 6 reported his level of pain as “7.” He told Dr. Villavicencio that the medications were working, but he “needs higher doses” of his medications. Dr. Villavicencio increased the dosage of OxyContin. (St. Ex. 6 at 5, 106)
125. In December 2005, Patient 6’s level of pain was “5” and he continued to have low back pain. Dr. Villavicencio ordered home exercises for Patient 6. (St. Ex. 6 at 5, 105)

¹³Patient 6 worked in a seasonal industry and he apparently expected his work responsibilities to lessen in September 2005.

¹⁴The progress notes indicate that Patient 6’s next office visit took place on August 15, 2005. However, the staff’s notes do not list an office visit for August 15, 2005. Instead, the staff’s notes reflect that Patient 6 returned on July 18, 2005. (St. Ex. 6 at 6, 109) The discrepancy is inconsequential.

126. In January 2006, Patient 6's pain level was "6." He stated that he would begin physical therapy so that an MRI can be obtained. Dr. Villavicencio ordered nerve conduction tests for Patient 6. Also, Dr. Villavicencio prescribed physical therapy "dynamic lumbar stabilization and core strengthening exercises," two to three times per week. In February 2006, Patient 6 reported that he had lost the prescription, and Dr. Villavicencio ordered physical therapy a second time. In March 2006, Dr. Villavicencio documented that Patient 6 had completed the physical therapy, but was then denied insurance coverage for an MRI. By April 2006, the insurer had approved the MRI. (St. Ex. 6 at 5, 20-21, 24-25101-104)

127. An MRI of the lumbar spine was conducted in April 2006 and it reflected the following:

- L4-5 shallow posterior disc protrusion gently encroaching upon ventral dural sac and near to right L5 nerve root.
- L5-S1 shallow broad posterior disc protrusion. Without neural compression.

(St. Ex. 6 at 40)

128. In May 2006, Dr. Villavicencio referred Patient 6 to a pain management specialist. (St. Ex. 6 at 99) In August 2006, the specialist reported back to Dr. Villavicencio, and the report reflects the following:

- Patient 6 injured his back in 1996 during an accident with a Quad Runner, an all-terrain vehicle.
- Before treating with Dr. Villavicencio, Patient 6 had not had any significant treatment.
- Patient 6 reported that the current medications kept him functional.
- With regard to Patient 6's pain, the specialist described it as "a constant aching, throbbing pain in the lower back, which radiates to the right leg to the level of the knee. He denies any numbness in the leg, however reports numbness in both hands. His pain level is 7/10 at its worst, 4/10 at its best. Pain is aggravated with walking, standing, and lifting."
- The specialist's impression was "[c]hronic back pain, secondary to L4-5 disk protrusion and persistent radicular symptoms into the right lower limb. Also with increased pain with lumbar extension, which is suggestive of lumbar facet syndrome."
- The specialist made recommendations, stating: "I think he would be a good candidate for a series of lumbar epidural injections to help with his radicular symptoms. Unfortunately he is self-pay, and would be unable to afford the injections * * *. He may also benefit from a series of lumbar facet injections as well. I have encouraged him to continue with a home exercise program. * * * [I]t would be reasonable to begin another course of [physical] therapy once he undergoes the epidural injections. * * * At this time, I have asked him to try and wean back on the Percocet to 2-3 per day as needed for breakthrough pain. He will continue on the OxyContin 40 mg 3 times per day for long-acting pain control. * * * I would suggest

obtaining a urine toxicology screen * * * [and] specifically ask for oxycodone in order to have this tested.”

(St. Ex. 6 at 94-96)

129. At the office visit following the specialist’s August 2006 report, Patient 6 reported his level of pain as “8.” Dr. Villavicencio ordered physical therapy, namely, “dynamic lumbar stabilization and core strengthening exercises,” two to three times per week. Dr. Villavicencio prescribed an increase in the number of Percocet pills. (St. Ex. 6 at 4, 93; Tr. at 185)
130. In October 2006, Patient 6 reported that his pain was worse and his level of pain was “10.” The staff documented that Patient 6 came to the office because he “was going to go to [the emergency room].” Dr. Villavicencio documented that Patient 6 was limping. Dr. Villavicencio referred Patient 6 to a pain management specialist for injections. Also, Dr. Villavicencio ordered a nerve conduction study. (St. Ex. 6 at 4, 90, 91)
131. In November 2006, Patient 6 stated that he did not return for a third epidural injection because the prior injections did not help. He reported his level of pain as “7” that day. (St. Ex. 6 at 3, 89)
132. In January 2007, Patient 6 went to the emergency room for throat tightness. A series of tests were conducted. The medication list did not include OxyContin, Soma, or Motrin. (St. Ex. 6 at 79-87)
133. Thereafter in 2007, Patient 6 continued to complain about his throat. Dr. Villavicencio referred Patient 6 to an ear/nose/throat specialist. Similarly, Dr. Villavicencio arranged for a spirometry test (pulmonary function test) after Patient 6 expressed concerns about his lungs. (St. Ex. 71, 77)
134. Dr. Villavicencio ordered a urine drug screen in February 2007. That screen reflected the presence of oxycodone, carisoprodol (Soma), and cannabinoids (marijuana). There is no documentation that the results of the February 2007 urine screen were discussed at Patient 6’s next office visit in March 2007. (St. Ex. 6 at 3, 16-17, 75; Tr. at 190)
135. In July 2007, Dr. Villavicencio did a pill count and Patient 6 “passed.” (St. Ex. 6 at 2)
136. In October 2007, Patient 6 reported that he had gone to the hospital for chest pain, arm numbness, and weakness and numbness in one leg. (St. Ex. 6 at 66)
137. In December 2007, Patient 6 underwent throat surgery and “moderate squamous dysplasia” was diagnosed. (St. Ex. 6 at 45-55, 59, 61-62)
138. In April 2008, another urine sample was tested. It was positive for oxycodone and carisoprodol, which is consistent with the OxyContin, Percocet, and Soma prescriptions. It was also positive

for the metabolite of methadone. Dr. Villavicencio had not prescribed methadone to Patient 6 at that time, although he had prescribed it one time in October 2006. (St. Ex. 6 at 1, 36-38)

139. Dr. Villavicencio discussed the positive methadone result with Patient 6 at his next office visit. Dr. Villavicencio documented that Patient 6 had said that the methadone was an old prescription. Then, Dr. Villavicencio instructed Patient 6 to bring the medicine bottle to the office, which he did. Also, Dr. Villavicencio referred Patient 6 to a pain management specialist. (St. Ex. 6 at 32-35)

140. Patient 6 complained of low back pain at each office visit, although he also stated at times that he was doing “ok” or “well.” Dr. Villavicencio prescribed the following medications between May 2005 and June 2008:

Date	Relevant Medication	Dosages (no refills provided)	Comments	St. Ex. 6 Cite
5/16/05	Ultracet Robaxin Motrin	37.5/325 mg, 1 tablet four times a day, #120 750 mg, 1-2 tablets three times a day, prn, #30 600 mg, 1 tablet four times a day, #30	15- to 30-day supply of Robaxin prescribed. 7.5-day supply of Motrin prescribed.	112
6/14/05	Percocet Soma Motrin	5/325 mg, 1 tablet four times a day, #150 350 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	37.5-day supply of Percocet prescribed.	111
7/12/05	Avinza Percocet Soma Motrin	30 mg, 1 tablet a day, #30 5/325 mg, 1 tablet four times a day, #150 350 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	Avinza added. 37.5-day supply of Percocet prescribed.	110
8/15/05 9/13/05 10/10/05	OxyContin Percocet Soma Motrin	20 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	Avinza switched to OxyContin on 8/15/05.	107-109
11/8/05- 7/25/06	OxyContin Percocet Soma Motrin	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day, #90 350 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	OxyContin dosage increased on 11/8/05. 22.5-day supply of Percocet prescribed.	99-106
8/23/06 9/29/06	OxyContin Percocet Soma Motrin	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120		92, 93
10/17/06	Dilaudid methadone Medrol Dosepak	4 mg, 1 tablet four times a day, #90 20 mg, 1 tablet 2-3 times a day, #60 1 pack	Early refills. Roughly 3 weeks after last appointment, all medications were changed. 22.5-day supply of Dilaudid prescribed. 20- to 30-day supply of methadone prescribed.	91
10/31/06 11/30/06	OxyContin Percocet Soma Motrin	40 mg, 2 tablet twice times a day, #120 5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	On 10/31/06, two weeks after last appointment, all medications were changed again and OxyContin dosage increased.	89, 90

Date	Relevant Medication	Dosages (no refills provided)	Comments	St. Ex. 6 Cite
12/29/06	OxyContin Percocet Soma Motrin	40 mg, 2 tablet twice times a day, #135 5/325 mg, 1 tablet six times a day, #135 350 mg, 1 tablet four times a day, #105 600 mg, 1 tablet four times a day, #120	Percocet dosage increased. 33.75-day supply of OxyContin, 22.5-day supply of Percocet and 26.25-day supply of Soma prescribed.	88
2/1/07– 6/09/08	OxyContin Percocet Soma Motrin	40 mg, 2 tablet twice times a day, #120 5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	Percocet and Soma dosages decreased on 2/1/07.	32, 35, 39, 47, 58, 60, 64-66, 69-76

Opinion of Dr. Kelly

141. Dr. Kelly stated that the review of systems and physical examination section of the progress note from Patient 6's initial visit are largely identical to those sections in other patients' records. Also, he stated that the history of Patient 6 was "really, really skimpy" because there is no description of the frequency, severity, and location of his leg pain. He further found that the initial examination, diagnosis, and treatment plan were not documented adequately. (St. Ex. 18 at 25, 28; Tr. at 590-591)
142. Dr. Kelly stated that the switch from Avinza to OxyContin in August 2005 was a significant increase (tripling the opiate dosage). He did not find a justification for the increase. He also noted that, soon thereafter in November 2005, Dr. Villavicencio doubled the OxyContin dosage. (St. Ex. 18 at 25; Tr. at 594)
143. Dr. Kelly noted that, after Dr. Villavicencio received the recommendations from the pain management specialist, urine drug testing was not done for six months (until February 2007) and the Percocet dosage was increased instead of being decreased. He noted also that Dr. Villavicencio did not document why he did not follow the specialist's recommendations. (St. Ex. 18 at 26, 28)
144. Dr. Kelly found that, at the end of October 2006, Dr. Villavicencio also did not document rationales for Patient 6's early office visit, for switching the medication regimen, for increasing in the OxyContin dosage, and for ordering a nerve conduction test. (St. Ex. 18 at 27)
145. Dr. Kelly further stated that Dr. Villavicencio was required to address the February 2007 urine drug screen with Patient 6, specifically regarding his use of marijuana and any other illegal substances, and the failure to do so was in violation of the standard of care. (Tr. at 603-604)
146. Dr. Kelly noted that the major focus of Dr. Villavicencio's care and treatment of Patient 6 was for chronic pain, and that medication doses included 180 mg of oxycodone each day. He opined that the documentation did not support the eventual prescribed dose of pain medication or the relatively rapid increase in opiate medications. Moreover, he stated that Dr. Villavicencio did not "carefully begin, titrate, or monitor the use of methadone," because of its known risk for respiratory depression and death. (St. Ex. 18 at 28; Tr. at 598-602, 1374)

147. Dr. Kelly concluded that Dr. Villavicencio's care of Patient 6 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances. Also, he stated that Dr. Villavicencio's controlled substance prescribing and the documentation of his care of Patient 6 constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 28)

Opinion of Dr. Villavicencio

148. Dr. Villavicencio testified that Patient 6 was not taking any narcotic medication at the time he was first seen at Dr. Villavicencio's office. (Tr. at 176-177)

149. Dr. Villavicencio testified that he did not order a urine drug screen for six months after the pain management specialist recommended it because Patient 6 would not have been able to afford it. However, Dr. Villavicencio acknowledged that Patient 6 did obtain injections soon after the pain management specialist made that recommendation. (Tr. at 186-188)

150. Dr. Villavicencio testified that he believes that Patient 6's pain was undertreated and it is for that reason that Patient 6 took methadone in 2008, even though Dr. Villavicencio had not prescribed it at that time. He further explained that he gave Patient 6 the benefit of the doubt and did not believe the patient was diverting or abusing the medications. Dr. Villavicencio added that he kept a close eye on Patient 6 thereafter. (Tr. at 193-195)

151. Dr. Villavicencio agreed with the following:

- Dr. Villavicencio began treating Patient 6 in May 2005 for conditions including lumbrosacral sprain, back pain, sciatica, and asthma. (Tr. at 1611)
- The chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. (Tr. at 1579)
- Dr. Villavicencio referred Patient 6 to specialists and for physical therapy and testing, and often Patient 6 did not timely comply with these referrals. Dr. Villavicencio acknowledged that Patient 6 did not follow up with physical therapy, one pain management specialist, and an ear/nose/throat specialist. Dr. Villavicencio stated that Patient 6 did not have insurance. Dr. Villavicencio added that he had the option to cease treating the patient, but he chose to continue treating Patient 6. (Tr. at 1615-1616)
- According to test results appearing in Patient 6's chart, on at least two occasions, tests of his urine showed positive results for cannabinoids, and on one occasion, showed a positive result for a drug Dr. Villavicencio had not recently prescribed (methadone). Dr. Villavicencio did not address and/or document addressing the inconsistent test result involving cannabinoids and continued to prescribe the same or escalating doses of controlled substances. Dr. Villavicencio did not refer Patient 6 for substance-abuse counseling or treatment.

Dr. Villavicencio stated that he should have addressed and documented a discussion with Patient 6 after the February 2007 urine screen reflected cannabinoids. He also stated that patients use marijuana to control their pain and for other reasons. He stated that typically he advises the patient to lower the concentrations and then monitors usage. Additionally, Dr. Villavicencio stated that he considers marijuana to be a red flag, but only a high risk issue when the MRI findings do not justify the reported level of pain. (Tr. at 190, 1619-1622)

152. Dr. Villavicencio disagreed with the following:

- When Dr. Villavicencio prescribed methadone to Patient 6, Dr. Villavicencio did not appropriately begin, titrate or monitor the use of methadone by Patient 6. Dr. Villavicencio contends that it was within the standard of care for him, as a family practice physician, to prescribe methadone to Patient 6 for his chronic pain. Moreover, he stated that it was appropriate to start methadone, and he appropriately titrated and monitored its use by Patient 6. (Tr. at 1614-1615)
- When Patient 6 did appear for an examination by a specialist per Dr. Villavicencio's order, Dr. Villavicencio failed to follow and/or document considering the advice of the specialist. Dr. Villavicencio stated that Patient 6 did receive one lumbar injection, but chose not to return to the specialist because he did not think that the injection worked. Moreover, Dr. Villavicencio testified that he considered the pain management specialist's recommendations, but he was "more aware" of Patient 6 occupation. Dr. Villavicencio added that he complied with the pain management specialist's recommendations "fairly well," adding one dose to the short-acting medication and one dose to the long-acting medication. (Tr. at 1618)
- The medical record lacks documentation to support the use of the controlled and non-controlled medications, or the increases in dosages. Dr. Villavicencio stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical records is taken into consideration (including the intake forms and his staff's notes), he believes that his medical record is "better documented than * * * the allegations would suggest." (Tr. at 1575-1576)
- Dr. Villavicencio did not address and/or document addressing the inconsistent test result involving the methadone. Dr. Villavicencio stated that he did discuss the issue with Patient 6, and the discussion was documented. He stated that a "patient who's testing negative for the medication would mean that they're being undertreated for pain and run out of medications." Moreover, he stated that a "patient who tests – who shows a positive medication that not been prescribed on top of their prescribed medication also may be a case of under-treatment of pain." (Tr. at 1621)

Patient 7

(Medical record reflects treatment between October 2005 and April 2008, 30 months)

153. Patient 7, a male, was born in 1974. He first saw Dr. Villavicencio on October 31, 2005, when he was 31 years old. Patient 7 complained of low back pain and leg pain. He stated that he had had pain for years and that he was a heavy equipment operator. He reported high cholesterol and blood pressure as well. Additionally, Patient 7 identified his prior physician, who is another family-medicine physician. Patient 7 also stated that his then-current medications were OxyContin 40 mg, Percocet 5 mg, Soma 3.75 mg, and Valium 10 mg. His blood pressure was 150/100. Dr. Villavicencio diagnosed low back pain and hypertension. He ordered an MRI and prescribed OxyContin, Percocet, Soma and Valium. Dr. Villavicencio never obtained Patient 7's prior medical records from the former physician. Patient 7 executed a pain management contract in October 2005 and in April 2007. (St. Ex. 7 at 12-13, 22, 24, 25, 64, 65; Tr. at 197-198)
154. Dr. Villavicencio diagnosed low back pain repeatedly over the course of treating Patient 7. He essentially prescribed the same medications to Patient 7 throughout the 30-month treatment period – namely, OxyContin, Percocet, Soma, and Valium. Patient 7 reported that the medications were working, and once reported that he was doing well. (St. Ex. 7 at 27-60)
155. Patient 7 obtained an MRI of the lumbar spine in November 2005, which revealed the following:
- Negative for dominant or neutrally compressive disc herniation.
 - Borderline small spinal canal as described – congenital.
- (St. Ex. 7 at 62)
156. Dr. Villavicencio referred Patient 7 to a pain management specialist in November 2005. In January and in September 2006, Dr. Villavicencio ordered physical therapy – “dynamic lumbar stabilization and core strengthening exercises.” In September 2006, he also ordered traction. (St. Ex. 7 at 51, 58, 60) However, there is no indication in the medical record that Patient 7 ever obtained physical therapy or traction. (St. Ex. 7)
157. In March 2006, Patient 7 reported a pain level of 2. Dr. Villavicencio ordered a nerve conduction study and electromyography. Afterward, Patient 7 reported that he had obtained the nerve conduction study, but notes from Dr. Villavicencio reflect that Patient 7 had *not* obtained the study. The medical record does not contain a report or any description of the results of a nerve conduction study and there is no further mention of the electromyography. (St. Ex. 7 at 4, 49-51, 56)
158. From July 2006 through February 2007, Patient 7's pain levels were between “1” and “3.” (St. Ex. 7 at 2-3)
159. In October 2006, Dr. Villavicencio referred Patient 7 to a second pain management physician. The next month, Patient 7 informed Dr. Villavicencio that he would go instead to a third pain

management physician. (St. Ex. 7 at 49, 50) In February 2007, Patient 7 saw the third pain management physician, whose report reflects the following:

- Patient 7 has a past medical history of asthma, and reported a history of obstructive sleep apnea, for which he had not been tested.
- His last physical therapy was six to eight months earlier.
- “His lumbar range of motion produces shooting pain down to his knees in extension up to 30 degrees. Flexion at 80 degrees also produces some pain going down his legs. Side flexion is positive to 20 degrees. Left rotation produces some pain on his right side. Straight leg raising is positive on the left for hamstring tightness. The FABER and PSIS are negative. There is right-sided paravertebral tenderness overlying vertebrae L1 to L5. He has 0/5 Waddell’s signs positive. There are no trigger points. There is no motor or sensory deficit. He has 0 of 18 fibromyalgia points.”
- Clinical impressions of lumbar spinal stenosis and lumbar spondylosis.
- “[I]n my opinion, [Patient 7 needs] a set of diagnostic facet injections to confirm what clinically appears to be pain coming from his facets, mainly the right side. This would be followed by two more injections if the first one does take his pain down. Should he get long periods of benefit from that, these can either be repeated at a later date or followed by radiofrequency neurotomy of the medial branches overlying the facets. We also talked about the possibility of doing epidural injections in case his diagnostic facet injections are negative. Of course, physical therapy, a sleep study would not be bad idea. * * * Compliance issues related to use, abuse of narcotics were discussed in detail. He was also cautioned about the combination of benzodiazepines and opioids in high doses. * * * [W]e should give him a chance and try to lessen his pain by the interventions that I already mentioned and get him off these medications if possible. He certainly is doing fine on them since he continues to work. Needless to say that doing urine tox screen from time to time to check for his compliance since his MRI does not appear to be very remarkable for producing high degree of pain. He could possibly be maintained on a smaller dose of prn [as-needed] pain medication. Addition of an anti-inflammatory should certainly provide added benefit.”

(St. Ex. 7 at 44-45)

160. At the following visit with Dr. Villavicencio, Patient 7 reported his level of pain as “5.” Dr. Villavicencio continued the same medications for Patient 7, and prescribed an increased number of OxyContin tablets. (St. Ex. 7 at 2, 43)
161. In April 2007, Dr. Villavicencio documented that Patient 7 had received five injections, had mild discomfort (his pain level was noted as “3”), had mild paraspinal muscle spasm, and “gets about a week’s worth of medications.” He also noted that there was a plan was to give

- Patient 7 a discogram. He prescribed 30-day supplies of OxyContin, Percocet, Soma, and Valium. (St. Ex. 7 at 2, 42)
162. In June 2007, Patient 7's level of pain was recorded as "3.5." Moreover, Dr. Villavicencio noted that the injections had provided three to four weeks of relief to Patient 7. Dr. Villavicencio prescribed 30-day supplies of OxyContin, Percocet, Soma, and Valium. (St. Ex. 7 at 40)
163. In July 2007, Patient 7 reported that the OxyContin only worked for five to six hours and that he wanted an increase in his medications. Dr. Villavicencio noted that Patient 7 had "gone back to outdoor labor" and that his activities were fairly hard on his back. Dr. Villavicencio prescribed an increased number of Percocet tablets. (St. Ex. 7 at 39)
164. In September 2007, Patient 7 complained of numbness in both hands and stated that he wanted to visit the pain management specialist. There is no further documentation of an examination of Patient 7's hands or diagnosis related thereto in September, or any notes addressing the hands in October or November ("numbness" is recorded, but the notes do not specify the location). Dr. Villavicencio also noted that Patient 7 was doing well on the current anxiolytics (Valium), but was unable to taper the use. (St. Ex. 7 at 35-37)
165. In December 2007, Dr. Villavicencio referred Patient 7 to two different pain management specialists. There is no explanation for the change in specialist. Patient 7 did not appear for the appointments. (St. Ex. 7 at 29, 33-34)
166. A urine screen was conducted in December 2007. It was negative for oxycodone (OxyContin and Percocet), carisoprodol (Soma), and Neurontin,¹⁵ although all had been prescribed. It was positive for methadone, which had not been prescribed by Dr. Villavicencio.¹⁶ (St. Ex. 7 at 31-32)
167. In January 2008, Dr. Villavicencio discussed the urine drug screen with Patient 7, who denied taking methadone and stated it is possible that the urine was not his because he "fairly regularly" smoked marijuana and it was not found. Additionally, Patient 7 stated that he provided multiple urine samples for his employer, and those screens were all consistent, particularly with regard to the marijuana. Dr. Villavicencio prescribed OxyContin, Percocet, Soma, Valium, and Neurontin. (St. Ex. 7 at 30)
168. In March 2008, Patient 7 reported that he did not receive injections from the pain management specialist because he had been in prison and in a psychiatric hospital. He further reported that he had been diagnosed with bipolar disorder. Dr. Villavicencio switched Patient 7's prescription from OxyContin to methadone, and prescribed Depakote and Remeron. In April

¹⁵Neurontin, a brand name for gabapentin, is used to treat seizures, neuropathic pain, pain from postherpetic neuralgia, and restless leg syndrome. (Tr. at 342; U.S. National Library of Medicine, *PubMed Health*, <http://www.ncbi.nlm.nih.gov/pub/med/health>, accessed June 25, 2012)

¹⁶The laboratory did not test for the presence/absence of marijuana/THC. (St. Ex. 7 at 31)

2008, Patient 7 reported that he had not switched to the methadone, and he requested OxyContin. Dr. Villavicencio prescribed OxyContin, Percocet, and Soma. (St. Ex. 7 at 27, 28)

169. The medical record reflects that no anti-inflammatory medications were prescribed although a pain management specialist recommended it in February 2007. Also, a urine drug screen was not done until 10 months after it was recommended by the pain management specialist. (St. Ex. 7)

Although Dr. Villavicencio often diagnosed hypertension, he did not prescribe medications to treat that condition. (St. Ex. 7; Tr. at 206)

Over the course of treatment, Dr. Villavicencio also prescribed medications to Patient 7 to treat conditions that he failed to document in his list of diagnoses. Those medications included Ventolin and Nicoderm in November 2005, Nasonex in June 2006, Zithromax and Medrol Dosepak in February 2007, and Remeron and Depakote in March 2008. However, Dr. Villavicencio included information in his February 2007 progress note to explain the basis for prescribing Zithromax and Medrol Dosepak – Patient 7 had wheezing and a cough producing greenish phlegm. He also included information in his March 2008 progress note that Patient 7 reported that he had been diagnosed with bipolar disorder by another provider, which explains in part Dr. Villavicencio’s Depakote prescription. (St. Ex. 7 at 28, 46, 54, 60)

170. Below is a summary of the medications that Dr. Villavicencio prescribed to Patient 7 between October 2005 and April 2008:

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 7 Cite
10/31/05 11/14/05	OxyContin Percocet Soma Valium	40 mg, 1 tablet three times a day, #45 5/325 mg, 1 tablet four times a day, #60 350 mg, 1 tablet three times a day, #45 10 mg, 1 tablet three times a day, #45	15-day supplies of all medications prescribed.	63, 64
11/28/05- 4/25/06	OxyContin Percocet Soma Valium	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 10 mg, 1 tablet three times a day, #90		55-60
6/19/06- 11/15/06	OxyContin Percocet Soma Valium	40 mg, 1 tablet three times a day, #75 5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 10 mg, 1 tablet three times a day, #90	6/19/06 visit is nearly two months after 4/25/06 visit. 25-day supply of OxyContin prescribed.	49-54
12/13/06	OxyContin Percocet Soma Valium	40 mg, 1 tablet three times a day, #85 5/325 mg, 1 tablet six times a day, #135 350 mg, 1 tablet four times a day, #105 10 mg, 1 tablet four times a day, #105	Percocet, Soma and Valium doses increased. 28.3-day supply of OxyContin, 22.5-day supply of Percocet, and 26.25-day supply of Soma and Valium prescribed.	3, 48
1/18/07 2/12/07	OxyContin Percocet Soma Valium	40 mg, 1 tablet three times a day, #75 5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 10 mg, 1 tablet three times a day, #90	Percocet, Soma and Valium dosages decreased. 25-day supply of OxyContin prescribed. Medrol Dosepak also prescribed on 2/12/07.	46, 47

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 7 Cite
3/13/07-6/7/07	OxyContin Percocet Soma Valium	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 10 mg, 1 tablet three times a day, #90		40-43
7/9/07-8/6/07	OxyContin Percocet Soma Valium	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day, #150 350 mg, 1 tablet three times a day, #90 10 mg, 1 tablet three times a day, #90	37.5-day supply of Percocet prescribed.	38-39
9/5/07-1/3/08	OxyContin Percocet Soma Valium Neurontin	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day, #150 350 mg, 1 tablet three times a day, #90 10 mg, 1 tablet three times a day, #90 300 mg, 1 tablet at bedtime, #30	37.5-day supply of Percocet prescribed. Neurontin was added.	30, 34-37
3/7/08	methadone Percocet Depakote Remeron Soma	10 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day, #150 500 mg, 1 tablet twice a day, #60 15 mg, 1 tablet at bedtime, #30, 2 refills 350 mg, 1 tablet three times a day, #90	Visit is roughly two months after last visit. Switched to methadone and Remeron. Depakote prescribed after Patient 7 was diagnosed elsewhere with bipolar disorder. 37.5-day supply of Percocet prescribed.	28
4/4/08	OxyContin Percocet Soma	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90	OxyContin prescribed after patient reported that he did not take the methadone.	27

171. Patient 7 died on April 25, 2008, from “multiple drug toxicity (cannabinoids, carisoprodol, methadone, mirtazapine [Remeron], valproate [Depakote]).” (St. Ex. 7A at 1, 3, 7-9; Tr. at 224)

Opinion of Dr. Kelly

172. With regard to Patient 7’s initial visit with Dr. Villavicencio, Dr. Kelly raised several criticisms:

- The initial examination and history were not adequate for the low back pain diagnosis and medications prescribed. Dr. Kelly explained that the review of systems says “noncontributory” and the physical examination did not have sufficient information – the straight-leg raise test was negative, there was motor strength, and there was no sensory deficit. (St. Ex. 18 at 33; Tr. at 607-608)
- The medications prescribed were a continuation of what Patient 7 stated he had been taking, but there are no prior medical records to confirm the history. Dr. Kelly stated that they are “very high” doses. (St. Ex. 18 at 29; Tr. at 609)

173. With regard to the subsequent visits, Dr. Kelly argued that there was no rationale included in the progress note in March 2006 for the nerve conduction study and electromyography, there was no indication of symptoms of anxiety even though it was diagnosed, and there was no indication for prescriptions to treat hypertension even though hypertension was diagnosed. Dr. Kelly added that the medical record does not contain any documentation as to how the

patient's blood pressure was treated and what medications he was taking. He further stated that the recommendations of the pain management specialist were not followed and Dr. Villavicencio included no rationale for not following those recommendations. Moreover, Dr. Kelly found that portions of the chart are identical to prior office visits and identical to the same sections in other patients' medical records. (St. Ex. 18 at 29, 30, 32, 33; Tr. at 610, 616-617, 1374-1375)

174. Dr. Kelly also pointed out that, in January 2008, Dr. Villavicencio did not attempt to confirm Patient 7's claims that the urine was someone else's urine. Dr. Kelly stated that Dr. Villavicencio could have ordered a repeat test of the sample because the laboratory had not tested for THC and the patient claimed it should have THC. Dr. Kelly added that he had found the whole episode "difficult to believe." Yet, Dr. Kelly added that, if the patient had been truthful, Dr. Villavicencio needed to refer Patient 7 to drug rehabilitation and to stop prescribing controlled substances to him. (St. Ex. 18 at 31; Tr. at 610-612)
175. Dr. Kelly stated that the primary focus of Dr. Villavicencio's treatment of Patient 7 was chronic pain, and that medication doses included 140 mg of oxycodone each day. Dr. Kelly also stated that Patient 7 received 90 tablets of methadone in March 2008 and that there are "black box" warnings for methadone. He opined that the documentation did not support the initial choice of treatment, the eventual doses of pain medication or the increases in opiate medications. Moreover, he stated that Dr. Villavicencio did not "carefully begin, titrate, or monitor the use of methadone," particularly since Patient 7 admitted regular use of marijuana and had a prior drug screen that was positive for methadone. Dr. Kelly explained that the physician needed to gradually decrease the oxycodone, simultaneously and gradually increase the methadone, and then carefully monitor the patient's pain control and sedation. (St. Ex. 18 at 32-33; Tr. at 615, 1377-1380)
176. Dr. Kelly concluded that Dr. Villavicencio's care of Patient 7 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances. Also, he stated that Dr. Villavicencio's controlled substance prescribing and the documentation of his care of Patient 7 constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 33)

Opinion of Dr. Villavicencio

177. Dr. Villavicencio stated that he prescribed OxyContin, Percocet, Soma, and Valium to Patient 7 at the first office visit based on what Patient 7 had reported. Dr. Villavicencio explained that he had prescribed both Soma and Valium to Patient 7 to relieve pain associated with muscle spasms. He further stated that he had assessed how the pain experienced by Patient 7 at that time was having an impact on his daily function, although he did not document such an assessment. He elaborated that he conducted such assessments as a matter of course, and they included whether the patient was working. (Tr. at 199-201, 203-204)

178. Dr. Villavicencio stated that Patient 7's 2005 MRI did not show "a lot of degeneration or disk disease." (Tr. at 202) Dr. Villavicencio added that some patients nonetheless have pain:

I – I have some patients, such as these, that do not show a lot on the MRI, but it's basically when you do a discogram that you can actually prove that he has something wrong with his disks. And, you know, in my practice of pain management, you've got some patients that are in pain with no obvious reasons, no organic reasons, but – but these people are losing their homes because of inability to work.

(Tr. at 208)

179. Dr. Villavicencio stated that he referred Patient 7 to a different pain management specialist in December 2007 because Patient 7 continued to have pain. He added, "I was hoping that somebody could perform a discogram on this gentleman." (Tr. at 210)

180. Dr. Villavicencio stated that he did not reduce or cease the medications for Patient 7 after he failed to show for an appointment with the pain management specialist in January 2008 because Patient 7 "had no prior history of noncompliance" and "he was * * * pretty aggressive in trying to find out why he's hurting * * *." (Tr. at 210-211)

181. Dr. Villavicencio testified that he did not prescribe any high-blood pressure medications to Patient 7 over the 30 months of treatment because Patient 7's blood pressure readings were high or borderline on only a few occasions. Dr. Villavicencio also testified that lifestyle changes controlled Patient 7's blood pressures "pretty well." (Tr. at 199-200, 1628-1629)

182. Dr. Villavicencio agreed with the following:

- Dr. Villavicencio began treating Patient 7 in October 2005 for conditions including back pain and anxiety. (Tr. at 1623)
- Dr. Villavicencio prescribed methadone to Patient 7. (Tr. at 1614)
- The chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. (Tr. at 1579)
- Dr. Villavicencio referred Patient 7 to specialists and for physical therapy and testing, and often Patient 7 did not timely comply with these referrals. (Tr. at 1623)
- According to test results appearing in Patient 7's chart, a urine test showed positive results for a drug that Dr. Villavicencio had not prescribed (methadone) and negative for drugs he had prescribed (OxyContin, Percocet, Soma, and Neurontin). Although he did address the test results with Patient 7, Dr. Villavicencio accepted the explanation that the urine sample was not Patient 7's urine, as it did not test positive for marijuana, which he claimed he regularly used, and Dr. Villavicencio continued to prescribe the same or escalating doses of controlled substances without further

testing. Dr. Villavicencio stated that he considered the urine test to be a red flag, and the issue was discussed with Patient 7 and his office manager. Dr. Villavicencio also stated that his office had been training new employees and mistakes had been made. He added that Patient 7 had a specific reason for his pain. Dr. Villavicencio agreed that he could have ordered another urine screen in January 2008, but he did not do that because he preferred not to immediately retest the patients since “a lot of times they know better and * * * come to the next visit prepared.” Additionally, Dr. Villavicencio pointed out that soon after January 2008 Patient 7 lost his insurance. (Tr. at 212-213, 1627)

- Dr. Villavicencio failed to refer Patient 7 for substance-abuse counseling or treatment for his admitted use of marijuana. Dr. Villavicencio stated that he failed to see that Patient 7 needed treatment for substance abuse. (Tr. at 215, 1628)
- Dr. Villavicencio last treated Patient 7 on April 4, 2008. (Tr. at 1628)

183. Dr. Villavicencio disagreed with the following:

- Dr. Villavicencio did not appropriately begin, titrate, or monitor the use of methadone by Patient 7. Dr. Villavicencio testified that he prescribed methadone to Patient 7 in March 2008 because Patient 7 lost his insurance and could not afford OxyContin. He stated that he prescribed OxyContin to Patient 7 in April 2008 because he had insurance again, although the progress note reflects that Patient 7 asked for OxyContin. (Tr. at 217-218, 221, 1623)
- When Patient 7 admitted his failure to see the specialist because he was in prison, Dr. Villavicencio failed to address and/or document addressing with him the reason he was in prison. Dr. Villavicencio stated that he was aware of the surrounding circumstances – Patient 7 was involved in a fight and he injured a police officer who tried to restrain him. (Tr. at 1624-1625)
- The medical records lack documentation to support the use of the controlled and non-controlled medications, or the increases in dosages, including when Patient 7 at times advised that he was doing better. Dr. Villavicencio stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical records is taken into consideration (including the intake forms and his staff’s notes), he believes that his medical record is “better documented than * * * the allegations would suggest.” (Tr. at 1575-1576)

Patient 8

(Medical record reflects treatment between June 2005 and June 2007, 24 months)

184. Patient 8, a male, was born in 1973. He first saw Dr. Villavicencio on June 8, 2005, when he was 32 years old. Patient 8 complained of low back pain, left arm pain, and bilateral leg

pain, which he had had for three years. Patient 8 reported that he smoked marijuana in order to deal with the pain, and that he had tried Percocet for the pain. Dr. Villavicencio recalled that Patient 8 was not taking any medications at the time of the first office visit. Patient 8's blood pressure was 120/90. Dr. Villavicencio diagnosed pain lumbar region and coronary artery disease. He prescribed Percocet, Soma, and Motrin. He also ordered a stress test. (St. Ex. 8 at 53, 64; Tr. at 225)

185. Patient 8 executed a pain management contract in June and July 2005. (St. Ex. 8 at 61, 62)
186. In July 2005, Patient 8 saw Dr. Villavicencio for a second visit. Patient 8 reported that he had had "several episodes of anterior chest pain and left arm pain" since his prior visit. However, he did not have any chest pain at the time of his second visit. Dr. Villavicencio prescribed Percocet, Soma, Motrin, and Nitroglycerin. He ordered a stress test again. (St. Ex. 8 at 52)
187. In August 2005, Patient 8 reported pain levels of "9" and "10+," and worsening of his pain. Moreover, Patient 8 stated that he had tried OxyContin previously and would like to try it again for his pain. Dr. Villavicencio informed Patient 8 that he could prescribe OxyContin "for now but would need documentation in the form of an MRI." (St. Ex. 8 at 3, 50-51)
188. In August 2005 or thereafter, Dr. Villavicencio received an MRI report from June 2003. The report reflects that Patient 8 had "[m]inor degenerative disc disease and disk bulge at L4-5. No high grade focal stenosis or asymmetric disc protrusion seen." (St. Ex. 8 at 54; Tr. at 226-227)
189. In September and October 2005, Dr. Villavicencio referred Patient 8 to a pain management specialist. (St. Ex. 8 at 48, 49)
190. Patient 8 did not obtain the stress test ordered in June and July 2005. In November 2005, he reported that he no longer had anterior chest pain and he had forgotten to follow up. Patient 8 was "encouraged to at least check his labs (cholesterol) * * *." (St. Ex. 8 at 47)

Also in November 2005, Patient 8 reported his level of pain as "10," but also claimed that the medications were working. Dr. Villavicencio ordered physical therapy for Patient 8, "dynamic lumbar stabilization and core strengthening exercises" two to three times per week. In December 2005, Patient 8 reported that the physical therapy "is helping." Per reports from Patient 8, he completed physical therapy in March 2006. (St. Ex. 8 at 42, 46, 47)

191. In February 2006, Dr. Villavicencio included in the progress note that Patient 8 "also has anxiety" and diagnosed anxiety. He prescribed Xanax, along with prescribing OxyContin, Percocet, and Soma. (St. Ex. 8 at 44)
192. In late-February-2006, Patient 8 was seen at a hospital for an abscess. The hospital report reflects that Patient 8 had been taking no medications at the time. Similarly, in March 2006, Patient 8 was seen in an emergency department after he was involved in an accident with an all-terrain vehicle. The initial report of that hospital visit, which is the only report in the

- medical record, stated that Patient 8 had been taking no medications at the time. (St. Ex. 8 at 56-59)
193. In April 2006, Dr. Villavicencio again referred Patient 8 to physical therapy and to a pain management specialist. He ordered physical therapy again in May 2006 and in June 2006. (St. Ex. 8 at 36, 39, 40, 42)
194. Patient 8 saw Dr. Villavicencio three times in June 2006. The first visit was nearly two weeks after a late-May 2006 appointment and receipt of prescriptions for OxyContin, Percocet, Soma, and Xanax. In early June, Patient 8 reported that he had been involved in an automobile accident and that his level of pain was “10.” Dr. Villavicencio prescribed 10+-day supplies of MS Contin, Percocet, and Zanaflex, and ordered an MRI of the knee. Two days later in June 2006, Patient 8 admitted that he had consumed all of his medications already, but he also stated that he could not tolerate MS Contin or Dilaudid. Dr. Villavicencio prescribed a 37.5-day supply of Roxicodone.¹⁷ Patient 8 returned to Dr. Villavicencio’s office a third time in June 2006 and complained of back pain and headaches. Dr. Villavicencio prescribed a 37.5-day supply of Roxicodone,¹⁸ a 30-day supply of OxyContin, 40-day supply of Soma, and a 30-day supply of Xanax. (St. Ex. 8 at 2, 36-38)
195. At his July 2006 office visit, Dr. Villavicencio conducted a urine drug screen, which was negative for opiates. He referred Patient 8 to a pain medicine specialist. Dr. Villavicencio did not document a discussion with Patient 8 about the urine screen result. (St. Ex. 8 at 7, 34, 35, 55)
196. Dr. Villavicencio ordered a nerve conduction study in November and December 2006. He ordered MRIs in November 2006, and January and April 2007. (St. Ex. 8 at 29-31)
197. Patient 8 reported that he had been in an automobile accident in January 2007. He stated that his level of pain was “10.” Dr. Villavicencio documented that Patient 8 had been hospitalized and was wearing a brace. Dr. Villavicencio prescribed OxyContin, Roxicodone, Soma, and Xanax. (St. Ex. 8 at 1, 29)
198. In April 2007, Patient 8 reported that he had a “lost script,” and Dr. Villavicencio told Patient 8 that he would “consider giving him other meds if he gets his mri.” Dr. Villavicencio ordered MRIs and prescribed Opana. However, Opana was not approved by Patient 8’s insurer. Dr. Villavicencio noted that, as a result of the insurance denial, Patient 8 “would like to try the [R]oxicodone.”¹⁹ Dr. Villavicencio prescribed Roxicodone. (St. Ex. 8 at 25, 26)

¹⁷Dr. Kelly stated that Roxicodone has three times the oxycodone contained in Percocet. As a result, Dr. Kelly concluded that the breakthrough medication prescribed to Patient 8 at this visit was tripled. (Tr. at 1113)

¹⁸This 37.5-day supply of Roxicodone was prescribed seven days after a 37.5-day supply of Roxicodone was prescribed earlier in June 2006. (St. Ex. 8 at 36-37)

¹⁹Patient 8’s medical record indicates that he had been prescribed Roxicodone from June 2006 through March 2007. It is not clear why he wanted to “try” it in April 2007.

199. Patient 8's medical record reflects that the ordered stress test was never performed. Also, there are no MRIs during the treatment period and no pain management consultation report in the medical record. In addition, there are no records to verify that physical therapy was done, as Patient 8 had reported. (St. Ex. 8)
200. Dr. Villavicencio prescribed the following medications to Patient 8 between June 2005 and June 2007:

Date	Relevant Medication	Dosages (no refills provided)	Comments	St. Ex. 8 Cite
6/8/05 7/6/05	Percocet Soma Motrin	5/325 mg, 1 tablet three times a day, #90 350 mg, 1 tablet three times a day, #90 600 mg, 1 tablet three times a day, #90		52, 53
8/2/05	Percocet Soma Motrin	5/325 mg, 1 tablet four-six times a day, #140 350 mg, 1 tablet three times a day, #90 600 mg, 1 tablet three times a day, #90	Percocet dosage increased. 23.3- to 35-day supply of Percocet prescribed.	51
8/30/05- 10/25/05	OxyContin Percocet Soma Motrin	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four-six times a day, #90 350 mg, 1 tablet three times a day, #90 600 mg, 1 tablet three times a day, #90	15- to 22.5-day supply of Percocet prescribed. In both September and October, 5 refills of Motrin were prescribed.	48-50
11/28/05- 1/11/06 ²⁰	OxyContin Percocet Soma	40 mg, 1 tablet three times a day, #120 5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #120	40-day supplies of OxyContin and Soma prescribed.	45-47
2/7/06 3/8/06	OxyContin Percocet Soma Xanax	40 mg, 1 tablet three times a day, #120 5/325 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #120 1 mg, 1 tablet at bedtime, #30	Xanax added. 40-day supplies of OxyContin and Soma prescribed.	43, 44
4/5/06	OxyContin Percocet Soma Xanax	40 mg, 1 tablet three times a day, #120 5/325 mg, 1-2 tablets four times a day, #150 350 mg, 1 tablet three times a day, #120 1 mg, 1 tablet at bedtime, #30	Percocet dosage increased. 18.75- to 37.5-day supply of Percocet and 40-day supplies of OxyContin and Soma prescribed.	42
5/3/06 5/25/06	OxyContin Percocet Soma Xanax	40 mg, 1 tablet three times a day, #120 5/325 mg, 1-2 tablets four times a day, #150 350 mg, 1 tablet three times a day, #120 1 mg, 1 tablet twice a day, #60	Xanax dosage doubled. 18.75- 37.5-day supply of Percocet, and 40-day supplies of OxyContin and Soma prescribed. 5/25/06 prescriptions issued early.	39, 40
6/7/06	MS Contin Percocet Zanaflex	15 mg, 1 tablet twice a day prn for pain, #30 10 mg, 1 tablet four-six times a day, #90 4 mg, 1 tablet three times a day prn, #30	15-day supply of MS Contin, 15- to 22.5-day supply of Percocet, and 10-day supply of Zanaflex prescribed.	38
6/9/06	Roxicodone	30 mg, 1 tablet four times a day for break-through pain, #150	Patient 8 could not tolerate MS Contin. 37.5-day supply of Roxicodone prescribed.	37
6/16/06 7/14/06	OxyContin Roxicodone Soma Xanax	40 mg, 1 tablet three times a day, #120 15 mg, 1 tablet four times a day for break-through pain, #150 350 mg, 1 tablet three times a day, #120 1 mg, 1 tablet twice a day, #60	Early refills of all medications. Roxicodone dosage decreased by half. 40-day supplies of Soma and OxyContin, and 37.5-day supply of Roxicodone prescribed.	35, 36

²⁰The progress note from the December 19, 2005 visit does not document the full dosing instructions for the OxyContin prescription. (St. Ex. 8 at 46)

Date	Relevant Medication	Dosages (no refills provided)	Comments	St. Ex. 8 Cite
8/15/06	OxyContin Roxicodone Soma Xanax	80 mg, 2 tablets in a.m. and three tablets in p.m., #150 15 mg, 1-2 tablets four times a day for breakthrough pain, #220 350 mg, 1 tablet three times a day, #120 2 mg, 1 tablet three times a day, #90	OxyContin dosage increased. Roxicodone dosage increased. 27.5- to 55-day supply of Roxicodone prescribed. Xanax dosage tripled.	34
9/25/06 10/25/06	OxyContin Roxicodone Soma Xanax	80 mg, 2 tablets twice a day, #110 15 mg, 1 tablet four times a day for breakthrough pain, #150 350 mg, 1 tablet three times a day, #120 2 mg, 1 tablet twice a day, #60	OxyContin and Roxicodone dose decreased. 27.5-day supply of OxyContin prescribed. 37.5-day supply of Roxicodone prescribed. Xanax dosage decreased.	32, 33
11/21/06	OxyContin Roxicodone Soma Xanax	80 mg, 2 tablets twice a day, #110 15 mg, 1 tablet four times a day for breakthrough pain, #150 350 mg, 1 tablet three times a day, #120 2 mg, 1 tablet three times a day, #60	Xanax dosage increased and 20-day supply prescribed.	31
12/19/06	OxyContin Roxicodone Soma Xanax	80 mg, 2 tablets twice a day, #120 15 mg, 1 tablet every 5 hours for breakthrough pain, #175 350 mg, 1 tablet four times a day, #135 2 mg, 1 tablet three times a day, #70	Roxicodone and Soma dosages increased. 35+-day supply of Roxicodone, 33.75-day supply of Soma, and 23.3-day supply of Xanax prescribed.	30
1/23/07- 3/20/07	OxyContin Roxicodone Soma Xanax	80 mg, 2 tablets twice a day, #110 15 mg, 1 tablet four times a day for breakthrough pain, #150 350 mg, 1 tablet three times a day, #120 2 mg, 1 tablet three times a day, #60	27.5-day supply of OxyContin, 37.5-day supply of Roxicodone, 40-day supply of Soma, and 20-day supply of Xanax prescribed.	27-29
4/2/07	Opana ER	10 mg, 1 tablet twice a day, #60		26
4/4/07	Roxicodone	30 mg, 1 tablet four times a day for breakthrough pain, #60	15-day supply of Roxicodone prescribed.	25
4/14/07	OxyContin Roxicodone Soma Xanax	80 mg, 2 tablets twice a day, #100 15 mg, 1 tablet four times a day for breakthrough pain, #150 350 mg, 1 tablet three times a day, #120 2 mg, 1 tablet three times a day, #60	Roxicodone filled early. 25-day supply of OxyContin, 37.5-day supply of Roxicodone, 40-day supply of Soma, and 20-day supply of Xanax.	24
5/16/07	OxyContin Roxicodone Soma Xanax	80 mg, 2 tablets twice a day, #90 15 mg, 1 tablet four times a day for breakthrough pain, #150 350 mg, 1 tablet three times a day, #120 2 mg, 1 tablet three times a day, #60	22.5-day supply of OxyContin, 37.5-day supply of Roxicodone, 40-day supply of Soma, and 20-day supply of Xanax.	23
6/13/07	OxyContin Roxicodone Soma Xanax	80 mg, 2 tablets twice a day, #100 15 mg, 1 tablet four times a day for breakthrough pain, #150 350 mg, 1 tablet three times a day, #120 2 mg, 1 tablet three times a day, #60	25-day supply of OxyContin, 37.5-day supply of Roxicodone, 40-day supply of Soma, and 20-day supply of Xanax.	22

201. Patient 8 died on June 15, 2007, as the result of bronchopneumonia, which was caused by “combined drug intoxication.” A toxicology test revealed multiple drugs, including a high level of oxycodone. (St. Ex. 8 at 18, 41)

Opinion of Dr. Kelly

202. With regard to the first office visit with Patient 8, Dr. Kelly stated the following:

- Dr. Villavicencio included no documentation that explains the diagnosis of coronary artery disease or the ordering of a cardiac stress test.
- The initial history, examination, diagnosis and treatment plan were not documented adequately.
- Dr. Villavicencio did not document a discussion with Patient 8 about his marijuana use and his actions for the future.

(St. Ex. 18 at 34, 38; Tr. at 618-620)

203. Dr. Kelly had no issues with the doses of medications prescribed to Patient 8 at the initial office visit. (Tr. at 1093) However, Dr. Kelly commented that multiple prescriptions were issued later to Patient 8 without an explanation (e.g., symptoms or physical examination) when an explanation was required. They are listed below:

- Dr. Villavicencio prescribed a five-fold increase in oxycodone (from 20-25 mg to 135 mg per day) in August 2005.
- Dr. Villavicencio increased the dosage of OxyContin again in November 2005 (from 135 mg to 180 mg per day) without rationale.
- In April 2006, no rationale was documented for increasing Percocet and Xanax.
- In mid-June 2006, prescriptions were given one week early.
- In August 2006, the Xanax dosage was tripled, the OxyContin dosage was increased 2.5 times, and the Roxicodone dosage was increased by 1.5. The oxycodone dosage is more than 500 mg per day.
- In September 2006, the Xanax dosage was doubled. Although the OxyContin and Roxicodone dosages were decreased, the patient was still prescribed a total of 315-395 mg of oxycodone per day.
- In June 2007, Dr. Villavicencio prescribed oxycodone totaling 350 mg to 395 mg per day.

(St. Ex. 18 at 34-36; Tr. at 1100) Moreover, Dr. Kelly added that the oxycodone dosages were “stratospheric” for a patient with nonterminal chronic pain. (Tr. at 620-621)

204. Dr. Kelly stated that, in June 2006 after Patient 8 reported that he had taken all of his medications that had been prescribed two days earlier, Dr. Villavicencio inappropriately did not alter his management plan, and did not refer the patient to a pain specialist, to an addictionologist, or to rehabilitation. Similarly, Dr. Kelly commented that, if Patient 8 had lost his prescription in April 2007 as he alleged, he would have been experiencing major narcotic withdrawal given the massive amount of oxycodone that the patient was supposedly taking. Dr. Kelly pointed out that there is no documentation that withdrawal was happening or that Dr. Villavicencio

inquired. He added that this incident also warranted some change in the management plan and possibly referral to a specialist. (St. Ex. 18 at 37; Tr. at 624-629)

205. Dr. Kelly stated that the primary focus of Dr. Villavicencio's treatment of Patient 8 was chronic pain, and that medication doses included 300-400 mg of oxycodone and 4 mg of Xanax each day. Dr. Kelly explained that there was no diagnosis of anxiety for Patient 8 or other documentation of why Xanax was prescribed.²¹ However, Xanax could have been used as a muscle relaxant. He also stated that the oxycodone doses were extremely high, unjustified and unexplained. He opined that the documentation did not support the initial choice of treatment, the eventual doses of pain medication, or the increases in opiate medications. Moreover, he stated that Dr. Villavicencio did not obtain recommendations from a pain management specialist and did not respond appropriately to patient behaviors/requests that should have been considered "red flags." Additionally, Dr. Kelly noted that chart notes, including review of systems and physical examinations, were identical to prior visits and were identical to the same sections in other patients' records. (St. Ex. 18 at 37; Tr. at 621-622, 634-635, 628-629, 1129, 1383)
206. Dr. Kelly concluded that Dr. Villavicencio's care of Patient 8 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances. Also, he stated that Dr. Villavicencio's controlled substance prescribing and the documentation of his care of Patient 8 constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 38; Tr. at 1383)

Opinion of Dr. Villavicencio

207. Dr. Villavicencio testified that, at Patient 8's first visit, he did not prescribe only Motrin, or Soma and Motrin, because Dr. Villavicencio thought Patient 8's bilateral leg pain was radicular pain. He added that Patient 8 owned his own business and Dr. Villavicencio felt sympathetic to him. Dr. Villavicencio agreed that he had known that Patient 8 used street drugs and still had prescribed a narcotic to him. (Tr. at 227-228)
208. Dr. Villavicencio agreed that the results of Patient 8's 2003 MRI were benign. (Tr. at 232)
209. Dr. Villavicencio acknowledged that the increases in medication and early refills that were given to Patient 8. In particular, Dr. Villavicencio admitted to the following:
- He increased the Percocet prescription in early August 2005 and that the increase had been "pretty significant." He further acknowledged that the increase was based solely on the patient's description that the pain had worsened. (Tr. at 230-231)
 - He acknowledged that, after he had prescribed OxyContin (40-day supply), Percocet (18.75-37.5-day supply), Soma (40-day supply), and

²¹This is an error on Dr. Kelly's part. Dr. Villavicencio did diagnose anxiety in February 2006. He added Xanax that day to the medication regimen. (St. Ex. 8 at 44) It appears that Xanax was prescribed to treat the anxiety.

Xanax (30-day supply) in late May 2006, he then prescribed MS Contin, Percocet (15- to 22.5-day supply), and Zanaflex (10-day supply) after Patient 8's automobile accident in early June 2006. (Tr. at 239)

- On June 9, 2006, Patient 8 reported that he did not tolerate the MS Contin because he was allergic to morphine. He also reported that he had taken all of his other medications prescribed on May 25, 2006. Dr. Villavicencio prescribed Roxycodone at that time. Dr. Villavicencio acknowledged that he had prescribed 120 mg per day of Roxycodone on June 9, 2006, after he had prescribed 140-160 mg per day of oxycodone on May 25.²² Dr. Villavicencio admitted that the June 9 prescription was a "massive increase" in pain medication. (Tr. at 239-241)
- He further agreed that Patient 8 received early refills of OxyContin, Roxycodone, Soma, and Xanax on June 16, 2006, and that this behavior was a "red flag." (Tr. at 242-243)
- He testified that in August 2006, he significantly increased the dosage of OxyContin. He also stated that, when he increased the medications in August 2006, Patient 8 was supposed to take "five of the Roxycodone 15 [mg], which is 65 [mg], plus three 20s, so 385 [mg of oxycodone] a day" and he was supposed to take it for 40 days. However, the prescriptions were written as follows: (a) OxyContin, 80 mg, 2 tablets in the a.m. and three tablets in p.m., #150; and (b) Roxycodone, 15 mg, 1-2 tablets four times a day for breakthrough pain, #220. Dr. Villavicencio explained that he prescribed to Patient 8 in that manner because Patient 8 would not be seen again until 40 days later and the insurance company would not otherwise approve a large number of pills. (Tr. at 243-245)
- He agreed that, by 2007, he prescribed 385 mg of oxycodone per day to Patient 8. (Tr. at 248)

210. Dr. Villavicencio testified that Patient 8 was a favorite patient and he "got special treatment" because Dr. Villavicencio trusted Patient 8 after he had identified other patients who were possibly selling their medications. Dr. Villavicencio acknowledged that he did not include that information in Patient 8's medical record. Dr. Villavicencio explained that he had not questioned Patient 8's descriptions of his pain and his need for more pain relief. Additionally, Dr. Villavicencio allowed Patient 8 to be seen without an appointment, and let him miss another appointment. As a result, he prescribed controlled substances to Patient 8 under circumstances that he would not prescribe to other patients. (Tr. at 234-236, 241-242, 1682-1683, 1685)

²²Dr. Villavicencio actually agreed that he had prescribed 185 mg per day of oxycodone medications in May 2006. However, when calculated, the total daily oxycodone dose was 140-160 mg. (Tr. at 241; St. Ex. 8 at 39)

211. He explained further why he prescribed as he did to Patient 8 in the following testimony:

This was a learning process for me. I think that this patient got very high doses and I explained partly the reason why. * * * I really got blindsided by this gentleman.

That the – the other things that I wanted to – to say is that his parents came also and – and, you know, I – I do try to corroborate the patient's history with – with family members, especially if they're young, I – I insist on talking to their parents. And his parents came with him.

I mean, you know, I – I – I – I was – I was very naive and – and I – I would say now that I – when – when I first started practicing medicine, I – I – I – I – it was very hard for me to – to – to be in a position where I don't trust them, but – but that's exactly where we are right now because – because – and it's nothing – it's as I have evolved as a physician, you know, I think that a lot of patients have legitimate reasons for pain and that they hurt, but – but when they are in – in a stressful situation, that – that can lead to aberrant behavior, abuse, and outright addiction. So – So it's a learning process.

And – And whether they come with their parents or not, whether they bring their kids and show me how hard they work, at the end of the day, I – you know, instead of – of blind trusting the patients, I – I have to – to listen to all other red flags.

* * *

But – But, you know, looking back at these records, I would say that, you know, it was – it was dose after dose of increasing. I mean, I can't – I can't explain why he never – I mean, he just always – [Patient No. 8] – Patient No. 8 always gave me reasons. "I don't have insurance," you know, and – and that's always a constant issue.

But we press the issue with MRI and threaten most of our other patients that they're not going to get seen unless it gets done. But – But we did not hold him up to the same standards.

(Tr. at 248-250)

212. Dr. Villavicencio agreed with the following:

- Dr. Villavicencio began treating Patient 8 on June 8, 2005, for conditions including back pain and anxiety. (Tr. at 1629)
- Dr. Villavicencio prescribed long-acting and short-acting opiate medications. (Tr. at 1629)

- Dr. Villavicencio frequently entered a diagnosis of coronary artery disease in Patient 8's medical record, but there is no documentation in the chart to support this diagnosis. Dr. Villavicencio stated that he diagnosed coronary artery disease based on Patient 8's subjective complaints. Additionally, Dr. Villavicencio stated that the history forms reflected complaints of chest pain and left arm pain.²³ (Tr. at 1629)
- Dr. Villavicencio ordered a stress test, and there is no documentation in Patient 8's chart that the test was completed and/or that shows the test results. Dr. Villavicencio acknowledged that Patient 8 never obtained the stress test. Dr. Villavicencio stated that he could not force Patient 8 to get the test. (Tr. at 1630)
- The chart entries appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. (Tr. at 1579)
- Dr. Villavicencio referred Patient 8 to specialists and for tests and physical therapy, and Dr. Villavicencio failed to take and/or document taking appropriate action when Patient 8 failed to keep the appointments and/or provide documentation of compliance with clinical instructions. Dr. Villavicencio stated that Patient 8 failed to follow up on the referrals due to insurance reasons. (Tr. at 1630-1631)
- According to test results appearing in Patient 8's chart, a urine test showed a negative result for drugs that Dr. Villavicencio had prescribed (opiates). Dr. Villavicencio did not address and/or document addressing the inconsistent test result and continued to prescribe the same or escalating doses of controlled substances. Dr. Villavicencio explained that the test that he had used at that time did not test for Vicodin or Percocet.²⁴ (Tr. at 1631-1632)
- Dr. Villavicencio prescribed over 200 mg of oxycodone per day to Patient 8. Dr. Villavicencio stated that it is an unusual dose, but Patient 8 was opiate tolerant. (Tr. at 1633-1634, 1678-1679)

213. Dr. Villavicencio disagreed with the following:

- When Patient 8 admitted he had taken in two days medication, including MS Contin and Percocet, which should have lasted at least two weeks, Dr. Villavicencio did not counsel or refer and/or document counseling or referring Patient 8 for substance-abuse counseling or treatment. Dr. Villavicencio testified that his note intended to reflect that Patient 8 had taken all of the medications prescribed before the MS Contin and Percocet had been prescribed. (Tr. at 1632-1633)

²³Dr. Villavicencio is incorrect on this point. The history form included in Patient 8's medical record contains no reference to chest pain or left arm pain. (St. Ex. 8 at 9) However, there is a reference in a progress note that Patient 8 had three risk factors. (St. Ex. 8 at 47)

²⁴Just prior to this urine drug screen, Dr. Villavicencio had not prescribed Vicodin or Percocet. He had prescribed OxyContin, Roxicodone, Soma and Xanax. (St. Ex. 8 at 36)

- The medical chart lacks documentation to support the use of the controlled and non-controlled medications, or the increases in dosages. He stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical records is taken into consideration (including the intake forms and his staff's notes), he believes that his medical record is "better documented than * * * the allegations would suggest." (Tr. at 1575-1576)

Patient 9

(Medical record reflects treatment between March 2005 and October 2006, 19 months)

214. Patient 9, a female, was born in 1964. Patient 9 first saw Dr. Villavicencio on March 3, 2005, when she was 40 years old. At her first appointment, Patient 9 reported that she had low back pain and weakness on one side. She also stated that she had had a 4-wheeler accident three years earlier. She listed her then-current medications as Coumadin and Seroquel,²⁵ and Dr. Villavicencio documented that Patient 9 was "without prescription." Dr. Villavicencio diagnosed cerebrovascular accident [CVA] and pain in the lumbar region. Patient 9 executed a pain management contract (a second pain management agreement was executed in July 2005). He ordered physical therapy and "PTT," and he prescribed Percocet and Xanax. (St. Ex. 9 at 5, 14, 36, 43; Tr. at 253)
215. Patient 9 returned less than two weeks later and reported that the Percocet was not working for her and that her job required lifting. Patient 9 requested Soma. Dr. Villavicencio diagnosed back sprain and prescribed Soma and Motrin. (St. Ex. 9 at 42)
216. Patient 9 returned early for the next three visits, reporting twice that she was unable to attend the later-scheduled appointments. Thirty-day supplies of Percocet, Xanax, Soma, and Motrin were prescribed each time. In April 2005 (at the fifth office visit), Dr. Villavicencio documented the following:
- Patient told that it has only been two weeks since last meds. Patient averages 3000 mg of Tylenol per day. Warned [patient] and told patient it has to last 3 weeks this time.
- (St. Ex. 9 at 39)
217. In May 2005, Patient 9 reported that, while being robbed, she had fallen and her medications were stolen. Dr. Villavicencio documented that Patient 9 had filed a police report. Dr. Villavicencio diagnosed pain in the lumbar region, CVA, and abrasion. He prescribed 30-day supplies of Percocet, Xanax, Soma, and Motrin. (St. Ex. 9 at 2, 38)

²⁵Coumadin is a blood thinner, used to prevent blood clots or treat venous thrombosis and pulmonary embolism. Seroquel is used to treat schizophrenia, bipolar disorder or depression. (U.S. National Library of Medicine, *PubMed Health*, <http://www.ncbi.nlm.nih.gov/pubmedhealth> accessed June 22, 2012).

218. Two weeks later, Patient 9 saw Dr. Villavicencio and reported that she was experiencing pain in her shoulder from the earlier fall and that she wanted x-rays and a week away from work. Dr. Villavicencio diagnosed pain in the lumbar region, CVA, and a shoulder sprain. He again prescribed Percocet, Xanax, Soma, and Motrin. (St. Ex. 9 at 37)
219. In August 2005, Patient 9 reported that her pain level was "10" and that she was having some emotional problems. She also reported that she was "doing ok." Dr. Villavicencio documented that Patient 9 hoped to be able to have an MRI done. The following month, Patient 9 again reported that she was "doing ok," and her level of pain was "7+." In October 2005, Patient 9's level of pain was "9," but she reported that she was "doing ok." Dr. Villavicencio documented that she had not received physical therapy/PTT because she could not afford it. In December 2005, she "declined" physical therapy/PTT. Her level of pain was "10." (St. Ex. 9 at 2, 29, 31, 33)
220. In February 2006, Patient 9 provided a urine sample, which was positive for cocaine. It was negative for Xanax, Soma, and Motrin although they had been prescribed by Dr. Villavicencio before the test. Dr. Villavicencio documented that Patient 9 "will be discharged." A later notation, dated March 6, 2006, states "Per Dr. Villa: 1 more chance." (St. Ex. 9 at 2, 25-27)
221. At her next office visit in March 2006, Patient 9 reported a pain level of "8." Dr. Villavicencio noted that Patient 9 was admitted back to the practice and would be "subjected to ra[n]dom drug tests." (St. Ex. 9 at 24) There is no documentation of any drug screens in Patient 9's medical record from March to October 2006, when the medical record ends. (St. Ex. 9)
222. From April to October 2006, Patient 9's pain levels were between "8" and "10." She continued to complain of back pain and Dr. Villavicencio prescribed Percocet, Xanax, Soma, and Motrin. In July 2006, Dr. Villavicencio diagnosed an upper respiratory infection, although no symptoms were listed and nothing in the review of systems supported an upper respiratory infection. In August 2006, Dr. Villavicencio added Duragesic and ordered CT scans. In October 2006, Dr. Villavicencio diagnosed nausea with vomiting and diarrhea, and prescribed medication for those diagnoses. However, he also listed in the review of symptoms that Patient 9 had no nausea, vomiting and diarrhea. (St. Ex. 9 at 16-21)
223. The medical record reflects no referral to a pain management specialist and no order for an MRI by Dr. Villavicencio. There is mention on one occasion that Patient 9 hoped to be able to have an MRI done, but nothing reflects that an MRI was completed. (St. Ex. 9)
224. Dr. Villavicencio prescribed the following medications to Patient 9 between March 2005 and October 2006:

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 9 Cite
3/03/05	Percocet Xanax	5/325 mg, 1 tablet four times a day, #120 0.5 mg, 1 tablet three times a day, #90		43
3/14/05	Soma Motrin	350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120		42

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 9 Cite
3/24/05 4/12/05 4/25/05 5/23/05	Percocet Xanax Soma Motrin	5/325 mg, 1 tablet four times a day, #120 0.5 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120	Early refills of all four medications at 3/24/05, 4/12/05 and 4/25/05 visits.	38-41
6/6/05 7/5/05	Percocet Xanax Soma Motrin	5/325 mg, 1 tablet four times a day, #140 0.5 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120	35-day supply of Percocet prescribed.	35, 37
7/20/05	Percocet Percocet Xanax Soma Motrin	5/325 mg, 1 tablet four times a day, #60 5/325 mg, 1 tablet four times a day, #120 1 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120	Patient complained of ear pain also. Early refills of all four medications. Percocet and Xanax dosage increased. 22.5- to 45-day supply of Percocet prescribed.	34
8/17/05	Percocet Xanax Soma Motrin Coumadin Seroquel	5/325 mg, 1-2 tablets four times a day, #180 1 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120 5 mg, 1 tablet every morning, #30, 5 refills 100 mg, 1 tablet twice a day, #60, 5 refills	22.5- to 45-day supply of Percocet prescribed. Percocet dosage decreased.	33
9/13/05- 11/8/05	Percocet Xanax Soma Motrin	5/325 mg, 1-2 tablets four times a day, #180 1 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120	22.5- to 45-day supply of Percocet prescribed.	30-32
12/7/05	Percocet Xanax Soma Motrin	5/325 mg, 1-2 tablets four times a day, #240 1 mg, 1-2 tablet three times a day, #120 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120	30- to 60-day supply of Percocet. Dosage of Xanax increased. Noted that patient would be out of state until the end of January 2006.	29
1/10/06	Percocet Xanax Soma Motrin Coumadin Seroquel	5/325 mg, 1-2 tablets four times a day, #180 1 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120 5 mg, 1 tablet every morning, #30, 5 refills 100 mg, 1 tablet twice a day, #60, 5 refills	Patient returned before expected. 22.5- to 45-day supply of Percocet prescribed.	28
2/7/06 3/13/06	Percocet Xanax Soma Motrin	5/325 mg, 1-2 tablets four times a day, #180 1 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120	22.5- to 45-day supply of Percocet prescribed.	24, 27
4/11/06	Percocet Xanax Soma Motrin Coumadin	5/325 mg, 1-2 tablets four times a day, #180 1 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120 7.5 mg, 1 tablet each day, #30, 5 refills	22.5- to 45-day supply of Percocet prescribed.	22
5/9/06- 7/7/06	Percocet Xanax Soma Motrin	5/325 mg, 1-2 tablets four times a day, #180 1 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120	22.5- to 45-day supply of Percocet prescribed.	19-21
8/3/06- 10/4/06	Percocet Xanax Soma Motrin Duragesic	5/325 mg, 1-2 tablets four times a day, #180 1 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120 50 mcg/hr, "apply to dry intact skin; hold for 30 seconds," #2	Patient complained of abdominal/pelvic pain on 8/3/06. 22.5- to 45-day supply of Percocet prescribed. The Duragesic prescribed on 9/6/06 and 10/4/06 was "#10," a 30-day supply. (St. Ex. 18 at 40)	16-18

225. On October 13, 2006, Patient 9 died as the result of cocaine and Fentanyl intoxication. A toxicology test revealed multiple drugs, including cocaine and a “toxic to lethal” level of Fentanyl. Patient 9 was wearing a 75 mcg/hr Fentanyl patch at the time, but Dr. Villavicencio had prescribed 50-mcg/hr patches. (St. Ex. 9A)

Opinion of Dr. Kelly

226. Dr. Kelly stated that the documentation in Patient 9’s medical record was inadequate for the following reasons:

- The initial history, examination, diagnosis, and treatment plan were not documented adequately. Dr. Kelly stated that there is no detail about the intensity of Patient 9’s pain, the location, associated symptoms, and prior treatments. He added that the back examination was incomplete, and there are no symptoms related to the use of Xanax. (St. Ex. 18 at 41; Tr. at 997-999)
- No history or examination supported the diagnosis of an upper respiratory infection in July 2006. (Tr. at 639)
- No documentation supported the prescription of Zestril (a blood pressure medication) in July 2006. (Tr. at 639)

227. Dr. Kelly criticized Dr. Villavicencio’s prescribing to Patient 9 as follows:

- Dr. Kelly noted that, at the beginning of his care and treatment of Patient 9, Dr. Villavicencio issued four separate prescriptions for the same medications in two months (March and April 2005) and that all of those prescriptions were 30-day supplies. (Tr. at 633, 636-637, 1003-1003, 1009)
- Dr. Villavicencio refilled her prescriptions early in June 2005 and January 2006. (Tr. at 1024-1025, 1028)
- Dr. Kelly found that Dr. Villavicencio prescribed Coumadin and Seroquel in January 2006 without any explanation. He acknowledged that Patient 9 previously had reported taking those two medications, but stated that there is no understanding of why they were prescribed in January 2006. He added that Coumadin requires monitoring and testing on at least a monthly basis because of its anti-coagulating effect.²⁶ (Tr. at 1029-1030)
- Dr. Kelly stated that Dr. Villavicencio increased Percocet and Xanax in July 2005 without a clear rationale for the increases. (St. Ex. 18 at 39; Tr. at 635)
- Dr. Kelly pointed out that there was essentially no interruption in controlled substance prescriptions despite the drug screen in February 2006 which was positive for cocaine and no further drug testing was done. Dr. Kelly opined that a referral to an addictionologist, and tapering/

²⁶Patient 9’s chart reflects that Dr. Villavicencio tested the anti-coagulating effect of Coumadin once – in March 2006 and it was normal. (St. Ex. 9 at 23)

discontinuing the controlled substances should have been done. In his opinion, continuing to prescribe controlled substances to Patient 9 was not an appropriate response. (St. Ex. 18 at 40, 41; Tr. at 637-638, 1033-1036)

- In August 2007, Dr. Villavicencio added Duragesic without a precipitating change in her back pain and with only an undiagnosed complaint of abdominal pain. Dr. Kelly opined that there was no clear rationale for adding Duragesic patches in August 2006. (St. Ex. 18 at 40; Tr. at 641, 1039-1040, 1042)

228. Dr. Kelly concluded that the primary focus of Dr. Villavicencio's treatment of Patient 9 was chronic pain, and that the medication doses included 30 mg of oxycodone, 3 mg of Xanax, and 1,400 mg of Soma each day. He also stated that the oxycodone doses were extremely high, unjustified and unexplained. He opined that the documentation did not support the initial choice of treatment, the eventual doses of pain medication or the increases in opiate medications, particularly after the urine drug screen that was positive for cocaine. Additionally, Dr. Kelly noted that chart notes, including the reviews of systems and physical examinations, were identical to prior visits and were identical to the same sections in other patients' records. (St. Ex. 18 at 41; Tr. at 1042)
229. Furthermore, Dr. Kelly concluded that Dr. Villavicencio's care of Patient 9 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances. Also, he stated that Dr. Villavicencio's controlled substance prescribing and the documentation of his care of Patient 9 constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 41; Tr. at 1043)

Opinion of Dr. Villavicencio

230. Dr. Villavicencio testified that, other than Patient 9's report of an accident years before her first visit with him, he had no other basis for prescribing narcotic medications to Patient 9 at her first visit. Additionally, Dr. Villavicencio stated that Patient 9 had severe anxiety (although he did not list it) and he had prescribed Xanax to treat that condition. (Tr. at 253-254)
231. Dr. Villavicencio acknowledged that Patient 9 returned early for medications on several occasions in March and April 2005 and that he did not reduce the number of pills prescribed to recognize the early appointments. He stated that Patient 9 had an excuse for the early visits and he did not know any better at that time. Similarly, he also acknowledged that, after he had prescribed an extra month of Percocet and Xanax, Patient 9 returned early in January 2006. When asked why he would then prescribe Percocet and Xanax again in January, he stated that he "missed that." (Tr. at 255-257, 259-260)
232. Dr. Villavicencio testified that, after her urine screen in February 2006 disclosed cocaine, he had counseled Patient 9. He stated that he did not refer her to an addiction specialist because she had no insurance. (Tr. at 262)

233. Dr. Villavicencio acknowledged that, when he had added Duragesic to Patient 9's medications in August 2006, she had been his patient for roughly 15 months and he had not obtained any diagnostic tests, e.g., MRI or x-ray. (Tr. at 264-265)
234. Dr. Villavicencio testified that he was very sympathetic to Patient 9 because she was kindhearted. As a result, he prescribed controlled substances to her under circumstances that he would not prescribe to other patients. (Tr. at 1683, 1685)
235. Dr. Villavicencio agreed with the following:
- Dr. Villavicencio began treating Patient 9 on March 3, 2005, for conditions including back pain or sprain and/or CVA. (Tr. at 1637)
 - Dr. Villavicencio diagnosed an upper respiratory infection, although there were no symptoms documented to support the diagnosis and Patient 9's medical record documented that she had no cough, wheezing or shortness of breath. Dr. Villavicencio testified that the upper respiratory infection diagnosis was an error; he had "clicked on" it by mistake. (Tr. at 1638)
 - Although Patient 9's medical record indicated that she would be discharged from his practice based on the positive cocaine test result, in fact the doctor-patient relationship did not terminate, and Dr. Villavicencio prescribed the same or additional medications at the same or escalating dosages, with no further drug tests. Dr. Villavicencio testified that he gave Patient 9 one more chance because she struggled and her home environment was unfavorable. (Tr. at 1639-1640, 1642)
 - The chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. (Tr. at 1579)
236. Dr. Villavicencio disagreed with the following:
- Although Dr. Villavicencio referred Patient 9 to specialists and for tests and physical therapy, he failed to take and/or document taking appropriate action when she failed to comply. Dr. Villavicencio explained that Patient 9 had problems with insurance and had financial difficulties. He added that Patient 9 had planned to use some anticipated funds for the tests and referrals, but that did not happen. (Tr. at 1639)
 - The medical chart lacks documentation to support the use of the controlled and non-controlled medications, or the increases in dosages. Dr. Villavicencio stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical records is taken into consideration (including the intake forms and his staff's notes), he believes that his medical record is "better documented than * * * the allegations would suggest." (Tr. at 1575-1576)

Patient 10

(Medical record reflects treatment between April 2005 and December 2006, 20 months)

237. Patient 10, a male, was born in 1967. Patient 10 saw another physician for low back pain prior to initiating treatment with Dr. Villavicencio. An MRI of Patient 10's lumbar spine was conducted in December 2004, revealing the following:

Degenerative disc disease throughout the mid to lower lumbar spine with moderately large broad posterior protrusions from L3-4 through L4-S1, greatest at L5-S1, particularly to the right of midline. Possible posterior right S1 nerve root sleeve displacement; exiting right L5 nerve root sleeve compression is not excluded, particularly on the right. Broad posterior L1-2 disc protrusion also noted.

(St. Ex. 10 at 42-43, 45)

238. Patient 10 first saw Dr. Villavicencio on April 19, 2005, when he was 37 years old. Patient 10 complained of back pain and depression. He reported that Percocet, which he had received from his prior physician, was not helping him and that he wanted something else for anxiety. Dr. Villavicencio diagnosed chronic lumbosacral sprain and anxiety. He prescribed OxyContin, Percocet, and Xanax. (St. Ex. 10 at 11, 41; Tr. at 276)
239. At Patient 10's second office visit one month later, he complained of muscle spasms. Dr. Villavicencio added a muscle relaxer (Robaxin) and ordered a urine drug screen. (St. Ex. 10 at 40)
240. At the next office visit in June 2005, Patient 10 asked for a new muscle relaxer. Dr. Villavicencio noted that Patient 10 had tenderness of the low back and switched to Soma. (St. Ex. 10 at 39)
241. In July 2005, Patient 10's level of pain was recorded as "6." Dr. Villavicencio diagnosed low back pain, and referred Patient 10 to a pain management specialist. Also, Patient 10 executed a pain management contract in July 2005. (St. Ex. 10 at 38, 44)
242. In August, September, and October 2005, Patient 10's level of pain was "10." During those office visits, Patient 10 told Dr. Villavicencio that he was doing "ok," but also stated that he needed to take Percocet four times a day and to take "an extra pill" of OxyContin. Dr. Villavicencio increased the number of Percocet pills prescribed in August 2005, and increased the daily dosage of OxyContin in September 2005. Dr. Villavicencio noted that the OxyContin dosage would be temporary until Patient 10 could follow up with the pain management specialist, but the OxyContin dosage level never decreased. In October 2005, Dr. Villavicencio referred Patient 10 to another pain management specialist and to physical therapy. Patient 10 went to physical therapy one time in October 2005; however, there are no other records from the physical therapist. (St. Ex. 10 at 3, 33-36)

243. In December 2005, Dr. Villavicencio confronted Patient 10 with multiple prescriptions from several providers and Patient 10 replied that “he does not know.” Dr. Villavicencio documented that Patient 10 “will be considered for discharge from [the] practice.” However, Dr. Villavicencio prescribed OxyContin, Percocet, Xanax, and Soma to Patient 10 at the same dosages that day. (St. Ex. 10 at 30)

Moreover, Patient 10 returned to the office in January 2006. He complained of low back pain and a cough that produced phlegm. Dr. Villavicencio documented “no cough/wheezing/[shortness of breath].” He prescribed OxyContin, Percocet, Soma and Xanax again. He added prescriptions for Rondec DM (for cough/congestion) and Amoxil, an antibiotic. (St. Ex. 10 at 29)

244. In March 2006, Dr. Villavicencio ordered an MRI. (St. Ex. 10 at 27) The MRI was conducted in April 2006 and revealed the following:

1. L3-4 broad posterior eccentric left disc herniation exerting mass upon left dural sac and left L4 nerve root. Moderate spinal stenosis.
2. L5-S1 shallow broad posterior disc protrusion with bilateral foraminal extension. Exerts mass upon right S1 nerve root. Moderately narrows right and mildly narrows left foramen.

(St. Ex. 10 at 26)

245. Dr. Villavicencio then referred Patient 10 to a pain management specialist and a neurosurgeon. Patient 10 did not appear for those appointments. (St. Ex. 10 at 2, 25)

246. In July 2006 or thereafter, Dr. Villavicencio received a report of the prescriptions received by Patient 10 between February and May 2006. The list reflects that Patient 10 received multiple prescriptions for narcotic medications from another provider at the same time he had received prescriptions from Dr. Villavicencio. The other provider prescribed oxycodone, clonazepam, and duloxetine.²⁷ (St. Ex. 10 at 8)

247. In August 2006, a urine screen was conducted. It was positive for cocaine and opiates. Laboratory confirmation of this urine test was ordered, but no report was included in the medical record. Dr. Villavicencio ordered a pill count, but there is nothing in the medical record to reflect that it was conducted. (St. Ex. 10 at 2, 21; Tr. at 301-304)

248. In November 2006, Patient 10 claimed that his level of pain was “8.” Dr. Villavicencio noted that the patient was told “we would raise his narcotics one last time before he has to see a pain specialist.” (St. Ex. 10 at 1, 18)

²⁷Clonazepam is a benzodiazepine used to treat seizures and panic attacks. One brand name of clonazepam is Klonopin. Duloxetine is a selective serotonin and norepinephrine reuptake inhibitor used to treat depression, generalized anxiety disorder, pain and fibromyalgia. A brand name of duloxetine is Cymbalta. (U.S. National Library of Medicine, *PubMed Health*, <http://www.ncbi.nlm.nih.gov/pubmedhealth>, accessed June 28, 2012)

249. The medical record contains conflicting information regarding Patient 10 seeing a pain management specialist. Although Dr. Villavicencio noted that Patient 10 had reported in November 2006 that he had seen the pain management specialist, there is strong evidence that Patient 10 did not see a pain management specialist. First, in June 2006, Dr. Villavicencio's staff noted that Patient 10 had failed to appear at the appointment with the pain management specialist. Second, in December 2006, Patient 10 stated that he anticipated being able to complete the referrals in the near future. Third, there are no reports from a pain management specialist in the medical chart. Fourth, Dr. Villavicencio testified that Patient 10 did not ever see any of the pain management specialists during the time that he had treated Patient 10. (St. Ex. 10 at 2, 17-18; Tr. at 281-283, 284)

250. Dr. Villavicencio's prescriptions to Patient 10 between April 2005 and December 2006 include the following:

Date	Relevant Medication	Dosages (no refills unless otherwise designated)	Comments	St. Ex. 10 Cite
4/19/05	OxyContin Percocet Xanax	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day for breakthrough pain, #60 1 mg, 1 tablet at bedtime, #30, 3 refills	15-day supply of Percocet prescribed. 120-day supply of Xanax prescribed, including refills.	41
5/17/05	OxyContin Percocet Xanax Robaxin	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day for breakthrough pain, #60 1 mg, 1 tablet at bedtime, #60, 3 refills 750 mg, 1-2 tablets three times a day prn for muscle spasms, #30	15-day supply of Percocet, 240-day supply of Xanax (including refills) and 15- to 30-day supply of Robaxin prescribed.	40
6/14/05	OxyContin Percocet Xanax Soma	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day for breakthrough pain, #60 1 mg, 1 tablet at bedtime, #60, 3 refills 350 mg, 1 tablet three times a day, #90	15-day supply of Percocet and 240-day supply of Xanax prescribed, including refills.	39
7/12/05	OxyContin Percocet Xanax Soma	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day for breakthrough pain, #60 1 mg, 1 tablet twice a day, #60, 3 refills 350 mg, 1 tablet three times a day, #90	15-day supply of Percocet prescribed. Dosing instructions changed for Xanax. 240-day supply of Xanax prescribed, including refills.	38
8/10/05	OxyContin Percocet Xanax Soma	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day for breakthrough pain, #120 1 mg, 1 tablet twice a day, #60 350 mg, 1 tablet three times a day, #90		37
9/7/05 10/5/05	OxyContin Percocet Xanax Soma	40 mg, 1-2 tablets three times a day, #120 5/325 mg, 1 tablet four times a day for breakthrough pain, #100 1 mg, 1 tablet twice a day, #60 350 mg, 1 tablet three times a day, #90	Dosage of OxyContin increased – Patient informed it would be “temporary.” 25-day supply of Percocet prescribed.	36
11/2/05- 3/14/06	OxyContin Percocet Xanax Soma	40 mg, 1-2 tablets three times a day, #120 5/325 mg, 1 tablet four times a day, #120 1 mg, 1 tablet twice a day, #60 350 mg, 1 tablet three times a day, #90	30-day supply of Percocet prescribed and Percocet not limited to breakthrough pain.	27-32

Date	Relevant Medication	Dosages (no refills unless otherwise designated)	Comments	St. Ex. 10 Cite
4/12/06 5/11/06	OxyContin Percocet Xanax Soma	80 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day, #120 1 mg, 1 tablet twice a day, #60 350 mg, 1 tablet three times a day, #90	New diagnosis of radiculopathy added 4/12/06. ²⁸	24, 25
6/8/06	OxyContin Percocet Xanax Soma	80 mg, 1-2 tablets twice a day, #100 5/325 mg, 1 tablet four times a day, #120 1 mg, 1 tablet twice a day, #60 350 mg, 1 tablet three times a day, #90	OxyContin dosage increased.	23
7/12/06 8/8/06 9/11/06	OxyContin Percocet Xanax Soma	80 mg, 1-2 tablets twice a day, #100 5/325 mg, 1 tablet four times a day, #150 1 mg, 1 tablet twice a day, #60 350 mg, 1 tablet three times a day, #90	37.5-day supply of Percocet prescribed on each date.	20-22
10/11/06	OxyContin Percocet Xanax Soma	80 mg, 1-2 tablets twice a day, #100 5/325 mg, 1 tablet four times a day, #175 1 mg, 1 tablet twice a day, #60 350 mg, 1 tablet three times a day, #90	43.75-day supply of Percocet prescribed.	19
11/9/06 12/7/06	OxyContin Percocet Xanax Soma	80 mg, 1-2 tablets twice a day, #100 7.5/500 mg, 1 tablet six times a day, #150 1 mg, 1 tablet twice a day, #60 350 mg, 1 tablet three times a day, #90	Percocet dosage more than doubled at November 2006 visit.	18

251. On January 1, 2007, Patient 10 died as the result of “acute intoxication by the combined effects of ethanol, methadone, and cocaine.” A toxicology test revealed multiple drugs, including cocaine and a “toxic to lethal” level of methadone. Trace levels of oxycodone and diazepam (Valium) were detected. The toxicology report does not reflect that alprazolam (Xanax) or carisprodol (Soma) were tested. (St. Ex. 10A at 1, 3, 8-10)

Opinion of Dr. Kelly

252. Dr. Kelly stated the following about Dr. Villavicencio’s documentation in Patient 10’s medical record:

- The initial history, examination, diagnosis and treatment plan were not documented adequately. Dr. Kelly pointed out that the first office visit does not clearly indicate the symptoms, pattern of symptoms, and severity of symptoms. He added that the physical examination was fairly incomplete relative to the patient’s back because there was no range of motion, flexibility, extension, and no straight-leg raise tests. (St. Ex. 18 at 45; Tr. at 643-644)
- The subjective sections of the office visits in September and October 2005 are identical. (St. Ex. 18 at 42)
- The objective data recorded in June through October 2006 is identical, except for the vital signs, even though Patient 10 presented new complaints of dental pain and productive cough. (St. Ex. 18 at 44; Tr. at 651)

²⁸Although he did not diagnose radiculopathy until April 2006, Dr. Villavicencio had noted pain going down one of Patient 10’s legs in January, February, and March 2006. (St. Ex. 10 at 27-29)

253. Dr. Kelly also criticized Dr. Villavicencio's prescribing to Patient 10, stating the following:

- The first prescription of oxycodone issued to Patient 10 was a very high dose without a specific history to justify the dosage. (Tr. at 642, 644, 1044, 1050, 1063)
- The "temporary" increase in OxyContin issued in September 2005 continued without interruption for more than a year afterward, and the breakthrough medication (Percocet) was also increased, even though Patient 10 never saw a pain specialist per Dr. Villavicencio's referral. Moreover, Dr. Kelly stated that the increases were not justified. (St. Ex. 18 at 43; Tr. at 645, 1055, 1064)
- Long-acting oxycodone was increased from 120 mg to 240 mg per day in September 2005 without justification.²⁹ The progress notes reflect that Patient 10 said he was doing okay, but needed an extra pill of OxyContin. Dr. Kelly acknowledged that the pain levels decreased with the increases in pain medication. However, he added that the pain levels "creep back up" afterward. (St. Ex. 18 at 43; Tr. at 1077-1079)
- The number of Percocet tablets prescribed increased from 120 to 175 between June and October 2006 without justification. Dr. Kelly found no significant changes warranted the increase. (St. Ex. 18 at 43-44; Tr. at 649-650)
- Chronic opiate prescriptions were continued without interruption despite evidence of controlled substance prescribing by other physicians. Dr. Kelly stated that Dr. Villavicencio was required to address the issue with the patient and there is no documentation of that occurring after the July 2006 pharmacy report.³⁰ Also, Dr. Kelly opined that a referral to an addiction-ologist or cessation/tapering of controlled substance prescribing was warranted. (St. Ex. 18 at 45; Tr. at 646, 649, 1087-1088)

254. Dr. Kelly concluded that the primary focus of Dr. Villavicencio's treatment of Patient 10 was chronic pain, and that the medication doses included 300 mg of oxycodone each day. He opined that the documentation did not support the initial treatment dosages, the eventual doses of pain medication or the increases in opiate medications. Additionally, Dr. Kelly noted that sections of the chart notes, including reviews of systems and physical examinations, were identical to prior visits and were identical to the same sections in other patients' records. (St. Ex. 18 at 45; Tr. at 1084-1085, 1387-1388)

²⁹Dr. Kelly stated that the increase to 240 mg per day occurred in April 2006, but the chart documents that the increase occurred in September 2005, when Dr. Villavicencio prescribed OxyContin, 40 mg, one to two tablets, three times a day. (St. Ex. 10 at 36; St. Ex. 18 at 43) It is also noted that, later in 2006, Patient 10's doses of OxyContin exceeded 300 mg per day, based on the number of pills being prescribed for a 30-day period. (St. Ex. 18 at 44)

³⁰Dr. Kelly also pointed out that, in December 2005, when Patient 10 was also confronted with allegations of multiple providers, Dr. Villavicencio did not document how that information was received or how that allegation was raised. (Tr. at 1388-1389)

255. Dr. Kelly also concluded that Dr. Villavicencio's care of Patient 10 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances. Finally, he stated that Dr. Villavicencio's controlled substance prescribing and the documentation of his care of Patient 10 constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 41)

Opinion of Dr. Villavicencio

256. Dr. Villavicencio testified that the prescriptions of OxyContin, Percocet, and Xanax issued to Patient 10 at his first office visit were based on the reported past medical history. Dr. Villavicencio further stated that the December 2004 MRI report was brought to the second office visit. (Tr. at 275-277)
257. Dr. Villavicencio explained that he decided to prescribe Xanax at Patient 10's first office visit because Patient 10 was under stress that had caused panic attacks and/or sleeping problems. Dr. Villavicencio admitted that he did not document those details in his office notes. (Tr. at 278-279)
258. Dr. Villavicencio acknowledged that the "temporary" increase in the dosage of OxyContin in September 2005 remained for the duration of his treatment of Patient 10, an additional 14 months. (Tr. at 283-284)
259. Dr. Villavicencio stated that he did not identify, in December 2005, the source of the information about Patient 10 obtaining prescriptions from multiple providers and that he should have documented that information. Dr. Villavicencio did not know if he counseled Patient 10 at that time. He acknowledged that he did not order a drug screen, order a pill count, or reduce the medication. (Tr. at 285-288)
260. Dr. Villavicencio stated that, although he prescribed one hundred twenty 40 mg tablets of OxyContin from September 2005 to March 2006 with instructions to take one to two tablets three times a day, Patient 10 was "really supposed to take only two tablets twice a day." He further explained in the following exchange:

Q. Well, this one says three times a day.

A. Yes. That was a – but – but in – in the reality, when we have patients on 120 of OxyContin, they're meant to take it one – I mean, two tablets twice a day. It's supposed to be a b.i.d. dosing medication for the most part.

Q. B.i.d. is three times a day – or, no – twice a day.

A. Twice a day. So when we – when we do the 120, usually the – the patients are told to take it two twice a day.

(Tr. at 289-290)

261. Dr. Villavicencio testified that he did not discuss the July 2006 prescription list with Patient 10 because Dr. Villavicencio had “reason to believe that the patient was actually being undertreated” or because the patient “may not have understood” the rules. He added that Patient 10 was “pretty compliant.” He also stated that he did not alter his prescriptions because of July 2006 prescription list. (Tr. at 295, 297-298)
262. Dr. Villavicencio agreed that he did not obtain a confirmation of the August 2006 urine test, which was positive for cocaine. He explained that Patient 10 was a compliant patient – Patient 10 did not show up early, did not file any missing medication reports, and attempted to see a neurosurgeon. (Tr. at 304, 308) When it was pointed out that, on two occasions, Dr. Villavicencio had information that Patient 10 was receiving drugs from other sources at the time Dr. Villavicencio was treating him, Dr. Villavicencio testified as follows:

I would consider this an aberrant behavior. But as I said, in this gentleman, my interpretation of that was he was not getting enough pain relief from the medications that we were giving him. And – And that – And that’s actually a very common reason why patients used to be seeing multiple providers, because they – they are not able to get enough pain relief from one physician.

(Tr. at 305)

263. Dr. Villavicencio acknowledged that, when he increased the Percocet dosage in November 2006, he did not include document his analysis in determining that Patient 10’s pain had increased. (Tr. at 299)

Patient 11

(Medical record reflects treatment between March 2005 and March 2007, 24 months)

264. Patient 11 is a female born in 1981. Patient 11 was treated for pain before she saw Dr. Villavicencio. She saw a pain specialist in 2004, and his report included the following information:
- Injured back in August 2002 while pulling/lifting a table on wheels.
 - Pain was described as “throbbing, shooting, stabbing, sharp, cramping, gnawing, burning, aching, heavy, tender, splitting as well as exhausting, sickening, and cruel.”
 - Pain was located in the “lower back area with bilateral legs anterior and posterior.”
 - Pain is 6/10 with medications and 9/10 without medications.
 - Current medications were MS Contin, 200 mg three times a day, and Tylenol PM, two a day.
 - “Though she has a BWC claim she does not intend to use the medical coverage to get the care she needs to get better. * * * [S]he will not be able to get the procedures performed that I have recommended to her. * * *

Frankly, I see absolutely no reason, given the above circumstances, why she should not work a 40 hour workweek.”

(St. Ex. 11 at 26-28)

265. Patient 11 first saw Dr. Villavicencio on March 2, 2005, when she was 23 years old. She reported that, among other things, she had back trouble, pain in both legs, depression and seizures. She also reported that she was currently taking Zoloft, methadone, Soma, Percocet, propranolol,³¹ trazadone, ibuprofen, and Tylenol PM. Dr. Villavicencio diagnosed a lumbar sprain, hyperlipidemia, and a benign essential tremor. He prescribed, among other things, Percocet, Zoloft, Soma, Motrin, Inderal and trazadone. He ordered an MRI. (St. Ex. 11 at 62, 126)
266. In early April 2005, Patient 11 reported a reaction to the Percocet. Also, Dr. Villavicencio documented that his office had received notes from another pain clinic related to Patient 11, and those notes indicated that Patient 11 was “not to be on anything stronger than a [V]icodin.”³² At that time, Dr. Villavicencio diagnosed hyperlipidemia, lumbar sprain and fibromyalgia. He prescribed Vicodin for Patient 11. (St. Ex. 11 at 124)
267. Patient 11 obtained an MRI in April 2005, the results of which state “Near normal MRI of the lumbar spine with very nominal protrusion at L5-S1, disc desiccation and mild facet inflammation.” (St. Ex. 11 at 21-22, 127-128)
268. In mid-April 2005, Dr. Villavicencio noted that Patient 11 was upset about the MRI results and found it hard to believe that she has fibromyalgia. He prescribed OxyContin and Percocet at that time. (St. Ex. 11 at 123)
269. In late-April 2005, Patient 11 reported that the OxyContin had helped her. She also stated that she “thinks that a stronger medication is necessary.” Dr. Villavicencio also documented that Patient 11 previously had taken “as much as 200 of oxycontin” and that she was reminded of the “suggestion” of the former pain clinic (namely, that Patient 11 was not to be on any medication stronger than Vicodin). Dr. Villavicencio prescribed Sinequan³³ and

³¹Propranolol (generic of Inderal) is a beta blocker used to treat hypertension, abnormal heart rhythms, certain types of tremors, and migraines. (U.S. National Library of Medicine, *PubMed Health*, <http://www.ncbi.nlm.nih.gov/pubmedhealth>, accessed June 22, 2012).

³²The pain clinic physician saw Patient 11 in March 2005, after a referral from Patient 11’s prior physician. The pain clinic physician diagnosed fibromyalgia, and documented his philosophy of avoiding narcotics for the treatment of fibromyalgia, stating “I personally, therefore, have avoided getting on the dose escalation train in caring for most fibromyalgics. The narcotics that I do prescribe for fibromyalgics, I try to prescribe in relatively low doses, medications like Vicodin, and I try to prescribe for the worst two to three days of the week.” That physician further documented that his office would not prescribe medications, but would forward the evaluation report to Patient 11’s physician. (St. Ex. 11 at 7, 29-32)

³³Sinequan is a tricyclic antidepressant. (U.S. National Library of Medicine, *PubMed Health*, <http://www.ncbi.nlm.nih.gov/pubmedhealth>, accessed June 22, 2012).

OxyContin 40 mg, 1-2 tablets three times a day, #120. This OxyContin prescription is a 120-240 mg dose of oxycodone per day. Also, it is a 20- to 40-day supply of OxyContin. At that same time, Dr. Villavicencio instructed Patient 11 to return in two to three days, which she did. (St. Ex. 11 at 121-122)

270. At the end of April 2005, Dr. Villavicencio included the following in his progress note:

Patient on her last day of Medicaid. Patient claims that [t]he 80 mg of oxycontin is not doing her any good. Suspect attempt to hoard supplies for the next month, but can[’t] really prove it or confront patient. Patient told that this is the last time that we are going to do this for her.

(St. Ex. 11 at 121) On that day, Dr. Villavicencio prescribed OxyContin 40 mg, 3 tablets four times a day for 10 days, #120. In early May 2005, after a pharmacist stated that “12 tabs of oxy a day is a ‘red flag,’” Dr. Villavicencio noted the following: “Correction 60 tabs for next 10 days.” (St. Ex. 11 at 7, 121)

271. Patient 11 executed a pain management contract in April and June 2005. (St. Ex. 11 at 50, 68)

272. In June 2005, Dr. Villavicencio diagnosed low back pain. He switched from OxyContin to Avinza. However, Patient 11 complained of a side effect, and Dr. Villavicencio switched Patient 11 to MS Contin. (St. Ex. 11 at 116, 117)

273. In July 2005, Patient 11 reported her level of pain as “7-7.5.” (St. Ex. 11 at 6)

274. In September 2005, Patient 11 stated that her pain level was “8” and that the MS Contin was not working. Dr. Villavicencio prescribed Neurontin, Soma and Ambien. He also prescribed Kadian, but Patient 11 stated that it did not work and he switched her back to MS Contin. Also, in September 2005, Dr. Villavicencio referred Patient 11 to physical therapy and a pain management specialist, and ordered an MRI and a nerve conduction study. Patient 11 failed to appear for the physical therapy appointment. Patient 11 obtained the MRI, which indicated minimal lumbar spondylosis, as well as “a shallow broad-based central L5-S1 disk protrusion currently, however, without evidence of spinal compromise or nerve root impingement.” (St. Ex. 11 at 5, 33-34, 107-109)

275. In early October 2005, Patient 11 claimed that she was “running short” of MS Contin and her level of pain was “10.” Dr. Villavicencio conducted a urine drug screen and again referred Patient 11 to a pain management specialist. He prescribed MS Contin as well. (St. Ex. 11 at 6, 53, 105, 106)

276. The October 2005 urine sample was positive for morphine, opiate metabolites, and carisoprodol (Soma). (St. Ex. 11 at 54)

277. Patient 11 saw a pain management physician for consultation in December 2005. His impression was that Patient 11 had lumbar radiculopathy, sacroiliitis, lumbar spondylosis, and myofascial pain syndrome. The pain management specialist recommended epidural steroid injections, Zanaflex and Lidoderm patches. He instructed Patient 11 to continue the MS Contin, Neurontin, and ibuprofen. However, he also stated that the dose of narcotics is high and he did not feel comfortable prescribing 600 mg of morphine per day and that a decrease in the opioid usage should be considered with the injections. (St. Ex. 11 at 19-20)
278. In late 2005 or early January 2006, all of Patient 11's teeth were removed. She asked Dr. Villavicencio to increase her pain medications at multiple visits because of the dental work. (St. Ex. 11 at 101, 102)
279. In late January 2006, Patient 11 reported that she was seeing a back specialist. Moreover, she reported her pain as "9" and "insisted" on increasing the MS Contin. Dr. Villavicencio documented that the patient was told that "we have to taper to 5 to 4 to 3 etc." (St. Ex. 11 at 5, 101)
280. In March 2006, Dr. Villavicencio diagnosed radiculopathy. Patient 11 agreed to see a physical therapist and a pain specialist. Dr. Villavicencio referred her to both. In May 2006, he referred Patient 11 to the pain management specialist she had seen prior to initiating treatment with Dr. Villavicencio, and then in June he again referred Patient 11 to a physical therapist and a pain specialist. (St. Ex. 11 at 25, 96, 97, 99)
281. In July 2006, Patient 11 reported her level of pain as "10." However, Dr. Villavicencio documented that Patient 11 believed she would be better with a lower dose of medication ("60 of the oxy TID"). Dr. Villavicencio decreased the dosage of MS Contin accordingly.³⁴ He added Klonopin as well. Also, he documented that he would conduct a pill count in one week and a drug screen in one month. (St. Ex. 11 at 4, 95)
282. In late July 2006, Patient 11 saw the pain management specialist that she had seen in December 2005. He ordered that epidural steroid injections be scheduled. Patient 11 also saw him again in November 2006. It does not appear from the reports of those visits and the rest of the medical record that Patient 11 received the injections. (St. Ex. 11 at 15-18)
283. A drug screen was done in August 2006. The notation reflects simply that Patient 11 "passed" the drug screen. In August 2006, after Dr. Villavicencio had decreased the MS Contin prescription, Patient 11 reported seizures and a level of pain of "10." Dr. Villavicencio ordered an MRI and increased the MS Contin dosage. (St. Ex. 11 at 4, 94)
284. In early September 2006, Patient 11 reported that her pain was "8" and she had consumed all of the MS Contin and Klonopin prescriptions issued three weeks earlier. Dr. Villavicencio informed Patient 11 that he was trying to taper off the medications and that she had put

³⁴Although Dr. Villavicencio's progress note refers to "oxy," he was prescribing MS Contin, long-acting morphine, and decreased the dosage of the MS Contin. (St. Ex. 11 at 95)

herself “in the same category as before the taper.” Dr. Villavicencio prescribed MS Contin and Klonopin at the same dosage levels as before. (St. Ex. 11 at 93)

285. Approximately three weeks later, Patient 11 saw Dr. Villavicencio again. She reported that her pain was an “8” and she claimed that she had been given only 120 tablets of the 180 tablets of MS Contin 80 mg previously prescribed. She also stated that she wanted a referral to another pain management physician. Dr. Villavicencio prescribed OxyContin and referred her to a pain management practice for nerve blocks. At Patient 11’s mid-October 2006 office visit, Patient 11 reported a pain level of “7.” An in-office urine screen was positive for opiates. Dr. Villavicencio increased the pain medication, informing Patient 11 that the OxyContin prescription issued that day (80 mg, 2 tablets twice a day, #120 [320 mg/day]) would be “the last increase” until she saw the pain management specialist. (St. Ex. 11 at 4, 24, 90, 91; Tr. at 78)
286. In November 2006, Patient 11 returned to Dr. Villavicencio. She reported that her insurance would cover up to 120 tablets of OxyContin. Dr. Villavicencio documented that Patient 11 would be given OxyContin 40 mg, 2 tablets three times a day, #80, which is 240 mg/day. Despite noting in mid-October 2006 that there would be no further medication increases until Patient 11 saw a pain management specialist, Dr. Villavicencio increased the OxyContin dosage in mid-November 2006 to 80 mg, two tablets twice a day, #120, which is 320 mg mg/day. (St. Ex. 11 at 88, 89)
287. In December 2006 and January 2007, Dr. Villavicencio switched Patient 11’s medications from OxyContin to methadone, and then switched back to OxyContin after he learned that Patient 11 was pregnant. He also attempted to taper the pain medications. Patient 11 reported having seizures. (St. Ex. 11 at 84-88)
288. At the end of January 2007, Patient 11 saw Dr. Villavicencio. He documented that she was “frantic” because she was going to lose her insurance and she needed her medications. Dr. Villavicencio issued early prescriptions for OxyContin and Roxicodone at that time. He also issued an early refill for Roxicodone in mid-February 2007 after Patient 11 reported her pain level as “9.” (St. Ex. 11 at 2, 79, 80)
289. On February 23, 2007, Patient 11 reported that her level of pain was still “9.” She further reported that she was taking the Roxicodone, she believed she was having withdrawal symptoms and she had had seizures. Dr. Villavicencio noted that her last dose of OxyContin was two weeks earlier. Dr. Villavicencio documented that Patient 11 was nauseated and achy. Dr. Villavicencio prescribed OxyContin and Roxicodone. (St. Ex. 11 at 2, 78)
290. On February 28, 2007, Patient 11 reported that it was the last day of her insurance, and she had a seizure. Dr. Villavicencio prescribed Roxicodone. (St. Ex. 11 at 2, 77)
291. In March 2007, a urine drug screen was conducted, which was positive for methadone but negative for oxycodone. At that time, Dr. Villavicencio had not prescribed methadone to Patient 11, but had been prescribed Roxicodone. (St. Ex. 11 at 2, 8-10; Tr. at 327-328)

292. Dr. Villavicencio's office attempted to reach Patient 11 for a pill count in March, but was not successful. At the end of March 2007, Patient 11 reported a level of pain of "10." She also claimed that she had been given only two weeks of medication at her prior visit. With regard to the March urine screen, she stated that she had not taken her medication at the time because she had nausea and vomiting. She denied any knowledge of the methadone. Dr. Villavicencio discharged Patient 11 at the end of March 2007, but issued final prescriptions for Roxicodone and Percocet. His progress note on March 28, 2007, stated in the subjective portion: "[p]atient is beind [sic] discharged from the practice and will be tapered off for the final time" and stated in the treatment section "discharge from clinic." (St. Ex. 11 at 1-2, 75)

293. Dr. Villavicencio prescribed the following medications to Patient 11 between March 2005 and March 2007:

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 11 Cite
3/2/05	Percocet Soma Motrin Zoloft Trazadone	10/650 mg, 1 tablet four times a day, #120 350 mg, 1 tablet four times a day, #30 600 mg, 1 tablet four times a day, #120 100 mg, 1 tablet each morning, #30 50 mg, 1 tablet at bedtime, #30	7.5-day supply of Soma prescribed.	126
3/30/05	Percocet Soma Motrin Zoloft Trazadone	5/325 mg, 1 tablet four times a day, #180 350 mg, 1 tablet four times a day, #90 600 mg, 1 tablet four times a day, #120 100 mg, 1 tablet each morning, #30 50 mg, 1 tablet at bedtime, #30	45-day supply of Percocet prescribed. 22.5-day supply of Soma prescribed. Dosage of Percocet changed because of cost.	125
4/8/05	Vicoden	10 mg, 1 tablet four times a day, #120	Vicodin prescribed after patient had a reaction to Percocet.	124
4/13/05	Percocet OxyContin Motrin Trazadone	5/325 mg, 1 tablet four times a day, #180 20 mg, 1 tablet twice a day, #40 600 mg, 1 tablet four times a day, #120 50 mg, 1 tablet at bedtime, #30	45-day supply of Percocet prescribed. 20-day supply of OxyContin prescribed.	123
4/26/05	OxyContin Sinequan	40 mg, 1-2 tablets three times a day, #120 25 mg, 1 tablet at bedtime, #7	20- to 40-day supply of OxyContin prescribed. 7-day supply of Sinequan prescribed.	122
4/28/05	OxyContin Sinequan	40 mg, 3 tablets four times a day, #120 25 mg, 1 tablet at bedtime, #7	OxyContin dosage increased. After a pharmacist stated that "12 tabs of oxy a day is a 'red flag,'" OxyContin prescription was corrected 5/4/05: "60 tabs for next 10 days."	7, 121
5/20/05	OxyContin Trazadone	40 mg, 1 tablet three times a day, #30 100 mg, 1 tablet at bedtime, #10	OxyContin dosage decreased. 10-day supply of OxyContin prescribed.	120
5/23/05	Percocet Zoloft Neurontin	5/325 mg, 1 tablet, four times a day, #60 100 mg, 1 tablet twice a day, #60 100 mg, 1 tablet at bedtime, #30	Percocet prescribed when insurer refused to cover OxyContin. 15-day supply of Percocet.	119
6/6/05	OxyContin Trazadone	40 mg, 1 tablet three times a day, #30 100 mg, 1 tablet at bedtime, #10, 5 refills	10-day supply of OxyContin prescribed.	118
6/22/05	Avinza Neurontin	90 [mg], 1 tablet each day, #30 100 mg, 1 tablet at bedtime, #30		117

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 11 Cite
6/30/05	MS Contin	30 mg, 1 tablet twice a day, #60		116
7/6/05	Neurontin Zoloft	100 mg, 1 tablet at bedtime, #30, 5 refills 100 mg, 1 tablet twice a day, #60, 5 refills		115
7/11/05	MS Contin Neurontin Zoloft Trazadone	60 mg, 1 tablet twice a day, #60 300 mg, 1 tablet at bedtime, #30, 5 refills 50 mg, 1-2 tablets twice a day, #60, 5 refills 100 mg, 1 tablet at bedtime, #10, 5 refills	MS Contin dosage doubled. Neurontin dosage tripled.	114
7/12/05	Soma	350 mg, 1 tablet four times a day, #90, 5 refills	22.5-day supply of Soma prescribed, plus refills.	113
7/27/05	MS Contin Cymbalta	60 mg, 1 tablet twice a day, #60 60 mg, 1 tablet each day, #30		112
8/1/05	MS Contin	60 mg, 1 tablet three times a day, #90	Early refill of MS Contin (prior prescription issued 4 days earlier) and dosage increased.	111
8/24/05	MS Contin Cymbalta Motrin	100 mg, 1 tablet twice a day, #60 60 mg, 1 tablet each day, #30 600 mg, 1 tablet four times a day, #28	Early refill of MS Contin and dosage decreased. 7-day supply of Motrin prescribed.	110
9/12/05	Neurontin Soma Ambien	300 mg, 1 tablet at bedtime, #30 350 mg, 1 tablet four times a day, #120 10 mg, 1 tablet at bedtime, #30		109
9/19/05	Kadian Neurontin Ambien	50 mg, 1 tablet each day, #30 300 mg, 1 tablet at bedtime, #30 10 mg, 1 tablet at bedtime, #30		108
9/21/05	MS Contin Motrin	100 mg, 1 tablet twice a day, #60 600 mg, 1 tablet four times a day, #120, 5 refills	Patient returned Kadian because it "did not work"	107
10/5/05	MS Contin	100 mg, 1 tablet three times a day, #90	Early refill and dosage increased.	106
10/19/05	Soma Motrin Ambien	350 mg, 1 tablet four times a day, #30 600 mg, 1 tablet four times a day, #28 5mg, 1 tablet at bedtime, #10	7.5-day supply of Soma prescribed. 7-day supply of Motrin prescribed. 10-day supply of Ambien prescribed.	105
10/31/05	MS Contin Soma	100 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120	Early refill of MS Contin.	104
11/30/05	MS Contin Soma Klonopin	100 mg, 1-2 tablets three times a day, #110 350 mg, 1 tablet four times a day, #120 1 mg, 1 tablet three times a day, #90, 5 refills	MS Contin dosage increased. 18.3- to 36.6-day supply of MS Contin prescribed. 6-month supply of Klonopin prescribed.	103
1/3/06	MS Contin Soma Klonopin	100 mg, 1-2 tablets three times a day, #150 350 mg, 1 tablet four times a day, #120 1 mg, 1 tablet three times a day, #90, 5 refills	25- to 50-day supply of MS Contin prescribed. Patient asked to have pain medications increased due to dental work. Dosage not increased, but number of MS Contin pills increased. 6-month supply of Klonopin prescribed.	102
1/23/06	MS Contin Soma Klonopin Zoloft	200 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120 1 mg, 1 tablet three times a day, #90, 5 refills 100 mg, 1 tablet each morning, #30, 5 refills	6-month supply of Klonopin prescribed.	101
2/21/06	MS Contin Soma	200 mg, 1 tablet twice a day, #60 350 mg, 1 tablet four times a day, #120	MS Contin dosage decreased.	100

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 11 Cite
3/21/06 4/20/06 5/18/06	MS Contin Soma Cymbalta	200 mg, 1 tablet twice a day, #60 350 mg, 1 tablet four times a day, #120 60 mg, 1 tablet each day, #30		97-99
6/15/06	MS Contin Soma Cymbalta Sonata ³⁵ Motrin	200 mg, 1 tablet twice a day, #60 ³⁶ 350 mg, 1 tablet four times a day, #120 60 mg, 1 tablet each day, #30 10 mg, 1 tablet at bedtime, #30 600 mg, 1 tablet four times a day, #28		96
7/14/06	MS Contin Soma Cymbalta Sonata Motrin Klonopin	60 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120 60 mg, 1 tablet each day, #30 10 mg, 1 tablet at bedtime, #30 600 mg, 1 tablet four times a day, #28 1 mg, 1 tablet three times a day, #90	MS Contin dosage decreased.	95
8/15/06	MS Contin Soma Motrin Klonopin	100 mg, 1-2 tablets three times a day, #120 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120 1 mg, 1-2 tablets three times a day, #120	MS Contin dosage increased after patient reported seizures.	94
9/5/06	MS Contin Klonopin	100 mg, 1-2 tablets three times a day, #75 1 mg, 1-2 tablets three times a day, #75	Patient returned early after consuming all the MS Contin and Klonopin prescribed on 8/15/06. 25- to 12.5-day of both prescribed.	93
9/19/06	MS Contin Soma Motrin Klonopin Neurontin Restoril	100 mg, 1-2 tablets three times a day, #180 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #120 1 mg, 1-2 tablets three times a day, #120 300 mg, 1 tablet three times a day, #90 30 mg, 1 tablet at bedtime as needed, #30		92
10/9/06	OxyContin	80 mg, 1 tablet twice a day, #40	20-day supply of OxyContin	91
10/16/06	OxyContin Soma Klonopin Neurontin Restoril Zoloft	80 mg, 2 tablets twice a day, #120 350 mg, 1 tablet four times a day, #120 1 mg, 1 tablet three times a day, #90 600 mg, 1 tablet at bedtime, #30, 5 refills 30 mg, 1 tablet at bedtime as needed, #20 100 mg, 1 tablet each morning, #30, 5 refills	Klonopin and Neurontin dosages decreased. Soma, Klonopin, Neurontin and Restoril filled early.	90
11/2/06	OxyContin	40 mg, 2 tablets three times a day, #80	13.3-day supply of OxyContin	89
11/16/06	OxyContin Soma Klonopin Dilaudid	80 mg, 2 tablets twice a day, #120 350 mg, 1 tablet four times a day, #120 1 mg, 1 tablet four times a day, #120 2mg, 1 tablet three times a day for break-through pain, #60		88
12/4/12	methadone	10 mg, 2 tablets four times a day, #120		87

³⁵Sonata is a sedative used to treat insomnia. (U.S. National Library of Medicine, *PubMed Health*, <http://www.ncbi.nlm.nih.gov/pubmedhealth>, accessed June 22, 2012).

³⁶On the June 15, 2006 progress note, Dr. Villavicencio crossed through part of this MS Contin prescription and wrote in "60 - TID." However, this handwritten notation does not appear to be a modification of the June 2006 prescription for MS Contin; rather, it appears to be a notation as to the prescription to issue in July 2006 because it is consistent with what Patient 11 asked to receive at her next office visit. (St. Ex. 11 at 95, 96)

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 11 Cite
12/14/06	methadone Dilaudid Soma Klonopin	10 mg, 4 tablets three times a day, #270 2mg, 1 tablet three times a day before dressing changes, #90 350 mg, 1 tablet four times a day, #120 1 mg, 1 tablet four times a day, #120	Methadone dosage increased.	86
12/27/06	OxyContin	40 mg, 2 tablets twice a day, #120	"Patient is to be tapered off the methadone and started on the oxycontin."	85
1/6/07 1/8/07	OxyContin	80 mg, 1 tablet twice a day, #30	Patient was not able to fill 1/6/07 prescription for lack of preauthor.	83, 84
1/11/07	Roxicodone	30 mg, 2 tablets four times a day for breakthrough pain, #120	Patient claimed that the pharmacy would not fill the OxyContin.	82
1/24/07	OxyContin Roxicodone	80 mg, 1 tablet three times a day, #45 30 mg, 2 tablets four times a day for breakthrough pain, #120	OxyContin dosage increased. 15-day supply of OxyContin prescribed.	81
1/31/07	OxyContin Roxicodone	40 mg, 2 tablets in the am, pm and evening, #45 15 mg, 1-2 tablets, six times a day for breakthrough pain, #240	Early refills of OxyContin and Roxicodone. 7.5-day supply of OxyContin prescribed. 20- to 40-day supply of Roxicodone prescribed.	80
2/12/07	Roxicodone	30 mg, 1 tablet three times a day, #90	Early refill of Roxicodone.	79
2/23/07	OxyContin Roxicodone	40 mg, 1 tablet three times a day, #90 30 mg, 1 tablet three times a day for breakthrough pain, #60	Early refill of Roxicodone.	78
2/28/07	Roxicodone	30 mg, 1 tablet four times a day for breakthrough pain, #60	Early refill of Roxicodone. Dosage increased.	77
3/13/07	Roxicodone	30 mg, 1 tablet four times a day for breakthrough pain, #40	Early refill of Roxicodone. 15-day supply of Roxicodone prescribed.	76
3/28/07	Roxicodone Percocet	15 mg, 1 tablet four times a day for breakthrough pain, #28 5/325 mg, 2 tablets four times a day for one week, 1 tablet four times a day for one week, 1 tablet three times a day for one week and 1 tablet twice a day for one week, #135		75

Opinion of Dr. Kelly

294. With regard to Patient 11's first office visit, Dr. Kelly stated:

- There was no history of the doses of the patient's previous controlled substances. (St. Ex. 18 at 46)
- The initial history, examination, diagnosis and treatment plan were not documented adequately. Dr. Kelly added that there was no documentation of an examination of the diagnosed tremor. Dr. Kelly acknowledged that there was sufficient information in Patient 11's chart to substantiate the prescriptions for Zoloft and trazadone that Dr. Villavicencio issued at her first visit. (St. Ex. 18 at 49; Tr. at 652-656)

295. Dr. Kelly had several criticisms of the prescriptions that Dr. Villavicencio issued to Patient 11:

- Dr. Kelly stated that, based on the reports from a prior pain management specialist and a prior pain clinic, it should have been clear to Dr. Villavicencio that Patient 11 did not respond to even very high doses of narcotic medications. (St. Ex. 18 at 47)
- Early refills of Percocet were provided in mid-April 2005. (St. Ex. 18 at 46)
- Also in mid-April 2005, a 20-day supply of OxyContin was consumed in 14 days and yet Dr. Villavicencio prescribed OxyContin again and increased the dosage. (St. Ex. 18 at 47; Tr. at 661-664)
- In April 2005, Dr. Villavicencio prescribed Percocet to Patient 11 after she reportedly had had an allergic reaction to it and after he had switched for one month to Vicodin. Dr. Kelly stated that an explanation for prescribing the Percocet at the later date should have been included in the medical record. (Tr. at 659-660)
- Between October 2005 and May 2006, morphine doses were increased from 200 mg per day to 300 mg per day, to 600 mg per day, and then reduced to 400 mg per day. Dr. Kelly stated that no clear rationales were documented for any of those changes. (St. Ex. 18 at 48)
- Between June and October 2006, the MS Contin dose decreased to 180 mg per day, then increased to 400 mg per day and increased again to 600 mg per day without adequate rationales. (St. Ex. 18 at 49; Tr. at 666)
- In December 2006, the patient was switched to methadone at 80 mg per day and rapidly escalated to 120 mg per day without adequate rationale. Dr. Kelly testified that the levels of methadone are “kind of heroin addict maintenance levels of methadone.” (St. Ex. 18 at 49; Tr. at 669)
- In January 2007, Dr. Villavicencio saw Patient 11 five times. He prescribed OxyContin 80 mg #30 (twice), OxyContin 40 mg #45 (twice), Roxicodone 30 mg #120 (twice) and Roxicodone 15 mg #240. (St. Ex. 18 at 50)

296. Dr. Kelly concluded that the primary focus of Dr. Villavicencio’s treatment of Patient 11 was chronic pain, and that medication doses included 240 mg of oxycodone, 600 mg of morphine, and 120 mg of methadone each day. He stated that there were many changes in doses and medications without documented rationales. He opined that the documentation did not support the initial choice of treatment, the frequent dose escalations, or change in medications. Also, he stated that the recommendations of the pain management specialist were not followed. Additionally, Dr. Kelly noted that sections of the chart notes, including reviews of systems and physical examinations, were identical to prior visits and were identical to the same sections in other patients’ records. (St. Ex. 18 at 50-51; Tr. at 672-673, 1391-1392)

297. Dr. Kelly also concluded that Dr. Villavicencio’s care of Patient 11 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances. Also, he stated that Dr. Villavicencio’s controlled substance prescribing and the documentation of his care of Patient 11 constituted a failure to conform to the minimal

standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 51)

Opinion of Dr. Villavicencio

298. Dr. Villavicencio agreed that Patient 11's April 2005 MRI was basically "normal." Later, Dr. Villavicencio testified that the April 2005 MRI indicated a mild back condition. He explained that a former physician had prescribed high doses of narcotics, and Patient 11 was complaining of pain and had problems sleeping due to her pain. For those reasons, he increased the dosage of pain medications in April 2005. (Tr. at 310, 317, 1697-1698) Dr. Villavicencio further explained as follows:

[S]he basically went down in her medication because of nonmedical reasons. I think that after the pain specialist has exhausted all the – that BWC would allow in terms of expensive injections and maneuvers, I think that she found herself being kicked to the curb and being tapered at that.

So that was my take on this, because I find it disingenuous for this pain management specialist to charge BWC \$1,200 to \$3,000 for the procedures, and the minute they exhausted that and that they cannot – not get any more money from BWC, they will say that the patient is not responding to treatment and they will discharge the patient out there. So I find that disingenuous.

(Tr. at 317-318) Dr. Villavicencio agreed that he should have documented more in mid-April 2005 to explain why he was choosing to prescribe the medications and dosages when the MRI findings were minimal. (Tr. at 1699)

299. Dr. Villavicencio testified that, in June 2005, when he switched from Avinza to MS Contin, he did not have Patient 11 bring back the unused Avinza pills. He added that "[w]e didn't know any better at that time" and that he should have done that. (Tr. at 321)

300. Dr. Villavicencio testified that, in early 2006, Patient 11 had seen a back specialist and that Dr. Villavicencio had been told to continue Patient 11 on 200 mg of MS Contin three times a day. (Tr. at 323)

301. Dr. Villavicencio stated that he switched Patient 11 from OxyContin to MS Contin and then to methadone because the latter two medications were less expensive. (Tr. at 327, 1671, 1672)

302. Dr. Villavicencio acknowledged that Patient 11 was dependent on the opiates that he prescribed. He further stated that she had withdrawal seizures. (Tr. at 329-330)

303. Dr. Villavicencio agreed with the following:

- Dr. Villavicencio began treating Patient 11 on March 2, 2005, for conditions including back pain, lumbar sprain, radiculopathy, hyperlipidemia, and fibromyalgia. (Tr. at 1646)
- Dr. Villavicencio prescribed long-acting and, at times, short-acting opiate medications, as well as other medications. (Tr. at 1646-1647)
- Although Dr. Villavicencio referred Patient 11 to specialists and for physical therapy, Patient 11 failed to comply with all the referrals. Dr. Villavicencio stated that Patient 11 had “a lot” of insurance problems and was not able to afford referrals/consultations. Dr. Villavicencio also stated that Patient 11 had received a number of procedures for her pain prior to her treatment with him and that, while he treated her, she received injections from a specialist and obtained physical therapy. (Tr. at 325-326, 1647)
- When Patient 11 was examined by a specialist, Dr. Villavicencio failed to follow and/or document consideration of the recommendations of the specialist. Dr. Villavicencio stated, “this is what a family practitioner is faced with. They have a patient who appears to be in pain, and when you send them to a pain specialist, there is no concurrence or agreement on how to manage this patient. And that makes it pretty hard on us.” (Tr. at 1648)
- Although Dr. Villavicencio discharged Patient 11 from his practice when a sample of her urine tested positive for a drug that he did not prescribe and negative for a drug that he did prescribe, there is no indication that Dr. Villavicencio sent her a written notice of termination. Dr. Villavicencio testified first that Patient 11 was tapered and discharged from the practice and that he typically provided a termination letter to his patients. He added that, in Patient 11’s case, a termination letter was not sent and it was a deviation from his procedures to not have given her a termination letter. Later, Dr. Villavicencio testified that Patient 11 was discharged from pain management because the patient wanted to be tapered off when she became pregnant, but she was not discharged as a patient. She was able to come back for any other medical care. He acknowledged that Patient 11 never returned to his practice after he stopped the pain management treatment. (Tr. at 327, 330-332, 1649, 1693)
- The chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients’ records from similar time periods. (Tr. at 1579)

304. Dr. Villavicencio disagreed that the medical record lacks documentation to support the use of the controlled and non-controlled medications, or the increases in dosages. Dr. Villavicencio stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical records is taken into consideration (including the intake forms and

his staff's notes), he believes that his medical record is "better documented than * * * the allegations would suggest." (Tr. at 1575-1576)

Patient 12

(Medical record reflects treatment between November 2005 and November 2007, 24 months)

305. Patient 12, a female, was born in 1962. Before seeing Dr. Villavicencio, Patient 12 received treatment for her back and surgeries on her spine. (St. Ex. 12 at 12, 79-87)
306. Patient 12 first saw Dr. Villavicencio on November 2, 2005, when she was 43 years old. She complained of low back pain, neck pain, and foot pain, and reported her level of pain as "10." She told Dr. Villavicencio about her prior prescriptions and reported that she had recently injured her toes. Dr. Villavicencio diagnosed low back pain and neck pain. He prescribed, among other things, Avinza, Depakote, Topamax, Zolof, and Zyprexa. Patient 12 executed a pain management contract at her first visit. (St. Ex. 12 at 10, 17, 78)
307. Patient 12 returned a couple weeks later seeking "more pain meds." She complained of hip and foot pain after falling, stating that her level of pain was "9." Dr. Villavicencio noted some swelling. He diagnosed low back pain, hip pain, and foot pain. He ordered an MRI and an x-ray. He issued prescriptions for Avinza, Topamax, Zanaflex, and Lunesta.³⁷ (St. Ex. 12 at 4, 77)
308. Patient 12 returned in December 2005 stating that the medications were not working. She stated that her foot no longer hurt and that her hip was better but still painful. She requested MS Contin and complained of spasms. Dr. Villavicencio ordered MRIs and prescribed MS Contin, Soma, and Lunesta. (St. Ex. 12 at 75)
309. Patient 12 obtained several MRIs, which indicated the following:
- Left hip: low-grade bursal inflammation.
 - Cervical spine: tri-level posterior spondylotic protrusions, greatest at C5-6 and C6-7.
 - Lumbar spine: L5-S1 laminectomy/laminotomy and shallow spondylotic protrusion effaces the ventral dural sac. L4-5 shallow disc protrusion with annular rent encroachment on the ventral dural sac. Mild spinal stenosis secondary to hypertrophic moderately degenerated facets.
- (St. Ex. 12 at 72-74, 76)
310. In January 2006, Dr. Villavicencio referred Patient 12 to two pain management groups seeking consideration of a morphine pump. He also increased the dosages of the MS Contin and Soma. (St. Ex. 12 at 71)

³⁷Lunesta is used to treat insomnia. (U.S. National Library of Medicine, *PubMed Health*, <http://www.ncbi.nlm.nih.gov/pubmedhealth>, accessed June 25, 2012).

311. Eight days later, Patient 12 returned because of anxiety due to “a lot of stressors at this time.” Dr. Villavicencio prescribed Xanax. (St. Ex. 12 at 70)
312. In March 2006, Dr. Villavicencio documented that Patient 12 wanted to see a particular pain management group, and wanted more frequent doses of MS Contin. Dr. Villavicencio referred her to that group and decreased her daily MS Contin dosage. Patient 12 was refused admission to the pain management group. (St. Ex. 12 at 65, 67)
313. In July 2006, Patient 12 complained of low back pain, new pain in one arm and new pain in her hands. She reported her pain level as a “9.” Dr. Villavicencio prescribed MS Contin, Soma, Symbyax,³⁸ Ambien, and Neurontin. Dr. Villavicencio referred Patient 12 to another pain management specialist. He also ordered a nerve conduction study. (St. Ex. 12 at 3, 62)
314. Patient 12 saw the pain management specialist in September 2006. His report reflects that Patient 12 had two neck surgeries in 2002, and two low back surgeries in 2001 and 2002. He stated that Patient 12’s past medical history included hypertension, COPD, and obstructive sleep apnea. He also stated that Patient 12 was taking, at that time, 480 mg of morphine each day. His clinical impressions were post cervical laminectomy, post lumbar laminectomy, lumbar spondylosis, cervical spondylosis, fibromyalgia and narcotic dependence. He found that, if Patient 12 had had facet injections and radiofrequency, the only option for her was a spinal cord stimulator or drug administration system. He recommended a trial with a spinal cord stimulator and a specific drug rotation – moving from MS Contin to Duragesic patches. (St. Ex. 12 at 53-55)
315. In October 2006, Dr. Villavicencio began to wean Patient 12 off the MS Contin and prescribed Duragesic patches. Seven days later, she returned to Dr. Villavicencio, stating that she was not responding to the Duragesic patches. Patient 12 reported her pain level as a “9.” He switched her to methadone. (St. Ex. 12 at 50, 51)
316. In early 2007, Patient 12 received a spinal cord stimulator. At her next office visit with Dr. Villavicencio in March 2007, he noted that the stimulator was placed in the “wrong spot.” (St. Ex. 12 at 39-42, 44)
317. A urine drug screen was conducted in March 2007, which was positive for opiates, benzodiazepine metabolites, methadone, oxycodone, amitriptyline (Elavil), and sertraline (Zoloft). It was negative for Soma and Neurontin. (St. Ex. 12 at 35-38)
318. Patient 12 encountered difficulties with the spinal cord simulator due to infection, and in May 2007, the stimulator was removed. (St. Ex. 12 at 30-33)

³⁸Symbyax is used to treat schizophrenia and depression. (U.S. National Library of Medicine, *PubMed Health*, <http://www.ncbi.nlm.nih.gov/pubmedhealth>, accessed June 25, 2012)

319. From July to October 2007, Patient 12 visited the hospital for several reasons, including broken toes, severe headache, and a fainting spell. Dr. Villavicencio referred Patient 12 for a nerve conduction study in April and October 2007. He ordered a TENS unit in October 2007. (St. Ex. 12 at 23-27, 33)
320. On November 21, 2007, Patient 12 claimed that her medications were impounded and, as a result, she had suffered withdrawal seizures. One such seizure occurred at Dr. Villavicencio's office. The pain management specialist was consulted at that time and he advised that Patient 12 undergo inpatient detoxification, but Patient 12 was opposed. Patient 12 scheduled injections and thought that, after the injections, she would be able to decrease her pain medications. Dr. Villavicencio confirmed the dates for the injections. He further documented that Patient 12 was at risk for excessive intake and chose to prescribe only one week's worth of pain medications (methadone, MS Contin, Soma and Percocet). He also decreased the dosage of Percocet. (St. Ex. 12 at 1, 22)
321. Dr. Villavicencio prescribed the following medications to Patient 12 between November 2005 and November 2007:

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 12 Cite
11/2/05	Avinza Depakote Topamax Zoloft Zyprexa	60 mg, 1 tablet twice a day, #60 500 mg, 1 tablet twice a day, #60 100 mg, 1 tablet twice a day, #30 100 mg, 1 tablet twice a day, #60 5 mg, 1 tablet at bedtime, #30	15-day supply of Topamax	78
11/15/05	Avinza Topamax Zanaflex Lunesta	90 mg, 1 tablet twice a day, #60 100 mg, 1 tablet twice a day, #30 4 mg, 1 tablet three times a day prn, #30 2mg, 1 tablet at bedtime, #30	Early refills of Avinza and Topamax. Avinza dosage increased.	77
12/14/05	MS Contin Soma Lunesta	60 mg, 1 tablet three times a day, #90 350 mg, 1 tablet three times a day, #90 2mg, 1 tablet at bedtime, #30	Switched from Avinza to MS Contin and added Soma.	75
1/11/06	MS Contin Soma Lunesta	100 mg, 1 tablet twice a day, #60 350 mg, 1 tablet four times a day, #120 2mg, 1 tablet at bedtime, #30	MS Contin and Soma dosages increased.	71
1/19/06	Xanax	1 mg, 1 tablet three times a day, #90		70
2/11/06	MS Contin Soma Lunesta Depakote Topamax Zyprexa ³⁹ Valium Elavil	100 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120 2 mg, 1 tablet at bedtime, #30 500 mg, 1 tablet twice day, #60 100 mg, 1 tablet twice a day, #30 5 mg, 1 tablet at bedtime, #30 10 mg, 1 tablet three times a day, #90 50 mg, 1 tablet at bedtime, #30	MS Contin dosage increased. 15-day supply of Topamax prescribed. Switched from Xanax to Valium. Added Zyprexa and Elavil.	69
2/17/06	Xanax Restoril	1 mg, 1 tablet three times a day, #90 30 mg, 1 tablet at bedtime as needed, #30	Patient was "unable to get lunesta and valium."	68

³⁹Zyprexa is used to treat schizophrenia and bipolar disorder. (U.S. National Library of Medicine, *PubMed Health*, <http://www.ncbi.nlm.nih.gov/pubmedhealth>, [accessed June 25, 2012])

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 12 Cite
3/16/06	MS Contin Soma Xanax	60 mg, 1-2 tablets twice a day, #120 350 mg, 1 tablet four times a day, #120 1 mg, 1 tablet three times a day, #90	MS Contin dosage decreased.	67
4/13/06	MS Contin MS Contin Soma Elavil Xanax Restoril	60 mg, 1-2 tablets twice a day, #120 20 mg, 1-2 tablets twice a day, #120 350 mg, 1 tablet four times a day, #120 100 mg, 1 tablet at bedtime, #30 1 mg, 1 tablet four times a day, #120 30 mg, 1 tablet at bedtime as needed, #20	MS Contin, Xanax and Elavil dosages increased.	66
5/12/06	MS Contin MS Contin Soma Elavil Xanax Cymbalta	100 mg, 1-2 tablets twice a day, #90 30 mg, 1-2 tablets twice a day, #90 350 mg, 1 tablet four times a day, #120 100 mg, 1 tablet at bedtime, #30, 5 refills 1 mg, 1 tablet four times a day, #120 60 mg, 1 tablet twice a day, #30	MS Contin dosage increased. 15-day supply of Cymbalta prescribed.	65
6/13/06 7/13/06	MS Contin MS Contin Soma Symbyax Ambien CR Neurontin	100 mg, 1-2 tablets twice a day, #90 60 mg, 1-2 tablets twice a day, #90 350 mg, 1 tablet four times a day, #120 "25/6" mg, 1 tablet in the evening, #30 12.5 mg, 1 tablet at bedtime, #30 300 mg, 1 tablet at bedtime, #30	MS Contin dosage increased.	62, 63
7/17/06	Xanax	1 mg, 1 tablet four times a day, #120		61
8/10/06	MS Contin Soma Symbyax Ambien CR Neurontin Xanax	100 mg, 1-2 tablets twice a day, #90 350 mg, 1 tablet four times a day, #120 "25/6" mg, 1 tablet in the evening, #30 12.5 mg, 1 tablet at bedtime, #30 300 mg, 1 tablet at bedtime, #30 1 mg, 1 tablet four times a day, #120	MS Contin dosage decreased.	60
9/12/06	MS Contin MS Contin Soma Ambien CR Neurontin Xanax	100 mg, 1-2 tablets twice a day, #90 60 mg, 1 tablet three times a day, #90 350 mg, 1 tablet four times a day, #120 12.5 mg, 1 tablet at bedtime, #30 300 mg, 1 tablet at bedtime, #30 1 mg, 1 tablet four times a day, #120	MS Contin dosage increased.	56
10/11/06	MS Contin Duragesic Soma Ambien CR Neurontin Xanax Percocet	100 mg, 1-2 tablets twice a day, #90 50 mcg/hour, #3 350 mg, 1 tablet four times a day, #120 12.5 mg, 1 tablet at bedtime, #30 300 mg, 1 tablet at bedtime, #30 1 mg, 1 tablet four times a day, #120 5/325 mg, 1 tablet four times a day, #120	Duragesic added.	51
10/18/06	methadone	20 mg, 3 tablets in the a.m. and 2 tablets in the p.m., #75 ⁴⁰	15-day supply of methadone prescribed.	50

⁴⁰The dosing instructions for this methadone prescription were crossed out and other instructions were handwritten on the prescription. The handwritten instructions are: "10 mg 6 tabs am 4 tabs pm #140." The total daily dosage of methadone remained the same. (St. Ex. 12 at 50)

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 12 Cite
11/10/06 12/5/06	methadone MS Contin Soma Ambien CR Neurontin Xanax Zolofit	10 mg, 6 tablets in the a.m. and 4 tablets in the p.m., #140 100 mg, 1 tablet in the morning, #30 350 mg, 1 tablet four times a day, #120 12.5 mg, 1 tablet at bedtime, #30 600 mg, 1 tablet at bedtime, #30 1 mg, 1 tablet four times a day, #120 100 mg, 1 tablet twice a day, #60, 5 refills	Neurontin dosage increased. Elavil also prescribed on 12/5/06. 14-day supply of methadone prescribed.	47, 49
12/6/06	methadone Percocet Lunesta	10 mg, 6 tablets in the a.m. and 4 tablets in the p.m., #160 5/325 mg, 1 tablet four times a day, #120 3 mg, 1 tablet at bedtime, #30	Patient claimed she did not get the full dose of methadone and Ambien CR was not approved. 16-day supply of methadone prescribed.	46
1/8/07	methadone MS Contin Soma Neurontin Xanax Percocet Lunesta	10 mg, 6 tablets in the a.m. and 4 tablets in the p.m., #160 100 mg, 1 tablet in the morning, #30 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet at bedtime, #30 1 mg, 1 tablet four times a day, #120 5/325 mg, 1 tablet four times a day, #120 3 mg, 1 tablet at bedtime, #30	Acute exacerbation of low back reported. 16-day supply of methadone prescribed.	45
2/2/07	methadone MS Contin Soma Neurontin Xanax Percocet Lunesta Zolofit	10 mg, 6 tablets in the a.m. and 4 tablets in the p.m., #300 100 mg, 1 tablet in the morning, #30 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet at bedtime, #30 1 mg, 1 tablet four times a day, #120 5/325 mg, 1 tablet four times a day, #120 3 mg, 1 tablet at bedtime, #30 100 mg, 1 tablet in the a.m., #30, 5 refills		44
3/2/07- 4/30/07	methadone MS Contin Soma Neurontin Xanax Percocet Lunesta	10 mg, 6 tablets in the a.m. and 4 tablets in the p.m., #300 100 mg, 1 tablet in the morning, #30 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet at bedtime, #30 1 mg, 1 tablet four times a day, #120 5/325 mg, 1 tablet four times a day, #120 3 mg, 1 tablet at bedtime, #30		33-34, 39
5/29/07- 9/21/07	methadone MS Contin Soma Neurontin Xanax Percocet Lunesta Elavil	10 mg, 6 tablets in the a.m. and 4 tablets in the p.m., #300 100 mg, 1 tablet in the morning, #30 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet at bedtime, #30 1 mg, 1 tablet four times a day, #120 5/325 mg, 1 tablet six times a day, #150 3 mg, 1 tablet at bedtime, #30 100 mg, 1 tablet three times a day, #90, 1 refill	Percocet dosage increased on 5/29/07.	25-29

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 12 Cite
10/22/07	methadone MS Contin Soma Neurontin Xanax Magnacet ⁴¹ Lunesta Elavil	10 mg, 6 tablets in the a.m. and 4 tablets in the p.m., #300 100 mg, 1 tablet in the morning, #30 350 mg, 1 tablet four times a day, #120 600 mg, 1 tablet at bedtime, #30 1 mg, 1 tablet four times a day, #120 7.5/400 mg, 1 tablet four times a day, #120 3 mg, 1 tablet at bedtime, #30, 5 refills 100 mg, 1 tablet three times a day, #90, 1 refill	Percocet dosage increased.	24
10/29/07	Percocet	10/650 mg, 1 tablet four times a day, #120	Percocet dosage increased.	23
11/21/07	methadone MS Contin Soma Neurontin Xanax Percocet Elavil	10 mg, 6 tablets in the a.m. and 4 tablets in the p.m., #75 100 mg, 1 tablet in the morning, #7 350 mg, 1 tablet four times a day, #30 600 mg, 1 tablet at bedtime, #30 1 mg, 1 tablet four times a day, #120 5/325 mg, 1 tablet four times a day, #30 100 mg, 1 tablet three times a day, #90, 1 refill	7-day or 7.5-day supplies of MS Contin, methadone, Soma and Percocet prescribed. Percocet dosage decreased.	22

322. On November 23, 2007, Patient 12 died as a result of multiple drug toxicity – amitriptyline (Elavil), carisoprodol (Soma), diphenhydramine, doxylamine, methadone, nortriptyline, oxycodone, promethazine (Phenergan), sertraline (Zoloft), and valproate (Depakote). (St. Ex. 12A at 1, 3, 5-6)

Opinion of Dr. Kelly

323. Dr. Kelly stated, with respect to Patient 12’s initial visit, the following criticisms:

- Two anti-convulsant medications and two antidepressants were prescribed at Patient 12’s first visit. (St. Ex. 18 at 52)
- The initial history, examination, diagnosis, and treatment plan were not documented adequately. Dr. Kelly explained that there is no description of Patient 12’s current pain – severity, frequency, location, weakness, radiation, and radicular components. He added that the physical examination results do not support the diagnoses of low back pain and neck pain. He acknowledged that Patient 12’s lumbar spine MRI was indicative of mild back pain. Also, Dr. Kelly stated that the Avinza prescription issued at the first office visit could be reasonable, depending on the patient’s prior prescriptions, which were not listed in the progress note or in the patient history form. (St. Ex. 18 at 55; Tr. at 677-680)

⁴¹Magnacet is a brand name for oxycodone with acetaminophen, like Percocet. (Tr. at 354)

324. With regard to the prescriptions issued to Patient 12, Dr. Kelly testified:

- The dose of morphine in January 2006 increased to 200 mg per day, and further increased to 480 mg per day. Dr. Kelly stated that these doses are “very, very high” and not justified by the information in the medical record. (St. Ex. 18 at 52-53; Tr. at 683-684)
- In October 2006, methadone was initiated at a high dose without any transition or tapering of the MS Contin and Duragesic prescribed seven days earlier. (Tr. at 685-686)
- In December 2006, Patient 12 received a prescription for methadone, 140 tablets. The next day, she received an additional prescription for methadone, 160 tablets, after telling Dr. Villavicencio that the pharmacy had not dispensed all of the earlier prescribed tablets. Dr. Kelly stated that Dr. Villavicencio should not have taken Patient 12 at her word; he needed to confirm this event with the pharmacist in order to not prescribe excessive amounts of medication. (Tr. at 687-688)
- The January 2007 prescription for methadone was only a 16-day supply. If taken as prescribed, it would not have lasted until Patient 12’s February 2007 appointment. Dr. Kelly stated that this “stopping and starting” could result in less pain relief for the patient. (Tr. at 695-696)
- In February 2007, methadone was started at a very high dose – not a low starting dose. Methadone was prescribed as an additional pain medication, not as a substitute for other pain medication as suggested by the pain management specialist. Dr. Kelly stated that the standard of care required an explanation/rationale for not following the specialist’s recommendation. (St. Ex. 18 at 53; Tr. at 681)
- In November 2007, Dr. Villavicencio decreased the number of pills prescribed, but the dosage of medications was not altered after Patient 12 demonstrated excessive intake, had withdrawal symptoms, and a pain management specialist recommended detoxification. Dr. Kelly stated that Dr. Villavicencio’s actions under the circumstances were below the standard of care. (St. Ex. 18 at 54; Tr. at 700)

325. Dr. Kelly stated that the primary focus of Dr. Villavicencio’s treatment of Patient 12 was chronic pain, and that medication doses included 40 mg of oxycodone, 100 mg of morphine, 100 mg of methadone and 4 mg of Xanax each day. He opined that the documentation did not support the eventual doses of pain medications, the use of more than one long-acting opiate medication at a time and the increases in opiate medication. Also, he stated that the recommendations of the pain management specialist did affect treatment for Patient 12, and to the extent he followed those recommendations, Dr. Villavicencio’s care and treatment was within the standard of care. Additionally, Dr. Kelly noted that sections of the chart notes, including review of systems and physical examinations, were identical to prior visits and were identical to the same sections in other patients’ records. (St. Ex. 18 at 55; Tr. at 700-703, 1393, 1393, 1395-1396)

326. Dr. Kelly concluded that Dr. Villavicencio's care of Patient 12 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances. Also, he stated that Dr. Villavicencio's controlled substance prescribing and the documentation of his care of Patient 12 constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 55)

Opinion of Dr. Villavicencio

327. Dr. Villavicencio testified that, at Patient 12's first visit, he simply continued the medications prescribed by her prior physician. He further acknowledged that he does not know why he prescribed Avinza to her that day. (Tr. at 335-338)

328. Dr. Villavicencio acknowledged that, based on the MS Contin prescriptions he issued in May 2006, the daily dosage of MS Contin ranged from 260 to 520 mg. However, Dr. Villavicencio testified that Patient 12 was supposed to take three of each pill each day, for a total of 390 mg of MS Contin. Dr. Villavicencio agreed that, within the first six months of treating Patient 12, he had tripled the amount of morphine prescribed to her. (Tr. at 346, 349)

329. Dr. Villavicencio agreed with the following:

- He began treating Patient 12 on November 2, 2005, for conditions including back pain, neck pain, hip pain, and anxiety. (Tr. at 1650)
- He documented that the pain management physician to whom he referred Patient 12 had noted that she had become tolerant of her medications and should undergo inpatient treatment for detoxification. Patient 12 refused such treatment. Dr. Villavicencio explained that he had consulted with the pain management specialist. He added that they had decided to monitor Patient 12 and the specialist scheduled her to return to him for injections. (Tr. at 1650)
- The chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. (Tr. at 1579)

330. Dr. Villavicencio disagreed that the medical record lacks documentation to support the use of the controlled and non-controlled medications, or the increases in dosages. He stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical records is taken into consideration (including the intake forms and his staff's notes), he believes that his medical record is "better documented than * * * the allegations would suggest." (Tr. at 1575-1576)

Patient 13

(Medical record reflects treatment between August and December 2005, four months)

331. Patient 13, a female, was born in 1982. Patient 13 underwent an EMG procedure in April 2005, which found that she had mild cervical radiculopathy. (St. Ex. 13 at 3, 21)
332. Patient 13 first saw Dr. Villavicencio on August 22, 2005, after she had suffered a broken nose. She was 23 years old. She stated that she had issues with her neck and one eye, and numbness in one leg. Also, she reported that she suffered from arthritis and headaches. She stated that her level of pain was “9.” Patient 13 stated that she had recently taken Percocet, Soma, Xanax, and Naprosyn. Dr. Villavicencio noted that Patient 13 had had neck surgery. He diagnosed a nasal fracture and rheumatoid arthritis. He prescribed Percocet, Soma, Xanax, Ventolin, Advair, Alavert D, Folic Acid and Naprosyn.⁴² Patient 13 executed a pain management contract at her first office visit. (St. Ex. 13 at 1, 3, 20, 22)
333. Dr. Villavicencio saw Patient 13 on six occasions between August and December 2005, and she complained of pain at each visit. (St. Ex. 13 at 12, 13, 17-20) Her medical record includes the following:
- In September 2005, Patient 13 reported her pain as 9 and reported that all her medications had been stolen. Dr. Villavicencio advised that no refills would be given for “lost scripts” and “we cannot overcome [the] 30 day rolling period of [medicaid].” Patient 13 was told to “make do” with other medications. However, Dr. Villavicencio prescribed Vicodin, Soma, and Valium that day. (St. Ex. 13 at 1, 18)
 - Dr. Villavicencio ordered a blood test to confirm Patient 13’s rheumatoid arthritis, and the results were normal. (Tr. at 375-376; St. Ex. 13 at 14-16)
 - Dr. Villavicencio received a pharmacy report in late October 2005 or thereafter, which reflected that Patient 13 had received prescriptions between May and August 2005 from five different providers and four unknown prescribers. (St. Ex. 13 at 2)
 - Dr. Villavicencio referred Patient 13 to an ear, nose and throat specialist and to a rheumatology specialist, per her request, in November 2005. (St. Ex. 13 at 13)

⁴²Dr. Kelly stated that Ventolin is a bronchodilator, typically given for asthma, COPD, emphysema, or chronic bronchitis. Similarly, Advair is a long-acting bronchodilator combined with an inhaled steroid. He also stated that they are not used to treat allergies. (Tr. at 969-970) Alavert is a hay fever/allergy medication. (U.S. National Library of Medicine, *PubMed Health*, <http://www.ncbi.nlm.nih.gov/pubmedhealth>, accessed June 25, 2012)

334. Dr. Villavicencio prescribed medications to Patient 13 as follows during the four months that he treated her:

Date	Relevant Medication	Dosages (no refills provided)	Comments	St. Ex. 13 Cite
8/22/05	Percocet Soma Xanax Naprosyn	5/325 mg, 1 tablet four times a day, #60 350 mg, 1 tablet three times a day, #90 1 mg, 1 tablet three times a day, #90 500 mg twice a day, #60	15-day supply of Percocet prescribed.	20
9/19/05	Percocet Soma Xanax Naprosyn	5/325 mg, 1 tablet four times a day, #90 350 mg, 1 tablet three times a day, #90 1 mg, 1 tablet three times a day, #90 500 mg twice a day, #60	22.5-day supply of Percocet prescribed.	19
9/26/05	Vicodin Soma Valium	5 mg, 1 tablet four times a day, #120 350 mg, 1 tablet three times a day, #90 10 mg, 1 tablet three times a day, #90	Prescribed after patient reported her medications were stolen.	18
10/17/05	Percocet Soma Xanax	5/325 mg, 1 tablet four times a day, #90 350 mg, 1 tablet three times a day, #90 1 mg, 1 tablet three times a day, #90	Switched back to Percocet and Xanax. Refilled prescriptions 9 days early. 22.5-day supply of Percocet prescribed.	17
11/15/05	Percocet Soma Xanax	5/325 mg, 1 tablet four times a day, #90 350 mg, 1 tablet three times a day, #90 1 mg, 1 tablet three times a day, #90	22.5-day supply of Percocet prescribed.	13
12/14/05	Percocet Soma Xanax Neurontin	5/325 mg, 1 tablet four times a day, #90 350 mg, 1 tablet three times a day, #90 1 mg, 1 tablet three times a day, #90 300 mg 1 tablet at bedtime, #30	22.5-day supply of Percocet prescribed. Neurontin added.	12

335. On December 16, 2005, Patient 13 died from “the combined effects of alprazolam [Xanax] and carisoprodol [Soma].” (St. Ex. 13A at 1, 3, 8)

Opinion of Dr. Kelly

336. Dr. Kelly opined that Dr. Villavicencio’s assessment of Patient 13 and the related documentation were problematic for the following reasons:

- Dr. Villavicencio prescribed Advair and Ventolin although there was no history, examination findings, or diagnosis of asthma or COPD. Similarly, Dr. Villavicencio prescribed Soma and Xanax without a corresponding diagnosis or justification. (St. Ex. 18 at 56; Tr. at 708, 709, 713, 966-967)
- The initial history, examination, diagnosis, and treatment plan were not documented adequately. Dr. Kelly stated that there was no history of rheumatoid arthritis, no “real” examination of the nose (nasal fracture), and no joint examination. (St. Ex. 18 at 57; Tr. at 704-706, 958-959, 964)
- When Patient 13 reported in September 2005 that her medications had been stolen, Dr. Villavicencio prescribed Vicodin, Soma, and Valium, and then Patient 13 received early prescriptions of Percocet, Soma, and Xanax in October 2005. Dr. Kelly testified that the Vicodin and Valium were

“pretty equivalent” to the Percocet and Xanax that Patient 13 had been taking. (St. Ex. 18 at 57; Tr. at 975, 977-979, 990)

337. Dr. Kelly stated that the primary focus of Dr. Villavicencio’s treatment of Patient 13 was neck and “multiple joint” pain, and that the medication doses included 15 mg of oxycodone, 3 mg of Xanax and 1,050 mg of Soma each day. He opined that the documentation only minimally supports the initial choice of treatment with Percocet and the continued prescriptions of Percocet. He explained that it is unclear whether Percocet was prescribed for the nasal fracture, neck pain, and/or rheumatoid arthritis. Moreover, Dr. Kelly stated that Soma, Valium, and Xanax were not supported, the diagnosis and treatment of rheumatoid arthritis was not confirmed by testing and there was no diagnosis justifying the asthma medications. Additionally, Dr. Kelly noted that sections of the chart notes, including review of systems and physical examinations, were identical to prior visits and were identical to the same sections in other patients’ records. (St. Ex. 18 at 57; Tr. at 713-714, 988-995)
338. Dr. Kelly concluded that Dr. Villavicencio’s care of Patient 13 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances; however, Dr. Kelly stated that the amounts/dosages of the prescribed medications were not at issue for Patient 13. Also, he stated that Dr. Villavicencio’s controlled substance prescribing and the documentation of his care of Patient 13 constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 57; Tr. at 1398)

Opinion of Dr. Villavicencio

339. With regard to Patient 13’s first office visit, Dr. Villavicencio stated that her broken nose was not acute. He acknowledged that his documentation of that office visit did not specify, however. Dr. Villavicencio pointed out that his handwritten notes on that day’s progress notes reflect that Patient 13 had a nerve conduction velocity test, she was prescribed methotrexate by a rheumatologist, and “probably” was on Celebrex and folic acid. Dr. Villavicencio stated, with regard to the medications he had prescribed to Patient 13 at her first office visit, Percocet, Soma and Naprosyn were prescribed for Patient 13’s neck pain and joint pain, Xanax was prescribed for anxiety and spasms, Ventolin and Advair were for asthma, and Alavert D was for her nasal/breathing problems. (Tr. at 364, 365, 1275-1281)
340. Dr. Villavicencio stated that he believed that Patient 13 had rheumatoid arthritis because she had seen a specialist who only sees patients with rheumatological diagnoses, she was already on folic acid, and she reported that she had juvenile rheumatoid arthritis. Dr. Villavicencio acknowledged that incidences of juvenile rheumatoid arthritis are fairly rare, but he had believed Patient 13. (Tr. at 1653-1655)
341. Dr. Villavicencio opined that there was not much he could have attempted for Patient 13’s rheumatoid arthritis other than narcotic medications and anti-inflammatories. However, Dr. Villavicencio agreed that tests can be done to confirm rheumatoid arthritis, such as a blood test and x-rays. Dr. Villavicencio did a blood test, but the results were normal. He agreed

that he had not received medical records from Patient 13's prior treating physician and did not order an x-ray. (Tr. at 365-367, 375-377; St. Ex. 13 at 14-16)

342. Dr. Villavicencio stated that he did not require Patient 13 to provide a police report about her stolen medication, but that he began doing that approximately one year later. When the matter was discussed further at the hearing, Dr. Villavicencio testified that he had a standing order that the patient should make a police report. He also stated that, even so, when he had discussed the event with Patient 13, he had believed her story, and therefore he had prescribed the additional medications. (Tr. at 369-370, 1283-1284)
343. Dr. Villavicencio agreed with the following:
- He treated Patient 13 for conditions including neck pain and rheumatoid arthritis. (Tr. at 1274, 1279, 1281)
 - When Patient 13 claimed that her medications were stolen, he refused to replace the lost prescriptions but then prescribed medications which effectively replaced the medications claimed to be stolen and without any reduction for medication used. Dr. Villavicencio explained that he did not "refill" the prior medications because Medicaid would not cover the refills. (Tr. at 1701-1702)
 - The chart entries appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. (Tr. at 1579)
344. Dr. Villavicencio disagreed that the medical record lacks documentation to support the use of the controlled and non-controlled medications. He stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical records is taken into consideration (including the intake forms and his staff's notes), he believes that his medical record is "better documented than * * * the allegations would suggest." (Tr. at 1575-1576)

Patient 14

(Medical record reflects treatment between June 2005 and February 2008, 32 months)

345. Patient 14 is a male born in 1969. Patient 14 first saw Dr. Villavicencio on June 15, 2005, when he was 35 years old. He complained of back pain and frequent headaches. Patient 14 advised that he injured his back while diving. He reported that a former physician had prescribed methadone for deteriorating disks in his back and that he had been "off it" for one month. He listed no medications on his history form. Dr. Villavicencio informed Patient 14 that he needed to provide his prior MRI and physical therapy records. Dr. Villavicencio diagnosed migraines and chronic lumbosacral sprain. He prescribed OxyContin, Percocet, Motrin, and Imitrex. (St. Ex. 14 at 14, 26, 36)
346. Patient 14 executed a pain management agreement in June 2005, July 2005, and April 2007. (St. Ex. 14 at 20-22, 24, 25)

347. In September 2005, after Patient 14 could not obtain copies of his prior records, Dr. Villavicencio ordered an x-ray and physical therapy. He diagnosed low back pain at this time. The x-ray of the thoracic spine was negative, there was a suggestion of muscle spasm in the cervical spine, and there was mild anterior wedging of L1 in the lumbar spine. In addition, Dr. Villavicencio received another x-ray report, which indicated a normal "AP" and lateral lumbar spine. (St. Ex. 14 at 33, 42-44)
348. In November 2005, Patient 14's level of pain was listed as 5-6, and he reported that he had started physical therapy. However, there was no report from the physical therapist in Patient 14's medical record. Dr. Villavicencio documented in February 2006 that Patient 14 was "not ready" for physical therapy. (St. Ex. 14 at 4, 71, 78)
349. In May 2006, Patient 14 reported that he continued to have back pain, his level of pain was "6," and he tried to "keep off" OxyContin. Also, he stated that his anxiety was greater and he had twitching and nausea. Dr. Villavicencio noted that Patient 14 used to take methadone. Dr. Villavicencio prescribed methadone, Percocet, Motrin, and Zanaflex. The methadone prescription instructed Patient 14 to take two tablets twice a day, and it was written for a 10-day supply. (St. Ex. 14 at 3, 66)
350. In June 2006 (27 days after the May 2006 appointment), Patient 14 reported a level of pain of "5." Dr. Villavicencio noted that Patient 14 liked the methadone, that he had run out of medications, and that he had taken one tablet twice a day "which was basically good for only 10 days." It is not clear which medication is being discussed in the progress note. (St. Ex. 14 at 3, 64)
351. In August 2006, Patient 14's level of pain was "10." Dr. Villavicencio noted "Pt continues to have lower back pain but claims that the medications do offer some relief. Pt otherwise doing well. Still working with computers." Dr. Villavicencio listed his review of systems and his examination. He diagnosed low back pain and migraines. He added Xanax without any explanation. (St. Ex. 14 at 3, 62)
352. From September to November 2006, Patient 14 complained of pain in the elbows and shoulder blades. (St. Ex. 14 at 59-61)
353. Patient 14 saw Dr. Villavicencio from December 2006 through April 2007, complaining of low back pain. He also stated a few times that he was doing well. Dr. Villavicencio prescribed methadone, Percocet, Motrin, Zanaflex, and Xanax. In May 2007, Dr. Villavicencio noted that Patient 14 had been incarcerated for gun possession and had not received his medications for a period of time. He further noted that Patient 14 "went into failure" and had been on a ventilator. The patient record does not identify how long Patient 14 did not take his medications or his level of pain at the May 2007 visit. Dr. Villavicencio prescribed the same medications (methadone, Percocet, Motrin, Zanaflex, and Xanax) at the same dosages as he had prescribed to Patient 14 in April 2007. (St. Ex. 14 at 2, 52-58)

354. In June 2007, Patient 14 complained of palpitations and weight loss. He checked Patient 14's blood, continued the same medications and ordered no other tests. (St. Ex. 14 at 51)
355. In July 2007, Dr. Villavicencio documented an incident in which another patient had one of Patient 14's prescriptions for OxyContin. Dr. Villavicencio had not prescribed OxyContin to Patient 14 since May 2006. (St. Ex. 14 at 48, 68)
356. In October 2007, Patient 14 reported that he was having difficulties with sleep. His level of pain was "7." (St. Ex. 14 at 2, 46)
357. In November 2007, Dr. Villavicencio noted that Patient 14 was "more active" on his medication regimen. The next month, he noted that Patient 14 was doing well on the current anxiolytics (Xanax), but was "unable to taper use of such." (St. Ex. 14 at 30-31)
358. In December 2007, Dr. Villavicencio received a report that Patient 14 was selling his medications. Dr. Villavicencio ordered a pill count, but his office was unable to reach Patient 14 and no pill count was conducted. (St. Ex. 14 at 1)
359. In January 2008, Dr. Villavicencio noted that he had received a report from a parole officer that some of Patient 14's pills were missing. Dr. Villavicencio discussed this issue with Patient 14, who claimed that a family member had stolen some of his medications. Patient 14 said that he was unwilling to file a police report. Patient 14 was informed that "this is the last time that we are going to make such allowances." Dr. Villavicencio prescribed methadone, Percocet, Motrin, and Xanax. He also ordered an echocardiogram. (St. Ex. 14 at 29)
360. In February 2008, Dr. Villavicencio explained that Patient 14 needed the echocardiogram because he "has remained tachycardic." He again reiterated that Patient 14 was unable to taper his use of Xanax. He ordered an MRI too. (St. Ex. 14 at 28)
361. Patient 14's medical record contains no drug screens or referrals to specialists. (St. Ex. 14)
362. Dr. Villavicencio saw Patient 14 every month from June 2005 through February 2008. He prescribed the following medications to Patient 14 during those 32 months:

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 14 Cite
6/15/05	OxyContin Percocet Motrin	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day for break-through pain, #120 600 mg, 1 tablet four times a day, #120, 5 refills		36

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 14 Cite
7/13/05-9/7/05	OxyContin Percocet	40 mg, 1 tablet three times a day, #90 5/325 mg, 1 tablet four times a day for break-through pain, #120		33-35
10/05/05-11/28/05	OxyContin OxyContin ⁴³ Percocet	40 mg, 1 tablet three times a day, #45 40 mg, 1 tablet three times a day, #45 5/325 mg, 1 tablet four times a day, #120		32, 77, 78
12/16/05 1/17/06	OxyContin OxyContin Percocet	40 mg, 1-2 tablets three times a day, #60 40 mg, 1-2 tablets three times a day, #60 5/325 mg, 1 tablet four times a day, #120	OxyContin dosage increased. 10- to 20-day supply of OxyContin prescribed.	72, 73
2/17/06	OxyContin OxyContin Percocet Motrin	40 mg, 1-2 tablets three times a day, #60 40 mg, 1-2 tablets three times a day, #60 5/325 mg, 1 tablet four times a day, #120 600 mg, 1 tablet four times a day, #28	10- to 20-day supply of OxyContin prescribed. 7-day supply of Motrin prescribed.	71
2/25/06	OxyContin Percocet	40 mg, 1-2 tablets three times a day, #60 5/325 mg, 1 tablet four times a day, #120	Written after pharmacy refused to fill prior prescriptions. 10- to 20-day supply of OxyContin prescribed. (Tr. at 385)	70
3/15/06	OxyContin Percocet	40 mg, 1-2 tablets three times a day, #120 5/325 mg, 1 tablet four times a day, #120	20- to 40-day supply of OxyContin prescribed.	69
4/11/06 5/9/06	OxyContin Percocet Motrin Zanaflex	40 mg, 1-2 tablets three times a day, #120 5/325 mg, 1-2 tablets four times a day, #180 600 mg, 1 tablet four times a day, #28 4 mg, 1 tablet three times a day as needed, #30	20- to 40-day supply of OxyContin prescribed. Percocet dosage increased. 22.5- to 45-day supply of Percocet prescribed. 7-day supply of Motrin prescribed. 10-day supply of Zanaflex prescribed.	67, 68
5/23/06	methadone Percocet Motrin Zanaflex	10 mg, 2 tablets twice a day, #40 5/325 mg, 1-2 tablets four times a day, #180 600 mg, 1 tablet four times a day, #28 4 mg, 1 tablet three times a day as needed, #30	10-day supply of methadone prescribed. 22.5- to 45-day supply of Percocet prescribed. 7-day supply of Motrin prescribed. 10-day supply of Zanaflex prescribed.	66
6/20/06 7/18/06	methadone Percocet Motrin Zanaflex	10 mg, 2 tablets twice a day, #90 5/325 mg, 1-2 tablets four times a day, #180 600 mg, 1 tablet four times a day, #28 4 mg, 1 tablet three times a day as needed, #30	22.5-day supply of methadone prescribed. 22.5- to 45-day supply of Percocet prescribed. 7-day supply of Motrin prescribed. 10-day supply of Zanaflex prescribed.	63, 64
8/16/06 9/25/06	methadone Percocet Motrin Zanaflex Xanax	10 mg, 2 tablets twice a day, #120 5/325 mg, 1-2 tablets four times a day, #240 600 mg, 1 tablet four times a day, #120 4 mg, 1 tablet three times a day as needed, #90 1 mg, 1-2 tablets at bedtime, #45	30- to 60-day supply of Percocet prescribed. 22.5- to 45-day supply of Xanax prescribed.	61, 62
10/25/06 11/22/06	methadone Percocet Motrin Zanaflex Xanax	10 mg, 3 tablets twice a day, #120 5/325 mg, 1-2 tablets four times a day, #240 600 mg, 1 tablet four times a day, #120 4 mg, 1 tablet three times a day as needed, #90 1 mg, 1-2 tablets at bedtime, #45	Methadone dosage increased. 20-day supply of methadone prescribed. 30- to 60-day supply of Percocet prescribed.	59, 60

⁴³Dr. Villavicencio testified that he did not believe the duplicate prescriptions are an error. Rather, he believes he purposefully wrote multiple prescriptions for OxyContin because of insurance constraints. (Tr. at 383-384)

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 14 Cite
12/22/06	methadone Percocet Motrin Zanaflex Xanax	10 mg, 3 tablets twice a day, #120 5/325 mg, 1-2 tablets four times a day, #240 600 mg , 1 tablet four times a day, #120 4 mg, 1 tablet four times a day as needed, #105 1 mg, 1-2 tablets at bedtime, #90	Zanaflex dosage increased. 20-day supply of methadone prescribed. 45- to 90-day supply of Xanax prescribed. 30- to 60-day supply of Percocet prescribed.	58
1/19/07- 9/17/07	methadone Percocet Motrin Zanaflex Xanax	10 mg, 3 tablets twice a day, #120 5/325 mg, 1-2 tablets four times a day, #240 600 mg , 1 tablet four times a day, #120 4 mg, 1 tablet three times a day as needed, #90 1 mg, 1-2 tablets at bedtime, #90	Zanaflex dosage decreased on 1/19/07. Early refills of Xanax. 20-day supply of methadone prescribed. 45- to 90-day supply of Xanax prescribed. 30- to 60-day supply of Percocet prescribed.	40, 47, 48, 51- 53, 55- 57
10/15/07- 1/16/08	methadone Percocet Motrin Xanax	10 mg, 3 tablets twice a day, #120 5/325 mg, 1-2 tablets four times a day, #240 600 mg , 1 tablet four times a day, #120 1 mg, 1 tablet three times a day, #90	Xanax dosage increased. 20-day supply of methadone prescribed. 30- to 60-day supply of Percocet prescribed.	29-31, 46
2/15/08	methadone Percocet Xanax	10 mg, 3 tablets twice a day, #120 5/325 mg, 1-2 tablets four times a day, #240 1 mg, 1 tablet three times a day, #90	20-day supply of methadone prescribed. 30- to 60-day supply of Percocet prescribed.	28

Opinion of Dr. Kelly

363. With regard to Patient 14's medical record, Dr. Kelly found that the following information was lacking or problematic:

- The initial examination, diagnosis and treatment plan were not documented adequately in June 2005. Dr. Kelly explained that the history is inadequate to support a migraine diagnosis. There is no information regarding the severity, radiation, and sensitivity of the back pain. Also, there is no range of motion testing, no straight-leg raise test, and no palpation of back musculature. (St. Ex. 18 at 60; Tr. at 715-716)
- The physical examinations at Patient 14's three visits in October and November 2005 were identical. (St. Ex. 18 at 58)
- Dr. Villavicencio did not include sufficient information about the period of time between his appointments in April and May 2007, during which Patient 14 did not take his medications. (Tr. at 719-720, 722)
- Dr. Villavicencio did not gather a sufficient history related to Patient 14's "failure" between his appointments in April and May 2007. (Tr. at 722-723)
- There is no documentation of an investigation by Dr. Villavicencio into the incident of another patient having one of Patient 14's prescriptions. (Tr. at 724-725)

364. As for the prescriptions issued to Patient 14, Dr. Kelly stated Dr. Villavicencio made several errors:

- Dr. Villavicencio prescribed a very high dose of oxycodone at the first visit, which is especially problematic because Patient 14 had reported that he had been off methadone for a month. (Tr. at 716)
- The history and examination did not justify the medications prescribed at Patient 14's first office visit. (Tr. at 719)
- There is no rationale in the medical record for switching from OxyContin to methadone in May 2006, for increasing doses of methadone in October 2006, increasing Percocet in April 2006, increasing Zanaflex in December 2006, and for adding Xanax in August 2006 and increasing it in October 2007. (St. Ex. 18 at 59; Tr. at 719)
- Prednisone was prescribed in July 2007 without any rationale. (Tr. at 725)
- Zanaflex was discontinued in September 2007 without explanation. (St. Ex. 18 at 59)
- Dr. Villavicencio continued to prescribe controlled substances to Patient 14 even after a parole officer reported that his pills were missing. (Tr. at 726-727)

365. Dr. Kelly concluded that the primary focus of Dr. Villavicencio's treatment of Patient 14 was chronic pain, and that the medication doses included 40 mg of oxycodone, 40 mg of methadone and 3 mg of Xanax each day. He opined that the documentation did not support the initial choice of treatment, the eventual doses of pain medication, and the increases in opiate medications. Also, he stated that indications of inappropriate use or diversion of medications did not cause changes or interruptions in treatment. He added that MRI records or new MRIs were not obtained. Additionally, Dr. Kelly noted that sections of the chart notes, including reviews of systems and physical examinations, were identical to prior visits and were identical to the same sections in other patients' records. (St. Ex. 18 at 60; Tr. at 727-728)

366. Dr. Kelly further concluded that Dr. Villavicencio's care of Patient 14 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances. Also, he stated that Dr. Villavicencio's controlled substance prescribing and the documentation of his care of Patient 14 constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 60)

Opinion of Dr. Villavicencio

367. In the following exchange, Dr. Villavicencio explained why he prescribed OxyContin and Percocet to Patient 14 at the first office visit in June 2005:

- Q. What did you document on this first visit to indicate your medical reasoning for giving this patient Percocet and OxyContin on the first visit?

A. Actually, I – I basically went with the history and with the physical examination. I – They – I didn't even note any spasm in his back. But as I said, we were new at this and **we basically were just looking for new patients. And if they can provide proof that they've been on the same medication and wanted to transfer their care to our clinic, we just took them in.** * * * It's not been a year that the clinic is open at that time.

Q. But what – Do you know what he provided you? You said you couldn't get ahold of his prior –

A. Yeah. Just – Just – Basically, just the history.

Q. What he told you?

A. Yes.

(Tr. at 381-382, emphasis added)

368. Dr. Villavicencio later added that he prescribed Percocet, OxyContin, Motrin and Imitrex at that first visit because Patient 14 was working and his back was a problem. Dr. Villavicencio stated that Patient 14 needed both a long-acting medication and a breakthrough medication. Dr. Villavicencio also stated that he did not think Patient 14 was off all of his medications for a very long time, stating "I was under the impression that – that he had it a month before, but I can't find that right now." (Tr. at 1560)
369. Dr. Villavicencio stated that, when he switched Patient 14 to methadone in May 2006, Patient 14 probably had lost his insurance. (Tr. at 386, 1561)
370. Dr. Villavicencio testified that the July 2007 incident involving another patient trying to fill a prescription in Patient 14's name seemed to be an incident involving a forged prescription, of which Patient 14 was unaware. (Tr. at 391)
371. Dr. Villavicencio acknowledged that he never had referred Patient 14 to a specialist over the 32 months of treatment because it had been a struggle to get an MRI of Patient 14, which was obtained after the time period covered by this medical record. (Tr. at 397-398)
372. Moreover, Dr. Villavicencio stated that he did not order any drug screens of Patient 14 during treatment because he had felt sorry for Patient 14 ("[a] lot of things" happened to Patient 14) and the patient had helped Dr. Villavicencio's medical practice with some repairs/maintenance work. Dr. Villavicencio stated that he gave Patient 14 special treatment. As a result, Dr. Villavicencio prescribed controlled substances to Patient 14 under circumstances that he would not prescribe to other patients. (Tr. at 395-397, 1682-1683, 1685)

373. Dr. Villavicencio agreed with the following:

- He began treating Patient 14 in June 2005 for complaints including lumbosacral sprain, migraine and/or back pain. (Tr. at 1655)
- When Patient 14 admitted that he had been in jail, Dr. Villavicencio failed to address and/or document the reason Patient 14 was in jail. Dr. Villavicencio testified that he knows exactly what happened to Patient 14. (Tr. at 1655)
- He also documented that Patient 14 did not receive his medications while in jail, although Dr. Villavicencio failed to document how the patient managed his pain. Dr. Villavicencio stated that Patient 14 was not in jail for very long and then was transferred to a hospital, where he was sedated and managed by other providers. Dr. Villavicencio stated that the sedation was almost a medical detoxification. (Tr. at 1656-1657)
- He received information that Patient 14 may not have been taking and/or using his medication appropriately, including a call from Patient 14's parole officer that pills were missing. Dr. Villavicencio stated that he confronted Patient 14 and felt that his answers were appropriate. (Tr. at 1657-1658)
- He also received information that Patient 14 may not have been taking and/or using his medication appropriately, including that another person had Patient 14's prescription for OxyContin. Dr. Villavicencio added that he had a few instances of people trying to duplicate his prescriptions. (Tr. at 1658)
- He failed to refer Patient 14 to specialists and for physical therapy. Dr. Villavicencio stated that Patient 14 had insurance initially, but lost it after four or five months of treating with Dr. Villavicencio. Then, Patient 14 was hospitalized. As a result, Dr. Villavicencio stated that Patient 14 was unable to see other providers. (Tr. at 1659)
- The chart entries appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. (Tr. at 1579)

374. Dr. Villavicencio disagreed that Patient 14's medical record lacked documentation to support the use of the controlled and non-controlled medications, or the increases in dosages. Dr. Villavicencio stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical records is taken into consideration (including the intake forms and his staff's notes), he believes that his medical record is "better documented than * * * the allegations would suggest." (Tr. at 1575-1576)

Patient 15

(Medical record reflects treatment between September 2005 and February 2008, 29 months)

375. Patient 15 is a female born in 1992. She first saw Dr. Villavicencio on September 21, 2005, when she was 13 years old. She complained of back pain, headaches, diabetes, depression,

thyroid problems, and stomach problems. She reported a history of polycystic ovarian syndrome, trouble sleeping, and school absences. She stated that she was taking Vicodin. Dr. Villavicencio diagnosed diabetes (adult onset, controlled), headaches, and polycystic ovary. He prescribed Vicodin and referred Patient 15 to Children's Hospital for neurological and behavioral evaluations. (St. Ex. 15 at 32-33, 81)

376. Patient 15 signed a pain management contract in September 2005 and again in May 2007. (St. Ex. 15 at 19, 22-23)
377. At Patient 15's second visit, she reported that she had been discharged previously from a neurology clinic, but was seeing a provider at a behavioral clinic. (St. Ex. 15 at 80)
378. Patient 15 reported the following pains over the next several months: ear, tailbone, low back, and headaches. Her level of pain was recorded as "8" on each occasion. Dr. Villavicencio diagnosed low back pain. (St. Ex. 15 at 4, 78-80)
379. Dr. Villavicencio ordered a KUB (abdominal) x-ray in December 2005. (St. Ex. 15 at 78)
380. Throughout 2006, Dr. Villavicencio prescribed Vicodin, Xanax, and Motrin to Patient 15. The following events were also noted in her medical record:
- In January 2006, Patient 15 reported that she would not be seen at Children's Hospital any longer and that she wanted to be treated at Ohio State University. (St. Ex. 15 at 77)
 - In April 2006, Patient 15 reported that her level of pain was "2," that the headaches are "pretty intense," and that she had to take two pills at a time. Dr. Villavicencio increased the dosage of Vicodin. (St. Ex. 15 at 4, 74)
 - In May 2006, Dr. Villavicencio documented that Patient 15 "missed the appointment for the 6th time."⁴⁴ Also, he noted that Patient 15 was seeing a psychiatrist and that her mother was told "to have it in writing" that Patient 15 can be on Xanax. He further stated that Patient 15 will have to be referred to a headache clinic by her mother and will have to find a neurologist from her insurer's list of approved physicians. (St. Ex. 15 at 73)
 - In July 2006, Dr. Villavicencio noted that Patient 15 was taking Glucophage, Seroquel, Synthroid,⁴⁵ Vicodin, and Xanax. He did not document who prescribed the Glucophage, Seroquel and Synthroid. He also noted that she would see an endocrinologist soon. He added hypothyroidism to her list of diagnoses and he ordered an MRI of the brain. Patient 15 obtained the MRI of the brain and it was inconsequential. (St. Ex. 15 at 26, 71)

⁴⁴It is unclear what appointment was missed six times. Dr. Villavicencio's medical record does not indicate that Patient 15 missed any visits with him. (St. Ex. 15)

⁴⁵Glucophage is used to treat type 2 diabetes. Synthroid is used to treat hypothyroidism. (U.S. National Library of Medicine, *PubMed Health*, <http://www.ncbi.nlm.nih.gov/pubmedhealth>, accessed June 25, 2012)

- In early August 2006, Patient 15's level of pain was listed as "2," but a few weeks later it was "10." There is no information in the patient record to explain the variation in Patient 15's pain. (St. Ex. 15 at 3, 69, 70)
- By October 2006, Patient 15 had a new endocrinologist. A report from the endocrinologist was sent to Dr. Villavicencio. (St. Ex. 15 at 24-25, 68)
- In October 2006, Dr. Villavicencio noted that Patient 15's mother had Patient 15 try Soma. (St. Ex. 15 at 68)

381. In January 2007, Patient 15 saw Dr. Villavicencio. He noted that Netcare had evaluated Patient 15 and wanted her "back on Zoloft and Seroquel." Dr. Villavicencio prescribed Zoloft, in addition to Vicodin, Xanax, Motrin, and Ambien. (St. Ex. 15 at 65)

382. In February 2007, Patient 15's pain level was reported as "8." When Patient 15 complained of pain in her back and shoulders, Dr. Villavicencio ordered an MRI. (St. Ex. 15 at 64)

383. By March 2007, Patient 15 had seen a psychiatrist. (St. Ex. 15 at 63)

384. In July 2007, Dr. Villavicencio ordered MRIs of the brain and back. (St. Ex. 15 at 18, 58) Patient 15 obtained the MRIs, which indicated the following:

- Brain: Pituitary gland at upper limits of normal * * * unchanged from 08/08 MRI. * * * Scant inflammation – ethmoid, sphenoid and frontal sinuses.
- Lumbar spine: L5-S1 broad shallow posterior eccentric left disc protrusion or shallow herniation encroaching upon and slightly posteriorly displacing left S1 nerve root; near to if not in part abutting right S1 nerve root.

(St. Ex. 15 at 51-53)

385. In August 2007, Dr. Villavicencio ordered a pill count. A notation on the order says "PASS." No other details are documented. (St. Ex. 15 at 2, 17)

386. In September 2007, a drug screen was conducted. Dr. Villavicencio's staff documented that the test was positive for THC (marijuana) and negative for all others. Dr. Villavicencio documented "drug screen performed today – patient took her vicoden [sic]." That same day, Dr. Villavicencio prescribed Vicodin, Xanax, Motrin, and Lyrica to Patient 15. The laboratory results indicate that the sample was positive for sertraline (Zoloft), propoxyphene (Darvocet) and cannabinoids (marijuana). It was negative for all three substances previously prescribed by Dr. Villavicencio – hydrocodone (Vicodin), alprazolam (Xanax), and ibuprofen (Motrin). (St. Ex. 15 at 1, 5-6, 54-56)

387. When Patient 15 next saw Dr. Villavicencio in October 2007, she reported her level of pain as "7." He did not alter his treatment of Patient 15. However, in November 2007, Dr. Villavicencio referred Patient 15 to a pain management specialist. (St. Ex. 15 at 1, 48-50) There is no indication in the chart whether Patient 15 ever saw that specialist.

388. Another urine drug screen was conducted in December 2007. It was positive for propoxyphene (Darvocet), which had not been prescribed by Dr. Villavicencio. It was negative for alprazolam (Xanax) and pregabalin (Lyrica), which had been prescribed. (St. Ex. 15 at 43-45)
389. In January 2008, Patient 15 informed Dr. Villavicencio that her insurance would not pay for Lyrica. Dr. Villavicencio prescribed Vicodin, Xanax, and Motrin to Patient 15. (St. Ex. 15 at 42)
390. Dr. Villavicencio repeatedly noted that other providers had attempted to arrange a neurologist for Patient 15. Patient 15 did not see a neurologist during the 29 months of treatment covered by the medical record. (St. Ex. 15 at 47, 57, 58; Tr. at 748-749, 935, 1264)
391. Dr. Villavicencio saw Patient 15 every month from September 2005 through February 2008. He prescribed the following medications to Patient 15:

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 15 Cite
9/21/05	Vicodin Xanax	5 mg, 1 tablet four times a day as needed, #120 0.5 mg [no instructions are listed]		81; Tr. at 1233
10/19/05 11/21/05	Vicodin Xanax	5 mg, 1 tablet four times a day as needed, #120 0.5 mg, 1 tablet three times a day, #90		79, 80
12/12/05 1/11/06	Vicodin Xanax Motrin	5 mg, 1 tablet four times a day as needed, #120 0.5 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #28	7-day supply of Motrin prescribed.	77, 78
2/7/06 3/13/06	Vicodin Xanax Motrin	5 mg, 1 tablet four times a day as needed, #120 0.5 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120		75, 76
4/11/06- 8/1/12	Vicodin Xanax Motrin	5 mg, 1-2 tablets four times a day as needed, #150 0.5 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	Vicodin dosage increased. 19- to 37.5-day supply of Vicodin prescribed.	70-74
8/29/06	Vicodin Xanax Motrin	5 mg, 1-2 tablets four times a day as needed, #175 0.5 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	Early refills. 22- to 44-day supply of Vicodin prescribed.	69
10/3/06 11/1/06	Vicodin Xanax Motrin Ambien CR	5 mg, 1-2 tablets four times a day as needed, #175 0.5 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120 12.5 mg, 1 tablet at bedtime, #30	22- to 44-day supply of Vicodin prescribed. Ambien CR added.	67, 68
12/4/06	Vicodin Xanax Motrin Ambien CR Ambien	5 mg, 1-2 tablets four times a day as needed, #175 0.5 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120 12.5 mg, 1 tablet at bedtime, #30 10 mg, 1 tablet at bedtime, #10	22- to 44-day supply of Vicodin prescribed. Ambien dosage increased.	66
1/2/07	Vicodin Xanax Motrin Ambien CR Ambien Zoloft	5 mg, 1-2 tablets four times a day as needed, #200 0.5 mg, 1 tablet four times a day, #105 600 mg, 1 tablet four times a day, #120 12.5 mg, 1 tablet at bedtime, #30, 5 refills 10 mg, 1 tablet at bedtime, #10, 5 refills 25 mg, 1 tablet in a.m., #30, 5 refills	25- to 50-day supply of Vicodin prescribed. Xanax dosage increased. 6-month supply of Ambien CR prescribed.	65

Date	Relevant Medication	Dosages (no refills provided unless otherwise designated)	Comments	St. Ex. 15 Cite
2/6/07	Vicodin Xanax Motrin Xanax	5 mg, 1-2 tablets four times a day as needed, #175 0.5 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120 1 mg, 1 tablet at bedtime, #30	22- to 44-day supply of Vicodin prescribed. Xanax dosage increased.	64
3/6/07	Vicodin Xanax Motrin	5 mg, 1-2 tablets four times a day as needed, #175 0.5 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	22- to 44-day supply of Vicodin prescribed. Xanax dosage decreased.	63
4/2/07	Vicodin Xanax Motrin	5 mg, 1-2 tablets four times a day as needed, #175 1 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	22- to 44-day supply of Vicodin prescribed. Xanax dosage doubled.	62
5/2/07	Vicodin Xanax Motrin Ambien	5 mg, 1-2 tablets four times a day as needed, #175 1 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120 10 mg, 1 tablet at bedtime, #10	22- to 44-day supply of Vicodin prescribed. Early refill of Ambien and 10-day supply prescribed.	61
5/30/07- 8/28/07	Vicodin Xanax Motrin	5 mg, 1-2 tablets four times a day as needed, #175 1 mg, 1 tablet three times a day, #90 600 mg, 1 tablet four times a day, #120	22- to 44-day supply of Vicodin prescribed.	57-59, 60
9/26/07- 12/27/07	Vicodin Xanax Motrin Lyrica	5 mg, 1-2 tablets four times a day as needed, #175 1 mg, 1 tablet twice a day, #60 600 mg, 1 tablet four times a day, #120 50 mg, 1 tablet twice a day, #60	22- to 44-day supply of Vicodin prescribed.	47, 49, 50, 56
1/23/08	Vicodin Xanax Motrin	5 mg, 1-2 tablets four times a day as needed, #175 1 mg, 1 tablet twice a day, #60 600 mg, 1 tablet four times a day, #120	22 -to 44-day supply of Vicodin prescribed.	42
2/21/08	Vicodin Xanax Motrin Zoloft	5 mg, 1-2 tablets four times a day as needed, #175 1 mg, 1 tablet twice a day, #60 600 mg, 1 tablet four times a day, #120 100 mg, 1.5 tablets each day, #45, 5 refills	22 -to 44-day supply of Vicodin prescribed.	41

392. Patient 15's medical record reflects that, in late 2005, Patient 15 weighed 124 pounds. The medical record also reflects that, in late 2006 and in late 2007, Patient 15 weighed more than 220 pounds. (St. Ex. 15 at 24, 29, 43; Tr. at 877)

Opinion of Dr. Kelly

393. With regard to documentation related to Patient 15's initial visit, Dr. Kelly stated the following:

- The initial examination, diagnosis, and treatment plan were not documented adequately. Dr. Kelly explained that the medical record is unclear as to whether another practitioner was treating Patient 15 for her diabetes, and there are no records/notes related to Patient 15's complicated history of polycystic ovary. He added that there were no symptoms or findings documented with regard to diabetes and polycystic ovary syndrome, but they were both diagnosed. (St. Ex. 18 at 63; Tr. at 730-735, 881-882)
- There is no explanation for prescribing Vicodin to a 13-year old who has a headache, diabetes, and polycystic ovary syndrome. Dr. Kelly stated that normally Vicodin would not be prescribed; instead, other non-opiate

strategies would be tried first. He added that, if the patient reports that Vicodin is the current treatment, the doctor needs to confirm and try to find out why Vicodin is the treatment, and then decide if Vicodin is still appropriate. (Tr. at 735)

394. Dr. Kelly raised other concerns with aspects of Dr. Villavicencio's care and treatment of Patient 15, as follows:

- There is no history, examination, or diagnosis that justified prescribing Xanax to Patient 15 in October 2005. Dr. Kelly stated that one should be reticent about prescribing benzodiazepines to a teenager and therefore should have a good reason to do it. He added that no reason was included in Patient 15's medical record. (Tr. at 735-736, 892-895, 904, 932)
- Dr. Villavicencio should have instructed Patient 15's mother in October 2006 to not provide other medications to Patient 15 after he learned that the mother had provided Soma to Patient 15, and then should have documented that instruction. (Tr. at 736-737, 913)
- A better explanation for prescribing Ambien to Patient 15 should have been documented in October 2006. Dr. Kelly testified that "Ambien is sedating, Vicodin is sedating, [and] Xanax is sedating. You've already heard about the patient getting very sedated when the mother used the Soma. So we're adding additional sedating agents. And that's a concern for anyone, but the younger you are and particularly the smaller you are, the more that would be an issue. So I would say yes, that's – that's a big concern for a 13-year-old." (Tr. at 737-738, 910-912)
- Dr. Villavicencio should have discussed the September and December 2007 urine drug screen results with Patient 15 and possibly stopped prescribing Xanax or Vicodin. Additionally, he should have recommended that she cease using marijuana and recommended a drug treatment program. Also, he should have documented those discussions and recommendations. Dr. Kelly doubted that Dr. Villavicencio's notations between October 2007 and February 2008 that Patient 15 "has remained more active on current pain medication regimen" meant that Patient 15 was more active on fulfilling the terms and conditions of her pain regimen. However, he stated that if those notations did reflect better compliance by Patient 15, it would have been a "positive step." (Tr. at 742-745, 917, 920-922, 927-930)
- There is no history or examination that justified prescribing Zoloft to Patient 15 in February 2008. Dr. Kelly added that the starting dose was very large and there was no justification for that dosage. (Tr. at 746-747)
- Dr. Villavicencio should have conducted a complete history and examination of Patient 15 related to her headaches once he began chronically treating for them, since Patient 15 was not treated by a neurologist as was originally anticipated. Dr. Villavicencio should have documented the examination as well. (Tr. at 750-751, 904-908, 931-932, 1402, 1416)

395. Dr. Kelly concluded that the primary focus of Dr. Villavicencio's treatment of Patient 15 was headache and back pain, and that the medication doses included 30 mg of hydrocodone and 2 to 3 mg of Xanax each day. He opined that the documentation poorly supported the initial choice of treatment for the headaches, the choice of Xanax, and the eventual doses of pain medication for the headaches over a long period of time. Additionally, Dr. Kelly noted that sections of the chart notes, including reviews of systems and physical examinations, were identical to prior visits and were identical to the same sections in other patients' records. (St. Ex. 18 at 63; Tr. at 753, 903, 934, 936)
396. Moreover, Dr. Kelly concluded that Dr. Villavicencio's care of Patient 15 constituted a failure to maintain minimal standards applicable to the selection and administration of controlled substances. Also, he stated that Dr. Villavicencio's controlled substance prescribing and the documentation of his care of Patient 15 constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 63; Tr. at 945-947)

Opinion of Dr. Villavicencio

397. Dr. Villavicencio testified that, at Patient 15's first office visit, Patient 15's mother had told him that Patient 15 had been prescribed Vicodin from a neurology clinic, but that the clinic had discharged Patient 15 because of noncompliance. Dr. Villavicencio stated that he had prescribed Vicodin on that date because the mother had provided proof that the neurology clinic had prescribed Vicodin in the past. He added that he was confident at that time that he could facilitate Patient 15's readmission into the clinic and would only treat her for a brief period of time. (Tr. at 400-401, 403, 1207, 1227)
398. Dr. Villavicencio stated that he had wanted to turn Patient 15 down, but they had begged him to accept her as a patient. He testified that it is a "red flag" to prescribe narcotics to someone under 16 years of age, especially since her complaints were headache, abdominal pain and lower back pain. However, he accepted Patient 15 because he had thought she was truly in pain. Dr. Villavicencio stated that Vicodin was prescribed to treat Patient 15's headaches, back pain, and pelvic pain. (Tr. at 415-416, 1216-1217, 1229)
399. In the following exchange, Dr. Villavicencio explained why he had continued to treat Patient 15 for pain:

- Q. This is your third visit with her. At what point do you believe this is going to be your patient and you've got to take care of her?
- A. I wasn't quite prepared to keep on giving narcotics to somebody who's 13 years old.
- Q. Doctor, you're taking care of her. This is your third visit.
- A. I know. But we tried --

Q. Are you merely naïve at this point?

A. I – I guess I was because I kept hoping that – that there’s a back door to the Neurology clinic. I was hoping that – that Endocrinology, since it belongs to the same hospital system, would be able to get her in Neurology clinic. I was hoping that Behavioral clinic, which is also in Children’s Hospital, would be able to convince the Neurology clinic to accept her back to the practice.

Q. This is your third month, Doctor. At what point are you going to decide this is your patient?

A. Well, they – they – they don’t get seen – I mean, she was my patient insofar as her other complaints are concerned; the back pain, the abdominal pain. But the headache was something that I wanted her to go back to the Neurology clinic. But the Vicodin there is for other reasons.

Q. And that was for what reasons?

A. The abdominal pain and – and the back pain.

(Tr. at 1243-1249)

400. Dr. Villavicencio testified that he had conducted a physical examination of Patient 15 for her headaches at her January 2006 appointment, and there was nothing specific to report. (Tr. at 1256-1257)
401. Dr. Villavicencio stated that he had prescribed Xanax to Patient 15 because she had been on Xanax previously and the mother had provided proof of it. He added that Patient 15 was adult-sized, which he took into consideration in prescribing Xanax. Dr. Villavicencio testified that the Xanax was prescribed for Patient 15’s pain problems and testified that Motrin was prescribed to Patient 15 as an adjunct to the pain medications as well. He acknowledged, however, that it is hard to determine that from his medical record. (Tr. at 401-403, 1240, 1251, 1255)
402. Dr. Villavicencio stated that it was a “red flag” when Patient 15 took Soma that had not been prescribed to her, but he considered it to be an isolated incident and considered her sleeping difficulties to be grave enough to warrant treatment with Ambien CR. He acknowledged that it is unusual to prescribe Ambient to a 13-year old. Dr. Villavicencio did not recall whether he spoke with Patient 15 or her mother about the Soma incident, although he stated that he generally does have a discussion in such circumstances. (Tr. at 404-406, 1260-1262)
403. Dr. Villavicencio testified that he did not discuss or counsel Patient 15 after he had received the September 2007 urine drug screen results. He stated that, because of Patient 15’s MRI,

he did not consider it very likely that diversion was taking place. He further stated that, at that point, he was probably considering whether enough pain medication was being provided. Later, Dr. Villavicencio stated that he spoke with Patient 15's mother about the urine drug screen results. He stated that the mother reported that they had run out of medication and had gotten Darvocet to help with the pain. Dr. Villavicencio stated that he had believed the mother. He also pointed out that the earlier MRI confirmed back pain. (Tr. at 409-410, 1268, 1270)

404. Dr. Villavicencio testified that he also did not discuss or counsel Patient 15 after he received the December 2007 urine drug screen results. He added that he routinely addresses discrepancies and he missed this one. (Tr. at 412)
405. Dr. Villavicencio explained his notation "[p]atient has remained more active on current pain medication regimen" as follows:

I meant that she – she tries to – to take it as prescribed. Because teenagers being teenagers, there was a lot – and mom would tell me that – that she wouldn't take it, she would take it when – as needed, and sometimes she would take two where she's in a lot of pain. So mother was telling me that.

And – And noncompliance with teenagers is a big issue. I – I have seen that with the way they take their ADHD medication, I see that with the way they – they take their insulin medication. They're – They're just not – not at peace with the fact that they have a medical illness that needs chronic treatment.

(Tr. at 1269)

406. Dr. Villavicencio stated that Patient 15 had a lot of medical problems and that she was a difficult patient. Dr. Villavicencio acknowledged his hesitation and reluctance to prescribe narcotics, Xanax, and Ambien to a 13-year old. (Tr. at 403-404, 1263)
407. Dr. Villavicencio agreed that the chart entries appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. (Tr. at 1579)
408. Dr. Villavicencio disagreed that the medical record lacks documentation to support the use of the controlled and non-controlled medications, or the increases in dosages. He stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical records is taken into consideration (including the intake forms and his staff's notes), he believes that his medical record is "better documented than * * * the allegations would suggest." (Tr. at 1575-1576)

Patient 16

(Medical record reflects treatment between October 2005 and May 2006, seven months)

409. Patient 16, a male, was born in 1976. He first saw Dr. Villavicencio on October 26, 2005, and complained of neck and low back pain. He was 29 years old. He explained that he had been involved in a four-wheeler accident. He described his pain level as “8.” His blood pressure was recorded as 186/120. Dr. Villavicencio diagnosed low back pain and anxiety. He ordered an MRI and prescribed Percocet, Naprosyn, and Xanax. Patient 16 executed a pain management contract at that visit. (St. Ex. 16 at 1, 2, 4, 18-20)

410. Dr. Villavicencio saw Patient 16 eight times from October 2005 through May 2006. At each visit, he documented that Patient 16 had low back pain and that he prescribed Percocet, Naprosyn, and Xanax to Patient 16 as follows:

Date	Relevant Medication	Prescription Dosages	Comments	St. Ex. 16 Cite
10/26/05 11/21/05	Percocet Naprosyn Xanax	5/325 mg, 1 tablet four times a day, #120 500 mg, 1 tablet twice a day, #60 1 mg, 1 tablet three times a day, #90		17, 18
12/17/05- 5/5/06	Percocet Naprosyn Xanax	5/325 mg, 1-2 tablets four times a day, #150 500 mg, 1 tablet twice a day, #60 1 mg, 1 tablet three times a day, #90	Percocet dosage increased on 12/17/05. 18.75- to 37.5-day supply of Percocet prescribed.	11-16

411. At his second office visit in November 2005, Patient 16 reported his pain level as “0.” His blood pressure was recorded as 162/98. Dr. Villavicencio documented that Patient 16 continued to have low back pain, and had tingling and numbness in his upper right extremity. (St. Ex. 16 at 17)

412. In December 2005, Dr. Villavicencio included a handwritten note on the progress note, stating “[left] forearm.” He increased the Percocet dosage on that date. (St. Ex. 16 at 16)

413. In January 2006, Patient 16’s blood pressure was 163/84. Dr. Villavicencio diagnosed hypertension. Patient 16 indicated that he did not want any medications for his elevated blood pressure at that time. Also, Patient 16 reported that his left forearm was swollen after he had fallen. Dr. Villavicencio ordered an x-ray of Patient 16’s left forearm. (St. Ex. 16 at 15)

414. In his notes from the February and March 2006 office visits, Dr. Villavicencio documented that Patient 16 was wearing an ankle monitor. No further information related to the ankle monitor was included. In April 2006, Dr. Villavicencio noted that Patient 16 had been “caught selling cocaine” and had a court date. He further documented that Patient 16 had reported that he was getting drug screens. In February, March and April 2006, Patient 16 reported pain levels of “7” or “8.” (St. Ex. 16 at 12-14)

415. In March 2006, Dr. Villavicencio diagnosed hypertension and prescribed Zestril for Patient 16’s elevated blood pressure. Zestril is a hypertension medication. Dr. Villavicencio prescribed Zestril in April and May 2006 as well. (St. Ex. 16 at 11-13; Tr. at 428, 639, 1542)

416. The medical record reflects that Patient 16's blood pressure was checked at each office visit, and below is a list of those findings:

Date	Blood Pressure
10/26/05	186/120
11/21/05	162/98
12/17/05	[illegible]/97
1/16/06	163/84
2/9/06	158/90
3/9/06	156/93
4/6/06	132/62
5/5/06	140/62 or 142/62

(St. Ex. 16 at 1, 11-18)

417. Patient 16's medical record does not indicate that any diagnostic tests were completed related to Patient 16's back pain. In February 2006, there is a notation that the MRI ordered in October 2005 was scheduled to take place. However, there is no information to reflect that the MRI was done. Moreover, Dr. Villavicencio testified that Patient 16 did not obtain the MRI. Also, there were no urine screens or referrals to any specialists. (St. Ex. 16; Tr. at 422)
418. On May 12, 2006, Patient 16 died from cardiorespiratory arrest as a result of multiple drug intoxication. The toxicology analysis reflected that Patient 16 had alcohol, alprazolam (Xanax) and oxycodone in his system. The alprazolam level was a "toxic to lethal" concentration. (St. Ex. 16A at 1, 3, 12-13)

Opinion of Dr. Kelly

419. Dr. Kelly raised several criticisms of Dr. Villavicencio's care and treatment of Patient 16. Dr. Kelly stated that the initial examination, diagnosis, and treatment plan were not documented adequately. Dr. Kelly explained that the specific location of back pain, the radiation of pain, frequency of pain, severity of pain, length of time of the pain, range of motion, and straight-leg raise testing were not listed. Similarly, he stated that there was no documentation of a history or examination related to anxiety. Similarly, Dr. Kelly stated that Dr. Villavicencio did not include in the history or examination a rationale for increasing the Percocet dosage in December 2005. (St. Ex. 18 at 64-65; Tr. at 754-755)
420. Next, Dr. Kelly stated that, because Dr. Villavicencio was prescribing controlled substances to Patient 16 when he learned of the ankle monitor in February 2006, Dr. Villavicencio should have inquired about it to confirm that there was no relation to drug use. (Tr. at 756)
421. Dr. Kelly further stated that Dr. Villavicencio should have stopped prescribing controlled substances to Patient 16 when he learned in April 2006 that Patient 16 had been caught selling cocaine. He explained that, because Patient 16 was involved in selling illegal drugs,

he certainly could have sold prescribed medications as well, and a doctor should not want to be involved in aiding or abetting such activity. (Tr. at 757-758)

422. Moreover, Dr. Kelly commented that Dr. Villavicencio had no notes to indicate he had checked on the urine drug screens that, in April 2006, Patient 16 claimed were taking place regularly. Dr. Kelly explained that, although he does not believe it was reasonable to continue prescribing controlled substances to Patient 16 at that time, Dr. Villavicencio should have checked those urine drug screens because he continued to prescribe controlled substances to Patient 16. (St. Ex. 18 at 64; Tr. at 758)
423. Dr. Kelly concluded that the primary focus of Dr. Villavicencio's treatment of Patient 16 was back and neck pain, and that the medications doses included 25 mg of oxycodone and 3 mg of Xanax each day. He opined that the documentation poorly supported the initial and continuing chronic treatment. Additionally, Dr. Kelly noted that sections of the chart notes, including reviews of systems and physical examinations, were identical to prior visits and were identical to the same sections in other patients' records. (St. Ex. 18 at 64; Tr. at 760)
424. Also, Dr. Kelly concluded that Dr. Villavicencio's documentation of his care of Patient 16 (as related to the controlled substances prescribed) constituted a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (St. Ex. 18 at 65; Tr. at 1404)
425. Dr. Kelly noted that, if the low back pain and anxiety diagnoses are accepted, Dr. Villavicencio's prescriptions to Patient 16 were within the standard of care. (Tr. at 755, 1404)

Opinion of Dr. Villavicencio

426. Dr. Villavicencio testified first that he did not know whether Patient 16 was already taking medications at the time he first saw Patient 16. Later, Dr. Villavicencio testified that Patient 16 had been taking Xanax and Percocet.⁴⁶ Dr. Villavicencio also stated that he chose to prescribe Percocet, in addition to Naprosyn, at the first visit because Patient 16 had a history of chronic back pain, and had had a couple of four-wheeler accidents. Dr. Villavicencio further testified that the dose of Percocet that was initially prescribed was the same as Patient 16 had been prescribed previously. (Tr. at 419-421, 1529, 1532)
427. Dr. Villavicencio explained that he had diagnosed anxiety at Patient 16's first office visit because Patient 16 had described having headaches and problems sleeping at night. He added that Patient 16 had been prescribed Xanax for anxiety in the past. (Tr. at 1531)
428. Dr. Villavicencio explained that he had given Patient 16 six months to obtain the MRI because of its cost. He further explained that he tries to get the MRIs as soon as possible, but not all

⁴⁶In a questionnaire that Patient 16 completed on the same day as his first office visit with Dr. Villavicencio, Patient 16 reported that he was taking Lortab, Percocet, and Xanax. (St. Ex. 16 at 2)

of his patients comply. Dr. Villavicencio stated that Patient 16 was a self-pay patient and had no insurance. (Tr. at 422, 1533, 1535-1536)

429. Dr. Villavicencio stated that he could not explain why he had not recommended physical therapy to Patient 16. (Tr. at 423)
430. Dr. Villavicencio testified that he had increased the dosage of Percocet in December 2005 because of an injury to Patient 16's left forearm. (Tr. at 423-424)
431. Dr. Villavicencio disagreed with Dr. Kelly's contention that the use of a short-acting opiate medication was not documented well. Dr. Villavicencio stated that his documentation could have been better, but there still were enough factors in the patient's history and physical examination to conclude that Patient 16 was in pain and needed something for the pain. (Tr. at 1550)
432. With regard to Patient 16's high blood pressure, Dr. Villavicencio stated that he had not documented, before March 2006, that he had tried to convince Patient 16 to take a blood pressure medication, and that it was not until March 2006 when Patient 16 had agreed to get the prescription. (Tr. at 1542, 1544-1545)
433. With regard to the ankle monitor, Dr. Villavicencio explained that, when he saw it on Patient 16 in February 2006, he did not inquire about it because he had not previously had a patient with such a monitor and did not realize that it could be related to the way the patient uses prescribed medications. He added that, in the first year of his practice, he was a little embarrassed to ask about the ankle monitor. He also stated that he mentioned the ankle monitor in his progress note because it was the reason why Patient 16 was stressed. (Tr. at 426-427, 1539-1540)
434. In the following exchange, Dr. Villavicencio discussed how he learned more from Patient 16 in April 2006 about the ankle monitor:

Q. What does that note mean to you in -- in relationship to the care of this patient?

A. Well, I finally -- I finally -- I -- I think what I did at that time is I tried to do a drug screen on him because -- and he finally told me that, "You know what? I am -- I am -- I'm -- you know, you see this ankle monitor? It's because I was convicted. And I -- I am getting regular drug screens as being part of -- of that system." And then I probably asked him at that point what -- what he did. And he told me that he got caught -- was accused of -- of -- of selling cocaine.

Q. Had he been convicted by that point?

A. No.

- Q. Okay. So he was on pretrial release?
- A. Something like that. I don't understand the – the system myself.
- Q. Dr. Kelly opined that you were required under the standard of care to stop prescribing to this individual. Do you believe that?
- A. I don't – I don't believe the gentleman has been convicted at this point.
- Q. There's a note here that says he was caught selling cocaine. Isn't –
- A. * * * He – Well, that was my way of saying that – that he is being accused of – of selling cocaine.

* * *

That – That may have been my – my wording, but – but the way I meant it to be was that he is being accused of dealing with cocaine. But – But sometimes, you know, I – whatever is – pops up to mind, you know. But one thing I know, it's he's not been convicted, so I know that the – the charges are there, but it's not been proven.

(Tr. at 1546-1548)

435. Dr. Villavicencio stated that, between 2005 and 2008, it was within the standard of care to continue to prescribe controlled substances to Patient 16 because Dr. Villavicencio was convinced that Patient 16 had a legitimate cause for pain. (Tr. at 1549)
436. Dr. Villavicencio stated that he did not obtain copies of the drug screens that Patient 16 had said were being done. (Tr. at 427)
437. Dr. Villavicencio agreed that the chart entries appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. (Tr. at 1579)
438. Dr. Villavicencio disagreed that the medical record lacked documentation to support the use of the controlled and non-controlled medications, or the increase in dosage. He stated that he realizes why Dr. Kelly had difficulty trying to justify the prescribing patterns as he reviewed each progress note. However, Dr. Villavicencio testified that, if all of the information in the medical records is taken into consideration (including the intake forms and his staff's notes), he believes that his medical record is “better documented than * * * the allegations would suggest.” (Tr. at 1575-1576)

Other Testimony of Dr. Kelly

Review of the Medical Records of Patients 1 through 16

439. Dr. Kelly explained that he reviewed both the staff's notes and Dr. Villavicencio's notes in Patients 1 through 16's medical records. He acknowledged that he did not look at each staff note in relation to Dr. Villavicencio's notes from that same date. Rather, he stated, "I based my impression and my conclusions primarily on what the doctor recorded." (Tr. at 1060, 1298-1299, 1314)
440. Further, Dr. Kelly testified that he did not remember any pain scales in the patients' records, which made it more difficult to know the initial assessment and the results of the pain prescriptions given. He stated that, if the records contained pain scales, it would have provided better documentation, but he would not change his opinions because there are other "major" issues. Dr. Kelly clarified later that he did not see any pain scale information in the documentation created by Dr. Villavicencio, and thus it was unclear whether Dr. Villavicencio considered the pain scales in his own assessments. (Tr. at 834-836, 864-865, 867-870)
441. Dr. Kelly acknowledged that many of Dr. Villavicencio's prescriptions were consistent with the history, examination and diagnoses as documented. Also, he found it appropriate that Dr. Villavicencio treated pain with a pain medication regimen. (Tr. at 1311-1312) Below is a summary of those findings per patient:

Patient 3: Tr. at 1134-1135

Patient 5: Tr. at 1158-1161, 1164, 1180-1181

Patient 8: Tr. at 1091, 1096-1098, 1118-1119

Patient 9: Tr. at 1002, 1041

Patient 10: Tr. at 1047, 1050, 1053, 1055-1056, 1075, 1079-1080, 1083-1084

Patient 12: Tr. at 969

However, Dr. Kelly explained that, despite the consistency or appropriate use of pain medications to treat pain, Dr. Villavicencio still did not meet the standard of care in his care and treatment of Patients 1 to 16 because assessments were inadequate, the choice of medication was improper, and/or the dose of medication was improper. (Tr. at 1412-1414, 1434-1435)

Medication Dosages and the Standard of Care, 2005-2008

442. Dr. Kelly testified that, if a patient had not already been taking opiates, the standard of care between 2005 and 2008 required doses of short-acting opiate first, not long-acting opiates. (Tr. at 1328-1329) Dr. Kelly described the difference between short-acting and long-acting medications:

So just to start with, a long-acting medication, it's a medication that does not get metabolized all that quickly so its effects last longer. And it is typically taken anywhere from once a day to, at most, three times a day, probably most

often twice a day, because it has enough duration taken twice a day to last for the whole day.

So it provides kind of an ongoing, if you want to think of sort of a smooth – smooth level without a lot of peaks and valleys in terms of its therapeutic effect on the system. But that would be long acting. So examples would be extended-release morphine, like MS Contin; extended-release oxycodone, like OxyContin; a Duragesic patch would be another type of long acting. So those would be the long acting.

The short-acting medications have a much shorter duration of activity before they get metabolized by the body. So they will just generally have a peak effect that occurs within a half an hour to, say, an hour-and-a-half or two after taking it, and then within four to six hours that effect has pretty much gone away.

So examples of that would be nonextended-release oxycodone, hydrocodone, and morphine. Those are generally taken as often as every four to six hours as a frequency of dosing.

(Tr. at 1407-1408)

443. Dr. Kelly stated that, for the 16 patients involved in this matter, a maximum daily amount of 80 mg of oxycodone would have been appropriate for Dr. Villavicencio, as an internal medicine physician, to prescribe between 2005 and 2008. (Tr. at 1321-1328, 1355, 1390, 1419-1420)
444. Dr. Kelly stated that the maximum daily dosage of long-term morphine that was acceptable for an internal medicine physician under the standard of care between 2005 and 2008 was 90 mg. (Tr. at 1364-1365, 1419-1420)
445. However, Dr. Kelly added that, if a pain management specialist had recommended higher doses of pain medications, a internal medicine physician would have been within the standard of care to follow the advice of the specialist and issue corresponding prescriptions thereafter. (Tr. at 1350-1353, 1421-1422)
446. Dr. Kelly testified that, between 2005 and 2008, it was not within the standard of care for a family practitioner to prescribe methadone to a non-cancer patient at any level, unless a pain management specialist specifically had recommended it. (Tr. at 1378-1380, 1394, 1399) Dr. Kelly explained as follows:

Well, essentially, methadone is another type of long-acting opiate. And it has major safety risks. So there are several much safer options. And that means that there's no reason to use this unsafe option when there are safer options. And in my experience with dozens and dozens of primary care physicians who

are not pain specialists, who are primary care physicians but who treat pain, methadone is not used, and the reason is because of the safety issue with its use.

It is used by some palliative care – palliative care specialists, and it is used by addiction medicine specialists, and it may also be used by some pain specialists who treat chronic nonterminal pain, but I can't think of any primary care physician that I know or have any knowledge of who uses methadone for pain treatment.

* * *

[I]t's my opinion that it's outside of the standard of care for a non-pain specialist to use methadone to treat pain in a primary care pain treatment environment.

(Tr. at 1420-1421)

447. Moreover, Dr. Kelly added that the maximum daily dosage level of diazepam (Valium) allowed under the standard of care for treating muscle spasms or anxiety between 2005 and 2008 was 40 mg. (Tr. at 1362, 1419-1420)

Patient Compliance

448. Dr. Kelly stated that patients are not always compliant with physician instructions, and sometimes their noncompliance is based on financial considerations and sometimes it is for other reasons. Dr. Kelly described several ways of working with the patients and monitoring the patients. (Tr. at 820-824)
449. Dr. Kelly testified that insurance and/or financial issues can prevent or delay testing and referrals from taking place. He does not criticize Dr. Villavicencio for the patients' failure to obtain testing or referrals. However, he stated that Dr. Villavicencio continued to prescribe medications to the patients at high levels and/or unsupported levels, despite test results that do not support such prescribing and despite the recommendations of specialists. (Tr. at 1415-1416, 1437)

Other Information

450. Dr. Kelly stated that emergency-medicine physicians are very attuned to drug-seeking behaviors because "a lot" of people that go to the emergency rooms are drug-seeking. (Tr. at 763-764, 830)
451. Dr. Kelly stated that pain can be confirmed by reproducing it through palpation, or by verifying restricted range of motion. (Tr. at 833-834)

452. In the following exchange, Dr. Kelly discussed Dr. Villavicencio's prescriptions of higher numbers of tablets than a 30-day supply:

Q. Is it okay for the dosing instructions – when the dosing instructions and the number of pills don't add up to a 30-day but add up to beyond a 30-day period?

A. I don't think that's a good – a good practice to do that, but I am not sure I can say it's outside of the standard of care.

* * *

Well, the problem with the prescription is, essentially, you've given the patient more doses to use in the 30-day period than the directions indicate you are, in theory, telling the patient to use. In practice, what – what typically happens is that most patients would, in fact, use all of the pills in a 30-day period. Not every patient would do that, but many would. And so it would be better to either give directions for the higher quantity in the way that you think it should be taken, or to not give the higher quantity.

Q. Is that kind of format for prescribing used because insurance won't cover certain types of dosages?

A. I – I don't know. I have not encountered that issue myself, and I haven't heard of that being a – an issue that would lead to this type of prescribing. So I'm not sure I can say that's not possibly an issue, but it's not an issue that I have encountered or heard of.

(Tr. at 1442-1444)

Additional Testimony of Dr. Villavicencio Regarding His Practices, 2005-2008

Intractable Pain Administrative Rules

453. Dr. Villavicencio testified that, between 2005 and 2008, he was familiar with the intractable pain rules and that he regularly reviewed them. Dr. Villavicencio considered "intractable pain" to be synonymous with "chronic pain" and even stated specifically that he had treated Patients 2, 3, 7, 9, 10, and 11 for intractable pain. He stated that he had attempted to fulfill the requirements of the intractable pain rules for all of his patients at that time, but that he had had a hard time getting roughly 40 percent of his patients to see a pain management specialist because they did not have medical insurance. (Tr. at 28-29, 104, 134, 197, 265, 308, 326, 1194-1197, 1682)

454. Dr. Villavicencio admitted that he “fell short” of the documentation requirements set forth in the intractable pain rules. (Tr. at 438-439). Furthermore, when asked whether he complied with other aspects of the intractable pain rules, Dr. Villavicencio stated the following:

I knew what the rules were and I tried to comply with them. The documentation part was missing. But I think that the – the – what – what is not visible really there until I expand on it is the problem with compliance. You know, it’s easy for the Medical Board to say we need this MRI, we need the pain consult. It’s easy to say that.

But in the real world, you’ve got patients with no insurance. You’ve got the practitioners who would not see a patient because they have no insurance. And a lot of times the decision to do that is outside their – their capacity because they belong to a group and the group makes the decisions.

It’s not a private person like me that I can tell my office manager, “We will see this patient even though she doesn’t have the money to pay.” We do that a lot in our Suboxone patients. If they don’t have the money to pay, we let them in. Second time around, we say we can’t do this.

So – But a lot of the practitioners, they are in groups and the groups have rules. So if you don’t have any insurance, there’s usually no recourse. Usually, you don’t get seen.

There – There’s – There’s that component of – the reality of the fact is we have a major health care crisis in this country and – * * * when patients faces me here, do I say, “Hey, I – I can – I can show where we tried to comply with the rules,” or “I can just kick you out the door, let you find another doctor, and after several months you can come here and we can start to count six months.” So I tried to do what I felt was the right thing to do.

(Tr. at 436-437)

Initial Visits with Pain Patients

455. Dr. Villavicencio stated that, with a new patient between 2005 and 2008, “we look at the doses that they have been on, and as a first measure, we prescribe them the same amount. And the only time we alter it is if we got new symptoms or information coming in, and either in the form of a – increased pain on physical exam, or a – in the form of an MRI, or in the form of a medical record that was transferred over from his previous doctor.” Dr. Villavicencio added that he asked the patient for the level of their pain and how it affected their lifestyle/livelihood. (Tr. at 1204-1205, 1532)

456. Dr. Villavicencio testified that he later stopped taking his patients at their word:

And then we changed our practice. So I – I – and I'm not tell – I'm not able to tell you as to what – what time, but we tried to constantly evolve in the practice. At some point after that, when we realized that patients were not totally upfront, then we would demand printouts from the old pharmacy.

* * *

Probably six months into the practice, we started demanding them to bring pills with names on them to show that they've been prescribed that. We would ask them for printouts from the pharmacy.

* * *

Sometimes they would bring records from the other doctors. It's – It's hard to obtain records from other doctors at that point.

(Tr. at 56-57)

457. He further testified that he obtained advice from other physicians about treating the pain patients:

I was a neophyte in pain management. And when I found myself with these patients, I – I – I – I consulted with a number of pain physicians as well as a number of family physicians. * * * So I did talk to a number of doctors.

The family practice doctors I got – took advice from would be the doctors in Logan, Ohio, where I worked as an emergency room doctor.

(Tr. at 1205-1206)

Use of the Ohio Automated Reported Rx System [OARRS]

458. Dr. Villavicencio testified that he was one of the first users of OARRS when it began in the late part of 2006. OARRS is a database containing prescriptions issued for controlled substances, carisprodol and tramadol. Dr. Villavicencio also noted that the OARRS reports contain information about the former physicians, including addresses and telephone numbers. Dr. Villavicencio stated that, initially, there were problems with OARRS, such as getting into the system and delays with entering the data. (Tr. at 448, 450, 1582-1583; Resp. Exs. C, D, E)

Referrals to Specialists

459. Dr. Villavicencio testified that, between 2005 and 2008, many pain specialists would not see any of his patients who did not have private insurance. (Tr. at 58-59)

Early Refills and Patient Noncompliance with Instructions

460. Dr. Villavicencio stated that, between 2005 and 2008, his office was “fairly lax” in prescribing medications if a patient was seen early (e.g., before the last day of the prior prescription). He explained that, during that time period, he periodically adjusted the office visits if the patient had repeatedly come in early. (Tr. at 78-79)
461. Dr. Villavicencio acknowledged that, if a patient was noncompliant with an MRI order or physical therapy, he did not have to continue prescribing narcotic medications. However, he stated that he initially had to learn this on his own. At that time, he believed that as long as the patients were employed and working, it supported a continuation of the pain medications. (Tr. at 1676-1677)

Dosing Instructions and Numbers of Pills Prescribed

462. Dr. Villavicencio testified that, at times, his prescriptions were based on the date of the patient’s next scheduled office visit. He explained that, if the next visit was scheduled to be more than 30 days later, insurance restrictions on filling more than a 30-day supply of medications could be triggered. Therefore, Dr. Villavicencio changed the dosing instructions and/or number of pills, but would tell the patient to continue taking the medication as had been previously prescribed. Dr. Villavicencio stated that such prescriptions were not medication increases. (Tr. at 167-168)
463. Dr. Villavicencio further stated that, at other times, he made errors in his dosing instructions. For instance, in the following exchange, Dr. Villavicencio testified that the increase in the number of OxyContin pills (from 90 to 120 tablets) prescribed to Patient 8 in November 2005 was intended and the dosing instructions were erroneously not modified:
- Q. Then if we look at [State’s Exhibit 8 at] Pages 47 and 48. And those are two office visits, and I believe, if I am looking at this correctly, that the dosing instructions for the OxyContin remain the same, but the number of pills that were prescribed between those two dates changed such that a larger number of pills was prescribed in November of 2005. Is that correct?
- A. From October to November, yes, it was increased.
- Q. Why were the – was a larger number of pills prescribed if the dosing instructions remained the same?
- A. That was an error on our part. Because the easiest way to change the direction would be to click on the medication and it brings up the medication and you change the amount, and most of the time you have to change the sig, but sometimes I failed to do that. But, normally, the pharmacist would call me and remind me to do that.

Q. So if there are other instances in the records that reflect a larger number of pills but the dosing instructions having not changed, would those be errors?

A. Yes.

Q. And it was not an error in the number of pills; it was an error in not modifying the dosing instructions?

A. Yes. The – When – When we increase the number of pills to an odd number, like 116, that means to say that it's temporary, and maybe because the patient's coming back after five days after 30 days and the insurance company would not let you fill a script without changing it.

So, in other words, if I give the patient a medication three times a day, but if they're coming back in 36, 37 days and I have to give extra pills, we change the directions to one tablet – two tablets twice a day in terms of OxyContin, but the patient is made aware that they should take it the way they should. It's just that we can't give them OxyContin one tablet three times a day and give them 116, something like that.

(Tr. at 1688-1691)

Pharmacy Rejections

464. Dr. Villavicencio stated that, between 2005 and 2008, pharmacies were not filling his prescriptions for certain levels of pain medications because he was not considered to be a pain specialist. He stated that the pharmacies considered the prescriptions to be “red flags.” (Tr. at 385-386)

Urine Drug Screens

465. Dr. Villavicencio testified that he initially had problems conducting urine drug screens because his office did not have the manpower. He also noted that some of his staff also did not correctly conduct the urine drug screens. In addition, he stated that his office used various laboratories for urine testing. (Tr. at 451-452)

Pill Counts

466. Dr. Villavicencio stated that he selectively conducted pill counts between 2005 and 2008. (Tr. at 1661-1662)

Pain Management Coursework

467. In 2006, Dr. Villavicencio attended two courses in pain management for which he also presented supporting documentation. Dr. Villavicencio testified that he believes he also took two additional courses that addressed pain medicine during the 2005-2008 timeframe. (Tr. at 17-18, 435; Resp. Ex. DD at 2-4)

Dr. Villavicencio's Testimony Regarding MS Contin, OxyContin and Methadone

468. Dr. Villavicencio presented excerpts from the Physicians' Desk Reference [PDR], 2007 Edition, regarding MS Contin and OxyContin. With regard to MS Contin, the PDR reflects that doses of 100 and 200 mg of MS Contin are for opioid-tolerant patients only. With regard to OxyContin, the PDR reflects that doses of 80 mg and 160 mg of OxyContin are for opioid-tolerant patients only. (Resp. Ex. EE at 2-4, 9)

469. Dr. Villavicencio disagreed with Dr. Kelly's opinion that it was below the standard of care for a family practitioner to prescribe methadone between 2005 and 2008. (Tr. at 1558-1559) He agreed with Dr. Kelly with regard to the problems associated with methadone and added that, between 2005 and 2008, he had tried to stay away from prescribing methadone:

I was actually trying to stay away from methadone. The only reason why we prescribe methadone is because of a very hard push from the medical providers, like Molina and CareSource, they – they actually deny a lot of the pres- – long-acting narcotic medications. And they would send us a letter asking us to – to try methadone, try morphine, try a fentanyl patch. So that – that's actually a push from the carriers. I –

* * *

I can tell you that in – in my patient database, I – I have about six, seven patients on methadone currently. So that's – it's – it's a recognition of the – I am very well aware of – of the problems with using methadone for pain control, but – but it does have its place. I mean, it's a long-acting medication and it lasts twice as long as oxycodone or Percocet. So there is – there is a – a time and a place where you can use them for patients who are very compliant. I have no problems using methadone, but – but as a general rule, I have resisted a push from the insurance carriers to use this drug more often just because of the – the fact that it's actually the cheapest pain control medication on the market.

(Tr. at 1557-1558)

470. He also stated that he would not prescribe methadone if the patient had private insurance. (Tr. at 1652)

471. Dr. Villavicencio presented an article entitled “Methadone Treatment for Pain States,” from American Family Physician, dated April 7, 2005. The article reflects that methadone can be prescribed by licensed family physicians for analgesia. Conversion to methadone should be based on the current daily oral morphine equivalent dosage. In addition, the article reflects that the transition to methadone and dosage titration should be completed slowly and with frequent monitoring, based on patient response and signs of toxicity. “Increases should not be made more frequently than every five to seven days * * * During the titration phase, daily telephone progress reports by the patient, family members * * * are recommended. Patients should be informed that several titrations might be necessary to reach optimal pain control.” (Resp. Ex. FF)

Dr. Villavicencio’s Testimony Regarding the Standard of Care

472. Dr. Villavicencio stated that the standard of care for a patient with insurance would be different for a patient without insurance and, similarly, the standard of care would be different between affluent and poor patients. Later, he stated that the standard of care should not change, but when judging a particular violation of the standard of care, one should take into consideration whether a patient had insurance. (Tr. at 1670, 1680)

Dr. Villavicencio’s Current Medical Practice

473. In his current practice, Dr. Villavicencio employs four medical assistants, all of whom are trained in medical assisting. There is also a second physician in the practice who sees Suboxone patients. (Tr. at 447-448)
474. As of January 2012, Dr. Villavicencio saw approximately 50 patients each day, and worked four and one-half days per week. He stated that his patient base is roughly 1,000 patients, consisting of roughly 425 chronic pain patients, 425 general family practice patients, and 150 Suboxone patients. (Tr. at 27, 31-32)
475. Dr. Villavicencio stated that OARRS is a valuable tool and is the “number one reason why we don’t have any more fatalities in our practice.” He now looks at OARRS for every new patient. Dr. Villavicencio said that the OARRS reports have made it easy for him to do a more complete screening of the patients starting with the initial visit. He added that, as of two years ago, he began looking at similar databases in other states – Indiana, Kentucky and West Virginia. (Tr. at 448, 450, 459, 1645-1646)
476. Moreover, he explained what he does with information in OARRS that reflects multiple prescribers:

Well, the –the – when I see a patient has multiple providers, I address that issue with the patient. If, to me, there’s – there’s evidence that the patient is – is selling drugs, I – I have very, very little tolerance for that and – and I would discharge the patient, but – but if the patient has significant findings on the MRI and appears to be undertreated, then I would address that issue with them.

A lot of times, the – the multiple providers from the OARRS is justifiable. A lot of these people have surgeries. If they have surgeries, I'll let the surgeon take care of their acute care. So if I review the chart of a number of my patients who have had surgeries, they will have other providers listed in the OARRS. * * * I justify that as a valid use of multiple providers because I would not take care of any acute surgical pain.

(Tr. at 1584)

477. For referrals to pain management specialists, he currently refers his cash-only patients to a pain management specialist. (Tr. at 1198-1199)

478. Dr. Villavicencio testified that his documentation has improved since he opened his private practice. He also presented the forms, documents, and policies that were established after 2008 and used in his medical practice as of the date of the hearing. His current intake forms for new patients ask the patient to list current medications. Dr. Villavicencio, however, does not include a list of current medications at all follow-up appointments for all patients. He further added that he classifies patients as low, moderate, and high risk for misuse of medications, and the treatment plans take that classification into consideration. (Tr. at 205, 1227-1228, 1660, 1663, 1686-1687, 1703-1705; Resp. Exs. A, B)

479. Dr. Villavicencio explained his current office policy for lost/stolen prescriptions:

[N]ow the policy of the clinic is we just don't fill any lost scripts. I mean, we believe that the patient has responsibility, we've made them aware of that, and we've actually stopped doing that because it – you know, I think that for them to go to the police and file a report, it just takes so much time and accomplishes nothing. So we have actually just stopped filling the lost scripts at this time.

(Tr. at 1702)

480. As of January 2012, Dr. Villavicencio adjusts the number of pills prescribed based on the patient's next scheduled office visit. (Tr. at 78-79)

481. At the hearing, Dr. Villavicencio stated that he has the necessary manpower to conduct urine drug screens and his staff has been properly trained. He added that his office does roughly ten urine drug screens a day. Moreover, he noted that he is doing "dipstick" tests in his office now, but is in the process of changing the urine screen procedures. (Tr. at 215, 451-453, 1662)

482. With regard to pill counts, Dr. Villavicencio stated that, currently, he does pill counts on most of the patients, which is roughly three to four pill counts each week. (Tr. at 288, 1662)

483. Dr. Villavicencio described the reasons he made changes in his medical practice after 2008:

I think the – the training that I got, I think the admission from the – from the – the admission on the part – the pain – pain management advocates that they have actually probably overemphasized and under – overemphasized the – the need to treat pain and they underemphasized the dangers associated with that stand. That admission – The public admission from some of their advocates did strike a chord in me.

I think that the deaths of these ten people affected me quite a bit. I think that my further experience with – with – with managing patients from a clinical point of view of pain and – and then looking at the other side of – of the coin, in some patients they have both problems, addiction and – and pain. And – And where you have one and not the other, it's simpler. I can – I treat addiction patients right now and – and that makes it easy on me if they don't have pain. I treat patients with pain and – and low risk for addiction, and that's simple for me to do.

If the patient's in the middle, that – that is constantly an evolving experience. And – And as a physician, I work hard. And I work six, seven days a week and – and I go out of my way to – to – to – to treat my patients. I think that I am a – better at prescribing now, I am better at documentation now.

But I can tell you that – that patients are patients. And – And while you can do your best as a physician, there will be one or two in the course of your – of your practice that will surprise you. And I would – And I would say that – that even these patients probably would find themselves in a situation where, "Hey, I didn't know I could do this. I didn't know that I am doing this, you know."

A lot of my patients who have a tendency towards addiction do struggle in accepting that and – and they – they're – they're – they would be very hard to convince them that – that the use of the medication must be strictly regulated and that – and that they're – they're – they face the dangers of – of misuse. So – So those are some of the things I learned.

And – And what I can say is we haven't had any deaths in the past two years. I – I have patients on Suboxone who fail to follow up and then I get a – a report that they died later on, so that has happened from – from drug overdose, not Suboxone, of course.

But, generally, I – I say that – that we are better at our practice and we are changing the way we practice all the time to – to adjust, but at the end of it, the patient has a role, too. You know, if they can't accept our help to help

them with – with the way to control the use of their medication, I can't do much, you know.

(Tr. at 432-434)

Other Information

484. Dr. Villavicencio testified that, while working in emergency rooms, the hospital staff regularly informed him that information was missing from his charts. He would then try to increase the documentation “in order to get [to] the level that’s deserving for the patient.” (Tr. at 61, 205, 1509-1510)
485. Dr. Villavicencio stated that, after 2008, he completed a Suboxone course and obtained certification from the American Board of Addiction Medicine. (Tr. at 17-18, 435)
486. Dr. Villavicencio does not hold privileges at any hospital. (Tr. at 18)
487. Dr. Villavicencio testified that his medical practice and patient population are very different from those of Dr. Kelly. (Tr. at 1512-1513)
488. Dr. Villavicencio made the following statement for the Board’s consideration:

We went through a difficult time installing electronic medical records in 2005. And the notes in 2005 and 2006 have, for the most part, been there to jog my memory. Today, the notes are much more detailed and – and if just to allow my nurse practitioner and my fellow physicians to cover for me.

So far as inappropriate prescribing is concerned, I have worked hard to further my training since 2005, 2006. As you have been made aware of, I have attained certification in addiction medicine, one of 3,000 doctors who have done so. Training in addiction currently allows me to work with patients with substance abuse and as well as psychiatric disorders. And on a lot of these patients I have been able to use the training to lower their medications of prescribed drugs.

The death of ten of my patients has deeply affected me and continues to affect me in a way because I am reminded every time I see the mother and the children of Patient 9, every time I see the patient of – sister of Patient No. 10, the son-in-law of Patient No. 12.

While these relatives and myself maintain that I was not solely or chiefly responsible for the deaths, as detailed analysis of the autopsy results would show, I – I do wish that I had then the training and experience that I have now in order to have detected the depression and the comorbid psychiatric conditions

that may have affected their judgment, their use and misuse of the drugs or the medications which I legitimately prescribed.

I continue to prescribe more narcotic medications than the expert witness, Dr. Kelly, does, but these prescriptions nowadays are – are sanctioned by pain specialists. The – The fact that I prescribe a lot more narcotic medications just comes with the territory. It – It's – It depends – It's a – a product of the patient population that I service.

There is on my part, for example, also a very high rate of prescribing of inhalers and pulmonary medications and diabetic medications. It's just the kind of patients that I serve.

Just the same, we have changed the direction of the clinic. Currently, we have less than 50 percent of our patients with chronic pain. We cater sometimes to as many as 15 patients with – occupational medicine patients a day. We have taken on a number of BWC patients. And we are in the process of trying to hire a pediatrician.

We also currently have 150 patients in our Suboxone program. This program has actually allowed us to return to function a fair number of nurses, businessmen, teachers, computer programmers, and homemakers.

I believe that my service as a physician has kept a lot of people from going to the emergency room for what is – for what appears to be episodic and disjointed medical care. I believe that our office is in a position to render health care services to more people should and when the health care act of President Obama become[s] implemented.

Our practice has renovated three abandoned buildings on the south side of Columbus, structures that would have remained eyesores for decades to come.

As a – As a doctor, I have worked very hard for the past seven years, 11 hours in the office and more hours at home later in the night reviewing the records for the following day. My – My – My faith – My religion and my faith sustains me in all these struggles, and I believe that God has given me custody of gifts and blessings that I need to multiply and give back. I would like for the Medical Board to judge me in this context and I hope that I will be allowed to continue practicing medicine.

(Tr. at 1666-1669)

RELEVANT RULES IN THE OHIO ADMINISTRATIVE CODE

Rule 4731-11-02(D), Ohio Administrative Code, as in effect between 2005 and September 29, 2008, stated “A physician shall complete and maintain accurate medical records reflecting the physician’s examination, evaluation, and treatment of all the physician’s patients. Patient medical records shall accurately reflect the utilization of any controlled substances in the treatment of a patient and shall indicate the diagnosis and purpose for which the controlled substance is utilized, and any additional information upon which the diagnosis is based.”

Rule 4731-21-02, Ohio Administrative Code, as in effect between 2005 and November 29, 2008, stated as follows:

- (A) When utilizing any prescription drug for the treatment of intractable pain on a protracted basis or when managing intractable pain with prescription drugs in amounts or combinations that may not be appropriate when treating other medical conditions, a practitioner shall comply with accepted and prevailing standards of care which shall include, but not be limited to, the following:
- (1) An initial evaluation of the patient shall be conducted and documented in the patient’s record that includes a relevant history, including complete medical, pain, alcohol and substance-abuse histories; an assessment of the impact of pain on the patient’s physical and psychological functions; a review of previous diagnostic studies and previously utilized therapies; an assessment of coexisting illnesses, diseases or conditions; and an appropriate physical examination;
 - (2) A medical diagnosis shall be established and documented in the patient’s medical record that indicates not only the presence of intractable pain but also the signs, symptoms, and causes and, if determinable, the nature of the underlying disease and pain mechanism;
 - (3) An individualized treatment plan shall be formulated and documented in the patient’s medical record. The treatment plan shall specify the medical justification of the treatment of intractable pain by utilizing prescription drugs on a protracted basis or in amounts or combinations that may not be appropriate when treating other medical conditions, the intended role of prescription drug therapy within the overall plan, and, when applicable, documentation that other medically reasonable treatments for relief of the patient’s intractable pain have been offered or attempted without adequate or reasonable success. The prescription drug therapy shall be tailored to the individual medical needs of each patient. The practitioner shall document the patient’s response to treatment and, as necessary, modify the treatment plan;
 - (4) (a) The practitioner’s diagnosis of intractable pain shall be made after having the patient evaluated by one or more other practitioners who specialize in the treatment of the anatomic

area, system, or organ of the body perceived as the source of the pain. For purposes of this rule, a practitioner “specializes” if the practitioner limits the whole or part of his or her practice, and is qualified by advanced training or experience to so limit his or her practice, to the particular anatomic area, system, or organ of the body perceived as the source of the pain. The evaluation shall include review of all available medical records of prior treatment of the intractable pain or the condition underlying the intractable pain; a thorough history and physical examination; and testing as required by accepted and prevailing standards of care. The practitioner shall maintain a copy of any report made by any practitioner to whom referral for evaluation was made under this paragraph. A practitioner shall not provide an evaluation under this paragraph if that practitioner would be prohibited by sections 4731.65 to 4731.69 of the Revised Code or any other rule adopted by the board from providing a designated health service upon referral by the treating practitioner; and

- (b) The practitioner shall not be required to obtain such an evaluation, if the practitioner obtains a copy of medical records or a detailed written summary thereof showing that the patient has been evaluated and treated within a reasonable period of time by one or more other practitioners who specialize in the treatment of the anatomic area, system, or organ of the body perceived as the source of the pain and the treating practitioner is satisfied that he or she can rely on that evaluation for purposes of meeting the further requirements of this chapter of the Administrative Code. The practitioner shall obtain and review all available medical records or detailed written summaries thereof of prior treatment of the intractable pain or the condition underlying the intractable pain. The practitioner shall maintain a copy of any record or report of any practitioner on which the practitioner relied for purposes of meeting the requirements under this paragraph; and
- (5) The practitioner shall ensure and document in the patient’s record that the patient or other individual who has the authority to provide consent to treatment on behalf of that patient gives consent to treatment after being informed of the benefits and risks of receiving prescription drug therapy on a protracted basis or in amounts or combinations that may not be appropriate when treating other medical conditions, and after being informed of available treatment alternatives.
- (B) Upon completion and satisfaction of the conditions prescribed in paragraph (A) of this rule, and upon a practitioner’s judgment that the continued utilization of prescription drugs is

medically warranted for the treatment of intractable pain, a practitioner may utilize prescription drugs on a protracted basis or in amounts or combinations that may not be appropriate when treating other medical conditions, provided that the practitioner continues to adhere to accepted and prevailing standards of care which shall include, but not be limited to, the following:

- (1) Patients shall be seen by the practitioner at appropriate periodic intervals to assess the efficacy of treatment, assure that prescription drug therapy remains indicated, evaluate the patient's progress toward treatment objectives and note any adverse drug effects. During each visit, attention shall be given to changes in the patient's ability to function or to the patient's quality of life as a result of prescription drug usage, as well as indications of possible addiction, drug abuse or diversion. Compliance with this paragraph of the rule shall be documented in the patient's medical record;
- (2) Some patients with intractable pain may be at risk of developing increasing prescription drug consumption without improvement in functional status. Subjective reports by the patient should be supported by objective data. Objective measures in the patient's condition are determined by an ongoing assessment of the patient's functional status, including the ability to engage in work or other gainful activities, the pain intensity and its interference with activities of daily living, quality of family life and social activities, and physical activity of the patient. Compliance with this paragraph of the rule shall be documented in the patient's medical record;
- (3) Based on evidence or behavioral indications of addiction or drug abuse, the practitioner may obtain a drug screen on the patient. It is within the practitioner's discretion to decide the nature of the screen and which type of drug(s) to be screened. If the practitioner obtains a drug screen for the reasons described in this paragraph, the practitioner shall document the results of the drug screen in the patient's medical record. If the patient refuses to consent to a drug screen ordered by the practitioner, the practitioner shall make a referral as provided in paragraph (C) of this rule;
- (4) The practitioner shall document in the patient's medical record the medical necessity for utilizing more than one controlled substance in the management of a patient's intractable pain; and
- (5) The practitioner shall document in the patient's medical record the name and address of the patient to or for whom the prescription drugs were prescribed, dispensed, or administered, the dates on which prescription drugs were prescribed, dispensed, or administered, and the amounts and dosage forms of the prescription drugs prescribed, dispensed, or administered, including refills.

- (C) If the practitioner believes or has reason to believe that the patient is suffering from addiction or drug abuse, the practitioner shall immediately consult with an addiction medicine or other substance abuse specialist. For purposes of this rule, “addiction medicine or substance abuse specialist” means a physician who is qualified by advanced formal training in addiction medicine or other substance abuse specialty, and includes a medical doctor or doctor of osteopathic medicine who is certified by a specialty examining board to so limit the whole or part of his or her practice. Prescription drug therapy may be continued consistent with the recommendations of the consultation, including, if the consulting addiction medicine or other substance abuse specialist recommends that it is necessary, prompt referral to an addiction medicine or other substance abuse specialist for physical examination and evaluation of the patient and a review of the referring practitioner’s medical records of the patient. The practitioner shall document the recommendations of the consultation in the patient’s record. The practitioner shall continue to actively monitor the patient for signs and symptoms of addiction, drug abuse or diversion. The practitioner shall maintain a copy of any written report made by any practitioner to whom referral for evaluation was made under this paragraph.

Rule 4731-27-01, Ohio Administrative Code, as in effect since September 30, 2006, states in relevant part the following:

A physician-patient relationship is established when the physician provides service to a person to address medical needs, whether the service was provided by mutual consent or implied consent, or was provided without consent pursuant to a court order. Once a physician-patient relationship is established, a person remains a patient until the relationship is terminated.

- (A) Except as provided in paragraph (B) of this rule [which is not applicable in the instant circumstances], in order to terminate a physician-patient relationship, a physician shall comply with the following requirements:
- (1) Mail to the patient via regular mail and certified mail, return receipt requested, a letter containing the following information:
 - (a) A statement that the physician-patient relationship is terminated;
 - (b) A statement that the physician will continue to provide emergency treatment and access to services for up to thirty days from the date the letter was mailed, to allow the patient to secure care from another licensee; and
 - (c) An offer to transfer records to the new physician upon the patient’s signed authorization to do so.
 - (2) For each letter sent in accordance with paragraph (A)(1) of this rule, the physician maintains in the patient record a copy of the

letter, the original certified mail receipt, and the original certified mail return receipt.

* * *

- (E) A physician's termination of a physician-patient relationship other than in accordance with the provisions of this rule, as determined by the state medical board of Ohio, shall constitute "a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

FINDINGS OF FACT

1. From 2005 to 2008, in the routine course of his practice, Jose Villavicencio, M.D., provided care and treatment for Patients 1 through 16 as identified on a Patient Key. Dr. Villavicencio inappropriately treated and/or failed to appropriately treat and/or failed to appropriately document his treatment of these 16 patients.
 - Further, Dr. Villavicencio repeatedly and/or continually treated patients by excessively and/or inappropriately prescribing medications. Dr. Villavicencio also continued to prescribe controlled substances without appropriately pursuing or documenting the pursuit of alternative non-narcotic therapies.
 - Additionally, Dr. Villavicencio failed to record in the patients' medical records the reason(s) he prescribed medication and/or the need or reason for prescribing multiple medications.
 - Dr. Villavicencio also repeatedly and/or continually treated patients without performing and/or documenting appropriate physical examinations or evaluations, and/or without utilizing and/or documenting appropriate diagnostic testing or other methods of evaluating the patients' health conditions, and/or without devising and/or documenting treatment plans, and/or without periodically reassessing or documenting the reassessment of the effectiveness of treatment for illnesses.
 - Additionally, Dr. Villavicencio failed to adequately and/or appropriately diagnose and/or document an adequate or appropriate diagnosis of the patients' medical conditions.
 - Dr. Villavicencio also failed to document in the patient record adequate findings to support his diagnoses.
 - Further, Dr. Villavicencio repeatedly and/or continually treated patients without making appropriate and/or timely referrals to specialists.
 - Dr. Villavicencio also failed to keep and maintain adequate records reflecting his care and treatment of the patients. The entries in the medical records frequently appeared verbatim from one office visit to the next and from one patient to another, with few or no changes.

2. Examples of the prescribing and/or conduct identified in Finding of Fact 1 are set forth in the following Findings of Fact.
 - a. Dr. Villavicencio began treating Patient 1 on June 7, 2005, for conditions including rash, anxiety, COPD, and back pain. Dr. Villavicencio prescribed long-acting and short-acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack of documentation in the patient record to support the use of such medications, or the increases in dosages. At times, he failed to record all appropriate information for the medications he prescribed and often the chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. Further, Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, history, diagnoses, or treatment plan. Although he did refer Patient 1 to specialists, he failed to take and/or document taking appropriate action when she failed to keep the appointments, nor did he take and/or document taking appropriate action when he learned that Patient 1 had been receiving controlled substances from more than one provider. According to her medical record, Dr. Villavicencio last treated Patient 1 on November 16, 2006. On November 17, 2006, Patient 1 died.

Dr. Kelly testified convincingly that Patient 1's medical record lacks documentation to support the use of long-acting and short-acting opiate medications, as well as the increases in dosages. For instance, there was no documented basis for switching from Percocet to Avinza in July 2005 and switching from Avinza to OxyContin in August 2005. Moreover, there was no documented basis for increasing the dosage of OxyContin in September 2005. Additionally, Dr. Villavicencio failed to do the following:

- First, Dr. Villavicencio failed to document adequately the initial history, examination, diagnoses, and treatment plan. At her first office visit, Dr. Villavicencio did not describe Patient 1's rash or its location, did not conduct a pulmonary examination to support a diagnosis of COPD, and did not document a treatment plan for COPD. Similarly, at her second office visit, Dr. Villavicencio did not support his initial diagnosis of anxiety or support his initial prescription of Percocet (which he testified was for her back pain), both of which he treated long-term thereafter. Furthermore, Dr. Villavicencio acknowledged that Patient 1's medical record lacked information required by the standard of care.
- Second, Dr. Villavicencio failed to take and/or document taking appropriate action when Patient 1 failed to keep appointments with specialists. Dr. Villavicencio had referred Patient 1 to a pain specialist four times and had referred her to physical therapy one time, but there were no consequences when Patient 1 failed for many months to see a specialist. Patient 1's medical chart reflects that she finally saw a pain specialist in May/June 2006, almost one year after Dr. Villavicencio

began treating her. However, that pain specialist was not one of the specialists to whom Dr. Villavicencio had referred Patient 1.

- Third, Dr. Villavicencio failed to take and/or document taking appropriate action when he learned in November 2005 that Patient 1 had received controlled substances from more than one provider. He did document that he would conduct pill counts, but no counts were conducted or documented afterward.

- b.
 - i. Dr. Villavicencio began treating Patient 2 on August 15, 2005, for conditions including back pain, hyperlipidemia and/or neck pain. He prescribed long-acting and short-acting opiate medications, as well as carisoprodol (Soma), alprazolam (Xanax) and other medications, despite a lack of documentation in the patient record to support the use of such medications or the increases in dosages, and even though Patient 2 at times advised that he was doing well or the medications offered some relief. At times, Dr. Villavicencio failed to record all appropriate information for the medications he prescribed and often the chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. Further, he failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, or treatment plan. Dr. Villavicencio did not refer Patient 2 to specialists during the 22 months of treatment covered by the medical record.

Dr. Kelly testified convincingly that Patient 2's medical record lacks documentation to support the use of long-acting and short-acting opiate medications, as well as the increases in dosages. This is particularly true since Dr. Villavicencio prescribed both long-acting and short-acting opiates to Patient 2 at the first office visit even though Patient 2's history form and Dr. Villavicencio's progress note from the initial office visit reflect that Patient 2 had not taken opiate medications for more than one month, and had not taken oxycodone for four or five months. Moreover, there was no explanation for prescribing Xanax or for prescribing both Soma and Xanax, if they were both prescribed as muscle relaxers. Additionally, Dr. Villavicencio failed to document adequately the initial history, examination, diagnoses and treatment plan. Dr. Kelly pointed out that the types/aspects of Patient 2's pain, location, range of motion, strength of the back and neurologic findings were missing from the initial examination of Patient 2. Also, Dr. Villavicencio did not provide documentation to support the increase in OxyContin, Lortab and Xanax dosages in May 2007. Although Patient 2 complained of additional pain in his left shoulder in May 2007, there is no documentation to support increasing all three of those medications.

- ii. The evidence is insufficient to demonstrate that Dr. Villavicencio failed to refer Patient 2 for testing, that Patient 2 failed to comply with referrals for testing for several months, and that Dr. Villavicencio failed to take and/or

document taking appropriate action thereafter. Patient 2's medical record reflects that Dr. Villavicencio ordered MRIs on two occasions and Patient 2 obtained them rather promptly – 3 months after the first order and one month after the second order. Moreover, the medical record justifies why there was some delay in obtaining the first MRI – there was a concern about being able to safely obtain an MRI of Patient 2's back and inquiries/discussions took place, which affected the speed with which Patient 2 could obtain the first MRI.

- c. Dr. Villavicencio began treating Patient 3 on July 5, 2005, for conditions including back pain, lumbar sprain, and cervical sprain. He prescribed long-acting and short-acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack of documentation in the patient record to support the use of such medications or the increases in dosages, even though Patient 3 at times advised that she was doing better. Dr. Villavicencio also prescribed medication for Patient 3 when the documentation in Patient 3's chart indicated that Patient 3 did not have the condition for which he prescribed the medication. For example, Dr. Villavicencio prescribed Maxalt in June 2006 for headaches, although there is no documentation of a complaint or symptom of headache in the chart on that visit and the medical record documents no headache. Further, the chart entries often appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. Dr. Villavicencio also diagnosed conditions, recorded symptoms or complaints and/or prescribed medication for Patient 3 despite conflicting and/or inconsistent documentation in the patient record. For example, he prescribed Phenergan even though the chart documents no nausea, vomiting, or diarrhea. Also, he made no notation that Phenergan was prescribed to potentiate the opiates prescribed. Additionally, he documented in November 2006 that Patient 3 had wheezing, but he also documented an examination finding of no wheezing in the chart on the same date. Further, he failed to perform and/or document an adequate initial examination, examination findings, diagnoses, or treatment plan. Additionally, throughout his care and treatment of Patient 3, Dr. Villavicencio failed to address adequately and/or document addressing adequately Patient 3's noncompliance with clinical instructions. Although he did refer Patient 3 to specialists and for physical therapy and testing, there is no documentation that she ever complied with these referrals. Further, according to test results appearing in Patient 3's chart, on two occasions, tests on her urine showed negative results for controlled substances that he had prescribed. Dr. Villavicencio failed to address adequately and/or document addressing adequately the inconsistent test results, as well as Patient 3's admission that she took controlled substances prescribed for others; instead, he continued to prescribe the same or escalating doses of controlled substances.

Dr. Kelly testified convincingly that Patient 3's medical record lacks documentation to support the use of the long-acting and short-acting opiate medications and other medications (Valium, Soma and Phenergan) or the increases in dosages. The medical record lacks symptoms, examination findings, and/or coordinating diagnoses. Moreover,

Patient 3 at times advised that she was doing “ok” or “well,” which would not support the prescribing at higher doses without further documentation. Similarly, Dr. Kelly testified convincingly that Dr. Villavicencio failed to perform adequately and/or document the adequate performance of the initial examination, examination findings, diagnoses, and treatment plan. The history of Patient 3’s back pain, location, then-current symptoms, type of restrictions, and a neck examination were lacking. Furthermore, Dr. Villavicencio acknowledged that Patient 3’s medical record lacked information required by the standard of care. Moreover, Dr. Villavicencio did not adequately address Patient 3’s noncompliance with numerous clinical instructions. Patient 3 never obtained an MRI during 35 months of treatment, did not see any referred pain management specialists, had abnormal urine screen results, and took others’ medications. Although Dr. Villavicencio discussed matters with Patient 3 during those 35 months, that response was inadequate for the continuing noncompliances.

- d. Dr. Villavicencio began treating Patient 4 on October 12, 2005, for conditions including back pain, radiculopathy, acne, and anxiety. He prescribed long-acting and short-acting opiate medications, as well as carisoprodol, diazepam and other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications or the increases in dosages, and even though Patient 4 at times advised that he was doing well otherwise. Dr. Villavicencio also diagnosed conditions and/or prescribed medication for Patient 4 despite conflicting and/or inconsistent documentation in the patient record. For example, at Patient 4’s first visit, Dr. Villavicencio diagnosed anxiety, although he failed to document any symptoms to support this diagnosis, and he prescribed Ultravate Cream, although he failed to document in the chart any symptoms or diagnosis to justify the prescription. Additionally, the chart entries often appeared verbatim from one visit to the next and identical to chart entries in other patients’ records from similar time periods. Further, Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, or treatment plan. He also failed to order appropriate tests to support his diagnoses or treatment, and failed to make appropriate referrals. When Patient 4 admitted that he had used medication prescribed for another, Dr. Villavicencio failed to address and/or document addressing that he counseled Patient 4 against using medication prescribed for another. According to his medical record, Dr. Villavicencio last treated Patient 4 on October 31, 2006. On November 3, 2006, Patient 4 died.

Dr. Villavicencio prescribed opiate medications and other medications to Patient 4 for 12 months. His medical record lacks documentation to support the medications and the increases in dosages. His progress note from the first office visit with Patient 4 reflects that Patient 4 had no prior history of trauma or any imaging studies. For numerous months thereafter, Dr. Villavicencio did not obtain any diagnostic/imaging studies, did not refer Patient 4 to a pain management specialist or even order physical therapy. Dr. Kelly’s testimony strongly supports the finding that the initial examination, findings, history, diagnoses, and treatment plan were not adequate because they did not contain information to support the diagnosis of anxiety, did not contain findings to

indicate Ultravate cream, did not identify the type of radiculopathy, and did not justify a diagnosis of radiculopathy. Furthermore, Dr. Villavicencio acknowledged that Patient 4's medical record lacked information required by the standard of care. Additionally, Dr. Kelly testified convincingly that the many medication changes occurred without adequate documentation of symptoms or examination findings that would justify the medication changes.

- e. Dr. Villavicencio began treating Patient 5 on May 25, 2006, for conditions including back pain and radiculopathy. He prescribed long-acting and short-acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications, or the increases in dosages. The entries in Patient 5's chart appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. Further, Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, or treatment plan. Although he did refer Patient 5 to a specialist, Dr. Villavicencio failed to follow and/or document considering the prescribing recommendations of the specialist, and he failed to take and/or document taking appropriate action when Patient 5 failed to return to the specialist as Dr. Villavicencio had ordered. Additionally, when Patient 5 indicated he previously was treated by another doctor, but chose to establish with Dr. Villavicencio (alleging that his doctor did not understand his pain and would not give him the medications he needed), and also agreed to pay cash if Dr. Villavicencio did not accept insurance, Dr. Villavicencio failed to discuss and/or document discussing this matter with Patient 5. There are no treatment records for Patient 5 between June 22, 2006, and September 5, 2006, nor is there any documentation of additional medication being prescribed and/or any documentation on how Patient 5 managed his pain for the approximately six weeks after his medication would have been exhausted. According to his medical record, Dr. Villavicencio last treated Patient 5 on October 10, 2006. On October 14, 2006, Patient 5 died.

Dr. Villavicencio prescribed opiate medications and other medications to Patient 5 for five months. His medical record lacks documentation to support the medications and the increases in dosages. Dr. Kelly testified convincingly that the initial dosages prescribed by Dr. Villavicencio were a "large increase" in the controlled-substance regimen and that the dosages were not supported by the history and examination at the first office visit. Moreover, the initial evaluation lacked important information about Patient 5's pain, including the frequency, numbness, severity, and limiting effects. Also, Dr. Villavicencio failed to take and/or document taking appropriate action when Patient 5 failed to return to the specialist as ordered in June 2006 at his second office visit. Patient 5 did not see Dr. Villavicencio for nearly 11 weeks after that order was given, and Dr. Villavicencio documented nothing about Patient 5 returning to the pain management specialist. However, Dr. Villavicencio increased the opiate dosage a second time, contrary to what the pain management specialist had recommended when he first met Patient 5.

- f. Dr. Villavicencio began treating Patient 6 on May 16, 2005, for conditions including lumbrosacral sprain, back pain, sciatica, and asthma. He prescribed long-acting and short-acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack of documentation in the patient record to support the use of such medications or the increases in dosages, and even though Patient 6 at times advised that he was doing “okay” or “well.” Dr. Villavicencio also prescribed methadone for Patient 6, although Dr. Villavicencio did not appropriately begin, titrate, or monitor the use of methadone by Patient 6. The chart entries often appeared verbatim from one visit to the next and identical to chart entries in other patients’ records from similar time periods. Further, Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, diagnosis, or treatment plan. Additionally, he failed to address and/or document addressing Patient 6’s noncompliance with clinical instructions. Although Dr. Villavicencio did refer Patient 6 to specialists and for physical therapy and testing, often Patient 6 did not timely comply with these referrals. When Patient 6 did appear for an examination by a specialist per Dr. Villavicencio’s order, Dr. Villavicencio failed to follow and/or document considering the advice of the specialist. Further, according to test results appearing in Patient 6’s chart, on one occasion, a test of his urine showed a positive result for cannabinoids, and on a different occasion, showed a positive result for a drug that Dr. Villavicencio had not recently prescribed (methadone). Dr. Villavicencio failed to address and/or document addressing the inconsistent test results and continued to prescribe the same or escalating doses of controlled substances. Dr. Villavicencio also failed to refer Patient 6 for substance-abuse counseling or treatment.

Dr. Kelly presented convincing testimony that the initial history, examination, diagnoses and treatment plan were not adequate. Among other things, Dr. Villavicencio did not describe the pain frequency, severity, and location. Patient 6’s history form includes no detailed information either. Additionally, Dr. Kelly opined convincingly that Patient 6’s medical record lacked documentation to support the use of the opiates and other medications and the increases in dosages. For the increases in August and November 2005, there are no details except that the level of pain is “10” and “7,” and Patient 6 “needs” higher dosages. This is insufficient to justify a tripling in the opiate dosage and then a later doubling in the opiate dosage.

Additionally, Dr. Kelly presented strong testimony about the need to cautiously begin, titrate, and monitor the use of methadone. Moreover, Dr. Villavicencio’s own exhibit (Resp. Ex. FF) supports Dr. Kelly’s statements. Dr. Villavicencio prescribed a 20- to 30-day supply. He also instructed Patient 6 to take two to three tablets each day; thus, Patient 6 could determine the amount to take. Nothing in the dosing instructions or in Patient 6’s medical record reflects that methadone was begun slowly or titrated, or that its use was monitored at all.

With regard to the urine drug screen results, Dr. Villavicencio failed to address and/or document addressing the inconsistent test result for one of the screens. With regard to the February 2007 screen, Dr. Villavicencio did not document any subsequent

discussion with Patient 6 about the positive cannabinoid result. With regard to the April 2008 screen, Dr. Villavicencio did address the inconsistent test result with Patient 6 and documented it in the April and May 2008 progress notes. In particular, the patient was confronted and told to bring in the methadone bottle to substantiate his claim that he took old medication. Dr. Villavicencio even documented that Patient 6 had followed through. Dr. Villavicencio did continue to prescribe the same doses of controlled substances after those urine drug screens.

- g. Dr. Villavicencio began treating Patient 7 on October 31, 2005, for conditions including back pain and anxiety. Dr. Villavicencio prescribed long-acting and short-acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack of documentation in the patient record to support the use of such medications or the increases in dosages, and even though Patient 7 advised once that he was doing well. Dr. Villavicencio also prescribed methadone for Patient 7, although Dr. Villavicencio did not appropriately begin, titrate, or monitor the use of methadone by Patient 7. Additionally, Dr. Villavicencio prescribed medications to Patient 7 to treat conditions that he failed to document in his list of diagnoses.⁴⁷ The chart entries often appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. Further, Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, diagnosis, or treatment plan. Additionally, Dr. Villavicencio failed to address and/or document addressing Patient 7's noncompliance with clinical instructions. Although Dr. Villavicencio did refer Patient 7 to specialists and for physical therapy and testing, often Patient 7 did not timely comply with these referrals. When Patient 7 explained his failure to see the specialist because he was in prison, Dr. Villavicencio failed to address and/or document addressing with him the reason he had been in prison. When Patient 7 was examined by a specialist per his order, Dr. Villavicencio failed to follow and/or document consideration of the advice of the specialist. Further, according to test results appearing in Patient 7's chart, a test on his urine showed positive results for a drug Dr. Villavicencio had not prescribed (methadone) and negative for drugs he had prescribed (OxyContin, Percocet, Soma, and Neurontin). Although he did address the test results with Patient 7, Dr. Villavicencio accepted the explanation that the urine sample was not Patient 7's urine, as it did not test positive for marijuana, which he claimed he regularly used, and Dr. Villavicencio continued to prescribe the same or escalating doses of controlled substances without further testing. Dr. Villavicencio also failed to refer Patient 7 for substance-abuse counseling or treatment for his admitted use of marijuana. According to his medical record, Dr. Villavicencio last treated Patient 7 on April 4, 2008. On April 25, 2008, Patient 7 died.

⁴⁷Those medications included Ventolin and Nicoderm in November 2005, Nasonex in June 2006, Zithromax and Medrol Dosepak in February 2007, and Remeron and Depakote in March 2008. However, Dr. Villavicencio included information in his February 2007 progress note to explain the basis for prescribing Zithromax and Medrol Dosepak – Patient 7 had wheezing and a cough producing greenish phlegm. He also included information in his March 2008 progress note to reflect that Patient 7 had been diagnosed with bipolar disorder by another provider, which explains in part the Depakote prescription.

Dr. Kelly opined persuasively that Patient 7's medical record lacked documentation to support the use of the opiate medications and other medications, and the increase in dosage. The pain management specialist recommended ceasing the medications if possible, or prescribing only smaller doses on an "as needed" basis. Moreover, Patient 7 reported low pain levels on multiple occasions. Yet the opiate and other medications were continuously prescribed and increased. Similarly, the medical record demonstrates that Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, diagnoses, or treatment plan. The review of systems at the first office visit was "noncontributory" and the physical examination had insufficient information. There were no prior treatment records. Moreover, Dr. Villavicencio admitted that he had prescribed OxyContin, Percocet, Soma and Valium at the first office visit based on what Patient 7 had reported. Dr. Villavicencio further admitted that Patient 7's medical record lacked information that was required by the standard of care.

Dr. Villavicencio did not appropriately begin, titrate, or monitor the use of methadone by Patient 7. Additionally, Dr. Kelly presented convincing testimony about the need to cautiously begin, titrate, and monitor the use of methadone. Moreover, Dr. Villavicencio's own exhibit (Resp. Ex. FF) supports Dr. Kelly's statements. Dr. Villavicencio prescribed a 30-day supply of methadone. He also instructed Patient 7 to take one tablet three times a day. Nothing in the dosing instructions or in Patient 7's medical record reflects that methadone was begun slowly or titrated, or that its use was monitored at all.

- h. Dr. Villavicencio began treating Patient 8 on June 8, 2005, for conditions including back pain and anxiety. Dr. Villavicencio prescribed long-acting and short-acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack of documentation in the patient record to support the use of such medications, or the increases in dosages, and even though Patient 8 at times advised that he was doing "well." Dr. Villavicencio also prescribed medication and/or entered diagnoses for Patient 8 when there was no documentation in the chart indicating that Patient 8 had the condition Dr. Villavicencio had diagnosed and/or for which he prescribed the medication. For example, Dr. Villavicencio frequently entered a diagnosis of coronary artery disease into Patient 8's medical record, but there is no documentation in the chart to support the diagnosis. Although Dr. Villavicencio did order a stress test, there is no documentation in Patient 8's chart that the test was completed and/or that show the test results. The chart entries appeared verbatim from one visit to the next and identical to chart entries on other patients' records from similar time periods. Further, Dr. Villavicencio failed to perform and/or document an adequate history, initial examination, examination findings, diagnosis, or treatment plan. Although Dr. Villavicencio did refer Patient 8 to specialists and for tests and physical therapy, Dr. Villavicencio failed to take and/or document taking appropriate action when Patient 8 failed to keep the appointments and/or provide documentation of compliance with clinical instructions. Further, according to test results appearing in Patient 8's chart, a test of his urine showed a negative result for drugs that Dr.

Villavicencio had prescribed (OxyContin and Roxicodone). Dr. Villavicencio failed to address and/or document addressing the inconsistent test result and continued to prescribe the same or escalating doses of controlled substances. Dr. Villavicencio also failed to counsel or refer and/or document counseling or referring Patient 8 for substance-abuse counseling or treatment when Patient 8 admitted in June 2005 that he had used marijuana and when he admitted in June 2006 that he had taken medication excessively. According to his record, Dr. Villavicencio last treated Patient 8 on June 13, 2007. On June 15, 2007, Patient 8 died.

Dr. Kelly presented convincing testimony that Patient 8's medical record lacked documentation to support the use of the opiate medications and other medication, and the increases in dosages. Dr. Villavicencio increased the oxycodone medications many times and Dr. Kelly described those dosages as "stratospheric." There were no symptoms, physical examination findings or MRI findings that support such elevated doses. Moreover, it appears that Xanax was prescribed for anxiety, but there are no details of how anxiety was affecting Patient 8 at the time it was first prescribed, and little detail to explain the various increases in its dosage. Furthermore, Dr. Villavicencio admitted that his medical record for Patient 8 lacked information required by the standard of care.

Although Dr. Kelly did not criticize the initial doses of Percocet, Soma and Motrin prescribed at Patient 8's initial office visit for his low back pain, Dr. Kelly presented convincing testimony that Dr. Villavicencio failed to perform and/or document an adequate history, initial examination, examination findings, or diagnosis related to the low back pain. There was also no discussion with Patient 8 about any continued use of marijuana, which he had used to treat his pain. Moreover, there was no documentation to explain Dr. Villavicencio's diagnosis of coronary artery disease or the ordering of a stress test. Accordingly, Dr. Villavicencio failed to perform and/or document an adequate history, initial examination, examination findings, diagnosis, and treatment plan.

It appears from the medical record that Patient 8 admitted on June 9, 2006, that he had taken in two days all of the MS Contin and Percocet prescribed although they should have lasted at least two weeks. If read as written, Patient 8's admission establishes that he consumed his prescriptions excessively and contrary to clinical instructions. However, Dr. Villavicencio argued that the notation actually meant that Patient 8 had consumed all of the May 25, 2006 prescriptions of OxyContin, Percocet, Xanax, and Soma. If Dr. Villavicencio is correct, the medical record still establishes that Patient 8 consumed his medications excessively and contrary to clinical instructions. Dr. Villavicencio prescribed more than 16-day supplies on May 25 prescriptions and Patient 8 should not have run out of them by June 9, 2006. Moreover, the medical record establishes that Dr. Villavicencio failed to counsel or refer and/or document counseling or referring Patient 8 for substance-abuse counseling or treatment in response to Patient 8's admission.

- i. Dr. Villavicencio began treating Patient 9 on March 3, 2005, for conditions including back pain or sprain and CVA. Dr. Villavicencio prescribed long-acting and short-acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack of documentation in the patient record to support the use of such medications, or the increases in dosages, and even though Patient 9 advised a few times that she was "ok." The chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods and, at times, documented conflicting and/or inconsistent information. For example, Dr. Villavicencio diagnosed an upper respiratory infection, although there were no symptoms documented to support the diagnosis, and Patient 9's medical record documented that she had no cough, wheezing, or shortness of breath. Similarly, Dr. Villavicencio diagnosed nausea with vomiting and prescribed medication, although Patient 9's medical record documented that she had no nausea or vomiting. Dr. Villavicencio also failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, or treatment plan. Although Dr. Villavicencio did refer Patient 9 to specialists and for tests and physical therapy, he failed to take and/or document taking appropriate action when she failed to comply. Further, according to test results appearing in Patient 9's chart, a test of her urine showed a negative result for drugs Dr. Villavicencio had prescribed (Xanax, Soma, and Motrin). He failed to address and/or document addressing the inconsistent test result and continued to prescribe the same or escalating doses of controlled substances. Dr. Villavicencio also failed to counsel or refer and/or document counseling or referring Patient 9 for substance-abuse counseling or treatment when, according to her chart, Patient 9 tested positive for cocaine on February 7, 2006. Although Patient 9's medical record indicated that she would be discharged from his practice based on this positive test result, the doctor-patient relationship did not in fact terminate, and Dr. Villavicencio prescribed the same or additional medications at the same or escalating dosages, with no further drug tests. According to her medical record, Dr. Villavicencio last treated Patient 9 on October 4, 2006. On October 13, 2006, Patient 9 died.

Dr. Kelly testified convincingly that Patient 9's medical record lacked documentation to support the use of opiate and other medications, and the increases in dosages. There is no justification for the many prescriptions issued before the prior prescriptions would have been consumed, no justification for dosage increases, no explanation for prescribing Coumadin and Seroquel, and an insufficient explanation for prescribing Duragesic. Dr. Kelly amply pointed out that Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, or treatment plan. There were no details about Patient 9's pain, its location, associated symptoms and prior treatments. Dr. Villavicencio testified that he had prescribed Xanax for anxiety, but the medical record contains no symptoms or diagnosis related to anxiety. Dr. Villavicencio further admitted that Patient 7's medical record lacked information that was required by the standard of care.

- j.
 - i. Dr. Villavicencio began treating Patient 10 on April 19, 2005, for conditions including back pain, lumbrosacral sprain, and anxiety. Dr. Villavicencio

prescribed long-acting and short-acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack of documentation in the patient record to support the use of such medications, or the increases in dosages, and even though Patient 10 at times advised that he was doing okay. The chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods and also contained conflicting, inconsistent or unsupported information or documentation. For example, Dr. Villavicencio documented that Patient 10 had a cough and prescribed medication for it, although the same progress note in the chart also explicitly documented no cough, wheezing, or congestion. Further, Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, or treatment plan. Although Dr. Villavicencio did refer Patient 10 to specialists and for tests and physical therapy, Dr. Villavicencio failed to take and/or document taking appropriate action when Patient 10 failed to comply with clinical instructions. Furthermore, Dr. Villavicencio failed to take and/or document taking appropriate action when he received information that Patient 10 received controlled substances from more than one provider; instead, Dr. Villavicencio continued to prescribe the same medications at the same or increasing dosages. According to his medical record, Dr. Villavicencio last treated Patient 10 on December 7, 2006. On January 1, 2007, Patient 10 died.

Dr. Kelly opined persuasively that Patient 10's medical record lacked documentation to support the use of opiate medications and other medications, and the increases in dosages. Dr. Kelly found that the first oxycodone prescription was "very high," without a specific history to justify the dosage. He added that dosage increases occurred without specific justification and despite evidence of Patient 10 receiving controlled substances from other providers. Moreover, Dr. Kelly stated convincingly that Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, and treatment plan. He pointed out that there is a lack of documentation of symptoms, pattern of symptoms, and the severity of symptoms associated with Patient 10's back pain. He added that the back examination was incomplete because there was no range of motion, flexibility, extension and no straight-leg raise tests. Dr. Villavicencio further admitted that Patient 7's medical record lacked information that was required by the standard of care.

- ii. The evidence is insufficient to establish that Dr. Villavicencio also prescribed medication for Patient 10 when there was no documentation in his chart indicating that Patient 10 had the condition for which Dr. Villavicencio prescribed the medication. Dr. Kelly did not address this topic, nor was this topic otherwise addressed at hearing.

- k. i. Dr. Villavicencio began treating Patient 11 on March 2, 2005, for conditions including back pain, lumbar sprain, radiculopathy, hyperlipidemia and fibromyalgia. Dr. Villavicencio prescribed long-acting and at times short-acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications or the increases in dosages, and even though Patient 11 at times advised that she was doing "ok." The chart entries often appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. Further, Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, or treatment plan. Additionally, throughout his care and treatment of Patient 11, Dr. Villavicencio failed to address and/or document addressing Patient 11's noncompliance with clinical instructions. Although Dr. Villavicencio did refer Patient 11 to specialists and for physical therapy, Patient 11 failed to comply with all the referrals. When Patient 11 was examined by a specialist, Dr. Villavicencio failed to follow and/or document consideration of the recommendations of the specialist. Although Dr. Villavicencio discharged Patient 11 from his practice when a sample of her urine tested positive for a drug he did not prescribe (methadone) and negative for a drug he did prescribe (Roxicodone), there is no indication that Dr. Villavicencio sent her a written notice of termination. Dr. Villavicencio also failed to refer Patient 11 for substance-abuse counseling or treatment.

Dr. Kelly presenting compelling testimony that Patient 11's medical record lacked documentation to support the use of opiate medications and other medications, and the increases in dosages. Multiple examples were provided, including that numerous early refills were provided without justification, separate recommendations from a pain clinic and a pain management specialist were not followed, and increases in dosages were prescribed without justification. Additionally, Dr. Villavicencio prescribed Vicodin after Patient 11 complained of a rash from Percocet. Five days thereafter, he prescribed Percocet again, but did not include any explanation for it. Dr. Villavicencio admitted that he had increased opiates based only on Patient 11's oral representations of continuing pain. Plus, Patient 11 advised at times that she was doing "ok." Dr. Kelly's testimony demonstrated that Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, or treatment plan. Dr. Villavicencio further admitted that his medical record for Patient 11 lacked information required by the standard of care.

Dr. Villavicencio provided conflicting testimony regarding Patient 11's departure from his medical practice. Dr. Villavicencio's later testimony, that he had discharged her only from pain management and not from the practice, was not convincing or believable for three reasons. First, his own progress

note twice stated that he had discharged Patient 11 from the practice. Second, Dr. Villavicencio's initial testimony about the situation was clear and decisive. Third, Dr. Villavicencio's tone and demeanor later in his testimony when he changed his testimony were not convincing.

- ii. The evidence is insufficient to establish that Dr. Villavicencio prescribed medication (Zoloft and trazadone) for Patient 11 when the documentation in Patient 11's chart did not indicate that Patient 11 had the condition for which Dr. Villavicencio prescribed the medication. Dr. Kelly stated that the progress note from Patient 11's first visit did not have sufficient information to support those two prescriptions. However, he acknowledged that Patient 11's history form contained information that, while not the "best" medical recordkeeping, was an adequate basis for prescribing those two medications.
- l. i. Dr. Villavicencio began treating Patient 12 on November 2, 2005, for conditions including back pain, neck pain, hip pain, and anxiety. He prescribed long-acting and short-acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack of documentation in the patient record to support the use of such medications or the increases in dosages, and even though Patient 12 once advised that she was doing "well." The chart entries often appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. Further, he failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, or treatment plan. According to her record, he last saw Patient 12 on November 21, 2007, at which time he documented that the pain management physician to whom he referred Patient 12 had noted that she had become tolerant of her medications and should undergo inpatient treatment for detoxification. Patient 12 refused such treatment, but there is no documentation in the patient record that Dr. Villavicencio referred her for substance-abuse counseling or treatment, and he continued to prescribe controlled substances for Patient 12. On November 23, 2007, Patient 12 died.

Dr. Kelly stated convincingly that Patient 12's medical record lacked documentation to support the use of opiate medications and other medications, and the increases in dosages. For instance, methadone was increased multiple times without justification, methadone was introduced without a transition/tapering of other medications, an extra prescription of methadone was provided without verifications of the patient's claim, and methadone was prescribed different from what was recommended by the pain management specialist without explanation. Additionally, Dr. Kelly testified persuasively that Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, or treatment plan. He explained that Dr. Villavicencio documented no current status of Patient 12's pain, such as, severity, location, frequency, weakness, radiation, and radicular components.

Dr. Kelly added that the neck examination was normal, and the back examination did not indicate much regarding her range of motion, tenderness, and palpation, thus not supporting the diagnoses of neck pain and low back pain. Moreover, Dr. Villavicencio admitted that his medical record for Patient 12 lacked information that was required by the standard of care.

- ii. The evidence is insufficient to establish that (a) Patient 12's medical record contained inconsistent or contradictory information, (b) Dr. Villavicencio entered diagnoses for Patient 12 but documented no symptoms or examination findings in the medical record to support the diagnoses, or (c) he prescribed medication, but documented no symptoms or diagnoses in Patient 12's medical record to explain the need for the medication he prescribed. Dr. Kelly did not address this allegation and no other evidence was presented on this topic.

- m. i. Dr. Villavicencio began treating Patient 13 on August 22, 2005, for conditions including neck pain and rheumatoid arthritis. He prescribed short-acting opiate medications. He also prescribed other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of or reasons for such medications. He also prescribed medication for Patient 13 when the documentation in her chart did not indicate that Patient 13 had the condition for which he prescribed the medication. When Patient 13 claimed that her medications were stolen, he refused to replace the lost prescriptions but then prescribed medications which effectively replaced the medication claimed to be stolen and without any reduction for medication used. The chart entries often appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. Further, he failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, or treatment plan. According to her medical record, he last treated Patient 13 on December 14, 2005. On December 16, 2005, Patient 13 died.

Dr. Kelly demonstrated that Patient 13's medical record lacked documentation to support the use of the non-opiate medications Dr. Villavicencio prescribed, and that Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, or treatment plan. Dr. Kelly stated that Soma, Valium, and Xanax were not supported by the medical record, the diagnosis and treatment of rheumatoid arthritis was not confirmed by testing (the test was normal), and there was no diagnosis for the asthma medications (Advair and Ventolin) that he prescribed. Moreover, he found that there was no examination of Patient 13's nasal fracture and no joint examination at her first office visit. Furthermore, Dr. Villavicencio admitted that his medical record for Patient 13 lacked information that was required by the standard of care.

- ii. The evidence is insufficient to establish that Dr. Villavicencio prescribe long-acting opiate medications to Patient 13. Moreover, the evidence is insufficient to establish that Dr. Villavicencio inappropriately prescribed short-acting opiate medications despite a lack of documentation in the patient record to support the use of or reasons for such medications. Dr. Kelly found that the initial choice of treatment with Percocet and continued use of Percocet were minimally supported by the documentation in the medical record. Finally, the evidence does not establish that there was an increase in the dosage of any medications prescribed to Patient 13. Based on Dr. Kelly's statement that Vicodin and Valium were "pretty equivalent" to Percocet and Xanax, there were no increases in the dosages of the medications prescribed to Patient 13 over the course of treatment.

- n. i. Dr. Villavicencio began treating Patient 14 on June 15, 2005, for complaints including lumbosacral sprain, migraine, and back pain. He prescribed long-acting and short-acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack of documentation in the patient record to support the use of such medications, or the increases in dosages, and even though Patient 14 at times advised that he was doing well. Further, he failed to perform and/or document an adequate initial examination, examination findings, diagnosis, or treatment plan. Additionally, the chart entries often appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. When Patient 14 admitted that he had been in jail, Dr. Villavicencio failed to address and/or document addressing with him the reason he had been in jail. He also documented that Patient 14 did not receive his medications while in jail, although he failed to document how Patient 14 managed his pain. He also received information that Patient 14 may not have been taking and/or using his medication appropriately, including that another person had obtained possession of Patient 14's prescription for OxyContin, and including a call from Patient 14's parole officer that pills were missing. Although he documented discussing these occurrences with Patient 14, Dr. Villavicencio continued to prescribe the same medications at the same or increasing dosages. Additionally, Dr. Villavicencio failed to address and/or document addressing Patient 14's noncompliance with clinical instructions. Further, Patient 14 never obtained his MRI records, nor did he obtain another MRI although Dr. Villavicencio ordered an MRI in February 2008. Additionally, Dr. Villavicencio failed to refer Patient 14 to specialists.

Dr. Kelly presented convincing testimony that Patient 14's medical record lacked documentation to support the use of opiate and other medications and the increases in dosages. For example, Dr. Villavicencio prescribed both OxyContin and Percocet (140 mg of oxycodone per day) to Patient 14 at the first office visit, even though Patient 14 had been off methadone for a month and listed no other medications. Similarly, he testified strongly that Dr. Villavicencio

failed to perform and/or document an adequate initial examination, examination findings, diagnosis, or treatment plan. Dr. Kelly noted that the history was inadequate to support a migraine diagnosis; there was no information about the back pain's severity, radiation, and sensitivity; and a range of motion test, straight-leg test, and palpation were not conducted. Additionally, Dr. Villavicencio admitted that he provided "special treatment" to Patient 14, which included prescribing controlled substances when he would not prescribe them in such a manner to other patients. Moreover, Dr. Villavicencio admitted that his medical record for Patient 14 lacked information that was required by the standard of care.

Additionally, the medical record establishes that Patient 14 did not comply with clinical instructions and there was no response by Dr. Villavicencio. For instance, Patient 14 did not follow up physical therapy as ordered at his first office visit. It is possible that Patient 14 had one session of physical therapy, based on the information in the medical record. However, Patient 14 did not complete physical therapy.

- ii. The evidence is insufficient to demonstrate that, although he did refer Patient 14 for testing, Dr. Villavicencio failed to take and/or document taking appropriate action when Patient 14 failed to timely comply with orders for tests. Dr. Villavicencio ordered Patient 14 to obtain x-rays in September 2005. He obtained those x-rays in October 2005, which is timely. Also, Dr. Villavicencio ordered Patient 14 to obtain an echocardiogram in January 2008. By the next month's appointment, Patient 14 had not obtained the echocardiogram and Dr. Villavicencio ordered it again. The medical record ends at that point, and there is insufficient information to find that Dr. Villavicencio did not take appropriate action at following visits.
- o. i. Dr. Villavicencio began treating Patient 15, a minor, on September 21, 2005, for conditions including diabetes, headache, and back pain. He prescribed short-acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack of documentation in the patient record to support the use of such medications, or the increases in dosages. He also documented diagnoses in Patient 15's medical record (polycystic ovary and diabetes) when there were no symptoms or findings documented to support the diagnoses. Further, he failed to perform and/or document an adequate initial examination, examination findings, diagnosis, or treatment plan. Additionally, the chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. Although he did refer Patient 15 to specialists and for tests, he failed to take and/or document taking appropriate action when she failed to timely comply with the referrals or tests. Further, according to test results appearing in Patient 15's chart, on at least two occasions, tests of her urine showed results that were inconsistent with the medications he prescribed, including a

positive result for marijuana. Dr. Villavicencio failed to address and/or document addressing the inconsistent test results and instead continued to prescribe the same medications to Patient 15 at the same or increasing dosages. Additionally, when Patient 15's mother stated that she had given Patient 15 a prescription medication that had not been prescribed for Patient 15 (Soma), he failed to address and/or document addressing this matter with Patient 15 or her mother. He also failed to refer Patient 15 for substance-abuse counseling or treatment.

Dr. Kelly presented convincing testimony that Patient 15's medical record lacked information to support the use of opiate medications and other medications, and the increases in dosages. For instance, he concluded that prescribing Vicodin to a 13-year old was atypical and that non-opiate strategies should be tried first. Also, Dr. Kelly found no history, examination, or diagnosis that justified the Xanax prescriptions and an insufficient explanation for the Ambien prescriptions. Additionally, Dr. Kelly was compelling in concluding that Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, diagnosis, or treatment plan. He pointed out that the medical record is unclear about who treated Patient 15's diabetes, and lacked information about her history of polycystic ovary. Dr. Villavicencio acknowledged that the bases for prescribing Vicodin, Xanax, and Motrin were difficult to determine from his medical record. He also acknowledged that it is unusual to prescribe Ambien to a 13-year old. Moreover, Dr. Villavicencio admitted that his medical record for Patient 15 lacked information that was required by the standard of care.

- ii. The evidence is insufficient to establish that Dr. Villavicencio prescribed long-acting opiate medications to Patient 15.
- p. i. Dr. Villavicencio began treating Patient 16 on October 26, 2005, for conditions including anxiety, hypertension, and back pain. He prescribed short-acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack of documentation in the patient record to support the use of such medications, or the increase in dosage at Patient 16's third office visit. Further, he failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, or treatment plan. Additionally, the chart entries appeared verbatim from one visit to the next and identical to chart entries in other patients' records from similar time periods. Further, he failed to refer and/or document referring Patient 16 to specialists. He also failed to address and/or document addressing that Patient 16 was wearing an ankle monitor, that he had been caught selling cocaine, that he was getting drug screens on a regular basis and that his court trial had been rescheduled. According to his medical record, Dr. Villavicencio last treated Patient 16 on May 5, 2006. On May 12, 2006, Patient 16 died.

Dr. Kelly presented compelling testimony that Patient 16's medical record lacked documentation to support the use of opiate medications and other medications, and the increase in dosage. Similarly, he presented convincing testimony that Dr. Villavicencio failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis, or treatment plan. There was no history or examination related to the anxiety diagnosis. There was no detailed information regarding the location, radiation, frequency, severity, or length of Patient 16's back pain. There was also no range of motion or a straight-leg raise tests.

Although the medical record reflects that Dr. Villavicencio spoke with Patient 16 about the ankle monitor, he did not have that conversation when he first noticed the monitor, and then he did not address the issue or take further action after inquiring. Dr. Villavicencio's testimony that Patient 16 had not actually reported that he was "caught selling cocaine" was unconvincing and self-serving.

- ii. The evidence is insufficient to establish that Dr. Villavicencio prescribed long-acting opiate medications to Patient 16. The only opiate Dr. Villavicencio prescribed to Patient 16 was Percocet. Also, the evidence is insufficient to establish that Dr. Villavicencio failed to refer Patient 16 for tests. The medical record shows that Dr. Villavicencio ordered an MRI and an x-ray. Lastly, the evidence is insufficient to establish that Dr. Villavicencio documented diagnoses in Patient 16's medical record when there were no symptoms or findings documented to support the diagnoses. He only documented three diagnoses throughout the course of treating Patient 16 – low back pain, anxiety, and hypertension. He documented symptoms for all three diagnoses.

CONCLUSIONS OF LAW

1. The acts, conduct, and/or omissions of Jose Villavicencio, M.D., as set forth in Findings of Fact (2)(a), (2)(b)(i), (2)(c), (2)(d), (2)(e), (2)(f), (2)(g), (2)(h), (2)(i), (2)(j)(i), (2)(k)(i), (2)(l)(i), (2)(n)(i) and (2)(o)(i) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as set forth in Section 4731.22(B)(2), Ohio Revised Code.
2. Dr. Villavicencio's acts, conduct, and/or omissions as set forth in Findings of Fact (1) and (2)(a), (2)(b)(i), (2)(c), (2)(d), (2)(e), (2)(f), (2)(g), (2)(h), (2)(i), (2)(j)(i), (2)(k)(i), (2)(l)(i), (2)(m)(i), (2)(n)(i), (2)(o)(i) and (2)(p)(i) above, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as set forth in Section 4731.22(B)(6), Ohio Revised Code.

3. Dr. Villavicencio's acts, conduct, and/or omissions as set forth in Findings of Fact (1) and (2)(a), (2)(b)(i), (2)(c), (2)(d), (2)(e), (2)(f), (2)(g), (2)(h), (2)(i), (2)(j)(i), (2)(k)(i), (2)(l)(i), (2)(m)(i), (2)(n)(i), (2)(o)(i) and (2)(p)(i) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as set forth in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(D), Ohio Administrative Code.
4. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, a violation of any provision of Rule 4731-11-02 shall constitute a violation of Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code.
5. Dr. Villavicencio's acts, conduct, and/or omissions as set forth in Findings of Fact (1) and (2)(a), (2)(b)(i), (2)(c), (2)(d), (2)(e), (2)(f), (2)(g), (2)(h), (2)(i), (2)(j)(i), (2)(k)(i), (2)(l)(i), (2)(m)(i), (2)(n)(i), (2)(o)(i) and (2)(p)(i) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-21-02, Ohio Administrative Code.
6. Pursuant to Rule 4731-21-05, Ohio Administrative Code, a violation of any provision of Rule 4731-21-02 shall constitute a violation of Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code.
7. Additionally, Dr. Villavicencio's acts, conduct, and/or omissions as set forth in Finding of Fact (2)(k)(i) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-27-01, Ohio Administrative Code.
8. The evidence is insufficient to establish that Dr. Villavicencio's acts, conduct, and/or omissions as set forth in Findings of Fact (2)(b)(ii), (2)(j)(ii), (2)(k)(ii), (2)(l)(ii), (2)(n)(ii), and (2)(o)(ii) constitute any of the following:
 - "Failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as set forth in Section 4731.22(B)(2), Ohio Revised Code.
 - "A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as set forth in Section 4731.22(B)(6), Ohio Revised Code.
 - "[V]iolating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule

promulgated by the board,” as set forth in Section 4731.22(B)(20), to wit: Rule 4731-11-02(D), Ohio Administrative Code.

- “[V]iolating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as set forth in Section 4731.22(B)(20), to wit: Rule 4731-21-02. Ohio Administrative Code.
9. The evidence is insufficient to establish that Dr. Villavicencio’s acts, conduct, and/or omissions as set forth in Findings of Fact (2)(m)(ii) and (2)(p)(ii) constitute any of the following:
- “A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as set forth in Section 4731.22(B)(6), Ohio Revised Code.
 - “[V]iolating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as set forth in Section 4731.22(B)(20), to wit: Rule 4731-11-02(D), Ohio Administrative Code.
 - “[V]iolating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as set forth in Section 4731.22(B)(20), to wit: Rule 4731-21-02. Ohio Administrative Code.

Rationale for the Proposed Order

In an attempt to explain the practice deficiencies that are evident in this case, Dr. Villavicencio described himself as inexperienced and naïve when he opened his family-medicine practice in 2004 and while he was treating these 16 patients between 2005 through 2008. He also stated that he was “learning on the job.” He further stated that he continued to learn and improve his care and his medical practice.

The evidence demonstrates that Dr. Villavicencio’s knowledge in the area of pain management (and treating chronic pain patients) did improve somewhat over time, and his office policies and practices have changed since opening his practice. Moreover, the Hearing Examiner accepts that Dr. Villavicencio’s transition to private practice involved a “learning curve” with respect to the management of a medical practice.

However, the Hearing Examiner is not convinced that the substandard care that Dr. Villavicencio provided to these patients can be explained away in such a manner. Further the Hearing Examiner is not convinced that Dr. Villavicencio was inexperienced or naïve when he treated these patients

between 2005 and 2008. In fact, the Hearing Examiner finds Dr. Villavicencio's testimony in this regard wholly unconvincing and not credible. Several factors support this conclusion:

- Dr. Villavicencio practiced for a number of years as a physician before opening his own medical practice. During at least seven of those years, he saw many patients in multiple emergency rooms.
- Dr. Kelly testified convincingly that emergency-room physicians provide care and treatment to chronic pain patients, as well as drug-seeking patients, among others. Thus, in Dr. Villavicencio's work as an emergency-room physician before opening his medical practice, he must have encountered chronic pain patients as well as drug-seeking patients.
- Dr. Villavicencio chose to accept chronic pain patients such that 90 percent of his patient base between 2005 and 2008 consisted of chronic pain patients.
- Dr. Villavicencio attended two courses on pain management in 2006, and possibly other courses before the end of 2008. Thus, Dr. Villavicencio gained specific knowledge about treating chronic pain patients.
- Dr. Villavicencio asserted that he had contacted family physicians and pain management physicians, seeking their advice. Thus, Dr. Villavicencio learned even more about treating chronic pain patients and the practice of family medicine.

Moreover, Dr. Villavicencio admitted that he knowingly gave "special treatment" to Patients 8 and 14, and treated Patient 9 differently because he was sympathetic to her. There was nothing inexperienced or naïve in that regard – he issued "special treatment" prescriptions to those patients voluntarily.

Dr. Villavicencio provided care and treatment to Patients 1 through 16 that was below the standard of care. His substandard care was poor in numerous respects, which are chronicled in the Findings of Fact. Moreover, this was not isolated conduct. Numerous patients were involved and it took place over multiple years. These patients were adversely affected as well.

Dr. Villavicencio presented mitigating evidence – his own testimony and current policies and forms used in his medical practice – to demonstrate that he has changed his office procedures and his approach to treating chronic pain patients. The changes reflect improvements. Yet, the evidence overwhelmingly demonstrates that Dr. Villavicencio placed patients in serious danger.

Moreover, Dr. Villavicencio provided questionable, self-serving testimony during the hearing. For instance, he recalled in 2012 that Patients 2 and 15 brought old medicine bottles or other proof of prior medications to their appointments in 2005, but did not document such events at the time they occurred. Also, he recalled that, during a gap in his treatment of Patient 5 in 2006, the patient had been working in Kentucky, although nothing in the medical record would substantiate that claim. Additionally, he did not appear truthful during the hearing. For example, he provided conflicting testimony about whether Patient 11 was terminated from the medical practice. Furthermore, Dr. Villavicencio's attempt to explain away his notation that Patient 16 was "caught selling cocaine" was disingenuous.

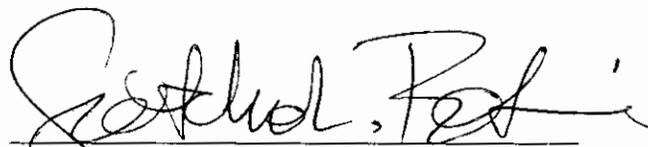
The evidence overwhelmingly establishes that Dr. Villavicencio's treatment of these patients placed them in serious danger. A physician who practiced in such a manner forfeits his or her privilege to practice medicine and surgery in this state. Dr. Villavicencio's certificate should be permanently revoked.

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of Jose Villavicencio, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

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



Gretchen L. Petrucci
Hearing Examiner



State Medical Board of Ohio

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

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

EXCERPT FROM THE DRAFT MINUTES OF SEPTEMBER 12, 2012

REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDERS

Dr. Mahajan announced that the Board would now consider the Reports and Recommendations, and the Proposed Findings and Proposed Order appearing on its agenda.

Dr. Mahajan asked whether each member of the Board had received, read and considered the hearing records; the Findings of Fact, Conclusions of Law, Proposed Orders, and any objections filed in the matters of: Jose Villavicencio, M.D.; Samuel J. Christian, M.D.; Terry Alan Dragash, D.O.; Yemi M. Fasakin, M.D.; Tumanya Nikol Jones, P.A.; Ali Khan, M.D.; Charmaine Nicole Reese; and Ernesto Compendio Tan, M.D.

A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Dr. Bechtel	- aye
	Mr. Hairston	- aye
	Dr. Suppan	- aye
	Dr. Steinbergh	- aye
	Dr. Mahajan	- aye
	Dr. Madia	- aye
	Dr. Talmage	- aye
	Ms. Elsass	- aye
	Mr. Kenney	- aye
	Dr. Ramprasad	- aye

Dr. Mahajan asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Dr. Bechtel	- aye
	Mr. Hairston	- aye
	Dr. Suppan	- aye
	Dr. Steinbergh	- aye
	Dr. Mahajan	- aye
	Dr. Madia	- aye
	Dr. Talmage	- aye
	Ms. Elsass	- aye
	Mr. Kenney	- aye
	Dr. Ramprasad	- aye

Dr. Mahajan noted that, in accordance with the provision in section 4731.22(F)(2), Ohio Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of any disciplinary matters. In the matter before the Board today, Dr. Strafford served as Secretary, Dr. Bechtel served as Supervising Member, and Dr. Talmage served as Secretary and/or Acting Supervising Member.

Dr. Mahajan reminded all parties that no oral motions may be made during these proceedings.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

.....
JOSE VILLAVICENCIO, M.D., Case No. 11-CRF-046
.....

Dr. Steinbergh moved to approve and confirm Ms. Petrucci's Findings of Fact, Conclusions of Law, and Proposed Order in the matter of Jose Villavicencio, M.D. Mr. Hairston seconded the motion.

.....
A vote was taken on Dr. Steinbergh's motion to approve:

ROLL CALL:	Dr. Strafford	- abstain
	Dr. Bechtel	- abstain
	Mr. Hairston	- aye
	Dr. Suppan	- aye
	Dr. Steinbergh	- aye
	Dr. Mahajan	- aye
	Dr. Madia	- aye
	Dr. Talmage	- abstain
	Ms. Elsass	- aye
	Mr. Kenney	- aye
	Dr. Ramprasad	- aye

The motion to approve carried.

State Medical Board of Ohio

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

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

April 13, 2011

Case number: 11-CRF- 046

Jose Villavicencio, M.D.
3339 Daglow Road
Columbus, Ohio 43232

Dear Doctor Villavicencio:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) From in or around 2005 to in or around 2008, in the routine course of your practice, you provided care and treatment for Patients 1 through 16 as identified on the attached Patient Key (**Key is confidential and to be withheld from public disclosure**). You inappropriately treated and/or failed to appropriately treat and/or failed to appropriately document your treatment of these patients.

Further, you repeatedly and/or continually treated patients by excessively and/or inappropriately prescribing medications. You also continued to prescribe controlled substances, without appropriately pursuing or documenting the pursuit of alternative non-narcotic therapies. Additionally, you failed to record in the patients' medical records the reason you prescribed medication and/or the need or reason you prescribed multiple medications.

You also repeatedly and/or continually treated patients without performing and/or documenting appropriate physical examinations or evaluations, and/or without utilizing and/or documenting appropriate diagnostic testing or other methods of evaluating the patients' health conditions, and/or without devising and/or documenting treatment plans, and/or without periodically reassessing or documenting the reassessment of the effectiveness of treatment for illnesses.

Mailed 4-14-11

Additionally, you failed to adequately and/or appropriately diagnose and/or document an adequate or appropriate diagnosis of the patients' medical conditions. You also failed to document in the patient record adequate findings to support your diagnoses.

Further, you repeatedly and/or continually treated patients without making appropriate and/or timely referrals to specialists.

You also failed to keep and maintain adequate records reflecting your care and treatment of the patients. The entries in the medical records frequently appeared verbatim from one office visit to the next and from one patient to another, with little or no changes.

(2) Examples of such prescribing and/or conduct identified in paragraph (1) include, but are not limited to, the following:

- (a) You began treating Patient 1 on or about June 7, 2005, for conditions including rash, anxiety, COPD, and/or back pain. You prescribed long acting and short acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications, or the increase in dosage. At times, you failed to record all required information for the medications you prescribed and often the chart entries appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. Further, you failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis or treatment plan. Although you did refer Patient 1 to specialists, you failed to take and/or document taking appropriate action when she failed to keep the appointments, nor did you take and/or document taking appropriate action when you learned that Patient 1 was receiving controlled substances from more than one provider. According to her medical record, you last treated Patient 1 on or about November 16, 2006. On or about November 17, 2006, Patient 1 died.
- (b) You began treating Patient 2 on or about August 15, 2005, for conditions including back pain, hyperlipidemia and/or neck pain. You prescribed long acting and short acting opiate medications, as well as carisoprodol, alprazolam and other medications, despite a lack or absence of documentation in the patient record to support the use of such medications or the increase in dosage, and even though Patient 2 at times advised that he was doing better. At times, you failed to record all appropriate information for the medications you prescribed and often the chart entries appeared verbatim from one visit to the next and identical to

chart entries from similar time periods of other patients. Further, you failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis or treatment plan. Although you did refer Patient 2 to specialists and for testing, you failed to take and/or document taking appropriate action when he failed to comply with these referrals after several months.

- (c) You began treating Patient 3 on or about July 5, 2005, for conditions including back pain, lumbar sprain and/or cervical sprain. You prescribed long acting and short acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications or the increase in dosage, and even though Patient 3 at times advised that she was doing better. You also prescribed medication for Patient 3 when the documentation in Patient 3's chart indicated that Patient 3 did not have the condition for which you prescribed the medication. For example, you prescribed Maxalt for headache, although there is no documentation of a complaint or symptom of headache in the chart on that visit and the medical record documents no headache. Further, the chart entries often appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. You also diagnosed conditions, recorded symptoms or complaints and/or prescribed medication for Patient 3 despite conflicting and/or inconsistent documentation in the patient record. For example, you prescribed Phenergan even though the chart documents no nausea, vomiting or diarrhea. Additionally, you documented that Patient 3 had wheezing, but you also documented no wheezing in the chart on the same date. Further, you failed to perform and/or document an adequate initial examination, examination findings, diagnosis or treatment plan. Additionally, throughout your care and treatment of Patient 3, you failed to address and/or document addressing Patient 3's noncompliance with clinical instructions. Although you did refer Patient 3 to specialists and for physical therapy and testing, there is no documentation that she ever complied with these referrals. Further, according to test results appearing in Patient 3's chart, on at least two occasions, tests on her urine showed negative results for controlled substances that you had prescribed. You failed to address and/or document addressing the inconsistent test results, as well as Patient 3's admission that she took controlled substances prescribed for others; instead, you continued to prescribe the same or escalating doses of controlled substances.
- (d) You began treating Patient 4 on or about October 12, 2005, for conditions including back pain, radiculopathy, acne and/or anxiety. You prescribed long acting and short acting opiate medications, as well as

carisoprodol, diazepam and other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications or the increase in dosage, and even though Patient 4 at times advised that he was doing better. You also diagnosed conditions and/or prescribed medication for Patient 4 despite conflicting and/or inconsistent documentation in the patient record. For example, at Patient 4's first visit, you diagnosed anxiety, although you failed to document any symptoms to support this diagnosis, and you prescribed Ultravate Cream, although you failed to document in the chart any symptoms or diagnosis to justify the prescription. Additionally, the chart entries often appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. Further, you failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis or treatment plan. You also failed to order appropriate tests to support your diagnoses or treatment and/or failed to make appropriate referrals. When Patient 4 admitted that he used medication prescribed for another, you failed to address and/or document addressing that you counseled Patient 4 against using medication prescribed for another. According to his medical record, you last treated Patient 4 on or about October 31, 2006. On or about November 3, 2006, Patient 4 died.

- (e) You began treating Patient 5 on or about May 25, 2006, for conditions including back pain and/or radiculopathy. You prescribed long acting and short acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications, or the increase in dosage. The entries in Patient 5's chart appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. Further, you failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis or treatment plan. Although you did refer Patient 5 to a specialist, you failed to follow and/or document considering the prescribing recommendations of the specialist, and you failed to take and/or document taking appropriate action when Patient 5 failed to return to the specialist as you ordered. Additionally, when Patient 5 indicated he previously was treated by another doctor, but chose to establish with you, alleging that his doctor did not understand his pain and would not give him the medications he claimed he needed and also agreed to pay cash if you did not accept insurance, you failed to discuss and/or document discussing this matter with Patient 5. There are no treatment records for Patient 5 between June 22, 2006, and September 5, 2006, nor is there any documentation of additional medication being prescribed and/or any documentation on how Patient 5 managed his pain

for the approximately six weeks after his medication would have been exhausted. According to his medical record, you last treated Patient 5 on or about October 10, 2006. On or about October 14, 2006, Patient 5 died.

- (f) You began treating Patient 6 on or about May 16, 2005, for conditions including lumbrosacral sprain, back pain, sciatica, and/or asthma. You prescribed long acting and short acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications or the increase in dosage, and even though Patient 6 at times advised that he was doing better. You also prescribed Methadone for Patient 6, although you did not appropriately begin, titrate or monitor the use of Methadone by Patient 6. The chart entries often appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. Further, you failed to perform and/or document an adequate initial examination, examination findings, diagnosis or treatment plan. Additionally, you failed to address and/or document addressing Patient 6's noncompliance with clinical instructions. Although you did refer Patient 6 to specialists and for physical therapy and testing, often Patient 6 did not timely comply with these referrals. When Patient 6 did appear for an examination by a specialist per your order, you failed to follow and/or document considering the advice of the specialist. Further, according to test results appearing in Patient 6's chart, on at least two occasions, tests on his urine showed positive results for cannabinoids, and on one occasion, showed a positive result for a drug you had not recently prescribed. You failed to address and/or document addressing the inconsistent test results and continued to prescribe the same or escalating doses of controlled substances. You also failed to refer Patient 6 for substance abuse counseling or treatment.

- (g) You began treating Patient 7 on or about October 31, 2005, for conditions including back pain and/or anxiety. You prescribed long acting and short acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications or the increase in dosage, and even though Patient 7 at times advised that he was doing better. You also prescribed Methadone for Patient 7, although you did not appropriately begin, titrate or monitor the use of methadone by Patient 7. Additionally, you prescribed medication to treat conditions that you failed to document in your list of diagnoses. The chart entries often appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients.

Further, you failed to perform and/or document an adequate initial examination, examination findings, diagnosis or treatment plan. Additionally, you failed to address and/or document addressing Patient 7's noncompliance with clinical instructions. Although you did refer Patient 7 to specialists and for physical therapy and testing, often Patient 7 did not timely comply with these referrals. When Patient 7 admitted his failure to see the specialist because he was in prison, you failed to address and/or document addressing with him the reason he was in prison. When Patient 7 was examined by a specialist per your order, you failed to follow and/or document considering the advice of the specialist. Further, according to test results appearing in Patient 7's chart, a test on his urine showed positive results for a drug you had not prescribed and negative for drugs you had prescribed. Although you did address the test results with Patient 7, you accepted his explanation that the urine sample was not his, as it did not test positive for marijuana, which he claimed he regularly used, and you continued to prescribe the same or escalating doses of controlled substances without further testing. You also failed to refer Patient 7 for substance abuse counseling or treatment for his admitted use of marijuana. According to his medical record, you last treated Patient 7 on or about April 4, 2008. On or about April 25, 2008, Patient 7 died.

- (h) You began treating Patient 8 on or about June 8, 2005, for conditions including back pain and/or anxiety. You prescribed long acting and short acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications, or the increase in dosage, and even though Patient 8 at times advised that he was doing better. You also prescribed medication and/or entered diagnoses for Patient 8 when there was no documentation in the chart indicating that Patient 8 had the condition you diagnosed and/or for which you prescribed the medication. For example, you frequently entered a diagnosis of coronary artery disease into Patient 8's medical record, but there is no documentation in the chart to support the diagnosis. Although you did order a stress test, there is no documentation in Patient 8's chart that the test was completed and/or that show the test results. The chart entries appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. Further, you failed to perform and/or document an adequate history, initial examination, examination findings, diagnosis or treatment plan. Although you did refer Patient 8 to specialists and for tests and physical therapy, you failed to take and/or document taking appropriate action when he failed to keep the appointments and/or provide documentation of compliance with clinical instructions. Further, according to test results appearing in

Patient 8's chart, a test of his urine showed a negative result for drugs you had prescribed. You failed to address and/or document addressing the inconsistent test result and continued to prescribe the same or escalating doses of controlled substances. You also failed to counsel or refer and/or document counseling or referring Patient 8 for substance abuse counseling or treatment when Patient 8 admitted that he used marijuana and when he admitted he had taken in two days medication, including MS Contin and Percocet, that should have lasted at least two weeks. According to his record, you last treated Patient 8 on or about June 13, 2007. On or about June 15, 2007, Patient 8 died.

- (i) You began treating Patient 9 on or about March 3, 2005, for conditions including back pain or sprain and/or CVA. You prescribed long acting and short acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications, or the increase in dosage, and even though Patient 9 at times advised that she was doing better. The chart entries appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients and, at times, documented conflicting and/or inconsistent information. For example, you diagnosed an upper respiratory infection, although there were no symptoms documented to support the diagnosis and Patient 9's medical record documented that she had no cough, wheezing or shortness of breath. Similarly, you diagnosed nausea with vomiting and prescribed medication, although Patient 9's medical record documented that she had no nausea or vomiting. You also failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis or treatment plan. Although you did refer Patient 9 to specialists and for tests and physical therapy, you failed to take and/or document taking appropriate action when she failed to comply. Further, according to test results appearing in Patient 9's chart, a test of her urine showed a negative result for drugs you had prescribed. You failed to address and/or document addressing the inconsistent test result and continued to prescribe the same or escalating doses of controlled substances. You also failed to counsel or refer and/or document counseling or referring Patient 9 for substance abuse counseling or treatment when, according to her chart, Patient 9 tested positive for cocaine on or about February 7, 2006. Although Patient 9's medical record indicated that she would be discharged from your practice based on this positive test result, in fact the doctor-patient relationship did not terminate, and you prescribed the same or additional medications at the same or escalating dosages, with no further drug tests. According to her medical record, you last treated

Patient 9 on or about October 4, 2006. On or about October 13, 2006, Patient 9 died.

- (j) You began treating Patient 10 on or about April 19, 2005, for conditions including back pain, lumbrosacral sprain and/or anxiety. You prescribed long acting and short acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications, or the increase in dosage, and even though Patient 10 at times advised that he was doing okay or better. You also prescribed medication for Patient 10 when there was no documentation in his chart indicating that Patient 10 had the condition for which you prescribed the medication. The chart entries appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients and also contained conflicting, inconsistent or unsupported information or documentation. For example, you documented that Patient 10 had a cough and prescribed medication for it, although the information in the chart documented no cough, wheezing or congestion. Further, you failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis or treatment plan. Although you did refer Patient 10 to specialists and for tests and physical therapy, you failed to take and/or document taking appropriate action when he failed to comply with clinical instructions. Nor did you take and/or document taking appropriate action when you received information that Patient 10 received controlled substances from more than one provider; instead, you continued to prescribe the same medications at the same or increasing dosages. According to his medical record, you last treated Patient 10 on or about December 7, 2006. On or about January 1, 2007, Patient 10 died.
- (k) You began treating Patient 11 on or about March 2, 2005, for conditions including back pain, lumbar sprain, radiculopathy, hyperlipidemia and/or fibromyalgia. You prescribed long acting and at times short acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications or the increase in dosage, and even though Patient 11 at times advised that she was doing better. You also prescribed medication for Patient 11 when the documentation in Patient 11's chart did not indicate that Patient 11 had the condition for which you prescribed the medication. The chart entries often appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. Further, you failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis or treatment plan. Additionally, throughout your care

and treatment of Patient 11, you failed to address and/or document addressing Patient 11's noncompliance with clinical instructions. Although you did refer Patient 11 to specialists and for physical therapy, Patient 11 failed to comply with all the referrals. When Patient 11 was examined by a specialist, you failed to follow and/or document considering the recommendations of the specialist. Although you discharged Patient 11 from your practice when a sample of her urine tested positive for a drug you did not prescribe and negative for a drug you did prescribe, there is no indication that you sent her a written notice of termination. You also failed to refer Patient 11 for substance abuse counseling or treatment.

- (l) You began treating Patient 12 on or about November 2, 2005, for conditions including back pain, neck pain, hip pain and/or anxiety. You prescribed long acting and short acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications or the increase in dosage, and even though Patient 12 at times advised that she was doing better. The chart entries often appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients and contained insufficient, inconsistent or contradictory information. For example, you entered diagnoses for Patient 12, but there were no symptoms or examination findings documented in the medical record to support the diagnoses. You also prescribed medication, but there were no symptoms or diagnoses documented in Patient 12's medical record to explain the need for the medication you prescribed. Further, you failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis or treatment plan. According to her record, you last saw Patient 12 on or about November 21, 2007, at which time you documented that the pain management physician to whom you referred Patient 12 had noted that she had become tolerant of her medications and should undergo inpatient treatment for detoxification. Patient 12 refused such treatment, but there is no documentation in the patient record that you referred her for substance abuse counseling or treatment and you continued to prescribe controlled substances for Patient 12. On or about November 23, 2007, Patient 12 died.

- (m) You began treating Patient 13 on or about August 22, 2005, for conditions including neck pain and/or rheumatoid arthritis. You prescribed long acting and short acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of or reasons for such medications or the increase in dosage. You also

prescribed medication for Patient 13 when the documentation in her chart did not indicate that Patient 13 had the condition for which you prescribed the medication. When Patient 13 claimed that her medications were stolen, you refused to replace the lost prescriptions but then prescribed medications which effectively replaced the medication claimed to be stolen and without any reduction for medication used. The chart entries often appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. Further, you failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis or treatment plan. According to her medical record, you last treated Patient 13 on or about December 14, 2005. On or about December 16, 2005, Patient 13 died.

- (n) You began treating Patient 14 on or about June 16, 2005, for complaints including lumbosacral sprain, migraine and/or back pain. You prescribed long acting and short acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications, or the increase in dosage, and even though Patient 14 at times advised that he was doing well. Further, you failed to perform and/or document an adequate initial examination, examination findings, diagnosis or treatment plan. Additionally, the chart entries often appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. When Patient 14 admitted that he had been in jail, you failed to address and/or document addressing with him the reason he was in jail. You also documented that Patient 14 did not receive his medications while in jail, although you failed to document how he managed his pain. You also received information that Patient 14 may not have been taking and/or using his medication appropriately, including that another person had Patient 14's prescription for OxyContin and a call from Patient 14's parole officer that pills were missing. Although you documented addressing these occurrences with Patient 14, you continued to prescribe the same medications at the same or increasing dosages. Additionally, you failed to address and/or document addressing Patient 14's noncompliance with clinical instructions. Although you did refer Patient 14 for testing, you failed to take and/or document taking appropriate action when Patient 14 failed to timely comply. Further, Patient 14 never obtained his MRI records, nor did he obtain another MRI, as you requested. Additionally, you failed to refer Patient 14 to specialists and for physical therapy.
- (o) You began treating Patient 15, a minor, on or about September 21, 2005, for conditions including diabetes, headache, and/or back pain. You prescribed long acting and short acting opiate medications, as well as

other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications, or the increase in dosage. You also documented diagnoses in Patient 15's medical record when there were no symptoms or findings documented to support the diagnoses. Further, you failed to perform and/or document an adequate initial examination, examination findings, diagnosis or treatment plan. Additionally, the chart entries appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. Although you did refer Patient 15 to specialists and for tests, you failed to take and/or document taking appropriate action when she failed to timely comply with the referrals or tests. Further, according to test results appearing in Patient 15's chart, on at least two occasions, tests on her urine showed results that were inconsistent with the medications you prescribed, including a positive result for marijuana. You failed to address and/or document addressing the inconsistent test results and instead continued to prescribe the same medications to Patient 15 at the same or increasing dosages. Additionally, when Patient 15's mother stated that she had given Patient 15 a prescription medication that had not been prescribed for Patient 15, you failed to address and/or document addressing this matter with Patient 15 or her mother. You also failed to refer Patient 15 for substance abuse counseling or treatment.

- (p) You began treating Patient 16 on or about October 26, 2005, for conditions including anxiety, hypertension and/or back pain. You prescribed long acting and short acting opiate medications, as well as other medications, both controlled and non-controlled, despite a lack or absence of documentation in the patient record to support the use of such medications, or the increase in dosage. You also documented diagnoses in Patient 16's medical record when there were no symptoms or findings documented to support the diagnoses. Further, you failed to perform and/or document an adequate initial examination, examination findings, history, diagnosis or treatment plan. Additionally, the chart entries appeared verbatim from one visit to the next and identical to chart entries from similar time periods of other patients. Further, you failed to refer and/or document referring Patient 16 to specialists or for tests. You also failed to address and/or document addressing that Patient 16 was wearing an ankle monitor, that he had been caught selling cocaine, that he was getting drug screens on a regular basis and that his court trial had been rescheduled. According to his medical record, you last treated Patient 16 on or about May 5, 2006. On or about May 12, 2006, Patient 16 died.

Your acts, conduct, and/or omissions as alleged in paragraphs (2)(a), (b), (c), (d), (e),

(f), (g), (h), (i), (j), (k), (l), (n) and (o) above, individually and/or collectively, constitute “[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2)(a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o) and (p) above, individually and/or collectively, constitute “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Additionally, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2)(a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o) and (p) above, individually and/or collectively, constitute “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(D), Ohio Administrative Code. Further, pursuant to Rule 4731-11-02(F), Ohio Administrative Code, a violation of any provision of Rule 4731-11-02 shall constitute a violation of Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2)(a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o) and (p) above, individually and/or collectively, constitute “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-21-02, Ohio Administrative Code. Further, pursuant to Rule 4731-21-05, Ohio Administrative Code, a violation of any provision of Rule 4731-21-02 shall constitute a violation of Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code.

Additionally, your acts, conduct, and/or omissions as alleged in paragraph (2)(k) above, individually and/or collectively, constitute “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-27-01, Ohio Administrative Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that “[w]hen the board refuses to grant a certificate to an applicant, revokes an individual’s certificate to practice, refuses to register an applicant, or refuses to reinstate an individual’s certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate.”

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.
Secretary

LAT/CDP/flb
Enclosures

CERTIFIED MAIL #91 7108 2133 3938 3022 3224
RETURN RECEIPT REQUESTED

CC: Douglas E. Graff
604 East State Street
Columbus, Ohio 43215-5341

CERTIFIED MAIL #91 7108 2133 3938 3022 3217
RETURN RECEIPT REQUESTED

**IN THE MATTER OF
JOSE VILLAVICENCIO, M.D.**

11-CRF-046

**APRIL 13, 2011, NOTICE OF
OPPORTUNITY FOR HEARING
PATIENT KEY**

**SEALED TO
PROTECT PATIENT
CONFIDENTIALITY AND
MAINTAINED IN CASE
RECORD FILE.**